STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675323	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baywind Village Skilled Nursing & Rehab	411 Alabama Ave League City, TX 77573

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure that the comprehensive care plan was reviewed and revised by an interdisciplinary team for 1(Resident # 64) of 18 residents reviewed for care plan. Resident #64's care plan was not revised to reflect her D\C use of catheter on 04/20/25. This failure could place residents at risk of not receiving needed services and care to improve their health. Findings Include: Resident #64: Record review or Resident #64's face sheet, dated 05/05/2025, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included essential hypertension (high blood pressure), type 2 diabetes mellitus without complications, lack of coordination, and muscle weakness. Record review of Resident #64's MDS, dated [DATE], revealed Resident #64's BIMS score was blank 15 out of 15 which indicated she was cognitively intact. Review of section H Bladder and Bowel was checked as having an indwelling catheter. Record review of Resident #64's care plan dated 04/10/25 revealed the following -Focus-Resident #64 has (Indwelling) Catheter: Date Initiated: 04/10/2025 Revision: 04/10/2025. Goal -Resident #64 will be/remain free from catheter-related trauma through the review date. Date Initiated: 04/10/2025, o Resident #64 will show no s/sx of Urinary infection through the review date. Date Initiated: 04/10/2025, Revision: 04/24/2025. Interventions: o Catheter care Q shift .o Check tubing for kinks each shift. o Enhanced Barrier Precautions Q shift. Date Initiated: 04/10/2025, Revision on: 04/24/2025. Observation and interview on 05/05/25 at 10:00AM revealed Resident #64 was in her room, watching television. She said she was looking forward to her therapy session. (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 05/06/25 at 1:00PM revealed Resident #64 sitting on her wheelchair. She said she was waiting for a family member for lunch. She said she had a catheter while in the hospital and was admitted with the catheter to the facility. She said she had the catheter for about 3 days at the facility and when it was taken out, she was unable to void urine on her own. She said another catheter was inserted to take out the urine. She said she has been voiding on her own and very happy, the catheter was out. She said she could not recall the date the catheter was removed. During an interview with MDS Coordinator A on 05/06/25 at 3:00PM she said Resident # 64 was admitted to the facility with a catheter, but it had been D\C'd. She looked at the care plan and said the care plan should have been revised to reflect that Resident #64 no longer had a catheter. She said the revision of the care plan was the responsibility of all the interdisciplinary team. She said the care plan was overlooked and she would revise the care plan to reflect Resident #64's status. She said updating the care plan was necessary to ensure that residents received needed care and services. In an interview with the DON on 05/07/25 at 4:30PM, she said all the care plans should reflect the resident's status and the care should have been revised when the catheter was discontinued. She said not updating the care plan may prevent nurse's from providing needed care to the residents. Record review of facility's policy on care plan dated 2001 revised March 2022 indicated title - Care Plans, Comprehensive Person-Centered- Policy Statement A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . 11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 12. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition; b. when the desired outcome is not met; c. when the resident has been readmitted to the facility from a hospital stay; and (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. at least quarterly, in conjunction with the required quarterly MDS assessment .

