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	04/10/2024

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

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48605 Based on interview, and record review, the facility failed to inform residents in advance of the risks and benefits of proposed care and treatment for 1 of 5 residents (Resident #3) reviewed for resident rights, in that: The facility failed to obtain a signed consent for antipsychotic medication, Quetiapine fumarate (Seroquel) that was administered to Resident #3. The failure could affect residents who received psychoactive medications without informed consents and placed them at risk of receiving treatments without informed consent. Findings include: Record review of Resident #3's face sheet dated 04/10/24 revealed he was an [AGE] year-old male who admitted to the facility on [DATE] with an initial admitted [DATE], with diagnoses of unspecified dementia, without behavioral disturbance psychotic disturbance, mood disturbance, and anxiety (group of symptoms that affects memory, thinking and interferes with daily life), anxiety disorder (group of mental illnesses characterized by intense anxiety and fear), and encephalopathy (a group of conditions that cause brain dysfunction), and major depressive disorder (a persistent feeling of sadness and loss of interest). Record review of the comprehensive MDS assessment, dated 02/07/2024, revealed Resident #3 was unable to complete the BIMS and a staff assessment was conducted. Resident #3's BIMS was 99, indicating resident was unable to complete the interview. The MDS staff assessment for mental status revealed Resident #3 had short-term and long-term memory problems; memory/recall problems; and severely impaired daily decision-making skills (never/rarely made decisions). The MDS assessment revealed no behavior problems during the look-back period. The MDS assessment for Resident #3 revealed he had received an antipsychotic 7 days in the 7-day -look -back -period. Record review of Resident #3's care plan dated 01/12/2024 revealed that Focus: Resident# 3 uses antipsychotic medication Quetiapine (Seroquel) related to yelling out. Goal: Resident# 3 will be/remain free of psychotropic drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction, or cognitive/behavioral impairment through review date. Record review of Resident #3's physician's order summary report revealed the following order: (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676309	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2024
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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 - Some	Quetiapine fumarate (Seroquel) tablet 25 mg give 0.5 mg by mouth two times a day for agitation with dementia related to unspecified dementia, unspecified severity, without behavioral disturbance psychotic disturbance, mood disturbance, and anxiety with a start date of 11/06/2023 and stop date of 03/27/2024. Quetiapine fumarate (Seroquel) tablet 25 mg give 0.5 mg by mouth at bedtime for antipsychotic/antimanic agent related to Mood Disorder due to known physiological condition, unspecified with a start date of 03/27/2024. Record review of Resident #3's MAR revealed that Resident #3 was actively taking the medication, Quetiapine fumarate (Seroquel). Interview on 04/09/24 at 10:43 AM, the DON stated [NAME] a nurse received an order for a psychotropic, they should make sure they have consents. If a resident does not have consent the nurse should contact the management nurse and the management nurse would let the doctor know. The DON was asked why it is important to inform a resident of the risk and benefits of the medication. The DON stated that it is every resident's right to be informed about the treatment and medication they received. Interview on 04/09/24 at 11:05 AM, the ADON stated that she was aware that Resident #3 was diagnosed with dementia and had been order the medication, Seroquel related to yelling out, mood disturbance, and agitation. The ADON stated Resident #3 was initially admitted on [DATE] with the diagnosis of dementia. The ADON stated that Resident #3 was initially ordered Quetiapine fumarate (Seroquel) tablet 25 mg give 0.5 mg by mouth at bedtime with a started date of 07/18/2023 related to Resident #3 behavior of yelling out. The ADON stated that Resident #3 had frequency changes to the medication on 11/06/2023 and an additional change to the medication frequency on 03/27/2023. The surveyor requested the documented consent for antipsychotic medication treatment for Resident #3. The ADON stated that the facility did not have a current consent for treatment. The ADON stated that she was working on obtaining consent from Resident #3's POA. She stated that she reached out to the Resident #3 's POA last week Wednesday, 04/03/2024 but had not followed up to obtain consent. The ADON stated she was waiting to receive the new form from the hospital as the facility no longer used Form 3713 (consent for antipsychotic medication treatment) prior to following up with the POA. The ADON was asked why it is important to inform a resident of the risk and benefits of the medication. The ADON stated that it is every resident's right to be informed about the treatment and medication they received. Record review of the facility's policy last revised January 2023, titled Psychotropic medication use, revealed the following: o Prior to administration of or with a change in the dosage of an antipsychotic medication, the facility shall obtain informed consent from the resident/resident representative. This will be documented on form 3713 in conjunction with the resident/resident representative, attending physician and/or psychiatrist and the facility staff.

