STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676309	A. Building B. Wing	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baywood Crossing Rehabilitation & Healthcare Cente	5020 Space Center Blvd Pasadena, TX 77505

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident had the right to be informed, in advance, of the care to be furnished for 1 (Resident #1) of 10 residents reviewed for pharmacy services. The facility failed to ensure that a consent was signed by Resident #1 for Mirtazapine (an antidepressant medication). The failure could place residents at risk of not having an opportunity to refuse medications, ask questions regarding medications and/or be knowledgeable regarding side effects.Findings included: Record review of Resident #1's face sheet dated 4/2/26, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including fracture of unspecified part of neck of left femur. Resident #1's face sheet also revealed that she was her own responsible party. Record review of Resident #1's admission MDS dated [DATE], section C (Cognitive Patterns) revealed a BIMS score of 15 that indicated cognition was intact (13-15).Record review of Resident #1's discharge MDS dated [DATE], section N (Medications) revealed Resident #1 was taking an antidepressant in the last 7 days. Record review of Resident #1's physician orders as of 2/18/26 revealed order for Mirtazapine oral tablet 7.5 mg with instructions to give 1 tablet by mouth at bedtime related to adjustment disorder with mixed anxiety and depressed mood with order and start date of 2/11/2026. Record review of Resident #1's February 2026 MAR revealed administration of Mirtazapine oral tablet 7.5 mg with instructions to give 1 tablet by mouth at bedtime on 2/12/26, 2/13/26, 2/14/26, 2/15/26, 2/16/26 and 2/17/26. Administration on 2/12/26 was signed by MA A. Record review on 4/1/26 at 1:55 p.m. of Resident #1's electronic medical record did not reveal a consent for Mirtazapine.Record review of the Intake Investigation Worksheet created 3/31/2026 revealed Resident #1 had passed away after being discharged from the facility. During interview on 4/3/26 at 9:29 a.m., the ADON said she was filling in for the DON since he was out on medical leave during the investigation. The ADON said Mirtazapine was a medication that should have had a consent. The ADON confirmed that Mirtazapine was given per Resident #1's February 2026 MAR and there was not a consent in the electronic medical record and there should have been. The ADON said when the nurse gets the order, before they proceed, the nurse was supposed to get the consent from the responsible party or the resident if they were their own responsible party. The ADON said she was over psychotropics and this included checking the order for psychotropics, appropriate diagnosis, monitoring order, consent and care plan were completed. The ADON said if a consent was not obtained for a psychotropic medication the resident would not know the warning signs to be aware of. The ADON said the consent was obtained so the resident or responsible party understood the risk and benefits. The ADON said that was why the nurses were told that the medication had to go on hold until the consent could be obtained. On 4/3/26 at 11:52 a.m., the surveyor attempted to contact MA A but was unable to reach MA A via phone. Record review of the facility's policy Psychotropic Medication Use revised January 2025 revealed Residents will only receive psychotropic medications when necessary to treat specific conditions for which they are indicated/effective and after informed consent is obtained and Antidepressant, antianxiety, sedative, hypnotic, and mood stabilizing medications consents will be obtained and will be recorded in the electronic health record.