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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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure residents who needed colostomy care were provided such care, consistent with professional standards of practice for 2 of 4 (Resident #76 and Resident #293) residents reviewed for colostomies (surgical opening in which a piece of the colon was diverted to an artificial opening in the abdominal wall to bypass a damaged part of the colon). The facility failed to ensure training, care and documentation was consistent for Resident #76 and Resident #293 as bowel movements were not consistently documented, a colostomy was documented as an ileostomy/urostomy and colostomies were not consistently emptied. The failure could place residents at risk of complications related to a colostomy and emotional distress. Resident #76 and #293 experienced discomfort, anxiety, embarrassment and refused to take medications to prevent constipation as a result of the failure. Findings included: Record review of Resident #76's face sheet dated [DATE], revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage (paralysis or weakness on one side of the body caused by non-traumatic bleeding in the brain) affecting left non-dominant side and colostomy status (having a surgical opening in which a piece of the colon was diverted to an artificial opening in the abdominal wall to bypass a damaged part of the colon). Record review of Resident #76's admission MDS dated [DATE] revealed a BIMS score of 15 that indicated cognition was intact. Record review of Resident #76's doctor's orders printed [DATE] revealed orders to Change Colostomy bag as needed and Colostomy care every shift with start dates of [DATE]. Record review of Resident #76's Care plan printed [DATE] revealed goal of Resident's dignity will be maintained, and the ostomy will remain patent and functional through the review date with intervention Provide ostomy care per order to prevent odors and keep ostomy patent. (Ostomy is an artificial opening in an organ of the body, created during an operation.) Record review of Resident #76's April and May MARs and TARs printed [DATE] revealed a section for Colostomy care every shift which was documented as being completed with first entry during 7 p.m./7 a.m. shift on [DATE] and then every shift through 7 a.m./7 p.m. shift on [DATE]. Record review also revealed section for Change Colostomy bag as needed starting [DATE] with no documentation for April and one documentation during May on [DATE]. Record review also revealed documentation for Senna (medication to treat constipation) Oral Tablet 8.6 mg with instructions to give 2 tablets by mouth at bedtime and Resident #76 refused the medication on [DATE], 4/21-[DATE], 4/28-[DATE], [DATE], and 5/3-[DATE]. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #76's nursing Progress Notes printed [DATE] revealed Resident #76's colostomy bag was changed on [DATE] at 2 a.m., 3 a.m., and 1:18 p.m. No other progress notes regarding colostomy noted back to [DATE]. Record review of Resident #293's face sheet dated [DATE], revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including multiple sclerosis (disorder where the protective cover around nerves are damaged which can cause muscle weakness, vision changes, numbness, and memory issues) and colostomy status (having a surgical opening in which a piece of the colon was diverted to an artificial opening in the abdominal wall to bypass a damaged part of the colon). Record review of Resident #293's admission MDS dated [DATE] revealed a BIMS score of 15 that indicated cognition was intact. Record review of Resident #293's doctor's orders printed [DATE] revealed orders to Change Colostomy bag as needed and Colostomy care every shift with start dates of [DATE]. Record review also revealed orders for Miralax (constipation medication) with instructions for 17 grams in the morning with order date of [DATE], KUB (abdominal x-ray) with order date of [DATE], Senna-Docusate 8.5-50 mg with instructions to give 2 tablets at bedtime for constipation with start date of [DATE] and Change Colostomy bag one time a day every 4 days with start date of [DATE]. Record review of Resident #293's Nursing admission Assessment - V2 dated [DATE] completed by RN G revealed no selection for colostomy and ileostomy/urostomy was selected. Record review of Resident #293's April MAR/TAR printed [DATE] revealed a section for Colostomy care every shift which was documented as being completed with first entry during 7 p.m./7 a.m. shift on [DATE] and then every shift through 7 p.m./7 a.m. shift on [DATE]. Record review also revealed section for Change Colostomy bag as needed with no documentation from 4/25-[DATE]. Record review of Resident #293's May TARs printed [DATE] revealed a section for Colostomy care every shift which was documented as being completed with first entry during 7 a.m./7 p.m. shift on [DATE] and then every shift through 7 a.m./7 p.m. shift on [DATE]. Record review also revealed section for Change Colostomy bag as needed with no documentation from 5/1-[DATE]. Record review of Resident #293's May TARs printed [DATE] revealed section for Change Colostomy bag as needed starting [DATE] with documentation that was added for [DATE] and [DATE] when compared to Resident #293's May TAR printed [DATE]. Also, section for Change Colostomy bag one time a day every 4 days with documentation being completed on [DATE] was also new when compared to Resident #293's May TAR printed [DATE]. Record review of Resident #293's May MAR printed [DATE] revealed documentation of