

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676282	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/10/2025
NAME OF PROVIDER OR SUPPLIER Bayou Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 4141 S Braeswood Blvd Houston, TX 77025	

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on 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 one resident (CR #1) of four residents reviewed for medication administration. -CR #1 had an order for an extended-release anti-Parkinsonism medication but was given the regular-release medication instead.-The error was repeated for one month before the resident's family member discovered the error.The failure placed residents at risk for health conditions not being adequately treated. Findings Include:Record review of the admission Record for CR #1 revealed she was [AGE] years old and was admitted to the facility on [DATE]. Her diagnoses included, but were not limited to, Parkinson's disease (a progressive movement disorder that occurs when brain cells stop producing enough of the brain chemical dopamine, leading to symptoms like tremor, stiffness, and slowness of movement), dementia, lack of coordination, and cognitive communication disease. She was discharged on 07/06/2025 to a hospital.Record review of a physician's order dated 06/05/2025 (date of admission) revealed CR #1 was to receive Carbidopa-Levodopa oral tablet (Regular-Release) 25-100 mg tablets, two tablets by mouth three times a day for Parkinson's.Record review of a different physician's order dated 06/05/2025 revealed CR #1 was to receive Carbidopa-Levodopa ER (Extended-Release) oral tablet 25-100 mg, one tablet by mouth at bedtime (8:00 p.m.) for Parkinson's. Record review of a physician's order dated 06/06/2025 revealed staff was to crush medications and/or open capsules for CR #1.Record review of the June 2025 MAR for CR #1 revealed the staff initialed that the Carbidopa-Levodopa ER 25-100 mg tablet scheduled for 8:00 p.m. was administered nightly from 06/05/2025 to 06/30/2025.Record review of the July 2025 MAR for CR #1 revealed the resident refused the Carbidopa-Levodopa ER on [DATE]. The staff had initialed that the Carbidopa-Levodopa ER tablet was administered nightly from 07/02/2025 to 07/05/2025 with no missed doses.n an interview via telephone on 11/10/2025 with CR #1's family member, the family member said the facility was not administering CR #1's Carbidopa-Levodopa ER. She said she went to the facility to visit CR #1. She said she noticed increased tremors and ataxia (loss of ability to control muscle movement). She said she was talking with the medication aide who was preparing CR #1's nighttime medications. She said she noticed that CR #1's Carbidopa-Levodopa ER tablets were not in the drawer. She said the medication aide was going to administer a regular-release tablet instead of the ER. The family member said she and the medication aide looked in the bottom drawer of the cart, and the Carbidopa-Levodopa ER tablets were in a locked compartment. She said she called EMS to take the resident to the hospital. In an interview on 11/10/2025 at 3:30 p.m., the[BR1] DON said CR #1 was not administered the Carbidopa-Levodopa ER from the admission date (06/05/2025) to the date of discharge (07/06/2025), but she was administered the regular-release. Record review of the Medication Error Report dated 06/06/2025 revealed CR #1 was administered the Carbidopa-Levodopa regular-release tablets.In an interview via telephone on 11/10/2025 at 4:20 p.m., Physician A said he was aware CR #1 had one order for the Carbidopa-Levodopa immediate release and one order for Carbidopa-Levodopa ER. He said the resident went to the hospital for syncope (fainting).In an interview via telephone on 11/10/2025 at 4:30 p.m., Pharmacist B said that a possible complication of administering immediate-release Carbidopa-Levodopa instead of ER would be breakthrough tremors during the night. Record review of the facility policy Administering Oral Medications (revised October 2010) read, in part, .Steps in Procedure.6. Check the label on the medication and confirm the medication name and dose with the MAR.</p>		