STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675999	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St James House of Baytown	5800 W Baker Rd Baytown, TX 77520

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44915 Based on observation, interview and record review the facility failed to immediately inform the resident, consult with the resident's physician, and notify consistent with his or her authority, the resident representative when there was a significant change in the resident's physical, mental, or psychosocial status and a need to alter treatment significantly for 1 of 5 residents (CR#1) reviewed for physician notification. The facility failed to contact the physician for over 5 hours when CR#1 had shortness of breath and was gurgling. After approximately 5 hours, CR #1 was sent to the hospital via emergency transport and was admitted with Pneumonia, Acute Kidney Failure, and Septic Shock and expired 2 days later. An Immediate Jeopardy (IJ) situation was identified on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated with the potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of corrective systems. This failure could place residents at risk of delayed treatment that has the propensity to lead to death. Findings include: Record review of CR #1 face sheet revealed a [AGE] year-old who was admitted to the facility on [DATE]. CR #1 had diagnoses which included Vascular Dementia (Occurs when blood vessels in the brain are damaged, reducing blood flow and brain function), Cerebral Infarction (Stroke), Cognitive Communication Deficit, Dysphagia (swallowing difficulties), Functional Dyspepsia (A chronic condition that causes pain or discomfort in the upper abdomen, often near the ribs), Anemia (lack of blood), Anxiety disorder, Hypoglycemia (low blood sugar), Unspecified Atrial Fibrillation (a heart condition), Neuromuscular dysfunction (A group of diseases that affect the nerves and muscles that control movement in the body), Constipation and Type 2 diabetes. Record review of CR#1's Quarterly MDS, dated [DATE], revealed a BIMS score of 99, which indicated the resident was unable to complete the interview. Record review of CR#1's baseline care plan, dated [DATE] and revised on [DATE], revealed allowing residents to make decision regarding treatment, care and provide opportunities for resident to make choices. (continued on next page)

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

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Communication: Resident has a communication problem related to minimal difficulty heating, history of stroke. Goal included: The resident will maintain current level of communication function through the review date. Interventions included: Anticipate and meet needs. Communication: Allow adequate time to respond, repeat as necessary, do not rush, request clarification from the ensure understanding, face when speaking, make eye contact, turn off TV/radio to reduce environmental noise, Ask yes/no questions if appropriate, use simple, brief, consistent words/cues, use alternative communication tools as needed. Discuss with resident/ family concerns or feelings regarding communication difficulty. Encourage resident to continue stating thoughts even if resident is having difficulty. Focus on a word or phrase that makes sense, or responds to the feeling resident is trying to express. Ensure/provide a safe environment: Call light in reach, Adequate low glare light, Bed in lowest position and wheels locked, Avoid isolation. Monitor for/record confounding problems: decline in cognitive status, mood, decline in ADL, deterioration in respiratory status, oral motor function, hearing impairment (ear discharge and cerumen (wax) accumulation, poor fitting/missing dental appliances etc. Record review of NP note, completed on [DATE] at 10:18 PM, revealed LVN A reported change of condition; CR#1 had difficulty breathing and crackles in breathing sound. Order-Stat Chest X Ray, Duonebs Q4 prn X 5 days ordered. Record review of progress note, completed on [DATE], *late entry*, revealed resident noted with rattles and 96 % 02 sats. V/S ,d+[DATE]- BP, 97.6 Temp, 70, 26. On Call Physician notified change in condition. NP with orders for STAT Chest X Ray and Duonebs (a sterile inhalation solution containing a combination of albuterol and ipratropium). every 4 hours PRN X 5 Days. Duonebs administered. Resident rattles present O2 Sats at 89%. Resident noted responsive to tactile stimuli with cold clammy skin and hands. 911 called at 1105 to transfer resident to hospital. RP notified of change in condition and transfer to ER. Resident left facility at 1120PM. In an interview on [DATE] with LVN A at 2:08 PM, she stated she got a report from LVN D that she needed to go check on CR #1. She stated when she assessed CR #1, his breathing was not good. She described the resident as, just not being the same person. She stated she took his vital signs and contacted the on-call NP. She stated she received orders to do Stat Chest X ray and to put him in Duonebs. She stated she completed Duonebs for about 5 minutes and it appeared it was not helping and the resident was not getting better so she called 911 and they came immediately, and CR #1 was transported to the hospital. She stated the resident was still responsive when 911 arrived. She stated she contacted the RP of the change in condition and CR #1's transfer to the hospital. She stated the nurse that was assigned to CR#1 prior to her was LVN E. She stated she last worked with CR #1 2 days prior and she did not see any difficult changes with the resident when she worked with him. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] with CNA B at 3:07 PM, she stated she checked on CR #1 around 3:00 pm on [DATE] and he was complaining of pain. She stated she informed LVN E and LVN E informed she could not give the resident any medication because the nurse on the prior shift had already given him medication. She stated she checked on CR #1 between 4 and 4:30 PM and she noticed he sounded a little congested, as if he could have been coming down with a cold, she stated it sounded like something was in his chest (mucus) but his breathing did not sound gurgly but she could hear it (the mucus) whenever he yelled. She stated the resident did not really eat his dinner, it is unknown if it was common for the resident. She stated between 8:00 PM-8:30 PM, she provided incontinent care and the resident sounded gurgly, as if he had mucus in his throat or possibly needed to cough. (Initially CNA B stated she informed LVN E but in a later interview she stated she left the resident's room to wash her hands and when she returned, LVN E was already in the room checking on CR #1). She stated she left the room to wash her hands and when she returned LVN E was in the room checking on the resident, trying to get him to cough (telling the resident to try to cough it up). She stated she was unsure of what occurred after because she only peeked in to check on the resident and she did not remain in the room. In an interview on [DATE] with CNA C at 10:09 AM, she stated she worked with CR #1 on Christmas Day. She stated she worked the night shift. She stated she checked on the resident at the start of her shift and the resident was in bed. She stated CR #1 was not complaining of pain, but he was making noises(random noises). She stated CR #1 was not responding to questions. She stated she informed LVN A there was a concern with CR #1 and LVN A provided a breathing medicine and she called 911. In an interview on [DATE] with the MD at 10:19 AM, he stated he last saw CR #1 on Christmas eve and he assessed the resident due to being constipated. He stated he did not notice issues with breathing or congestion when CR #1 was assessed. He stated when there was a change in condition, the facility staff should call him or the call center. He stated they had a 24-hour call center. He stated whenever there was a change of condition, they were expected to call as quickly as they could, got vitals and pertinent information so the provider could make a judgement of the situation. The MD stated no one from the facility contacted him at the time of the change in condition. He stated the facility contacted the call center with CR#1's change in condition and the call that was placed the night of [DATE]. He stated that his expectation is that the facility either reaches out to him for a change in condition or if it is after hours, they are to reach out to the on call center. In an interview on [DATE] with the DON at 10:35AM, she stated she was not at the facility when the incident occurred. She stated the gurgling was not a common thing for CR #1. She stated the gurgling, and the shortness of breath would be considered a change in condition. If the resident would have had these symptoms earlier, the staff are expected to assess, call the physician, order labs and send out if needed. She stated once the patient is stable, they would notify the family. She stated whenever a resident had a change in condition, the staff would complete a S Bar (Communication tool used to share information about a resident's condition, used when a resident had a change in condition) for the resident and provide vitals to the physician. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] with LVN D at 12:30 PM, she stated she works the 2:00pm-10:00pm. She stated she worked on Christmas day and she worked station 3. She stated she did see CR #1 on Christmas day. She stated she happen to see CR #1 when she was walking down his hall. She stated the resident did not look right and she gave him a washcloth. When asked to elaborate on what that meant; she stated the resident looked like he was sweating a little. She stated she seen the resident around 9:30pm/10:00pm. She stated the resident sounded a little congested when she seen him. She stated CR #1 did not sound gurgly when she seen him. She stated the resident did not complain of pain when she seen him. She stated she informed the CNA B of the residents condition. She stated she does not know if the nurse assigned to the resident was notified. She stated the night nurse (LVN A) that she should go check on the resident because she did not know what was going on with him. She stated she went back into the room with LVN A to assist with the nebulizer machine but she left shortly after. In an interview on [DATE] with LVN E at 2:02 PM, she stated she noticed after dinner (exact time unknown) CR #1 appeared to be a little congested, but his breathing was not labored, she stated it sounded more like wheezing than congestion. She stated one of the previous aides (name unknown) informed her CR #1 had been sick. She stated she assessed the resident for pain and he was provided pain medication. She stated they repositioned CR #1, and it helped his congestion. She stated she checked CR #1's O2 stats and he was fine. She stated she did not observe anything imminent. She stated towards the end of her shift, she checked on the resident again and she tried to get him to cough. She stated the resident coughed up a little mucus and it helped. She stated LVN A came in for night shift around 10:00 PM and contacted the NP and got an order for the nebulizer and x ray and they sent the resident out. She stated the xray was not completed because the resident was sent out instead. She stated she did not contact the MD sooner because she did not think anything was imminent. She stated the resident appeared to be congested as if he was coming down with a cold. Record review of CR#1's hospital medical records, dated [DATE], revealed CR#1's admitting diagnosis was pneumonia and septic shock with low blood pressure and low blood sugar. CR #1 expired at [DATE]. Record review of the facility's, undated, policy Change in a Resident's Condition or Status, revealed Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status . 