

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675999	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER St James House of Baytown		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to ensure that residents were free from any significant medication errors for 1 (Resident #88) of 4 residents reviewed for pharmacy services.-The facility failed to ensure Losartan (a blood pressure (BP) medication given to lower high blood pressure and help protect the kidneys) was administered to Resident #88 per physician order from [DATE] through [DATE]. -The facility failed to ensure accurate reconciliation (a process of comparing and verifying a resident's current list of medications with all prescribed medications to ensure accuracy and safety), of Resident #88's Losartan medication. -MA A administered Losartan 25 mg give 1/2 tablet to equal 12.5mg by mouth daily to Resident #88 and documented they administered Losartan 100 mg give 1 tablet by mouth daily. These failures could place residents at risk of not receiving desired therapeutic outcomes, increased side effects, adverse reactions and or decline in health. Findings included: Record review of Resident #88's admission Record dated [DATE] revealed he was an [AGE] year old male who admitted to the facility on [DATE] with some of the following diagnoses: acute respiratory failure with hypoxia, (a condition where the lungs cannot adequately oxygenate the blood leading to dangerously low levels of oxygen in the bloodstream), type 2 diabetes mellitus with diabetic nephropathy,(a chronic condition where the body does not produce or properly use insulin resulting in complications with damage to nerves throughout the body including the heart) chronic kidney disease, stage 3 (moderate kidney damage where the kidneys are not filtering waste and fluid as effectively as they should leading to build-up of waste products in the blood which can cause high blood pressure), and hypertensive heart disease without heart failure (a heart condition caused by long term high blood pressure, which can put extra strain on the heart increasing pressure in the arteries and or, over time, can lead to thickening of the heart muscle). Record review of Resident #88's admission MDS dated [DATE] revealed his BIMS (a score used to assess cognitive function) was 12 out of 15 indicating he had moderate cognitive impairment in decision making, had clear speech and was able to make himself understand and could understand others. The MDS also indicated he used a walker for mobility and required maximum assistance with bathing, dressing and personal hygiene and moderate assistance with toileting, bed mobility and transfers. Section I of the MDS for Active Diagnoses had him coded as having, 13. Medically Complex Conditions, and 10700. Hypertension. Continued record review of Resident #88's Quarterly MDS dated [DATE] revealed he had a BIMS score of 15 out of 15 indicating he was cognitively intact and Section I of the MDS for Active Diagnoses had him coded as having, 10700. Hypertension. Record review of Resident #88's physician Order Summary Report dated Active Orders As Of: [DATE] revealed Losartan Potassium Tablet 100 MG Give 1 tablet by mouth one time a day for hypertension hold if bp <110/60, pulse <60 .Order Status.Active.Order Date [DATE].Start Date.XXX[DATE] and had no end date. Record review of Resident #88's physician Order Summary Report dated Active Orders As Of: [DATE] revealed Losartan Potassium Oral Tablet 25 MG (Losartan Potassium) Give 0.5 tablet by mouth one time a day related to Hypertensive Heart Disease Without Heart Failure.Give 1/2 a Tab to =12.5 MG. Hold for SBP<110 or HR<60. Order Status.Active.Order Date [DATE].Start Date.XXX[DATE] and had no end date. Record review of Resident #88's physician Order Summary Report dated Active Orders As Of: (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: 675999	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER St James House of Baytown		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[DATE] revealed Losartan Potassium Tablet 100 MG.Give 1 tablet by mouth one time a day for hypertension.hold if bp<110/60, pulse<60. Order Status.Active.Order Date [DATE].Start Date.XXX[DATE] and had no end date. Continued record reviews of Resident #88's physician Order Summary Reports dated Active Orders As Of: [DATE], [DATE], [DATE] and [DATE] all revealed the same order for Losartan Potassium Tablet 100 MG.Give 1 tablet by mouth one time a day for hypertension.hold if bp<110/60, pulse<60. Order Status.Active.Order Date [DATE].Start Date.XXX[DATE] and had no end date. A copy of Resident #88's physician Order Summary Report for [DATE] was also requested but was not received in scanned documents prior to facility exit. Record review of Resident #88's CMA MAR dated [DATE]-[DATE] on [DATE] at 11:28 am revealed: Schedule for [DATE].Tue 19.Losartan Potassium Tablet 100 MG.Give 1 tablet by mouth one time a day for hypertension hold if bp <110/60, pulse ,60. BP.160/70.Pulse.66.0900 and had a check mark symbol and was initialed NPe. Continued record review of the CMA MAR dated [DATE]-[DATE] revealed Resident #88 was documented as having received Losartan Potassium