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain medical records on each resident that are accurately documented for 5 (Resident #1, Resident #2, Resident #3, Resident #4 and Resident #5) of 10 residents reviewed for resident records.1. The facility failed to ensure that antidepressant monitoring documentation was accurate and/or complete for Resident #1. 2. The facility failed to ensure that wound care documentation was accurate and/or completed for Resident #1, Resident #2, Resident #3, Resident #4 and Resident #5.3. The facility failed to ensure that Resident #1 was seen by a physician during her admission at the facility from 1/13/2026 through 2/18/2026. This failure could place residents at risk of an inaccurate medical record and could place the residents at risk of harm and health decline and/or possible missed diagnosis. Findings included: Record review of Resident #1's face sheet dated 4/2/26, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including fracture of unspecified part of neck of left femur. Face sheet also revealed Resident #1 was discharged on 2/18/26. Under care providers on Resident #1's face sheet MD A was listed as primary physician; PA A was listed as physician assistant and NP A was listed as nurse practitioner. Record review of Resident #1's admission MDS dated [DATE], section C (Cognitive Patterns) revealed a BIMS score of 15 that indicated cognition was intact (13-15). Record review of Resident #1's discontinued/completed physician orders revealed admitted to BWC under the care of MD A with revision date of 1/13/26 and end date of 2/22/26. Record review of Resident #1's physician progress notes revealed a progress notes written by NP A on 1/15/26, 1/20/26 1/22/26, 1/27/26, 2/3/26, 2/4/26, 2/6/26, 2/9/26, 2/10/26, 2/18/26 and progress notes written by PA A on 1/21/26, 1/24/26, 1/29/26, 2/10/26. Record review on 4/1/26 at 12:21 p.m. of the miscellaneous documents in the electronic medical record revealed physician notes for surgical, pain and psychology/psychiatry. Record review of the Intake Investigation Worksheet created 3/31/2026 revealed Resident #1 had passed away after being discharged from the facility. During interview on 4/1/26 at 2:32 p.m., the Administrator provided a progress note for Resident #1 dated 1/16/26 at 12:05 p.m. written by PA A and said the progress note said, discussed with MD A and also showed the surveyor in the note it was written Discussed with MD A. The Administrator denied having any progress notes for Resident #1 written by MD A. During interview on 4/3/26 at 8:21 a.m., the ADON said the DON was out on medical leave during the investigation. During interview on 4/3/26 at 9:29 a.m., the ADON said she was filling in for the DON since he was out on medical leave during the investigation. The ADON said either the attending or the PA or NP did the admission visits for residents. The ADON said usually for skilled residents it had to be a physician (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unless the physician was the physician of record at the hospital as it would be continuation of care. On 4/3/26 at 11:02 a.m., surveyor attempted to contact PA A via phone and left message with request to call surveyor. During interview on 4/3/26 at 11:03 a.m., MD A said PA A will see skilled nursing residents three times a week and the long term residents as needed. MD A said that he and PA A would both see residents. MD A said he and PA A both saw residents during the first 72 hours and would discuss the residents. MD A said he saw Resident #1 during her stay at the facility and never saw her in the hospital and was not one of his hospital patients. MD A said he did not have a way to attest the notes so there would not be notes written by him. MD A said PA A wrote in his notes that he discussed with MD A, and he had seen that when reviewing PA A's notes. MD A said, I don't have a way to edit and say I agree with PA A's note. MD A said I have been having him write the notes referring to PA A. During interview on 4/3/26 at 12:58 p.m., the Administrator said she knew the policy that the physician had to do the initial visit. The Administrator said if the physician did not do the initial visit the effect on the resident was that a diagnosis could be missed . Record review of facility's policy Physician Visits revised April 2013 revealed The Attending Physician must visit his/her patients at least once every thirty (30) days for the first ninety (90) days following the resident's admission, and then at least every sixty (60) days thereafter. Findings included: Resident #1Record review of Resident #1's face sheet dated 4/2/26, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including fracture of unspecified part of neck of left femur and adjustment disorder with mixed anxiety and depressed mood. Face sheet also revealed Resident #1 was discharged on 2/18/26. Under care providers on Resident #1's face sheet MD A was listed as primary physician; PA A was listed as physician assistant and NP A was listed as nurse practitioner. Record review of Resident #1's admission