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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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26867 Based on observation, interview, and record review, the facility failed to conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity for 4 of 20 (Resident # 8, #26, #76 and & #97) residents review for accuracy of assessment. Resident # 8, #26, #76 and resident #97 were not accurately assessed for their oral dental needs on their MDS assessments. Resident # 76 was not accurately assessed for his vision on his annual MDS assessment. These failures could place the residents at risk for not receiving care and services to maintain their highest practicable mental, physical, and psychosocial well-being. Findings included: Resident #8 Record review of Resident #8's electronic face sheet dated 04/09/24 indicated Resident #8 was [AGE] year-old, female, admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included bipolar disorder (is a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), major depressive disorder, anxiety disorder, depressive disorders, lack of coordination, muscle weakness, muscle wasting and atrophy, difficulty in walking, iron deficiency anemia, cognitive communication deficit, chronic obstructive pulmonary disease, hypertensive heart, and chronic kidney disease. Record review of Resident #8's Significant change assessment dated [DATE] indicated Resident #8 had a BIMS score of 3 which indicated severe cognitive impairment. Review of the section on oral dental indicated she had no oral dental concerns. All sections were left blank, indicating Resident #8 had no broken or loosely fitting full or partial dentures, no natural teeth or tooth fragments, no abnormal mouth tissue, no obvious or likely cavity or broken natural teeth, no inflamed or bleeding gums or loose natural teeth, and no mouth or facial pain, discomfort, or difficulty with chewing. Record review of Resident #8's care plan dated 06/02/21 with a revision date of 03/25/24 indicated Resident #8 had potential for oral dental health problems r/t missing teeth/Dentures: Goals- Resident # 8 will be free of infection, pain or bleeding in the oral cavity by review date of 03/25/24. Interventions- Monitor/document/report PRN any signs and symptoms of oral/dental problems needing attention, Pain (gums, toothache, palate), Abscess, Debris in mouth, Lips cracked or bleeding, Teeth missing, loose, broken, eroded, decayed, Tongue . (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 04/08/24 at 8:00AM, revealed Resident #8 in bed sleeping. Observation on 04/10/24 at 9:00Am revealed Resident #8 was in the activity room. She was alert and oriented. Attempt was made to have an interview, but she was not interviewable. Observation and interview on 04/09/24 at 12:15PM, revealed she was on a mechanical diet assisted with her meal. During an interview at the time, CNA' Q said Resident #8 had no teeth and no dentures. Resident #26 Record review of Resident #26's face electronic face sheet dated 04/09/24 revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included anxiety disorder, depression, dysfunction of bladder, multiple sclerosis, essential (primary) hypertension, other seizures, chronic obstructive pulmonary disease, acute kidney failure, quadriplegia, and lack of coordination. Record review of Resident #26's admission MDS assessment dated [DATE] revealed a BIMS score of 12 indicated she was moderately impaired on cognition. Review of the section on oral dental indicated she had no oral dental concerns. All sections were left blank, indicating Resident #26 had no broken or loosely fitting full or partial dentures, no natural teeth or tooth fragments, no abnormal mouth tissue, no obvious or likely cavity or broken natural teeth, no inflamed or bleeding gums or loose natural teeth, and no mouth or facial pain, discomfort, or difficulty with chewing Record review of Resident #26's care plan dated 08/08/23 read in part - Resident #26 is edentulous (few or no teeth) and wears upper and lower dentures. Goals: Resident # 26 will be free of infection, pain or bleeding in the oral cavity by review date. Revision on: 02/08/2024 Interventions Monitor/document/report PRN any signs and symptoms of oral/dental problems needing attention ., Observation on 04/08/24 at 7:30AM revealed Resident #26 was in bed alert and oriented. She attempts to communicate but her speech was unclear. Observation revealed she had a mechanically altered diet. She was assisted with her meal. Resident # 76 Record review of Resident #76's face sheet dated 04/09/24 indicated Resident #76 admitted on [DATE] and was [AGE] years old. His diagnoses included muscle wasting, unspecific chest pain, communicative deficit, cellulitis of left toe (inflammation of right toe), and prostatic cancer. Record review of MDS annual assessment dated [DATE] indicated Resident #76 had a BIMS score of 10, which indicated he was moderately impaired with cognition, had clear speech, and clear vision. He was assessed as having no problem in his oral cavity (section L oral dental) (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident # 76 care plan with a revision date of 11/09/23 read in part the resident has missing teeth and chooses not to wear his dentures. Dentures are at home'. Goal-The resident will be free of infection, pain, or bleeding in the oral cavity by review date. Revision on: 03/20/2024 Target Date: 02/09/2023. The resident will comply with mouth care at least daily through review date. Revision on: 03/20/2024 Intervention: Coordinate arrangements for dental care, transportation as needed/as ordered. Diet as Ordered. Consult with dietitian and change if chewing/swallowing problems