Tablet 100 MG.Give 1 tablet by mouth one time a day for hypertension hold if bp <110/60, pulse ,60, on the following dates, with the corresponding blood pressures:.. Fri 1. BP.170/73.Pulse 62.0900 and had a check mark symbol and was initialed NPe.Mon 4.BP.124/69.Pulse.65.0900 and had a check mark symbol and was initialed NPe. Tue 5.BP.141/88.Pulse 74.0900 and had a check mark symbol and was initialed NPe. Sat 9.BP.179/82.Pulse 68.0900 and had a check mark symbol and was initialed NPe. Sun 10.BP.167/78.Pulse 62.0900 and had a check mark symbol and was initialed NPe. Wed 13.BP.173/79.Pulse.60.0900 and had a check mark symbol and was initialed NPe. Thu 14.BP.162/78.Pulse.64.0900 and had a check mark symbol and was initialed NPe. Fri 15.BP.111/72.Pulse.76.0900 and had a check mark symbol and was initialed NPe. Mon 18.BP.165/74.Pulse.66.0900' and had a check mark symbol and was initialed NPe. Observation and interview with Resident #88 on [DATE] at 9:16 am in his room, during medication administration pass with MA A. Resident #88 was awake, alert, and oriented to person, place, and time. He was sitting upright in bed and was appropriately dressed in a tee shirt and pajama bottoms and appeared clean and groomed. Resident #88 said he had no care concerns at that time, and consented to the observation of his medication administration to be performed by MA A. MA A was observed obtaining Resident #88's BP and HR, which he reported to surveyor as: BP=161/70 and HR=66. MA A stated, his blood pressure is a little high today. MA A did not say what Resident #88's regular BP readings were, and surveyor was able to view Resident #88's blood pressures in the EMR. MA A said that Resident #88 took BP medications that had parameters (specific instructions or measurable factors that guide the proper and safe administration of medications). Observed MA A remove multiple blister packets of medication from the MA cart he was using and proceeded to read his computer screen and place pills in a 30 ml clear plastic cup, passing the blister packet to surveyor after each pill was added to the cup. MA A passed surveyor a blister packet numbered 1-60 that read in part: Resident #88 .Pharmacy A. Losartan/POT TAB 25 MG. Give 1/2 tablet by mouth daily. Hold for SBP <110 or HR <60.30 Tabs [DATE].Medical Director. and showed two 1/2 pill tablets remaining in blister packet. MA A proceeded to Resident #88's bedside with the small clear 30 ml plastic medication cup of pills and handed them to Resident #88 with one hand and handed Resident #88 a 6-8 oz clear plastic cup that contained a water mixture (mixed with a different dissolvable medication), with the other and said to Resident #88 that these were his morning medications and began naming some of the pills and what they were for. Resident #88 took all of the pills inside the 30 ml clear cup and drank all of the 6 oz water mixture and expressed no issues or concerns at that time. Follow-up interview and observation with MA A on [DATE] at 11:58 am regarding Resident #88's Losartan and review of blister packet revealed there were two 1/2 tablets out of 60 left in the blister packet. MA A said he realized after the medication administration pass with Resident #88 in the morning, that the order for his Losartan was incorrect and needed to be changed. MA A said he had not noticed the change in Resident #88's Losartan dose from 25mg, 1/2 tablet PO daily to 100mg, 1 tablet PO daily and thought he had been (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675999	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER St James House of Baytown		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administering the correct medication and correct dosage. MA A said he let Resident #88's charge nurse know about the discrepancy and that Resident #88's order for Losartan needed to be clarified because Losartan/POT TAB 25 MG. Give 1/2 tablet by mouth daily. Hold for SBP <110 or HR <60, was the only Losartan blister pack and only Losartan medication on the medication aide cart for Resident #88. MA A said that LVN A was notified around 9:30 am about Resident #88 receiving the incorrect dose of medication and reviewed Resident #88's medications with LVN A at that time. MA A said LVN A told him she would notify Resident #88's physician and get a clarification of Resident #88's Losartan order. MA A said that a resident could potentially have low blood pressure if they did not receive enough medication or if they received an incorrect dose of medication and that he had been trained on the 6 rights of medication administration., he just did not recognize it was the wrong dose. Interview and observation with LVN A on [DATE] at 12:00pm LVN A said MA A just told her earlier today around 10:00 am about the error in Resident #88's Losartan and she advised MA A at that time she would contact Resident #88's physician to clarify or change the order. When asked if she had already reached out Resident #88's physician about the error and order, as it was already lunchtime, LVN A said she would do it now. LVN A pulled up Resident #88's EMR on her computer screen on her nurse' cart and read the order for Losartan as Losartan Potassium Tablet 100 MG