administration of Miralax (medication to prevent constipation) 17 grams in the morning for constipation from 5/1-[DATE]. Senna-Docusate (medication to prevent constipation) 8.6-50 mg with instructions to give 2 tablets by mouth at bedtime was documented as being administered on [DATE]. Record review of Resident #293 B&B - Bowel and Bladder Elimination for range of 4/25-[DATE] revealed no bowel movements were documented from 4/28-[DATE]. (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #293's nursing Progress Notes for date range 4/25-[DATE] revealed resident's colostomy bag was changed on [DATE] at 8:22 a.m. with duplicate note at 8:10 a.m. On [DATE] at 8:15 a.m. it was revealed Resident has not had a BM in 3 days. This alert is a result of incorrect documentation. This writer spoke with and re-trained cna on documenting colostomy output. On [DATE] at 5:49 p.m. it was documented a KUB was ordered as well as scheduled Senna at bedtime due to low colostomy output and hardened stool and Resident #293 had a conversation with the NP about intentionally constipating herself by eating a grilled cheese. On [DATE] at 5:35 p.m. it was revealed Change Colostomy bag as needed as needed for colostomy care. On [DATE] at 11:16 a.m. it was revealed Loose adhesive requiring changing of colostomy bag. No other progress noted regarding colostomy noted back to [DATE]. Record Review of Resident #293's Skilled Assessment & Progress Note - V3 dated [DATE] at 3:41 p.m. revealed colostomy bag was changed. Record Review of Resident #293's doctor's Progress Note dated [DATE] revealed she was trying to eat things that would constipate her rather than pass stool. Record review of Resident #293's Abdomen KUB (x-ray) dated [DATE] revealed Findings would support the clinical diagnosis of constipation. During interview and observation of Resident #293 on [DATE] at 10:35 a.m., Resident #293 said that she was given Miralax and had a blow out from the stool and had started leaking [DATE] but has not leaked since. Resident #293's caregiver at bedside said, it is like staff does not want to deal with the colostomy. Resident #293 stated she had asked an aide for help with the colostomy, but they were hesitant and got the nurse to assist. Observation of Resident #293's colostomy revealed the colostomy was intact and the colostomy bag was not full at this time. During interview on [DATE] at 8:15 a.m., the DON said the CNAs could empty ostomies (an artificial opening in an organ of the body, created during an operation) and the nurse assigned to the resident was responsible for ostomy care. During interview on [DATE] at 9:33 a.m., RN H said they change colostomy bags as needed and every three to four days. RN H said they check ostomies on rounds and as needed. During interview and observation of Resident #293 on [DATE] at 12:01 p.m., Resident #293 said her colostomy bag had been changed on [DATE] and [DATE] since her arriving to the facility on [DATE]. Resident #293 said she had gone almost a whole week with nothing in the colostomy and did not want to eat and take all of her Miralax (constipation medication) because she was afraid she would have a blow out again. Resident #293 said she did not feel like staff on the weekends knew how to change the colostomy. Observation revealed resident #293's colostomy was clean, dry, and intact with no stool noted in the bag. (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on [DATE] at 12:40 p.m., RN G said colostomy care per the TAR meant she went around to the colostomy patients and made sure the colostomy did not need to be changed, replaced, emptied, or burped. RN G said depending on the assessment she would change or replace the colostomy if needed. RN G said she checked residents' ostomies like five times a day. RN G said everything on the ostomies were usually replaced no more than every 2-3 days. RN G said Resident #293's colostomy was replaced [DATE] and she had looked at Resident #293's colostomy today and it was good. RN G said she was not sure it was documented in Point Click Care when ostomies were replaced. RN G said she knew when the resident's colostomy was last changed by the 24-hour report which was verbal from the night nurse and written. RN G showed the state surveyor the current 24-hour report for Resident #293 and no date when her colostomy was last changed was listed. RN G said she changed Resident #76's colostomy today. During interview on [DATE] at 1:44 p.m., LVN C said ostomies should be changed every three to five days and as needed, because if you change the ostomies more often it could cause skin breakdown. LVN C said staff documented daily that colostomy care had been performed. LVN C said when the colostomy was changed it was documented in the change colostomy PRN order on the TAR. LVN C viewed Resident #76's May TAR with state surveyor and she confirmed no dates were documented so far in May in the change ostomy PRN order and said that means the colostomy was not changed or the colostomy was changed and was not documented. During an interview on [DATE] at 2:30 p.m., the Administrator said they did not have any training documentation regarding ostomy (an artificial opening in an organ of the body, created during an operation) care for staff and they would add ostomy care training moving forward for new hires and annually for staff. During interview on [DATE] at 2:30 p.m., the DON said staff would know how to care for ostomies due to their nursing education. The DON said she checked, and ostomy (an artificial opening in an organ of the body, created during an operation) care was not on the new hire or annual skills