STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676290	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spjst Rest Home 1	1810 Old Granger Road Taylor, TX 76574

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42600 Based on observations, interviews, and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one (Resident #7) of seven residents reviewed for quality of care. The facility failed to assess Resident #7 for emotional and physical distress after he was exposed to smoke inhalation after the air conditioning/heating unit began to smoke in his room and subsequently began not feeling well and had pain in his chest form smoke exposure. This failure could place residents at risk of not receiving necessary medical care, harm, and hospitalization . Findings included: Review of Resident #7's face sheet revealed an [AGE] year-old man admitted on [DATE] and diagnoses included: malignant neoplasm of prostate (cancerous tumor that forms in the prostate gland), chronic obstructive pulmonary disease (chronic lung disease that limits airflow and causes ongoing respiratory symptoms), unspecified asthma (chronic disease in which the bronchial airways in the lungs become narrowed and swollen and make it difficult to breathe), and atherosclerotic heart disease (condition that occurs when plaque builds up in the arteries, hardening them and limiting blood flow to the heart), and unspecified combined systolic heart failure (caused by other conditions that weaken the heart muscle). Review of Resident #7's quarterly MDS dated [DATE] revealed a BIMS score of 14 which indicated no cognitive impairment. Review of Resident #7 active diagnoses revealed resident had a diagnosies of asthma and/or COPD. Review of Resident #7's care plan dated 09/24/2024 revealed the resident has ineffective tissue perfusion related to potential syncope. Cardiac dysfunction and had an AEB pacemaker in place. Interventions included that resident's safety and comfort will be maintained this review period. Further review of the care plan revealed the resident was at risk for activity intolerance related to imbalance between supply oxygenation needs. Review of Resident #7's physician orders dated 07/02/2024 revealed the resident had an order for O2 per nasal cannula/mask as needed for shortness of breath, cough, or congestion. (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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Further review of Resident #7's progress notes dated 10/14/2024 to 10/15/2024 revealed no progress note related to incident in which the resident was exposed to smoke inhalation on 10/14/2024. Review of Resident #7's progress note dated 10/16/2024 revealed the resident complained of increased pain and discomfort to the center of his chest around the sternum. Resident #7 stated that he had a slight dry cough and that the pain made it difficult to swallow. Review of Resident #7's vital signs from 10/14/2024 through 10/17/2024 revealed only Resident #7's blood pressure had been taken and recorded. There were no vitals documented for respirations, oxygen saturation, temperature, or pulse. Further review revealed that blood pressure taken during this time frame were taken by medication aides. Review of Resident #7's skin assessments from 10/14/2024 to 10/17/2024 revealed no assessment was completed following the incident with resident's air conditioning/heating unit in the room. Further review of Resident #7's chart indicated there was no trauma/psychosocial assessment completed. Review of the nurse practitioner progress note dated 10/14/2024 revealed the NP visited the resident with chief complaint as nausea and history of present illness for the visit was the resident was exposed to smoke that was coming out of the air conditioning unit in his room, per DON report, he is participating in morning activities, c/o nausea denies any sob, cp, headache. Assessment and plan included order for Zofran every 6 hours as needed for nausea. Assessment and plan for Asthma/COPD included stable, on room air without exacerbation, and to monitor respiratory status with no issues reported at the time of the assessment. During an interview on 10/17/24 at 10:08 AM LVN F stated that the incident with the smoking unit happened Monday (10/14/2024) and that she was Resident #7's nurse on Tuesday. LVN stated that his vitals were normal, lung sounds were clear, and he was at baseline. LVN F stated that if she was Resident #7's nurse when the incident happened, she would have done a head- to- toe assessment on him and full vitals. LVN F stated that normally the NP iwas there, and she would have notified her as well. LVN F stated that the head-to- toe assessments were documented as a progress note and under observations on the Resident's chart. She stated that she would have written a progress note about what happened to the resident and who was notified. LVN F viewed Resident #7's chart and stated that Resident #7 did not have a progress note for the incident and did not have skin assessment for the incident either . During an interview on 10/17/24 at 10:33 AM LVN G stated you [NAME] supposed to ensure residents were okay. LVN G stated that this included to check lung sounds and a head-to-toe assessment. LVN G stated that these should be documented under a progress note. LVN G stated that she would have monitored the resident at least every shift after incident for 3 days as this was procedure for after an incident. LVN G stated that the potential risk for not assessing the resident [NAME] that the resident could potentially get a respiratory infection from inhaling smoke or staff could miss an injury. