STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676223	A. Building B. Wing	09/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayou Pines Care Center	4905 Fleming Street LA Marque, TX 77568

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review the facility failed to ensure personal privacy and confidentiality of personal and medical records was maintained for 2 (Hall A and Hall B) of 4 halls reviewed for privacy. LVN A and LVN B who worked Hall A and Hall B failed to hide the confidential health information of residents displayed on their work computers once they walked away. This failure could place residents at risk for HIPAA violations and experiencing a lack of privacy. Findings included:An observation on 8/21/25 at 10:31 am, revealed the nurse's station was in the middle of the facility surrounded by 4 hallways. At the nurse's station, thigh height desks were placed in a rectangular format and used to create a barrier from the walkway to the desk where the computer monitors were placed. Each computer monitor at the nurse's station faced outward towards the walkway and provided an open view of what was being inputted into the system by the nurses station. In between the nurse's station and Hall B, sat an unattended medication cart with the laptop screen opened on the MAR, with the screen slightly faced down. The screen was observed that way until 10:34 am. During that time, several guests were observed walking pass the screen. Visitors from a community camp were in the building, which included 3 adults and a small group of 8- 10 children. An observation on 8/21/25 at 2:53 pm, revealed the screen to a computer monitor at the nurse's station was left unattended and showed the MAR for 7 residents (names not captured). In plain view, the list of medications for those residents could be visibly read and a resident sat directly in front of the screen in a wheelchair. In an observation on 8/28/25 at 2:16 pm at the nurse's station, the screen to a computer monitor that faced Hall A was left unattended. On the screen was the MAR for 16 residents (names not captured), which included their picture, room number, and type of medications to be administered. Six residents were seated in wheelchairs around the nurse's station. During the investigation, the facility hosted an onsite event for staff and visitors. Once the event concluded, several staff and visitors mingled in the lobby and around the nurse's station before they headed to their destination. LVN A returned to the nurse's station and sat down at the unsecured computer screen. In an interview on 8/28/25 at 2:18 pm, LVN A stated that she had worked at the facility for 9 years and she worked from 7 am- 7 pm. She stated that the staff at the facility were not supposed to leave resident's private health information exposed and nurses should lock all screens before leaving them unattended. LVN A stated that she was supposed to lock the screen because of HIPAA to prevent disclosing any personal information. On 8/28/25 at 2:22 pm, the facility's HIPAA policy and personal health information was requested from the DON. In an interview on 8/28/25 at 3:45 pm, the DON stated that staff were supposed to lock the computer screen because of HIPAA. She explained that there were desks that surround the nurse's station that acted like a barrier, but information should not be left in plain view. In an interview on 8/28/25 at 4:00 pm, the ADM stated that they did not have a policy available and best practice should be followed. A HIPAA policy was not provided. In an interview on 8/28/25 at 4:07 pm, LVN B stated that on her nursing cart, she usually turned the computer screen facing downward and no one should be able to see her screen unless they were on the floor. She said the harm in leaving the screen up would be someone viewing another's personal information and residents should not be able to see the information either. She stated that sometimes she noticed nurses at the nurse's station would leave their computer screen unlocked, but they didn't realize that there was a screen they could click that would hide the information if they needed to walk away. The policy was to keep personal information hidden while you were not at your laptop or computer at the nurse's station.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of 1 (Resident #1) of 5 residents reviewed for pharmaceutical services. The facility failed to ensure Resident #1 received her Carbamazepine as prescribed due to her medication being placed in a bin for destruction instead of administered resulting in Resident #1 experiencing a seizure. The facility failed to ensure allegations of Resident #1's medications not being administered and being set aside or destruction were thoroughly investigated resulting in Resident #1's medication being destroyed instead of administered. The facility failed to ensure there was a system in place to document and track all medications being destroyed, including Resident #1 Carbamazepine. An IJ was identified on 9/15/25 at 1:48 pm. The IJ template was provided to the facility on 9/15/25 at 2:12 pm. While the IJ was removed on 9/16/25, the facility remained out of compliance at a scope of isolated and severity level of no actual harm with potential for more than minimal harm that is not IJ, due to the need for the facility to evaluate the effectiveness of the corrective action. This failure could place residents at risk for adverse side effects, illness, and possible hospitalization. Findings included: Record review of Resident#1's face sheet revealed a [AGE] year-old woman who was admitted to the skilled nursing facility on [DATE]. Her admitting diagnoses were cerebral palsy (brain damage that effects movement and posture), profound intellectual disabilities, and epilepsy (chronic neurological condition causing seizures). Record review of Resident #1's care plan disclosed that she utilized a feeding tube for meals and all medication was to be administered by way of g-tube (gastrostomy tube - a feeding tube that enters the stomach through a small opening in the abdomen to deliver nutrition, fluids, and medication). The care plan revealed that seizure medications should be administered as ordered. Record review of Resident #1's orders dated 11/07/2023 revealed she was to receive 1 Carbamazepine 200MG tablet (treated for epilepsy) via g-tube every 12 hours. Record review of Resident #1's TAR for August 2025 revealed that on 8/12/25 Carbamazepine 200 MG was marked given on the 7 pm- 7 am shift by LVN D and was marked given during the 7 pm- 7 am shift on 8/18/25 by LVN E. Record review of a progress note dated 8/9/25 at 7:11 am by LVN C revealed, Resident, non-verbal at baseline, history of seizures, observed to have two brief seizure episodes involving the upper extremities, each lasting approximately 10-15 seconds, during this shift. Resident returned to baseline alertness afterward, vitals stable. Attempted to Notify Provider at 7:10 am of observations and concern regarding possible sub-therapeutic seizure medication effect. Communicated with day shift (RN B) to Requested order for seizure medication therapeutic level lab draw for further evaluation will provider calls back. Record review of Resident #1's MDS (minimum data set) revealed that her baseline was at 0 and was severely impaired. There were functional limitations in her upper and lower extremities, she required the use of a wheelchair, and was dependent on staff for needs. Resident #1 also utilized a feeding tube and received anticonvulsant medication. In an interview on 8/21/25 at 11:52 am, RN A explained that Resident #1 had cerebral palsy, utilized a g-tube, was non-verbal, and was not alert and oriented. She explained that in the past, she would find medication packets of Carbamazepine 200 MG dated for the previous days that she was not on shift in the medication cart. She said she did not know why they were there, but she would take them out of the medication cart and place them in the cabinet inside of the locked medication room. She informed the DON in July 2025 regarding the found medication packets, and the DON responded, I'll deal with it. She stated that she had never seen Resident #1 have a seizure, but there was an issue with communication between the night shift and day shift at the facility. She stated the last time she found a medication packet was a week or 2 prior to 8/21/25. In an observation and interview on 8/21/25 at 12:28 pm, the DON showed the investigator a bucket of medication inside of a storage closet inside of her office. In the bucket, two packets of medication were found for Resident #1 that contained Carbamazepine 200 MG dated for 08/12/25 at 9:00 pm and 08/18/25 at 9:00 pm. The DON stated that those medication packets came from the facility's medication room and she collected and stored them in her storage room inside her office until the monthly destruction date (8/25/25). The DON explained that the facility utilized a pharmacy service that delivered pre-packaged medications daily, which included medication packets for up to 2 days in advance. The DON stated that for example, if the delivery was made today on 8/21/25, it would include medications for 8/22/25 and 8/23/25 as well. Each of the medication packets indicated the date and time the medication should be administered to each resident based off their