1. The Nurse Supervisor/Change Nurse will notify the resident's Attending Physician or On-Call Physician when there has been . c. A significant change in the resident's physical/emotional/mental condition .g. A need to transfer the resident to a hospital/treatment center .i. Instructions to notify the physician of changes in the resident's condition. This was determined to be an Immediate Jeopardy (IJ) on [DATE] at 4:34PM. The Administrator and DON were notified. The Administrator was provide with the IJ template on [DATE] at 4:38 PM. FACILITY'S PLAN OF REMOVAL DATED [DATE]. Introduction: On [DATE], at 4:35PM, an Immediate Jeopardy was identified due to failed to contact physician for over 5 hours when CR#1 had a change in condition in that he had shortness of breath and was gurgling. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	All current residents could be at risk of having a change of condition and have the potential to be impacted by this deficient practice. As a result of the IJ the facility has implemented the following. 1. Administrator, DON and ADON were in-serviced by Chief Nursing Officer as well as regional nurse: Healthcare regarding resident changes in condition, follow-up, staff reporting of incidents and changes in condition and notifying the medical director and or designated on call provider Admin, DON and ADON in-serviced on the need for increased staff education and monitoring including new hires and agency staff. All verbalized understanding. In service completed on [DATE]. 2. Facility reviewed policies and procedures prior to in-services. No changes were made to policies, as a result of the initial review. 3. Administrator, DON and ADON completed the following: a. The facility DON and ADON on [DATE] at 5:00 PM implemented the following: All on duty nursing staff were in-serviced on the following by DON and ADON. i. MD notification of change in condition, including change in mental status/alertness ii. Notification of DON/ Administrator of any change in condition. iii. Resident follow-up monitoring iv. Monitoring residents for change in condition. b. Signs/Symptoms of Resident change of condition to include but not limited to: i. mental status, ii. Changes in breathing iii. unarousable while sleeping, iv. changes to pupils v. inability to/or refusing to eat, drink or take medications. vi. Documentation 4. Facility also conducted additional in-services on: c. Abuse, neglect and exploitation. d. Documentation (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation of nurses station 1, revealed the DON set up a reference binder for nurses to review when signing in for work. The reference binder included the change in condition policy. Observation of quick reference binder created for agency staff; the binder included an agency staff orientation training acknowledgement check off list and policies for Abuse, Resident Care, Effective Communication, Mechanical Lift, HIPAA/Privacy/Confidentiality, Notification of Change, Incidents/Accidents, Resident Rights, Med Pass/MISC (Nurses only), PPE and Handwashing. Interviews on [DATE] between 8:00AM and 4:00 PM with 17 staff across three shifts to include 6AM-2PM, 2PM-10PM & 10PM-6AM (RN's, LVN's, CNA's, ADON, DON, Staffing Coordinator, and Administrator) indicated they had been in-serviced on Urgency, Changes in Conditions , taking vitals and how to identify change in condition and who to immediately report changes to (the nurse, DON, ADON or MD) and the importance of documentation in the system immediately (to ensure the resident is getting proper care). During the interviews each staff member was asked to provide an example of what they felt was urgency and what they would do. All CNA's interviewed indicated they would immediately contact the RN or LVN if the vitals were too low, or the resident had a change in condition. They also indicated if necessary and they were unable to contact the RN/LVN they would contact the ADON or DON and then complete the appropriate documentation afterwards. The RN and LVN indicated the same. They also indicated it was imperative for them not to wait to document, but to document all occurrences. The DON will closely monitor changes in conditions with patients by completing an audit daily and reviewing all new physician orders from 30 days prior to present and foregoing. Record review of the Plan of Removal revealed each medical staff member (RN's, LVN's, CNA's, ADON, DON, Staffing Coordinator, and Administrator) were in-serviced, between [DATE] and [DATE] on Urgency in the notifications when resident vitals were abnormal, any changes in resident conditions, heart rate are out of the normal parameters or any changes in breathing an immediate notification to nursing and physician is required and documentation of date and time of the occurrence. Record review of audit completed by DON revealed all residents were audits for change in conditions (skin, falls, incidents with injury, antibiotics, hospitalization , change on 24-hour report, wounds, MD notifications) within the last 30 days. All residents were in stable condition. There was no concerns. Record review of the facility in-service documentation dated [DATE], revealed All Staff were in-serviced for Abuse and Neglect Policy, Change of Condition Policy, Documentation Policy, Change of condition-when to report to MD/NP/PA. An Immediate Jeopardy (IJ) situation was identified on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated with the potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of corrective systems.