STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675999	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that a resident who was unable to carry out activities of daily living received the necessary services to maintain good grooming and personal hygiene for 1 (Resident #82) of 5 residents reviewed for ADL care. -The facility failed to ensure Residents #82 received timely incontinent care. This failure could affect all residents who needed ADL care and placed them at risk of not receiving needed assistance with personal hygiene care, poor self-image, and lower quality of life. Findings included: Resident #82 Record review of Resident #82's face sheet revealed she was admitted on [DATE]. Her [DIAGNOSES REDACTED]. Record review of Resident #82's quarterly MDS dated [DATE] revealed a BIMS of 5 indicating severe cognitive impairment. She needed supervision of one staff with toileting and personal hygiene and was frequently incontinent with urine. Record review of Resident #82"s undated care plan read in part . self-care deficit related to generalized weakness/debility/history of poor hygiene practices . requires supervision to limited with 1 staff assistance with toilet use and personal hygiene . intervention . encourage to perform . ADL as independently as possible . Observation and Interview on 3/4/20 at 12:06 p.m. of Resident #82 as she walked out of her room and said that her pants were wet with urine. She said she wanted to go to the dining room for lunch but needed help. The resident's pants were wet from her buttocks to middle thigh. She said she had not seen her aide for hours and her room smelled of ammonia. Interview on 3/4/20 at 12:15 p.m. with CNA QQ, she said she perceived a urine odor in Resident #82's room. She said she saw the resident last around about 8:30 a.m., when she picked up her breakfast tray. She said that the resident does her care by herself and the staff supervises because she is incontinent. She also said she makes rounds every two hours on all her residents to make sure they are clean and not wet. Interview on 3/5/20 at 10:35 a.m. with DON, she said CNAs should make rounds on all their residents every two hours, even the ambulatory residents to make sure they are clean and dry. Record review of undated facility policy on incontinence care read in part . provide incontinence care to all incontinent resident during routine . promote cleanliness and comfort, prevent infection . residents will be checked for incontinence at least every 2 hours . .
F 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation of controlled drugs in 1 (Station 1) of 2 medication rooms reviewed, in that: -Station 1's medication room contained an inaccurate narcotic log of the narcotic emergency kit. This deficient practice could affect any resident who required narcotics from the emergency kit. Findings included: Observation on 3/5/20 at 2:00 p.m. of the narcotic emergency kit located in Station 1's medication room with LVN B revealed the following medications: [REDACTED]. [MEDICATION NAME]/APAP ([MEDICATION NAME]) 10/325 . with no date revealed the last [MEDICATION NAME] tablet removed from the kit was on 2/17/20 at 5:30 p.m. The amount left of the medication was 21. The number 21 was scratched out, and no number replaced it. Record review of Emergency Kit: Controlled Administration Record . [MEDICATION NAME] 50 mg . with no date revealed the last [MEDICATION NAME] tablet was removed from the kit on 2/17/20 at 8:00 p.m. The amount left was 25. Interview on 3/5/20 at 2:10 p.m. with LVN B, she said nurses checked the emergency kit narcotics every so often. She said if a narcotic needed to be pulled from the emergency kit, the medication count needed to be verified and the removed medication needed to be signed out by the nursing staff. She said the controlled administration record was all over the place and she was unsure what system was in place to ensure the record matched the amount of medications on hand. She said it looked like the controlled administration record had not been updated when the Pharmacy delivered more narcotics. Interview on 3/5/20 at 3:19 p.m. with the DON, she said nurses should verify the emergency kit narcotic count every shift change. She said the controlled administration record must be updated every time the pharmacy delivered more narcotics. Record review of the facility's undated Medications - Controlled Substances policy read in part . Policy Statement: The facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of schedule II and other controlled substances . Policy Interpretation and Implementation . 3. Controlled substances must be counted upon delivery. The nurse receiving the medication, along with the person delivering the medication, must count the controlled substances together. Both individuals must sign the designated controlled substance record . 8. Nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing Services . .