MDS dated [DATE], section C (Cognitive Patterns) revealed a BIMS score of 15 that indicated cognition was intact. Record review of Resident #1's discharge MDS dated [DATE], section N (Medications) revealed Resident #1 was taking an antidepressant in the last 7 days. Section M revealed two unstageable pressure ulcers. Record review of Resident #1's physician orders as of 2/18/26 revealed order for antidepressant medication monitoring every shift with instructions to document N if none were observed and document Y and complete a progress note if side effects were observed with start date of 1/26/26. Physician orders also included orders for Mirtazapine (antidepressant medication) oral tablet 7.5 mg with instructions to give 1 tablet by mouth at bedtime with start date 2/11/26 and Sertraline (antidepressant medication) 25 mg with instructions to give 3 tablets by mouth one time a day with start date of 2/4/26. Record review of Resident #1's discharged and completed physician orders revealed orders for wound location of left buttock with instructions to apply Santyl, calcium alginate and covered with 4x4 bordered gauze one time a day with start date of 1/14/26 and end date of 2/13/26, wound location of (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	coccyx with instructions to apply Santyl, calcium alginate and covered with 4x4 bordered gauze one time a day with start date of 1/14/26 and end date of 2/22/26. Record review also revealed admitted to BWC under the care of MD A with revision date of 1/13/26 and end date of 2/22/26. Record review of Resident #1's January 2026 TAR revealed no documentation on 1/24/26, 1/25/26 and 1/31/26 for treatment of wound locations of left buttock and coccyx with instructions to apply Santyl, calcium alginate and cover with 4x4 bordered gauze. Record review of Resident #1's February 2026 MAR revealed Y was documented for antidepressant medication monitoring for day shift and evening on 2/15/26 by LVN D, night shift on 2/15/26 by LVN E and day shift on 2/16/26 by LVN F. Instructions included Document Y and complete a progress note if side effects are observed. Record Review of Resident #1's February 2026 TAR revealed no documentation on 2/9/26 and 2/18/26 for treatment of wound location of coccyx with instructions to apply Santyl, calcium alginate and cover with 4x4 bordered gauze. No documented revealed on 2/9/26 for treatment of wound location of left buttock with instructions to apply Santyl, calcium alginate and cover with 4x4 bordered gauze Record review of Resident #1's physician progress notes revealed a progress notes written by NP A on 1/15/26, 1/20/26 1/22/26, 1/27/26, 2/3/26, 2/4/26, 2/6/26, 2/9/26, 2/10/26, 2/18/26 and progress notes written by PA A on 1/21/26, 1/24/26, 1/29/26, 2/10/26. Record review of Resident #1's progress notes from 2/15-2/16/26 did not reveal any progress notes regarding side effects related to antidepressant monitoring. Record review of Resident #1's care plan with last care plan review completed 1/21/26 revealed focus of use of antidepressant medication with intervention to monitor and document side effects and adverse reactions to antidepressant therapy. Record review of the Intake Investigation Worksheet created 3/31/2026 revealed Resident #1 had passed away after being discharged from the facility. Record review of Resident #1's N Adv – Skin Check progress note dated 1/16/26 revealed wounds to left gluteus with measurements of 1 centimeter length, 0.7 centimeter width and 0.1 centimeter depth and to coccyx with measurements of 1.6 centimeter length, 3.6 centimeter width and 0.1 centimeter depth. Record Review of Resident #1's surgical note on 1/29/26 by MD B revealed wound progress of the wounds to her coccyx and left ischium had decreased in size. Note also revealed that healing of these wounds can not be guaranteed considering the patient diagnoses and risk factors that impact the healing process of these wounds. Record review of Resident #1's N Adv – Skin Check progress note dated 1/30/26 revealed wounds to left gluteus with measurements of 0.6 centimeter length, 0.5 centimeter width and 0.2 centimeter depth and to coccyx with measurements of 1.1 centimeter length, 2.1 centimeter width and 0.2 centimeter depth. Record review of the Intake Investigation Worksheet created 3/31/2026 revealed Resident #1 had passed away after being discharged from the facility. Record review on 4/1/26 at 12:21 p.m. of the miscellaneous documents in the electronic medical record revealed physician notes for surgical, pain and psychology/psychiatry. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2Record review of Resident #2's face sheet dated 4/3/26, revealed the resident was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses including senile degeneration (progress decline in cognitive function) of the brain. Record review of Resident #2's significant change MDS dated [DATE], section C (Cognitive Patterns) revealed a BIMS score of 6 that indicated severe cognitive impairment (0-7). Record review of Resident #2's N Adv – Skin Check progress note dated 2/2/26 revealed wounds to buttocks with measurements of 0.8 centimeter length, 1.3 centimeter width and 0.2 centimeter depth. Record review of Resident #2's N Adv – Skin Check progress note dated 2/23/26 revealed wounds to right heel with measurements of 4.2 centimeter length, 3 centimeter width and 0 centimeter depth, buttocks with measurements of 0.1 centimeter length, 0.1 centimeter width and 0.1 centimeter depth and possible deep tissue injury to right lateral calf. Record Review of Resident #2's surgical note on 3/26/26 by MD B revealed wound progress of the left buttock wound had decreased in size and right heel wound was undetermined as it was the first visit. Note also revealed that Resident #2 has a chronic wound which may or may worsen as a result of chronic comorbidities, restricted mobility, and thinning skin. Record review of Resident #2's physician orders with active orders as of 4/3/26 revealed order for wound location to left buttock (shear injury) with instructions to apply zinc oxide and nystatin powder and leave open to air one time a day with start date of 3/26/26. Record review of Resident #2's March 2026 TAR revealed no documentation on 3/1/26 and 3/2/26 for treatment of wound location of left buttock (MASD with opening) with instructions to apply collagen to wound, zinc oxide to peri wound and cover with 4x4 bordered gauze one time a day with order date of 1/29/26 and discontinue date of 3/2/26. No documentation on 3/28/26 and 3/31/26 for treatment of wound location of left buttock (shear injury) with instructions to apply zinc oxide, nystatin power and leave open to air one time a day with order date of 3/26/26. No documentation on 3/8/26 for treatment of wound location of left lateral mid foot with instructions to apply betadine and cover with 4x4 bordered gauze one time a day with order date of 3/6/26 and discontinue date of 3/12/26. No documentation on 3/1/26 and 3/8/25 for treatment for wound location of right heel with instructions to apply betadine and cover with 6x6 bordered gauze one time a day with order date of 2/23/26 and discontinue date of 3/12/26. No documentation on 3/1/26 and 3/2/26 for treatment of right lateral leg possible deep tissue injury with instructions to apply betadine and leave open to air one time a day with order date of 2/23/26 and discontinue date of 3/2/26. Observation on 4/1/26 at 10:42 a.m. revealed Resident #2 was clean and dressed covered with blankets lying in bed with her eyes closed and no foul odors noted. During interview on 4/1/26 at 10:42 a.m., Resident #2's family said the majority of Resident #2's care was pretty good and denied any concerns regarding neglect. Resident #2's family said Resident #2 had a sore on her butt and the staff putting salve or cream on the area when they change her. Resident #3Record review of Resident #3's face sheet dated 4/3/26, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnosis including cerebral infarction (stroke). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #3's quarterly MDS dated [DATE], section C (Cognitive Patterns) revealed a BIMS score of 9 that indicated moderate cognitive impairment. Section M revealed one stage 4 pressure ulcer and one unstageable pressure injury presenting as deep tissue injury. Record Review of Resident #3's surgical note on 2/19/26 by MD B revealed wound progress of the left 5th toe wound as being unchanged in size and right lateral foot wound. Record review of Resident #3's N Adv – Skin Check progress note dated 3/30/26 revealed wounds to right lateral foot of non-blanchable erythema, left lateral foot of deep tissue injury, other skin issues to the left dorsum 4th and 5th digits and right lateral foot. Record review of Resident #3's physician orders with active orders as of 4/3/26 revealed orders for would location of left and right lateral foot with instructions to apply betadine and cover with dry dressing one time a day with start date of 4/3/26. Record review of Resident #3's March 2026 TAR revealed no documentation on 3/1/26 and 3/8/26 for treatment of wound location to left 5th toe with instructions to apply collagen power and cover with 4x4 bordered gauze one time a day and to right lateral foot with instructions to apply betadine and cover with 4x4 bordered gauze with order date of 1/23/26 and discontinue date of 3/12/26. No documentation on 3/23/26, 3/27/26, 3/28/26, 3/29/26 and 3/30/26 for treatment of wound to right lateral food with instructions to apply calcium alginate with honey and cover with 4x4 bordered gauze one time a day with order date of 3/19/26 and discontinue date of 3/30/26. Observation on 4/2/26 at 9:42 a.m. revealed Resident #3 was clean and dressed lying in bed. Dressings to both of Resident #3's feet were visible and were clean, dry and intact with no foul odors noted. Observation on 4/3/26 at 2:28 p.m. revealed Resident #3 was clean and dressed lying in bed. Dressings to both of Resident #3's feet were visible and were clean, dry and intact with no foul odors noted. During interview on 4/3/26 at 2:28 p.m., Hospice Nurse B denied any concerns with Resident #3's care and