Give 1 tablet by mouth one time a day for hypertension hold if bp <110/60, pulse <60. LVN A said she did not see any blister pack or any other medication or pill bottle for Resident #88's Losartan Potassium Tablet 100 MG Give 1 tablet by mouth one time a day for hypertension hold if bp <110/60, pulse <60. LVN A said the only blister pack she saw was for Resident #88's resident's Losartan/POT TAB 25 MG. Give 1/2 tablet by mouth daily. Hold for SBP <110 or HR<60 and the MA's gave Resident #88 his daily blood pressure medications because the MAs gave the facility residents their scheduled medications. LVN A said she did not know what MA A had documented. LVN A said she was unsure who was responsible for verifying a residents physician order and usually it was the nurse who received the order from the physician. LVN A said she was unaware of who was responsible for monthly medication reconciliation at the facility and that she had been trained on the 6 Rights of Medication Administration. LVN A said a residents' blood pressure could bottom out or a resident could become dizzy or unresponsive if they were given the incorrect dose of blood pressure medication. Interview and observation with DON on [DATE] at 12:09 pm the DON said she first found out about the order discrepancy in Resident #88's Losartan order from her staff, LVN A and MA A. The DON confirmed that Resident #88's blister pack of Losartan revealed two (1/2) tablets left in blister pack that read Losartan Pot Tab 25 MG Give 1/2/ Tablet by mouth Daily Hold for SBP<110 OR HR <60. Dated 30 TABS-delivered [DATE] and expired [DATE]. Record review with DON of Resident #88's EMR order for Losartan revealed Losartan Potassium Tablet 100 MG Give 1 tablet by mouth one time a day for hypertension hold if bp <110/60, pulse <60.The DON said she would speak with Medical Director who was also Resident #88's attending physician and complete a facility medication error form, as the Medical Director was in the facility. The DON said the Medical Director would reevaluate and assess Resident #88, since he was in the building. The DON said the Pharmacy Consultant was the person responsible for reconciliation of all facility resident medications. The DON said the Pharmacy Consultant came to the facility monthly and completed resident medication reconciliations. The DON said that there was no in-house staff member in the facility, who was responsible for completing the monthly medication reconciliation reviews. The DON said that staff had been trained on the 6 rights of medication administration. The DON said she was still investigating and educating/reeducating staff. The DON said a resident could have increased blood pressure, or their blood pressure could not be controlled properly if they did not receive the correct dose of blood pressure medication. Interview with the Medical Director on [DATE] at 12:33 pm who was also the attending MD for Resident #88 said he had been notified by LVN A and MA A, a short while ago regarding Resident #88's Losartan order being incorrect. He said he had reviewed the residents file and found hospital records from an [DATE] hospitalization and readmission and said it looked like the Losartan medication dosage (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675999	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER St James House of Baytown		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	changed in [DATE] after Resident #88's readmission. The Medical Director said he was on his way to evaluate Resident #88 and further assess the situation. The DON was present and said she would be completing a facility medication error report, audit of at least Resident #88's orders and staff education/reeducation and would provide copies to surveyor once completed. In a follow-up interview with the Medical Director/MD for Resident #88, on [DATE] at 1:54 pm, he was notified by surveyor that upon continued record review, of Resident #88's CMA MARS from [DATE], through [DATE], and physician Order Summary Reports from [DATE], through [DATE], revealed Resident #88 had possibly received the incorrect dose of Losartan since [DATE]. The Medical Director said without actual medication packs and observations of the incorrect dose of Losartan being given to Resident #88 it would be difficult to definitively say the resident received the incorrect dose for the entire time. When asked if he considered that length of time to be a significant error, he said that sometimes Resident #88 had really good blood pressures and sometimes they were not good. He said he believed Resident #88 was stable, despite the error and was also taking Hydralazine (a medication primarily used to treat high blood pressure) if his blood pressure was up. The Medical Director also said he had requested a nephrology (branch of medicine that deals with the kidneys) consult for Resident #88 to ensure his kidneys were functioning ok and that Resident #88's laboratory test results so far were ok for the resident's kidney function. When asked who reconciled the medications for the facility monthly, he stated, as the Medical Director, I should have an answer for that, but I don't. The Medical Director said I should