F 0759 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that the medication error rate was not five percent or greater. The facility had a medication error rate of 7%, based on 2 errors out of 27 opportunities, which involved 1 (Resident #24) of 4 residents and 1 (MA G) of 4 staff reviewed for medication error, in that: -MA G crushed two medications that were not crushable and administered them to Resident #24. This failure could affect any resident who was dependent on staff for medication administration. Findings include: Resident #24 Record review of Resident #24's face sheet revealed she was a [AGE] year-old female admitted on [DATE]. Her [DIAGNOSES REDACTED]. Record review of Resident #24's significant change MDS dated [DATE] revealed a BIMS score of 14 indicating no cognitive impairment. She needed extensive assistance with bed mobility, transfer, dressing and personal hygiene. Record review of Resident #24's physician orders [REDACTED]. may crush crushable medications, no order date . Crush meds, order date 12/6/19 . Aspirin EC 325 mg tablet give one tablet by mouth daily, order date 7/10/18 . [MEDICATION NAME] CL ER 10 mg tablet 1 tab PO QD, order date 10/7/19 . Observation on 3/4/20 at 10:21 a.m. during medication pass, MA G prepared Resident #24's medications for administration. She prepared one Aspirin 325 mg coated tablet, and one [MEDICATION NAME] 10 mg ER tablet, along with other medications. She placed all the tablets in a plastic sleeve, crushed them, and mixed them with pudding. MA G then administered the pudding mixture to Resident #24. Interview on 3/4/20 at 10:54 a.m. with MA G, she said coated tablets and extended release tablets could not be crushed. She said she thought the Aspirin tablet was crushable because the bottle read coated tablet and not [MEDICATION NAME] coated. She said she did not know the difference between coated and [MEDICATION NAME] coating and said she did not know what ER meant. Interview on 3/6/20 at 10:39 a.m. with the DON, she said the facility had standing orders for crushed medications. She said [MEDICATION NAME] coated and extended release tablets could not be crushed. She

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

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F 0759 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) said [MEDICATION NAME] coated and coated tablets were the same thing. She said nursing staff could utilize the do not crush list available at the nursing station if they had questions about crushing medications. Record review of the facility's undated Tips on Crushing Medications information sheet provided by the DON read in part . Not all medication can be crushed! . These are the general categories of drugs that cannot be crushed: [MEDICATION NAME] coated (EC) . Extended release (ER, XR) . .
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe and sanitary environment and to help prevent the development and transmission of communicable diseases and infections, for 1 (Laundry Aide B) of 3 staff reviewed for infection control. -Laundry Aide B failed to follow hand hygiene technique while she collected dirty linen from the hallways and when she removed washed linen from the washer to dryer after handling dirty linen. -Laundry Aide B failed to ensure that she washed her hands in a clean sink. These failures could affect all residents and placed them at risk of cross-contamination and the spread of infection. Findings included: Observation on 3/4/20 from 11:19 to 11:21 a.m. revealed Laundry Aide B pushing a laundry basket in the 400 and 800 hallways wearing gloves. Interview on 3/4/20 at 11:21 a.m. with Laundry Aide B, she said when she picked up dirty laundry she wears the same gloves and goes from one hall to another to pick up dirty laundry. She said she used the same gloves to open the doors and barrels. She said that she had been in-serviced on infection control and she said she had been told not to wear gloves in the hall. She said she did not know why she wore the gloves. Observation on 3/4/20 at 11:35 a.m. of Laundry Aide B washing her hands in the sink in the dirty area of the laundry room. She held a black hose that had brown substance on it, attached to the faucet to rinse her hands of soap, switching from hand to hand. She then turned off the faucet with her wet hands and placed the hose back into the sink that appeared soiled and stained. She walked to the clean area, applied gloves from her uniform pocket and pushed a basket to the washer and removed the linen from the washer. She pushed the basket to the clean room and loaded the dryer. Also observed in the clean room was a handbag, a keychain with keys, and a sliver metallic cup on the clean linen folding table. Interview on 3/4/20 at 11:40 a.m. with Laundry Aide B, she said she should not have used the gloves from her pocket to take linen from the washer to the dryer and when she washed her hands she still touched the hose that was dirty. She said there was nothing she could do about it because the hose had been like that since she started working at the facility. She said that the folding table was for clean linen from the dryer and personal items should not be on the table to avoid cross contamination. She said she was not supposed to put her belongings on the folding table. Interview on 3/4/20 at 1:04 p.m. with Housekeeping and Laundry Supervisor, she said Laundry Aide B was trained on infection control when she first started, about two months ago. She said that the staff are not supposed to walk around the halls wearing gloves. She said staff are not supposed to keep gloves in their pockets, and clean gloves should be taken from the glove box. She said that the folding table should only be used for clean linen. She said that the laundry area needed a new sink. She said it was not sanitary to use the hose to spray water on hands while touching the dirty hose during hand washing because you are still contaminating your hands. Record review of the facility undated policy on handing soiled linen read in part . are handled, stored, processed and transported so as to prevent the spread of infection . Record review of the facility undated policy on Laundry read in part . facility to follow infection control methods related to washing clothes . .