are noted. Provide mouth care as per ADL personal hygiene. During observation and interview on 04/08/24 at 8:50 AM, Resident #76 placed his hand over his mouth during communication. He said he needed to see a dentist but was told that he had to pay for a dental visit. He said he eats what he can. He said all his teeth on his upper oral cavity are almost gone. He said he had two teeth on each side. He said he had none on his lower oral cavity. He said he can see large things but not in print. He pointed to his reading glasses and said he had his eyes examined few weeks ago and was told that he needed a bifocal eyeglass. Resident # 97 Record review of Resident #97's admission record indicated an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included type 2 diabetes mellitus, osteoarthritis (a chronic degenerative joint disease), chronic obstructive pulmonary disease, chronic pain, muscle weakness, communication deficit, generalized anxiety disorder, dementia, psychotic disturbance, mood disturbance, and anxiety. Record review of Resident #97's admission MDS assessment dated [DATE] indicated Resident #97 had a BIMS score of 13 out of 15 which indicated her cognition was intact. Review of the section on oral dental indicated she was assessed as having no problem in her oral cavity (section L oral dental) Record review of Resident # 97's care plan dated 12/12/23 read in part Resident #97 is edentulous and wears upper and lower dentures. Revision on: 12/12/2023 target date of 03/23/24 Goal; The resident will be free of infection, pain or bleeding in the oral cavity by review date.03/28/24 Interventiono Coordinate arrangements for dental care, transportation as needed/as ordered . During an interview with the MDS coordinator on 04/10/24 at 1:20PM, she looked at all identified areas and said she was new to the MDS position and was not sure what to code on residents' oral dental assessment. She said she would correct all identified MDS to reflect each resident's condition. During an interview with facility social worker on 04/09/24 at 2:00PM, she said Resident # 76 was a full vendor and he had to pay for his dental care service and his eyeglasses out of pocket. She said she would check on his insurance provider if he was covered for dental care and eyeglasses but had not heard anything from anyone. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow up interview on 04/10/24 at 1:50PM, the Social Worker said she had spoken with Resident # 76's insurance provider and resident was covered for routine dental care, and one pair of glasses per year. She said she did not follow up with the eye Dr. and she would. She said she would find a local company that would accept Resident #76's insurance. Record review of Facility's policy on resident assessment dated 2001 and updated 2019 read in part: A comprehensive assessment of every resident's needs is made at intervals designated by OBRA and PPS Requirements 2 comprehensive assessment includes: a. completion of the Minimum Data Set (MDS); b. completion of the care area assessment (CAA) process; and c. development of the comprehensive care plan. Admission Assessment and Follow Up: Role of the Nurse Level III Purpose The purpose of this procedure is to gather information about the resident's physical, emotional, cognitive, and psychosocial condition upon admission for the purposes of managing the resident, initiating the care plan, and completing required assessment instruments, including the MDS.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26867 Based on interviews and record review, the facility failed to ensure individuals with mental health disorders were provided an accurate Preadmission Screening and Resident Review (PASRR) Screening for 1 of 3 residents (Resident #8) reviewed for resident assessments. The facility failed to review Resident #8's PASRR level 1 assessment for accuracy and refer Resident #8 for further assessment for services. This failure could place residents at risk of not receiving needed assessments (PASRR Evaluation), individualized care, and specialized services to meet their needs. Findings included: Record review of Resident #8's face sheet printed 04/09/24 indicated Resident #8 was an [AGE] year-old, female, admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnosis including other bipolar disorder (is a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), major depressive disorder, anxiety disorder, depressive disorders, lack of coordination, muscle weakness, muscle wasting and atrophy, difficulty in walking, iron deficiency anemia, cognitive communication deficit, chronic obstructive pulmonary disease, hypertensive heart, and chronic kidney disease. Record review of Resident #8's MDS Significant change assessment dated [DATE] indicated Resident #8 had a BIMS score of 3 which indicated severe cognitive impairment. Review of the section on PASRR-section on Mental illness and other related condition were not checked. Review of the section on active diagnoses was checked for Bipolar, anxiety and depression. Record review of Resident #8's medical diagnoses dated 07/16/18 indicated Resident #8 had a diagnosis of Bipolar. Record review of Resident #8's PASRR Level 1 Screening dated 07/15/21 indicated .Mental illness .Is there evidence or an indicator this is an individual that has a Mental Illness .No . During an interview on 04/10/24 at 1:45 PM, the MDS Coordinator said she was responsible for completing the PASRRs and ensuring that all resident with mental illness diagnoses are referred for PASRR evaluation for services as needed. She said Resident # 8 should have been referred for PASRR evaluation on admission but was overlooked. She said she would request PASRR evaluation for Resident #8.

