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	01/15/2026

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 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ staff that are licensed, certified, or registered in accordance with state laws. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews the facility failed to ensure registry verification was received that the individual had met competency evaluation requirements before they were allowed to work as a medication aide for one (Medication Aide A) of four staff employees reviewed for registration verification. The facility failed to ensure Medication Aide A had a current medication aide certification while employed at the facility and actively administering medications to the Residents. This failure could place residents at risk of receiving care from someone unqualified to provide care. Findings included: Review of Medication Aide A's personnel fire revealed she was hired on [DATE] and her medication aide certification expired on [DATE]. Review of Medication Aide A's time punch card revealed she worked from [DATE] (the day of the certification expired) until [DATE]. Review of Texas Nurse Aide Registrar for Medication Aide A on unknown date revealed the facility checked the NAR/EMR registry and the Medication Aide A's certificate was expired. Record review job description for a certified medication aide revealed, Knowledge base: Current Medication Aid Administration certification from Texas. Observation on [DATE] at 10:35 a.m. revealed Medication Aide A was passing medication from 100-400 medication cart. In an interview on [DATE] at 11:02 a.m. with Medication Aide A she stated she has been working at the facility, off and on, since 2015. She stated her mediation aide certification has been expired since December due to issues with her renewal payment. When she was asked if she understood the risk to the Residents of her passing medication with an expired licensing, she stated she did not know her medication aide certification had expired. She stated when she checked the TULIP database, it showed she was still active with no new date. She stated it was the DON's responsibility to ensure that her medication aide certification was current but usually it was the staff member. In an interview on [DATE] at 5:14 p.m. with the DON, she stated she has a list of all the medication aide certificate expiration dates and will keep up with the dates. She stated the reason why Medication Aide A was currently working the floor with expired Medication Aide certificate was because the staff procrastinated and did not get them renewed in time. She stated Medication Aide A's medication aide certification expired on [DATE] and she did not schedule her renewal class until [DATE]. She stated Medication Aide A did receive a notification that she has paid for the renewal class on [DATE]. She stated this week, Medication Aide A received an email that her payment did not process, so the Administrator paid for it again on [DATE]. She stated the whole time Medication A was working with expired certification, she kept checking TULIP which stated her certification was expired but active. She stated she does understand the risk to the Residents for a medication aide to be passing medications with an expired certification. She stated the risk to the Residents was the staff was not up to date on doing her medication pass correctly. Record review of facility's policy titled administration medication (revised [DATE]) revealed 1. Only persons licensed or permitted by this state to prepare, administer and document the administration of medication may do so.

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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 out of 2 staff (LVN A) and 2 of 3 residents (Resident#1 and Resident #2) reviewed for infection control. LVN A failed to ensure hand hygiene was performed prior to handling Resident #1's medication(s) and after administering Resident #1's medication(s). LVN A failed to ensure hand hygiene was performed prior to handling Resident #2's medication(s) and after administering Resident #2's medication(s). These failures could place residents at risk for cross contamination, infection and decline in health. Findings include: Resident #1 Record Review of Resident #1's admission record dated 01/13/2026, revealed the resident was an [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including peripheral vascular disease (circulatory condition where narrowed blood vessels reduce blood flow to different parts of the body), Secondary drug induced Parkinsonism (a movement disorder where medications block hormone effects on the brain causing slow movements, tremors and stiffness), and emphysema (a chronic lung disease where damage to the lung's air sacs causes reduced oxygen intake and results in difficulty breathing). Record review of Resident's #1's Annual MDS dated [DATE] revealed a BIMS score of 9 that suggested moderate cognitive impairment. Record review of Resident #1's Order Summary Report dated 01/13/2026 revealed an order for Atorvastatin 20 mg one tab by mouth every day at bedtime (7pm) and Gabapentin 100 mg Give 2 tablets by mouth every night to equal 200 mg (7pm). Record review of Resident #1's MAR printed 01/13/2026 revealed Atorvastatin 20 mg one tab by mouth every day at bedtime (7pm) and Gabapentin 100 mg Give 2 tablets by mouth every night to equal 200 mg (7pm), were documented as administered by LVN A on 12/25/2025 at 7pm. Resident #2 Record Review of Resident #2's admission record dated 01/15/2026, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including pneumonia (a lung infection that inflames the air sacs causing them to fill with fluid or pus), dementia (a decline in mental ability severe enough to interfere with daily life affecting memory, thinking, reasoning and language), and epilepsy (a chronic brain disorder defined by a tendency to have recurrent, unprovoked seizure). Record review of Resident's #2's quarterly MDS dated [DATE] revealed a BIMS score of 4 that suggested severe cognitive impairment. Record review of Resident #2's Order Summary Report dated 01/15/2026 revealed an order for Atorvastatin 10 mg give one tablet by mouth at bedtime (8pm) Record review of Resident #2's MAR printed 01/15/2026 revealed Atorvastatin 10 mg one tablet by mouth at bedtime (8pm) and was documented by LVN A as administered on 12/25/2025 at 8pm. Record review of facility staffing sheet dated 12/25/2025 on 01/13/2026 at 6:23pm revealed LVN A worked on 12/15/2026 on the 7pm to 7 am shift. Observation on 1/13/2026 at 11:15 am of video evidence dated 12/25/2025at 7:46pm revealed LVN A entered the room of Resident #1 and Resident #2 holding 2 small clear medication administration cups in her ungloved, bare hands. LVN A walked to Resident #1's bedside table and placed both cups down on Resident #1's bedside table and without washing her hands or sanitizing them with ABHS or donning gloves, proceeded to administer Resident #1 her medications. Handling and maneuvering Resident #1's beverage straw with her bare hands and handing her the cup of medications. LVN A was observed in the video then picking up the second cup of medications off of Resident #1's bedside table and walking to the bedside of Resident #2 and without washing her hands or sanitizing then with ABHS or donning gloves, proceeded to administer Resident #2's medications from the clear plastic administration cup. LVN A was then observed leaving the room without washing her hands or using ABHS. Interview and observation of video evidence (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	01/13/2026 at 11:36 am with the DON who said LVN A should have washed her hands before she administered Resident #1's medications and then washed her hands again before administering Resident #2's medications. The DON said they did not know why LVN A had not washed her hands or used ABHS or donned or doffed gloves. The DON said that was not what they trained staff to do during medication administration. The DON said they would need to conduct a 1:1 in-service training with LVN A. The DON said LVN A should have washed her hands and because she did not, it was an infection control issue because she could pass germs from one resident to another. Interview and observation of video evidence 01/13/2026 at 11:36 am with Administrator who said LVN A should have washed her hands before she administered Resident #1's medications and then washed her hands again before administering Resident #2's medications. The Administrator said that the DON and nursing staff were responsible for ensuring staff were trained properly on medication administration. Unable to interview LVN A prior to facility exit. Attempted telephone interview with LVN A on 01/13/2026 at 6:15pm. Attempted telephone interview with LVN A on 01/15/2026 at 9:43pm. Record review of policy Infection Control Guidelines for all Nursing Procedures dated revised October 2010 revealed: a. Before and after direct contact with residents.