be reconciling the medications monthly, but to be honest, I usually just sign the orders. The Medical Director said he tried to make adjustments when he noticed changes or saw changes in medication orders but said he was not sure who at the facility actually completed the monthly medication reconciliation process, but they would be discussing and reviewing it. The Medical Director confirmed today ([DATE]) was the first day he was notified of the incorrect dose of Resident #88's Losartan and said the medication error was one of the good things to come out of the survey process, , was catching things that had been missed that would ultimately improve resident outcomes and thanked surveyor stating, good catch. The Medical Director said he had already reassessed Resident #88 and based on his blood pressure at that time, ordered a one-time does of Losartan. The Medical Director repeated that Resident #88 was stable, and he would be meeting with the administrative team at the facility to discuss, review and improve the medication reconciliation process. He said he had reviewed Resident #88's orders and found no other errors or discrepancies. Record review on [DATE] at 1:56 pm of copy of handwritten Medication Order for Resident #88 dated 8/19. Give Losartan 75 mg PO X 1 now. The order was signed by the Medical Director and there was no time or year indicated on the order. Interview with MA A on [DATE] at 1:57 pm MA A said he did not know why he documented that he had given Losartan 100 mg 1 tab PO daily instead of Losartan 25 MG 1/2 tab PO daily. MA A said he was used to documenting at the time of the medication administration and had not really looked at the blister pack until after the medication administration pass with the surveyor that morning and had a chance to review it. MA A said he should not have documented incorrectly because there was no Losartan 100 mg on the cart for Resident #88 as ordered and he had given the Losartan 25 mg 1/2 tab instead. MA A said he was not sure how long he had incorrectly documented on Resident #88's MAR but corrected it today as soon as he recognized his error, by reporting it to LVN A who was Resident #88's charge nurse. MA A said he was unsure how long he had been giving Resident #88 Losartan 25 MG 1/2 tab PO, but said it was the only blister pack of Losartan on the cart for Resident #88. Telephone interview with Pharmacy Consultant on [DATE] at 3:00pm said she was unaware of Resident #88's incorrect dose of Losartan. They said they had been the Pharmacy Consultant for about 6-7 years and conducted monthly consultations that included reconciliation of medications. They then said they did not conduct full MAR to MD order to cart type of medication reconciliations. The Pharmacy Consultant said they reconciled the orders at the facility. The Pharmacy Consultant said they did not understand how Resident #88's Losartan 25 mg 1/2 tab to = 12.5 mg by mouth daily was still being delivered and said Pharmacy A should have the (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675999	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER St James House of Baytown		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	correct medication prescription and wondered aloud, how the incorrect medication dose continued to be delivered, stating, Why would Pharmacy A keep delivering the wrong medication?. When asked if they thought that Resident #88 potentially receiving the incorrect dose of Losartan since [DATE], the Pharmacy Consultant said Resident #88's blood pressures looked good and had often had the medication held per parameters, so perhaps the Medical Director should look at the 100 mg dose because Resident #88 was being maintained on the lower 25 mg (1/2tab dose) per her own simultaneous, EMR record review. The Pharmacy Consultant said today was the first day they became aware of Resident #88's Losartan discrepancy and incorrect dose and said they did not remember doing a medication administration pass on Resident #88 but had done Medication pass/MAR to cart reviews in the past and facility staff had performed well. The Pharmacy Consultant said a possible outcome to the resident could be increased blood pressures if they did not receive the correct dose of medication. The Pharmacy Consultant stated, I really do not have an answer for how that happened and would be speaking with the facility about the incident. Record review of facility pharmacy review binder on [DATE] at 3:06pm for [DATE] through [DATE] revealed there were monthly pharmacy reviews conducted by Pharmacy Consultant, but there were no letters of recommendations or changes in medication reviews or orders for Resident #88. In a follow up interview with the DON on [DATE] at 3:12 pm she said the facility used Pharmacy A, but they were not fully integrated/computerized with Pharmacy A and still had to fax orders to the pharmacy. The DON said LVN A contacted Pharmacy A today with the faxed order for Losartan 100 mg one tablet by mouth daily, as previously ordered in Resident #88's EMR from [DATE]. The DON said a cart search for another blister pack of Resident #88's Losartan 100 mg tablets did not reveal any other Losartan medication for