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F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 26244

Based on observation, interview and record review, the facility failed to create a comprehensive resident-centered care plan with measurable objectives for person-centered care for 3 of 21 residents reviewed for care plan development (Residents # 17, 52, 158).

--- Resident # 17 did not have a care plan for ADL assistance

--- Resident # 52 did not have a care plan for ADL assistance

--- Resident # 158 did not have a care plan for ADL assistance

These failures placed residents at risk of not receiving accurate care and services according to their individual needs.

Findings include:

Resident # 17

Record review of the undated face sheet for resident # 17 revealed an 82- year- old female, admitted [DATE] with diagnoses including dementia, psychosis (mental condition causing loss of contact with reality), chronic kidney disease (longstanding kidney disease leading to kidney failure), dysfunction of bladder (lack of bladder control), cerebral infarction (disruption of blood flow to the brain), seizures (abnormal electrical activity in the brain).

Record review of Resident # 17's Significant Change MDS dated [DATE] revealed a BIMS score of 99, indicating severely impaired cognitive ability, was sometimes understood by others and sometimes understands others, always incontinent of bladder and bowel, and was dependent on staff assistance for toileting, bath/shower, dressing, and required maximum assistance for hygiene.

Record review of Resident # 17's comprehensive care plan (undated) revealed there was no care plan for ADL assistance, including goals and interventions for completion of tasks needing staff assistance.

Observation and interview with Resident # 17 at 8:30 am revealed she was in bed, awake, dressed in a clean gown, and looking out her window. Attempted interview at that time revealed she was not able to answer any questions, was confused, and kept repeating that a man was outside her window, and he was run over by a car.

Interview with LVN M on 4/9/24 at 2:30 pm revealed Resident # 17 does require staff assistance for ADLs, and she occasionally hallucinated, for which she was re-directed.

Resident # 52

(continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the undated face sheet for Resident # 52 revealed a 77- year- old female, admitted [DATE] with diagnoses including osteoarthritis (degeneration of joint cartilage and bone), major depressive disorder (persistently depressed mood or loss of interest in activities), hypertension (high blood pressure), dementia (progressive loss of intellectual functioning), speech disturbance (inability to form speech sounds), dysphagia (difficulty swallowing food). Record review Resident #52's Significant Change MDS dated [DATE] revealed Resident # 52 had unclear speech, sometimes understood by others, and usually understands, a BIMS score of 03 indicating severely impaired cognitive skills, always incontinent of bladder and bowel, and required extensive staff assistance for transfers, dressing, toileting, hygiene, and supervision for bath/shower. Record review of Resident #52's comprehensive care plan (undated) revealed there was no care plan for ADL assistance, to include goals and interventions for completion of tasks needing staff assistance. Observation and attempted interview with Resident #52 on 4/8/24 at 10:10 am revealed she was sitting up in bed, awake, dressed, with clean clothes and clean linen on the bed, but not responding verbally. Interview with LVN M on 4/8/24 at 10:40 am revealed Resident # 52 usually did not talk, but if she did her speech would not be clear. She said they do help her with transfers, bathing, toileting, and hygiene. Resident # 158 Record review of the undated face sheet of Resident # 158 revealed a [AGE] year-old female, admitted [DATE] with diagnoses including Metabolic Encephalopathy (chemical imbalance in the blood), enterocolitis (inflammation throughout the intestines), dementia (progressive loss of intellectual functioning), dysphagia (difficulty swallowing), hypertension (high blood pressure), chronic kidney disease (longstanding disease of the kidneys leading to kidney failure). Record review of Resident #158's Significant Change MDS dated [DATE] revealed she, sometimes understood others and was sometimes understood, BIMS score was 01 indicating severely impaired cognitive skills, and required moderate staff assistance with hygiene and maximum assistance with transfers, showers, toileting, and dressing. Record review of Resident #158's comprehensive care plan (undated) revealed there was no care plan for ADL's, including goals and interventions for completion of tasks needing staff assistance. Observation and attempted interview with Resident #158 on 4/8/24 at 9:20 am revealed she was in bed, awake, with clean linens on the bed. Resident was speaking but was not understandable, unable to answer any questions, and was reaching for the covers on the bed. Interview with LVN M on 4/8/24 at 9:30 am revealed Resident #158 wan not easy to understand when she talked, and they helped her with all her ADL's. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with MDS nurse on 4/10/24 at 2:10 pm revealed she does the care plans, with input from nurses and other staff and the MDS. She said the ADL care plans for Residents # 17, #52, #158 were missed and the risk of not having accurate care plans would be the resident not receiving proper care. Interview with the DON on 4/10/24 at 2:40 pm revealed the expectation is for all care plans to be accurate for the resident's condition, and the risk if it's not accurate would be improper resident care. Record review of the facility policy Care Plans- Comprehensive Person Centered, revised September, 2013, revealed in part: .assessments of residents are ongoing and revised as information about residents and resident conditions change . 26867

