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	06/27/2024

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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 38644 Based on observation, interview, and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 (Resident #20) of 6 residents reviewed for quality of care in that: The facility failed to ensure Resident #20 received a weekly skin assessment by a licensed nurse between 12/27/22 - 6/26/24 in accordance with the facility policy and care plan. This failure could place residents at risk of unidentified skin breakdown. The findings include: Record review of Resident #20's face sheet dated 6/27/24 revealed a [AGE] year-old female who admitted on [DATE]. Her diagnoses included dementia, muscle wasting, heart failure, mild protein-calorie malnutrition, hypertension (high blood pressure), and major depressive disorders. Record review of Resident #20's quarterly MDS assessment dated [DATE] revealed the resident was unable to complete the brief interview for mental status. Staff assessed her mental status as severely impaired. She required assistance from staff with ADL care. She was at risk of developing pressure ulcers. Record review of Resident #20's care plan dated 6/27/24 revealed she would remain free from tissue injury through preventative nursing measures. Interventions included a weekly body audit by LN. Record review of Resident #20's quarterly Braden Risk Assessment (used to predict pressure sore risk) dated 6/18/24 by the ADON revealed she was at mild risk of developing pressure sores. Record review of Resident #20's Skin Inspection revealed the last documented inspection was conducted on 12/27/2022 by the previous wound care nurse. There was no documentation of a weekly body audit conducted by a nurse in the resident's clinical record since 12/2022. Record review of Resident #20's Skin Concern Roster dated 12/1/23 - 6/27/24 revealed she had no new skin concerns. The skin concern roster was completed by CNAs during baths and incontinent care. (continued on next page)

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

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's computer-generated skin Assessment Schedule for Thursday 6/27/24 - Wednesday 7/3/24 revealed Resident #20 was not listed on it. In an observation and attempted interview on 6/25/24 at 11:28 a.m., Resident #20 was lying on a couch in the common area, groomed, and not in distress. She did not respond to this Surveyor's greeting. Interview on 6/27/24 at 11:00 a.m., the ADON said the wound care nurse normally conducted the weekly skin assessments, but she stopped working at the facility one month ago. She said she and the charge nurses currently did the skin assessments and used a computer-generated list to know which residents to assess on the assigned day. She said she was unsure how Resident #20 fell off the list. She said CNAs conducted a daily skin check during showers and would report any issues to the nurse. She said nurses were trained to do the detailed head to toe skin assessment to ensure no skin deviations for the residents. She said she did monitor to ensure nurses completed the weekly skin assessments but because Resident #20 was not on the list, she was unable to verify that it was done in the system. She said she never had any concerns with Resident #20's skin. Interview on 6/27/24 at 12:02 p.m., the DON said there was a glitch in the computer system. He said all other residents were on the skin assessment list. He said the purpose of the weekly skin assessment, conducted by the nurse, was to check the whole body and ensure the skin was intact and nothing was missed. He said nurses did skin assessments according to facility's protocol. He said daily skin checks were done by CNAs who would report any skin changes. Interview on 6/27/24 at 1:46 p.m., the Regional Administrator said he would submit a ticket through the IT department to see when Residents #20 fell off the weekly skin assessment schedule generated by the system. He said he expected skin assessments to be done as planned and according to schedule. He said the purpose of the weekly skin assessment, conducted by the nurse, was to check for skin tears, injuries, and for the health and care of the resident. He said CNAs were trained to report anything seen to the nurse for a more thorough inspection. Interview on 6/27/24 at 2:40 p.m., the DON said he did not realize there was a glitch in the system. He said the ADON was responsible for reviewing the weekly skin audits and would refer any concerns to him. He said no concerns were identified. He said if nurse skin assessments were not done the residents could end up with unknown skin issues. Record review of the facility's undated Skin Program, Pressure Ulcers & Other Wounds policy read in part, . Prevention, Treatment, & Documentation . Risk Assessment & Routine Care for All Residents . 4. Nursing assistants will check all residents' skin during each episode of care, bathing, etc. Reddened areas will be reported to the licensed nurse . 6. Body Audits for impaired skin integrity will be performed weekly by a licensed nurse and findings will be documented in the medical record .