Resident #88 except the incorrect dose of Losartan 25 mg Give 1/2 tab PO daily that was removed from the cart after the medication administration pass. The DON said she had not completed her investigation as to how long Resident #88 had received the incorrect dose of Losartan but based on her audit of Pharmacy A delivery slips for Resident #88 since his admission to the facility in [DATE], she could only find pharmacy delivery slips for the month of [DATE]. The DON said the only Losartan delivered for Resident #88 was on [DATE] for Losartan POT TAB 25 MG.Qty 30. When asked if she thought Resident #88 potentially receiving Losartan 25 mg 1/2 tab since [DATE] was a significant medication error, the DON did not answer. The DON said MA A should not have been documenting that he administered the correct Losartan medication for Resident #88 because it was not the correct dose as ordered and that would be considered falsifying documentation. The DON said she was still conducting the medication error report and staff one to one education and reeducation and would provide copies of those records once completed. The DON said she had only been the DON at the facility since the end of [DATE] and had previously been the ADON at the facility. The DON said the Pharmacy Consultant was the person who completed the monthly medication reconciliations at the facility. Interview with the Administrator on [DATE] at 3:46 pm who said she the DON started in their roles at the facility around the same time, which was around the middle/end of [DATE]. The Administrator said the DON was responsible for facility resident monthly medication reconciliations along with the Pharmacy Consultant. The Administrator said she did not have anything to do with the medication reconciliation process at the facility and had nothing to do with residents' medications. The Administrator said the DON would be the on-site/in-house person responsible for monthly resident medication reconciliations and was not aware of any issues with Resident #88's blood pressure medication. The Administrator said she did not know anything about medications or risks. Interview with the DON on [DATE] at 2:58pm surveyor requested the CMA MAR signature page for Resident #88's [DATE] MAR. The DON advised surveyor there was no copy of any signature page for the CMA MAR. The DON was asked which staff members initials were NPe, she replied, MA A. When the DON was asked how she could tell which initials belong to which staff member, she said that NPe initials were MA A's and then said MA A and another MA were the only MA's who passed Resident #88's medications and worked that cart and hall. The DON then said that (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675999	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER St James House of Baytown		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MA A was also the only MA who administered Resident #88's daytime medications on [DATE] and admitted to the medication error. Requested a copy of the staffing schedule from [DATE] and in-service trainings with staff. [DATE] at 3:10pm Telephone interview with Pharmacy A on [DATE] at 3:10 pm and spoke with Pharmacy Tech A who said the only order for Resident #88's Losartan 100 MG 1 tab PO Daily was from yesterday [DATE] and should have been delivered to the facility. Pharmacy Tech A said the only order they had for Resident #88 for Losartan before [DATE] were for Losartan 25 mg Give 1/2 tab to equal 12.5 mg PO daily and had been on the order log as active since [DATE]. Record review on [DATE] at 3:43 pm of staffing sheet dated [DATE] revealed MA A worked Days and Evenings on [DATE] and had signed his name and placed the initials NP next to his full name. Record review on [DATE] at 4:02pm of facility Medication Discrepancy Report dated [DATE] at 9:20 am revealed the following: Check items that are applicable: 3). Wrong Dose. Answer YES or NO 1. Was the order written correctly? Yes, was check marked. 2. Did you follow the THREE RULES? -LOOK at the medicine as you removed it from the cart? .COMPARE it with the MAR? LOOK at it as you replaced it in the cart? NO was check marked as the answer to all three questions. 3. Was the order plainly written? NO was check marked. 4. Was the order transcribed onto the MAR properly? YES, was check marked. Questions numbered 5, 6, 7, had been cut off in the photocopy. 8. Was attending physician notified? . If Yes: Date [DATE] at 12:13pm. 9. Was family or responsible party notified? If yes: Date: [DATE] at 12:15 pm. Resident is own RP. Describe the incident. Order was written for Losartan 100 mg but Losartan 12.5mg was administered. Outcome to resident. There was no injury or distress noted B/P rechecked B/P 141/66. Corrective action taken. MD notified and orders are to administer 75 mg of Losartan, correct orders sent to pharmacy. Measures taken to prevent recurrence. CMA inserviced on proper medication administration rules and rights. Physician's response. Recheck residents B/P and administer 75mg of losartan X1 time, which MA A signed. Record review of facility Rx History Report on [DATE] at 4:04 pm revealed the following entry for Resident #88 [DATE] for Losartan POT TAB 25 