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48605 Based on interview, and record review, the facility failed to inform residents in advance of the risks and benefits of proposed care and treatment for 1 of 5 residents (Resident #3) reviewed for resident rights, in that: The facility failed to obtain a signed consent for antipsychotic medication, Quetiapine fumarate (Seroquel) that was administered to Resident #3. The failure could affect residents who received psychoactive medications without informed consents and placed them at risk of receiving treatments without informed consent. Findings include: Record review of Resident #3's face sheet dated 04/10/24 revealed he was an [AGE] year-old male who admitted to the facility on [DATE] with an initial admitted [DATE], with diagnoses of unspecified dementia, without behavioral disturbance psychotic disturbance, mood disturbance, and anxiety (group of symptoms that affects memory, thinking and interferes with daily life), anxiety disorder (group of mental illnesses characterized by intense anxiety and fear), and encephalopathy (a group of conditions that cause brain dysfunction), and major depressive disorder (a persistent feeling of sadness and loss of interest). Record review of the comprehensive MDS assessment, dated 02/07/2024, revealed Resident #3 was unable to complete the BIMS and a staff assessment was conducted. Resident #3's BIMS was 99, indicating resident was unable to complete the interview. The MDS staff assessment for mental status revealed Resident #3 had short-term and long-term memory problems; memory/recall problems; and severely impaired daily decision-making skills (never/rarely made decisions). The MDS assessment revealed no behavior problems during the look-back period. The MDS assessment for Resident #3 revealed he had received an antipsychotic 7 days in the 7-day -look -back -period. Record review of Resident #3's care plan dated 01/12/2024 revealed that Focus: Resident# 3 uses antipsychotic medication Quetiapine (Seroquel) related to yelling out. Goal: Resident# 3 will be/remain free of psychotropic drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction, or cognitive/behavioral impairment through review date. Record review of Resident #3's physician's order summary report revealed the following order: Quetiapine fumarate (Seroquel) tablet 25 mg give 0.5 mg by mouth two times a day for agitation with dementia related to unspecified dementia, unspecified severity, without behavioral disturbance psychotic disturbance, mood disturbance, and anxiety with a start date of 11/06/2023 and stop date of 03/27/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676309	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2024

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

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 0758

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Quetiapine fumarate (Seroquel) tablet 25 mg give 0.5 mg by mouth at bedtime for antipsychotic/antimanic agent related to Mood Disorder due to known physiological condition, unspecified with a start date of 03/27/2024.

Record review of Resident #3's MAR revealed that Resident #3 was actively taking the medication, Quetiapine fumarate (Seroquel).

Interview on 04/09/24 at 10:43 AM, the DON stated [NAME] a nurse received an order for a psychotropic, they should make sure they have consents. If a resident does not have consent the nurse should contact the management nurse and the management nurse would let the doctor know. The DON was asked why it is important to inform a resident of the risk and benefits of the medication. The DON stated that it is every resident's right to be informed about the treatment and medication they received.