said they take really good care of her. Hospice Nurse B answered yes when asked if Resident #3's wound dressings were clean when she saw her at the facility. During interview on 4/3/26 at 2:29 p.m., LVN B said the wound of Resident #3's left foot was acquired during her last hospitalization. Resident #4Record review of Resident #4's face sheet dated 4/3/26, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including chronic respiratory failure with hypoxia (decreased oxygen levels). Record review of Resident #4's quarterly MDS dated [DATE], section C (Cognitive Patterns) revealed a BIMS score of 3 that indicated severe cognitive impairment. Section M revealed one stage 4 pressure ulcer. Record review of Resident #4's N Adv – Skin Check progress note dated 2/27/26 revealed wounds to sacrum with measurements of 5 centimeter length, 2 centimeter width and 0.3 centimeter depth, right heel with measurements of 4.5 centimeter length, 5.2 centimeter width and 0.3 centimeter (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	depth and buttocks with measurements of 1 centimeter length, 0.7 centimeter width and 0.2 centimeter depth. Record Review of Resident #4's surgical note on 3/26/26 by MD B revealed wound progress of the sacrum wound that the wound had increased in size but debridement was performed and had decreased in size to right heel wound. Record review of Resident #4's N Adv – Skin Check progress note dated 3/27/26 revealed wounds to sacrum with measurements of 6 centimeter length, 2.5 centimeter width and 0.3 centimeter depth, right heel with measurements of 3.5 centimeter length, 4.2 centimeter width and 0.2 centimeter depth and skin issue to buttocks was resolved. Record review of Resident #4's physician orders with active orders as of 4/3/26 revealed orders for right heel wound with instructions to apply collagen to wound, betadine to peri wound and cover with dry dressing once time a day with start date of 4/3/26 and for sacrum with instructions to apply calcium alginate with honey to wound, zinc oxide and nystatin power to peri wound and cover with 6x6 bordered gauze one time a day with start date of 4/3/26. Record review of Resident #4's March 2026 TAR revealed no documentation on 3/13/26, 3/14/26, 3/15/26, 3/16/26, 3/17/26, 3/23/26 and 3/28/26 for treatment of gentamicin ointment to be applied to the sacrum topically one time a day with order date of 3/12/26. No documentation on 3/23/26 and 3/28/26 for treatment to right heel with instructions to apply calcium alginate with honey and gentamicin to wound, betadine to peri wound and cover with dry dressing one time a day with order date 3/12/26. No documentation on 3/1/26 and 3/7/26 for treatment of right heel with instructions of calcium alginate with honey, betadine to peri wound and cover with dry dressing one time a day with order date of 2/19/26 and discontinue date of 3/12/26. No documentation on 3/1/26 for treatment to right buttock with instructions to apply calcium alginate with honey and cover with 4x4 bordered gauze one time a day with order date of 2/12/26 and discontinue date of 3/5/26. No documentation on 3/7/26, 3/8/26 for treatment to right buttock with instructions to apply collagen and cover with 4x4 bordered gauze one time a day with order date of 3/5/26 and discontinue date 3/19/26. No documentation on 3/1/26, 3/7/26, 3/8/26 and 3/23/26 for treatment to sacrum with instructions to apply calcium alginate with honey to wound, zinc oxide, antifungal power to peri wound and cover with 6x6 bordered gauze with order date of 1/23/26 and discontinue date of 3/26/26. No documentation on 3/28/26 for treatment of sacrum with instructions to apply calcium alginate with honey, triple antibiotic ointment to wound and cover with 6x6 bordered gauze one time a day with order date of 3/26/26. Observation on 4/1/26 at 12:19 p.m. revealed Resident #4 clean and dressed lying in bed covered with blankets with no foul odors noted. During interview on 4/1/26 at 12:54 p.m., Resident #4's family said her care was good. During interview of 4/1/26 at 3:01 p.m., Hospice Nurse A said Resident #4 was usually clean and felt like the facility did an adequate job of taking care of Resident #4. Hospice Nurse A denied any concerns regarding neglect. Resident #5Record review of Resident #5's face sheet dated 4/3/26, revealed the resident was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses including unspecified dementia (group of symptoms affecting memory, thinking and social abilities). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #5's quarterly MDS dated [DATE], section C (Cognitive Patterns) revealed a BIMS score of 3 that indicated severe cognitive impairment. Section M revealed no pressure ulcers. Record review of Resident #4's N Adv – Skin Check progress note dated 3/24/26 revealed wounds to left with measurements of 2.5 centimeter length, 1.2 centimeter width and 0.2 centimeter depth and left eyes due to a laceration. Record Review of Resident #5's surgical note on 4/2/26 by MD B revealed wound progress of the left lateral heel to have increased in size but had been debrided and left medial heel had decreased in size. Record review of Resident #5's March 2026 physician orders revealed orders for left lateral heel with instructions to apply Santyl and calcium alginate to wound and betadine to peri wound and cover with 4x4 bordered gauze one time a day with start date of 3/27/26 and left medial heel with instructions to apply Santyl and calcium alginate and cover with 4x4 bordered gauze one time a day with start date of 4/3/26. Record review of Resident #5's March 2026 TAR revealed no documentation on 3/28/26 and 3/31/26 for treatment of Santyl ointment to left lateral heel topically one time a day. No documentation on 3/1/26 and 3/8/26 for treatment of left lateral heel with instructions to apply betadine and cover with 4x4 bordered gauze one time a day. No documentation on 3/23/26 and 3/26/26 for treatment of left lateral heel with instructions to apply calcium alginate and cover with 4x4 bordered gauze one time a day. No documentation on 3/28/26 and 3/31/26 for treatment to left lateral heel with instructions to apply Santyl and calcium alginate to wound and betadine to peri wound and cover with 4x4 bordered gauze. No documentation on 3/1/26 and 3/8/26 for treatment to left medial heel with instructions to apply betadine and cover with 4x4 bordered gauze. No documentation on 3/28/26 and 3/31/26 for treatment to left median heel with instructions to apply xeroform and cover with 4x4 bordered gauze one time a day with order date of 2/26/26 and discontinue date of 3/12/26. Observation on 4/1/26 at 1:42 p.m. revealed Resident #5 was clean and lying in bed covered with blankets and no foul odors noted. Record review of Daily Nursing Assignment staffing sheets revealed the following persons were responsible for wound care: on 2/9/26 - charge nurse that included LVN A and LVN C, 2/18/26 – Wound Care Nurse, 2/20/26 – Wound Care Nurse, 3/2/26 – Wound Care Nurse, 3/13/26 – Wound Care Nurse, 3/16/26 – Wound Care Nurse, 3/17/26 – Wound Care Nurse, 3/23/26 – charge nurse that included LVN C, 3/26/26 – Wound Care Nurse, 3/27/26 – Wound Care Nurse, 3/30/26 – Wound Care Nurse, and 3/31/26 – charge nurse that included LVN A and LVN B. Record review of list of residents with pressure ulcers as of 4/1/26 included Resident #2, Resident #3, Resident #4 and Resident #5. During interview on 4/1/26 at 2:32 p.m., the Administrator provided a progress note for Resident #1 dated 1/16/26 at 12:05 p.m. written by PA A and said the progress note said, discussed with MD A and also showed the surveyor in the note it was written Discussed with MD A. The Administrator denied having any progress notes for Resident #1 written by MD A. During interview on 4/3/26 at 8:35 a.m., the Wound Care Nurse said she did all the dressing changes (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676309	A. Building B. Wing	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baywood Crossing Rehabilitation & Healthcare Cente	5020 Space Center Blvd Pasadena, TX 77505

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for residents in the facility Monday through Friday unless she was off work. The Wound Care Nurse said Resident #1's dressing changes were every day. The Wound Care Nurse said dressing changes were done daily for Resident #4, Resident #2, Resident #3 and Resident #5 through March 2026. The Wound Care Nurse said on the weekends, the Weekend Supervisor was responsible for dressing changes. The Wound Care Nurse said if she was off work during the week then the staffing scheduler would schedule someone to cover her shift or the hall nurse was responsible for the dressing changes. The Wound Care Nurse said if wound care was ordered daily and not completed daily then the wound could worsen in some cases. The Wound Care Nurse said she was not able to explain the weekends not being checked off regarding wound care. The Wound Care Nurse said she was out sick 2/4/26-2/9/26 and 3/31/26, out for an injury from 3/18/26-3/22/26 and was on vacation from 3/20/26-3/23/26. The Wound Care Nurse said she believed she was also off on 3/27/26 and 3/30/26. Regarding blanks for Resident #4's TAR for Gentamicin the Wound Care Nurse said she was not sure what happened but knew wound care was being provided . The Wound Care Nurse said if she was not available to get to the resident, she would notify the resident's nurse to provide wound care. The Wound Care Nurse said they had healed the wound to Resident #3's left foot before she had went to the hospital. During interview on 4/3/26 at 9:29 a.m., the ADON said she was filling in for the DON since he was out on medical leave during the investigation. The ADON said regarding Y being documented on Resident #1's MAR for February 2026 from 2/15-2/16/26 for antidepressant medication monitoring there should be a note in the progress notes that says Orders – Administration Note and confirmed looking at the February 2026 MAR and progress notes from 2/15-2/16/26 that there were not any progress notes. The ADON said what behavior that was observed and what intervention was performed should be in the progress