MG. Qty 30. Requested in-services with staff and any 1-to1 trainings of staff from DON on [DATE] at 12:33pm, and 3:12pm and again on [DATE] at 2:58 pm but did not receive them prior to facility exit. Record review of undated facility policy titled Medications-Medication Regime Review revealed in part: Policy: It is this facilities policy to provide a Medication Regime Review (MRR) for all residents admitted to the nursing facility. Policy Explanation and Compliance Guidelines: 1. Medication Regime Review (MRR) is a thorough evaluation of the medication regime of a resident with the goal of promoting positive outcomes. The review included preventing, identifying, reporting, and resolving medication-related problems, medication errors, or other irregularities and collaborating with other members of the interdisciplinary team. 15. The facility must (sic) insure that: b. Residents are free of any significant medication errors. Record review of undated facility policy titled Medication-Documentation of Administration revealed in part: The facility shall maintain a medication administration record to document all medications administered . 2. Administration of medication must be documented immediately after (never before) it is given. 3. Documentation must include as a minimum: a. Name and strength of drug; b. Dosage. f. Signature and title of the person administering the medication.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675999	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER St James House of Baytown		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 1 of 11 residents (Resident #88) whose records were reviewed for accuracy and completeness. MA A administered Losartan 25 mg give 1/2 tablet to equal 12.5mg by mouth daily to Resident #88 and documented they administered Losartan 100 mg give 1 tablet by mouth daily. This failure could place residents at risk for less than therapeutic benefits and/or not receiving ordered medications due to incomplete documentation. Findings include: Record review of Resident #88's admission Record dated 8/19/25 revealed he was an [AGE] year old male who admitted to the facility on [DATE] with some of the following diagnoses: acute respiratory failure with hypoxia, (a condition where the lungs cannot adequately oxygenate the blood leading to dangerously low levels of oxygen in the bloodstream), type 2 diabetes mellitus with diabetic nephropathy, (a chronic condition where the body does not produce or properly use insulin resulting in complications with damage to nerves throughout the body including the heart) chronic kidney disease, stage 3 (moderate kidney damage where the kidneys are not filtering waste and fluid as effectively as they should leading to build-up of waste products in the blood which can cause high blood pressure), and hypertensive heart disease without heart failure (a heart condition caused by long term high blood pressure, which can put extra strain on the heart increasing pressure in the arteries and or, over time, can lead to thickening of the heart muscle). Record review of Resident #88's admission Minimum Data Set (MDS) dated [DATE] revealed his Brief Interview for Mental Status (BIMS) (a score used to assess cognitive function) was 12 out of 15 indicating he had moderate cognitive impairment in decision making, had clear speech and was able to make himself understand and could understand others. The MDS also indicated he used a walker for mobility and required maximum assistance with bathing, dressing and personal hygiene and moderate assistance with toileting, bed mobility and transfers. Section I of the MDS for Active Diagnoses had him coded as having, 13. Medically Complex Conditions, and 10700. Hypertension. Continued record review of Resident #88's Quarterly MDS dated [DATE] revealed he had a BIMS score of 15 out of 15 indicating he was cognitively intact and Section I of the MDS for Active Diagnoses had him coded as having, 10700. Hypertension. Observation and interview with Resident #88 on 8/19/25 at 9:16 am in his room, during medication administration pass with MA A. Resident #88 was awake, alert, and oriented to person, place, and time. He was sitting upright in bed and was appropriately dressed in a tee shirt and pajama bottoms and appeared clean and groomed. Resident #88 said he had no care concerns at that time, and consented to the observation of his medication administration to be performed by MA A. Observation and interview with MA A on 8/19/25 at 9:16 am of Resident #88's morning medication administration pass. MA A was observed obtaining Resident #88's BP and HR, which he reported to surveyor as: BP=161/70 and HR=66. MA A stated, his blood pressure is a little high today. MA A did not say what Resident #88's regular BP readings were, and surveyor was able to view Resident #88's blood pressures in the EMR. MA A said that Resident #88 took BP medications that had parameters (specific instructions or measurable factors that guide the proper and safe administration of medications). Observed MA A remove multiple blister packets of medication from the MA cart he was using and proceeded to read his computer screen and place pills in a 30 ml clear