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/17/24 at 10:37 AM CNA H stated that the incident happened between 9:30 AM and 10:00 AM on 10/14/2024. CNA H stated that she smelled a smokey smell and described it as when you first turn on heater for first time in the year. CNA H stated that there was a lot of smoke in Resident #7's room and the smoke came out of the room when she opened the door. CNA H stated that she was coughing heavily and had a headache the rest of her shift. CNA H stated that she believed the DON checked on Resident #7 following the incident. LVN H stated the following day Resident #7 complained about his chest and throat hurting and she notified his nurse. She stated the nurse was LVN F. During an interview on 10/17/24 at 11:08 AM the NP stated that she saw Resident #7 on 10/14/2024 because he was nauseous and stated that he drank too much water with his medication. The NP stated that other than that everything was okay. The NP stated that she did not take his vitals and reviewed the vitals from his chart, and they appeared okay. The NP stated she saw Resident #7 again this morning (10/17/2024) and he was doing therapy. The NP stated that Resident #7 had issues with acid refluex. The NP stated that a GDR was recommend for his PPI and this could have been why he felt pain in his throat. The NP stated that Resident #7 did not complain of a cough this morning. The NP stated that earlier this week staff notified her that Resident #7 complained of a cough. The NP stated that when she assessed him on 10/15/2024 his lungs were clear. She stated that his chest pain was in the center and when he ate it felt like it burned and that his nurse mentioned that his chest pain happened before the smoke exposure . During an interview on 10/17/24 at 11:13 AM LVN I stated she worked on the hall with the unit smoking. LVN I stated that after she and the CNA smelled smoke, they pulled the fire alarm, and removed residents off the hall. LVN I stated initially that she did not recall Resident #7. LVN I stated that she was assigned to that room during that shift on 10/14/2024. LVN I stated that staff went one by one and checked the residents to make sure they were okay. LVN I stated that this included checking the residents vitals and asking if they were okay. LVN I stated that the vitals were not documented. LVN I stated that she did not believe Resident #7 had a head- to- toe assessment completed after the incident. LVN I stated she did not know why an assessment was not done. said Shethen stated it was not completed because it was chaotic. LVN I's vitals [NAME] documented in the vitals tab in the residents' charts. LVN I stated that usually after an incident residents were followed for 72 hours . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/17/24 at 11:29 AM the DON stated that LVN I worked the hall when Resident #7's unit began to smoke. The DON stated she notified the NP that he needed to be evaluated and that the NP went and evaluated him. The DON stated that she was not sure what was done during the NP's evaluation. The DON stated that she did not see that LVN I completed an assessment with Resident #7 or vitals. The DON stated that the NP stated Resident #7's vitals needed to be checked. The DON stated that vitals [NAME] documented in a resident's chart, under the vitals tab, and by progress note. The DON stated that she doe didoes not think anyone completed a head- to- toe assessment with Resident #7. The DON stated it was a lack of education for new nurses and the nurse should have been educated on what to do in the situation. The DON stated that she was only made aware that Resident #7 had been complaining of chest pain on 10/15/2024 and she asked the NP to reach out to the nurse. The DON stated that if a resident [NAME] not assessed after an incident there was potential risk for infection, bronchitis, and pneumonia. The DON stated that she asked the NP to order a chest x-ray the day of the incident on 10/14/2024 and again 10/17/2024. The DON stated that the NP denied and stated that his lungs were clear and did not feel an x-ray was needed at this time. The DON stated she was not aware of the Resident complaining daily of GERD issues prior to the incident. The DON stated that she expected nurses to monitor a resident for three days or 9 shifts after any incident. The DON stated that she expected the staff to gather vitals, watch for new symptoms, new cough or headache, and new chest pain. The DON stated that vitals included gathering blood pressure, respiratory rate, and pulse. The DON stated that CNAAN H had a cough and shortness of breath after the incident, and she was unsure if Resident #7 had a cough. The DON stated that she was unsure if Resident #7 was assessed for emotional or psychosocial distress since the facility did not have a social worker and she thought the ADM may be responsible to for completed that assessment. During an interview on 10/17/24 at 11:53 AM Resident #7 stated that he stated that he has not been feeling well since he had all the smoke in his room. Resident #7 stated he has been having pain in his chest and motioned in the middle of his chest. Resident #7 stated that he has not had pain in his chest before the exposure to smoke. Resident #7 stated that the nurse told him he has bronchitis. Resident #7 stated that he has pain mainly when he swallows, and did not associate a number with it, just stated it was the same since the incident and not getting worse. During an interview on 10/17/24 at 12:17 PM: LVN F checked Resident #7's vitals temperature 98.7 Fahrenheit, 76 was his heart rate, 99% O2, and 142/68. LVN F stated Resident #7 was going to start taking Carafate for his GERD. During an interview on 10/17/24 at 12:21 PM the MD stated that she expected for a routine assessment which included vital signs and oxygen level to be completed after exposure to smoke inhalation. The MD stated that if a resident has COPD, inhalation could have exacerbated it. The MD stated smoke inhalation could cause a cough or chest pain like any other irritant. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/17/24 at 03:07 PM the ADM stated that there was not a social worker and stated that the nurse would complete the psychosocial assessment for any emotional distress. He is unsure if this was completed and who assessed the resident for emotional or psychosocial distress. He stated if there was distress the resident would be referred to psychology. The ADM stated that the NP assessed Resident #7 right away after the incident. He stated that if she would not have been here, he would have expected that the charge nurse assessed him. The ADM stated that CNA H had a headache and sat in the lobby for a few hours after the incident. The ADM stated that he expected the NP to check Resident #7's lung sounds. The ADM stated that he didoes not know what else the NP would check, and he knew the NP talked to staff after, but he was unsure what happened with Resident #7's assessment . Review of facility in-service dated 07/14/2024 included topic of skin and pain assessments. Comments included for any new incident, a skin assessment must be done to document injuries and a pain assessment should be completed to ensure resident has no pain from new events. Skin and pain assessments should be completed for any admission, any change in condition or event. Review of facility policy titled Resident Examination and assessment dated [DATE] revealed the purpose of this procedure is to examine and assess the resident for any abnormalities in health status. Further review revealed the physical exam should include vital signs such as blood pressure, pulse, respirations, temperature, heart rate and rhythm, lung sounds, and cough. Documentation of the exam should be recorded in the resident's medical record and include the date and time the procedure was performed, name and title of the individuals who performed the procedure, and assessment data obtained during the procedure. Staff should notify the physician for worsening pain as reported by the resident and other information in accordance with facility policy and professional standards of practice. Review of facility quality of care policy titled Change in a Resident's Condition or Status dated May 2017 revealed the nurse will notify the resident's attending physician if there has been any accident or incident involving the resident. Further review revealed that prior to notification, the nurse will make detailed observations and gather relevant information including information prompted by the interact SBAR communication form. The policy revealed the nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42600 Based on observation, interview and record review, the facility failed to have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption in personal refrigerators for 1 of 1 residents. 1. The facility failed to conduct and/or document the temperature and contents of Resident #22's personal refrigerator. This deficient practice could place residents at risk for food-borne illness. Findings included: Review of undated face sheet for Resident #22 reflected an [AGE] year-old male admitted to the facility on [DATE]. His diagnoses include acquired absence of right leg below knee (below knee amputation), need for assistance with personal care, muscle weakness (lack of muscle strength), and major depressive disorder (a serious mental disorder that affects how a person feels, thinks, and acts). Review of Resident #22's quarterly MDS dated [DATE] reflected a BIMS score of 14 which indicated no cognitive impairment. Review of Resident #22's orders dated 10/17/2024 reflected assistance x 1 is required for toileting, transfers and eating. Observation and interview on 10/15/2024 at 1:40 PM revealed Resident #22 attempted to put a jar of peppers in his personal refrigerator. Further observation revealed the following: *Several uncovered drinks, *2 tomatoes that were shriveled with large black spots, *Dried food *Brown and yellow liquid spilled on bottom shelf and door of the personal refrigerator. *2 halves of a banana, *A bottle of mayonnaise with a best by date of [DATE], and * No thermometer was observed in the personal refrigerator. Resident #22 stated he did not know who, if anyone, checked his personal refrigerator. During an interview on 10/17/2024 with CNA O at 10:48 AM stated the refrigerators should be checked by dietary staff. CNA O stated if the personal refrigerators were not checked routinely by staff, then the resident could consume products and could end up with food borne illnesses. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/17/2024 at 1:50 PM LVN F stated she was unsure of who was supposed to check personal refrigerators. She stated if the personal refrigerators were not checked on a regular basis that the food can spoil and can cause food borne illness if consumed by residents. During an interview on 10/17/2024 at 3:12 PM the ADM stated housekeeping was supposed to check all personal refrigerators for spoiled food, but he was unsure of the frequency. The ADM stated he was unsure if personal refrigerator temperatures were being monitored at all. The ADM stated if a resident were to consume spoiled food, they could get food poisoning. During an interview on 10/17/2024 at 3:55 PM the DON stated there was not a policy for personal refrigerators at this time. She said that housekeeping was to clean and check temperatures daily in personal refrigerators for those residents with a low BIMS and incapable of checking the refrigerators themselves. She also stated that if the refrigerators were not checked it could lead to food spoilage, gastritis (an inflammation of the lining of the stomach) and illness if the food were to be ingested by the residents.