note. The ADON said it was the nurse who documented on the MAR's responsibility to complete the progress note. The ADON the effect it could have on the resident if progress notes were not completed related to the antidepressant medication monitoring on the MAR was the resident could have repeat behavior because they would not know what caused behavior or if it was a physical or mental cause and so the behavior doesn't occur again or could decrease the occurrence of the behavior. The ADON said she knew if there were blanks on a Monday in March 2026 on the TARS regarding wound care not being completed it was because the wound nurse was not present. The ADON said if the wound care nurse was not present during the week the nurses do their own wound care or the staffing coordinator would call and see if a nurse was off and could come and do wound care. The ADON said the Weekend Supervisor was responsible for wound care. The ADON said if wound care was not completed as ordered there could be a delay in healing but it would depend on the wound or the wound could become macerated or infected. The ADON said she did not feel like it would have an effect on the resident if the wound care was completed but not documented but the doctor or anybody, the NP, PA or the next nurse coming on could assume the wound care was not done. The ADON said if it was not documented then it was not done. The ADON said she would not know if the wound care was completed or not unless she interviewed that nurse. The ADON said to monitor documentation they run a report that was called a Missing Documentation Report. The ADON said they would do an investigation to see if missing documentation was a pattern. The ADON said if there was a pattern they would see what was the reason, and if interventions were needed. She said the MD and family would be notified as well. The ADON said either the attending or the PA or NP did the admission visits for residents. The ADON said usually for skilled residents it had to be a physician unless the physician was the physician of record at the hospital as it would be continuation of care. During interview on 4/3/26 at 10:31 a.m., LVN A said typically Monday through Friday the wound care nurse performs the wound care on residents. LVN A said she was not working on 3/13/26. LVN A said she did not remember anything regarding Resident #4's wound care on 3/17/26. LVN A said (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #4 would refuse wound care and if Resident #4 refused wound care they would mark it was refused. LVN A said if the Wound Care Nurse was off then the charge nurse would do the wound care unless the facility brought someone in to do the wound care. LVN A said regarding the missing documentation on the TAR for Resident #1 from 2/18/26-2/22/26 she believed she was off. During interview on 4/3/26 at 10:39 a.m., LVN B said typically Monday through Friday the Wound Care Nurse performs the wound care on residents. LVN B said the Wound Care Nurse rounds with the doctor on Thursdays. LVN B said on 3/31/26 she had left LVN C, who was the 2-10 p.m. nurse, wound care for some residents that could have included Resident #2 and Resident #5 and believed he may not have done the click off for the wound care. LVN B said she always rounds on her residents and makes sure their wound care was completed. LVN B said she did not remember anything regarding wound care for Resident #5 on 3/26/26 but believed the Wound Care Nurse was present that day. LVN B said regarding the gap for Resident #3 from 3/27-3/30/26 she had gone out to the hospital. LVN B said that if a resident was in the hospital or unavailable the nurse could document using a drop down box to choose hospital or out on pass or discharged or whatever the reason. LVN B said on the weekends the Weekend Supervisor was responsible for the wound care. On 4/3/26 at 11:02 a.m., surveyor attempted to contact PA A via phone and left message with request to call surveyor. During interview on 4/3/26 at 11:03 a.m., MD A said PA A will see skilled nursing residents three times a week and the long term residents as needed. MD A said that he and PA A would both see residents. MD A said he and PA A both saw residents during the first 72 hours and would discuss the residents. MD A said he saw Resident #1 during her stay at the facility and never saw her in the hospital and was not one of his hospital patients. MD A said he did not have a way to attest the notes so there would not be notes written by him. MD A said PA A wrote in his notes that he discussed with MD A, and he had seen that when reviewing PA A's notes. MD A said, I don't have a way to edit and say I agree with PA A's note. MD A said I have been having him write the notes referring to PA A. During interview on 4/3/26 at 11:17 a.m., MD B, who was the wound care doctor, said dressings were getting changed regularly at the facility and the wound healing rate was relatively high compared to other buildings. MD B said, I am very happy with how things are going from a wound care standpoint. During interview on 4/3/26 at 11:27 a.m.,