plastic cup, passing the blister packet to surveyor after each pill was added to the cup. MA A passed surveyor a blister packet numbered 1-60 that read in part: Resident #88 .Pharmacy A. Losartan/POT TAB 25 MG. Give 1/2 tablet by mouth daily. Hold for SBP <110 or HR <60.30 Tabs 06/13/2025. Medical Director. and showed two 1/2 pill tablets remaining in blister packet. MA A proceeded to Resident #88's bedside with the small clear 30 ml plastic medication cup of pills and handed them to Resident #88 with one hand and handed Resident #88 a 6-8 oz clear plastic cup that contained a water mixture (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675999	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER St James House of Baytown		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(mixed with a different dissolvable medication), with the other and said to Resident #88 that these were his morning medications and began naming some of the pills and what they were for. Resident #88 took all of the pills inside the 30 ml clear cup and drank all of the 6 oz water mixture and expressed no issues or concerns at that time. Record review of Resident #88's physician Order Summary Report dated Active Orders As Of: 08/01/2025 revealed Losartan Potassium Tablet 100 MG Give 1 tablet by mouth one time a day for hypertension hold if bp <110/60, pulse <60 .Order Status.Active.Order Date 01/08/2025.Start Date.01/09/2025 and had no end date. Record review of Resident #88's physician Order Summary Report dated Active Orders As Of: 01/01/2025 revealed Losartan Potassium Oral Tablet 25 MG (Losartan Potassium) Give 0.5 tablet by mouth one time a day related to Hypertensive Heart Disease Without Heart Failure.Give 1/2 a Tab to =12.5 MG. Hold for SBP<110 or HR<60. Order Status.Active.Order Date 12/26/2024.Start Date.12/27/2024 and had no end date. Record review of Resident #88's physician Order Summary Report dated Active Orders As Of: 02/01/2025 revealed Losartan Potassium Tablet 100 MG.Give 1 tablet by mouth one time a day for hypertension.hold if bp<110/60, pulse<60. Order Status.Active.Order Date 01/08/2025.Start Date.01/09/2025 and had no end date. Continued record reviews of Resident #88's physician Order Summary Reports dated Active Orders As Of: 03/01/2025, 04/01/2025, 06/01/2025 and 07/01/2025 all revealed the same order for Losartan Potassium Tablet 100 MG.Give 1 tablet by mouth one time a day for hypertension.hold if bp<110/60, pulse<60. Order Status.Active.Order Date 01/08/2025.Start Date.01/09/2025 and had no end date. A copy of Resident #88's physician Order Summary Report for May 2025 was also requested but was not received in scanned documents prior to facility exit. Record review of Resident #88's CMA MAR dated 8/1/205-8/31/2025 on 8/19/25 at 11:28 am revealed: Schedule for [DATE].Tue 19.Losartan Potassium Tablet 100 MG.Give 1 tablet by mouth one time a day for hypertension hold if bp <110/60, pulse ,60. BP.160/70.Pulse.66.0900 and had a check mark symbol and was initialed NPe. Continued record review of the CMA MAR dated 8/1/205-8/31/2025 revealed Resident #88 was documented as having received Losartan Potassium Tablet 100 MG.Give 1 tablet by mouth one time a day for hypertension hold if bp <110/60, pulse ,60, on the following dates, with the corresponding blood pressures:. Fri 1. BP.170/73.Pulse 62.0900 and had a check mark symbol and was initialed NPe.Mon 4.BP.124/69.Pulse.65.0900 and had a check mark symbol and was initialed NPe. Tue 5.BP.141/88.Pulse 74.0900 and had a check mark symbol and was initialed NPe. Sat 9.BP.179/82.Pulse 68.0900 and had a check mark symbol and was initialed NPe. Sun 10.BP.167/78.Pulse 62.0900 and had a check mark symbol and was initialed NPe. Wed 13.BP.173/79.Pulse.60.0900 and had a check mark symbol and was initialed NPe. Thu 14.BP.162/78.Pulse.64.0900 and had a check mark symbol and was initialed NPe. Fri 15.BP.111/72.Pulse.76.0900 and had a check mark symbol and was initialed NPe. Mon 18.BP.165/74.Pulse.66.0900' and had a check mark symbol and was initialed NPe. Follow-up interview and observation with MA A on 8/19/25 at 11:58 am regarding Resident #88's Losartan and review of blister packet revealed there were two 1/2 tablets out of 60 left in the blister packet. MA A said he realized after the medication administration pass with Resident #88 in the morning, that the order for his Losartan was incorrect and needed to be changed. MA A said he had not noticed the change in Resident #88's Losartan dose from 25mg, 1/2 tablet PO daily to 100mg, 1 tablet PO daily and thought he had been administering the correct medication and correct dosage. MA A said he let Resident #88's charge nurse know about the discrepancy and that Resident #88's order for Losartan needed to be clarified because Losartan/POT TAB 25 MG. Give 1/2 tablet by mouth daily. Hold for SBP <110 or HR <60, was the only Losartan blister pack and only Losartan medication on the medication aide cart for Resident #88. MA A said that LVN A was notified around 9:30 am about Resident #88 receiving the incorrect dose of medication and reviewed Resident #88's medications with LVN A at that time. MA A said LVN A told him she would notify Resident #88's