Interview on 04/09/24 at 11:05 AM, the ADON stated that she was aware that Resident #3 was diagnosed with dementia and had been order the medication, Seroquel related to yelling out, mood disturbance, and agitation. The ADON stated Resident #3 was initially admitted on [DATE] with the diagnosis of dementia. The ADON stated that Resident #3 was initially ordered Quetiapine fumarate (Seroquel) tablet 25 mg give 0.5 mg by mouth at bedtime with a started date of 07/18/2023 related to Resident #3 behavior of yelling out. The ADON stated that Resident #3 had frequency changes to the medication on 11/06/2023 and an additional change to the medication frequency on 03/27/2023. The surveyor requested the documented consent for antipsychotic medication treatment for Resident #3. The ADON stated that the facility did not have a current consent for treatment. The ADON stated that she was working on obtaining consent from Resident #3's POA. She stated that she reached out to the Resident #3 's POA last week Wednesday, 04/03/2024 but had not followed up to obtain consent. The ADON stated she was waiting to receive the new form from the hospital as the facility no longer used Form 3713 (consent for antipsychotic medication treatment) prior to following up with the POA. The ADON was asked why it is important to inform a resident of the risk and benefits of the medication. The ADON stated that it is every resident's right to be informed about the treatment and medication they received.

Record review of the facility's policy last revised January 2023, titled Psychotropic medication use, revealed the following:

o Prior to administration of or with a change in the dosage of an antipsychotic medication, the facility shall obtain informed consent from the resident/resident representative. This will be documented on form 3713 in conjunction with the resident/resident representative, attending physician and/or psychiatrist and the facility staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676309	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2024
NAME OF PROVIDER OR SUPPLIER: Baywood Crossing Rehabilitation & Healthcare Cente		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26867 Based on observation, interview, and record review, the facility failed to provide or obtain from an outside source dental services to meet the needs of 1 of 21 residents reviewed for dental services. (Resident #76) The facility did not assist Resident #76, who had missing teeth and dental decay, with a dental service consult. This failure could place the residents at risk for not receiving care and services to maintain their highest practicable mental, physical, and psychosocial well-being. Findings included: Record review of Resident #76's face sheet dated 04/09/24 indicated Resident #76 admitted on [DATE] and was [AGE] years old. His diagnoses included muscle wasting, unspecific chest pain, communicative deficit, cellulitis of left toe (inflammation of right toe), and prostatic cancer. Record review of MDS annual assessment dated [DATE] indicated Resident #76 was moderately impaired with cognition, (BIMS score 10), had clear speech, and clear vision. He was assessed as having no problem in his oral cavity (section L oral dental) Record review of Resident # 76 care plan with a revision date of 11/09/23 read in part the resident has missing teeth and chooses not to wear his dentures. Dentures are at home'. Goal-The resident will be free of infection, pain, or bleeding in the oral cavity by review date. Revision on: 03/20/2024 Target Date: 02/09/2023. The resident will comply with mouth care daily through review date. Revision on: 03/20/2024. Intervention: Coordinate arrangements for dental care, transportation as needed/as ordered. Diet as Ordered. Consult with dietitian and change if chewing/swallowing problems are noted. Provide mouth care as per ADL personal hygiene. During observation and interview on 04/08/24 at 8:50 AM, Resident #76 placed his hand over his mouth during communication. He said he needed to see a dentist but was told that he had to pay for a dental visit. He said he eats what he can. He said all his teeth on his upper oral cavity are almost gone. He said he had two teeth on each side of his mouth. He said he had none on his lower oral cavity but eat what he can. During an interview with facility social worker on 04/09/24 at 2:00PM, she said Resident # 76 was a full vendor and he had to pay for his dental care service out of pocket. She said she would check on Resident #8's insurance provider if he was covered for dental care. During a follow up interview on 04/10/24 at 1:50PM, the Social Worker said she had spoken with Resident #76's insurance provider and resident was covered for routine dental care, and she would refer Resident #76 to a dentist. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676309	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2024
NAME OF PROVIDER OR SUPPLIER Baywood Crossing Rehabilitation & Healthcare Cente		STREET ADDRESS, CITY, STATE, ZIP CODE 5020 Space Center Blvd Pasadena, TX 77505	

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility's policy on referral dated 2001 revised 2008 read in part- Policy Statement. Social services personnel shall coordinate most resident referrals with outside agencies. Social services will document the referral in the resident's medical record. Social services and administration will maintain a listing of referral agencies that may provide assistance or therapy to residents with special problems and/or needs. Social services will help arrange transportation to outside agencies, clinic appointments, etc., as appropriate.