checklists for nurses. The DON said no one had come to her regarding not knowing how to perform ostomy care and it was a good idea to have trainings. During interview on [DATE] at 3:15 p.m., RN G said on the Nursing admission assessment dated [DATE] for Resident #293 the urostomy should have been charted as colostomy and she would fix the assessment. RN G said she did a head-to-toe assessment on Resident #293 on [DATE]. RN G said her training at the facility consisted of hands-on training. RN G said she had heard nothing during report regarding Resident #293's bag bursting. During interview on [DATE] at 3:15 p.m., the DON said colostomy care every shift from the TAR was monitoring the site, making sure the stoma looked like it should, was draining and making sure the wafer was sealed and did not need to be changed. The DON said she had heard nothing regarding Resident #293's bag bursting. The DON said colostomies should be changed every 2-3 days or as needed. The DON said the PRN colostomy change on the TAR was documented if the colostomy bag burst and regular changes, were documented in the colostomy care section, but was not differentiated from regular checks. The DON said how nurses knew when the colostomies were last changed was nurses did verbal report or documented in the Skilled Assessment and Progress Note or the Progress Notes. The DON said an error in the Nursing admission Assessment would not affect the resident's daily care. The DON said there should be some output every shift in the colostomy section and the CNAs were taught to document stool consistency for colostomies. (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on [DATE] at 4:42 p.m., CNA D said she checked the ostomies every two hours, when she did her rounds. CNA D said if a resident was not having output in the colostomy at her two-hour checks, then she would let the nurse know. CNA D said she normally charted the consistency for a colostomy and when she emptied by putting in a new alert so the nurse could see it. CNA D denied any problems with either Resident #76 or Resident #293's colostomy's bursting. CNA D said she was trained by the nurses regarding colostomy care. CNA D said Resident #293 had not had a bowel movement today. CNA D said she had not notified the nurse yet and said she usually told the nurse at the end of the shift. During interview on [DATE] at 4:42 p.m., the DON said the KUB (abdominal x-ray) was ordered for Resident #293 due to low output from the colostomy. During interview and observation of Resident #76 on [DATE] at 9:00 a.m., it was revealed Resident #76's colostomy bag was very full of brown stool that was slightly formed and air. Resident #76 said she felt the stool in the colostomy bag, and it felt very hard. Resident #76 said the last time everything was changed for her colostomy was [DATE] and the colostomy bag had not been emptied since everything was changed on [DATE]. Resident #76 said her colostomy bag had burst three times since arriving at the facility due to it needing to be emptied. Regarding the colostomy change on [DATE], Resident #76 said she did not feel like the nurse had any idea what she was doing. Resident #76 said it took the nurse from 1:30-3:30 a.m. to change the colostomy and she could not participate in therapy the next morning because she was tired and worried/stressed. Resident #76 said she had spoken to RN I this morning and she said she would be back in 30 minutes to empty the colostomy. Resident #76 said she also had spoken to an aide early this morning before rounds regarding emptying the colostomy and they had said they would be back when they got settled. Resident #76 said when the bag was full she got stomachaches. Resident #76 said LVN C had changed the colostomy yesterday morning and knew what she was doing, and RN I had changed the colostomy and had done a good job. During interview and observation of Resident #293 on [DATE] at 9:21 a.m., Resident #293 said her colostomy bag was emptied about 8 a.m. this morning as there was a chunk that fell out and was stuck on top. Observation revealed Resident #293's colostomy was clean, dry, and intact and no stool in the bag. During interview and observation of Resident #293 and RN I on [DATE] at 9:25 a.m., RN I said she was comfortable providing colostomy care. RN I was observed emptying Resident #293's colostomy bag of stool and no concerns noted. Resident #293 said she did not eat a lot, so they don't have to empty the colostomy bag as often. During interview on [DATE] at 9:30 a.m., LVN C said she changed Resident #76's colostomy on [DATE] as it was leaking on the side. (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on [DATE] at 9:35 a.m., RN I said the aides could empty the colostomies if she was busy, but she told the aides to come get her if the colostomies needed to be emptied. RN I said CNA E told her Resident 76's colostomy needed to be emptied about 30 minutes ago, but she needed to check the residents' blood sugars and give insulin at that time. RN I said she changed Resident #293's colostomy on [DATE] because it was leaking. RN I said she had asked for colostomy training at the facility since she had not done colostomy care since nursing school. RN I said for colostomy training she was provided after requesting, she watched another nurse on the front hall provide colostomy care and she had an observation check off by nurse LVN C when she changed Resident 76's colostomy for the first time. RN I said she had asked for colostomy training at the facility since she had not done colostomy care since nursing school. During interview on [DATE] at 9:38 a.m., CNA E said