physician and get a clarification of Resident #88's Losartan order. MA A said that a resident could potentially have low blood pressure if they did not receive enough medication or if they received an incorrect dose of medication and that he had (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675999	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER St James House of Baytown		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	been trained on the 6 rights of medication administration., he just did not recognize it was the wrong dose. Interview with MA A on 8/19/25 at 1:57 pm MA A said he did not know why he documented that he had given Losartan 100 mg 1 tab PO daily instead of Losartan 25 MG 1/2 tab PO daily. MA A said he was used to documenting at the time of the medication administration and had not really looked at the blister pack until after the medication administration pass with the surveyor that morning and had a chance to review it. MA A said he should not have documented incorrectly because there was no Losartan 100 mg on the cart for Resident #88 as ordered and he had given the Losartan 25 mg 1/2 tab instead. MA A said he was not sure how long he had incorrectly documented on Resident #88's MAR but corrected it today as soon as he recognized his error, by reporting it to LVN A who was Resident #88's charge nurse. MA A said he was unsure how long he had been giving Resident #88 Losartan 25 MG 1/2 tab PO, but said it was the only blister pack of Losartan on the cart for Resident #88. Interview with the DON on 8/19/25 at 3:12 pm she said LVN A contacted Pharmacy A today with the faxed order for Losartan 100 mg one tablet by mouth daily, as previously ordered in Resident #88's EMR from 1/8/25. The DON said a cart search for another blister pack of Resident #88's Losartan 100 mg tablets did not reveal any other Losartan medication for Resident #88 except the incorrect dose of Losartan 25 mg Give 1/2 tab PO daily that was removed from the cart after the morning medication administration pass. The DON said based on her audit of Pharmacy A delivery slips for Resident #88 since his admission to the facility in December 2024, she could only find pharmacy delivery slips for the month of June 2025. The DON said the only Losartan delivered for Resident #88 was on 6/13/25 for Losartan POT TAB 25 MG.Qty 30. The DON said MA A should not have been documenting that he administered the correct Losartan medication for Resident #88 because it was not the correct dose as ordered and that would be considered falsifying documentation. Interview with DON on 8/20/25 at 2:58pm and requested the CMA MAR signature page for Resident #88's [DATE] MAR. The DON advised surveyor there was no copy of any signature page for the CMA MAR. The DON was asked which staff members initials were NPe, she replied, MA A. When the DON was asked how she could tell which initials belong to which staff member, she said that NPe initials were MA A's and then said MA A and another MA were the only MA's who passed Resident #88's medications and worked that cart and hall. The DON then said that MA A was also the only MA who administered Resident #88's daytime medications on 8/19/25 and admitted to the medication error. Record review on 8/20/25 at 4:02pm of facility Medication Discrepancy Report dated 8/19/25 at 9:20 am revealed the following: Check items that are applicable: 3). Wrong Dose.Answer YES or NO 1. Was the order written correctly? Yes, was check marked.2. Did you follow the THREE RULES? -LOOK at the medicine as you removed it from the cart? .COMPARE it with the MAR? LOOK at it as you replaced it in the cart? NO was check marked as the answer to all three questions. 3. Was the order plainly written? NO was check marked.4. Was the order transcribed onto the MAR properly? YES, was check marked. Questions numbered 5, 6, 7, had been cut off in the photocopy. 8. Was attending physician notified? . If Yes: Date 8/18/25 at 12:13pm.9. Was family or responsible party notified? If yes: Date: 8/18/25 at 12:15 pm.Resident is own RP.Describe the incident.Order was written for Losartan 100 mg but Losartan 12.5mg was administered.Outcome to resident.There was no injury or distress noted B/P rechecked B/P 141/66.Corrective action taken.MD notified and orders are to administer 75 mg of Losartan, correct orders sent to pharmacy.Measures taken to prevent recurrence.CMA inserviced on proper medication administration rules and rights.Physician's response.Recheck residents B/P and administer 75mg of losartan X1 time, which MA A signed. Requested in-services with staff and any 1-to1 trainings of staff from DON on 8/19/25 at 12:33pm, and 3:12pm and again on 8/20/25 at 2:58 pm but did not receive them prior to facility exit. Record review of undated facility policy titled Medication-Documentation of Administration revealed in part: The facility shall maintain a medication administration record to document all medications administered .2. Administration of medication must be documented immediately after (never before) it is given. 3. Documentation must include as a minimum: a. Name and strength of drug; b. Dosage.f. Signature and title of the person administering the medication.		