Resident #76 told her around 8 a.m. her colostomy bag needed to be emptied and she had told RN I. CNA E said she could see Resident #76's colostomy bag was full, and Resident #76 had felt the stool inside the bag. CNA E said she could burp and empty the colostomy bags but not change the bags. CNA E said she had training regarding ostomies at another facility but had not had any training at the current facility. CNA E said she documented regarding output when she emptied the colostomy bag. CNA E said last week Resident #76 had a decreased amount of stool in her colostomy bag and Resident #76 was worried as the stool was liquid when she first arrived at the facility. CNA E said she reported to the nurse if residents have not had a bowel movement or changes and puts in a new alert in the EMR. On [DATE] at 10:05 a.m., the state surveyor received from the administrator a copy of a facility action plan, Nurses New Hire Skills Checks and Skill: Colostomy Care for the Certified Nursing Assistant. Record review of the facility action plan revealed a problem identified of Lack of documentation on when colostomy bags are changed. An order was added to the facility's batch orders and a new task was added to the TAR to change colostomy bags every 4 days and PRN. An in-service was also initiated on [DATE] to introduce the new orders. Record review of the Nurses New Hire Skills Checks revealed a checklist that included colostomy care. Record Review of Skill: Colostomy Care for the Certified Nursing Assistant revealed steps regarding colostomy care for CNAs. During interview on [DATE] at 12:43 p.m., MD A said he had not had any complaints regarding colostomies. MD A said he had spoken to the DON regarding using the CPR dummy for hands on training regarding colostomy care. MD A said the biggest concern for a new ostomy was [NAME] for the resident. MD A said he did not consider constipation a complication from having a colostomy and constipation would be a systemic issue . During interviews on [DATE] at 4:33 p.m., the DON said if a colostomy was not being emptied then there would come a point the colostomy would burst, then feces could get on the resident's skin and the skin could get excoriated, and there would be a risk of infection. The Administrator and Assistant Administrator agreed with this statement. The DON said if staff don't have a clear understanding of something then most staff know who to ask. The DON said if colostomy care was not done correctly by the nurse, then the colostomy could be put on wrong or the stoma (opening in the abdomen for the colostomy) could get covered. The DON said CNAs should know they could empty the colostomy bags. The DON said she did not see any harm to the resident from a CNA not knowing how to empty the colostomy bag correctly. The Administrator and Assistant Administrator said they did not have anything to add to the DON's statements. (continued on next page)

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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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on [DATE] at 4:45 p.m., the ADON said she spoke with a resident this morning and she had concerns with her hands being able to perform colostomy care but that was all the concerns she was aware of. The ADON said new nurses and the CNAs at the facility shadow another staff member and should have opportunity for training regarding colostomy care. The ADON said colostomy care training was observing and hands on training. The ADON said initial hires have a skilled check off for procedures and annually, ostomy care had not been part of the check off list but was being added. The ADON said she did not have any knowledge of any of the ostomy resident's bags bursting but had heard of the colostomy bags occasionally leaking. The ADON said on all the residents there was a general batch order that had colostomy care. The ADON said how staff was to document when the colostomy bag was changed was to write a note or document on the TAR for ostomy bag change as needed . During an interview on [DATE] at 4:54 p.m., CNA F said they could burp and empty colostomies, but the nurse had to change the colostomy. During interview on [DATE] at 4:57 p.m., CNA G said they could burp and empty colostomies, but the nurse had to change the colostomy. CNA G she had not had ostomy care at the current facility but had training at a previous facility. On [DATE], after a policy was requested from the facility regarding colostomy care and received, record review of Colostomy/Ileostomy Care with revision date [DATE] revealed information regarding the purpose of this procedure is to provide guidelines that will aide in preventing exposure of the resident's skin to fecal matter. The document outlined the steps for colostomy/ileostomy care but did not specify who was responsible for such care, did not address emptying colostomy/ileostomy bags, or how often colostomy/ileostomy bags should be changed. Record review of American Cancer Society's Colostomy Guide revealed ostomy pouches should be emptied when it is about 1/3 to ½ full to keep it from bulging and leaking. Record review also revealed it is best to have a regular changing schedule for the pouch but can vary from changing every three days to changing every week depending on the type of pouch used. Record review of facility's undated policy Colostomy/Ileostomy Policy revealed Ostomy bags are to be changed every 3-4 days or as needed for leakage an/or soiling, Ostomy bags are to be changed every 3-4 days or as needed for leakage and/or soiling, and CNAS may expel air or empty a colostomy bag as needed.