STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676396	A. Building B. Wing	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
S.P.J.S.T. Rest Home 3	248 Wisteria Lane El Campo, TX 77437

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40249 Based on observation, interview, and record review, the facility failed to ensure that a resident who needs respiratory care, including tracheotomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences for 2 of 4 residents (Resident #1 and Resident #3) reviewed for respiratory care. -The facility failed to obtain a physician's order for Resident #1's oxygen he received via nasal cannula. The O2 tubing was not changed in over 16 days. -Resident #3's nasal cannula tubing not changed in over 10 days. These failures could affect all residents using supplemental oxygen and place them at risk of receiving incorrect or inadequate oxygen support and could result in a decline in health. Findings included: Resident#1 Record review of Resident #1's face sheet undated revealed the resident was a [AGE] year-old male admitted on [DATE] with diagnoses that included dementia, ataxia and anemia in other chronic diseases classified elsewhere Record review of Resident #1's MDS dated [DATE] revealed a BIMS score of 03 out of 15 indicating severely impaired cognitively. He required extensive assistance in performing all activities of daily living (ADLs). He was in-continent to bowel and in-continent to bladder. Section C0100. Special treatment, procedures and program was coded for receiving oxygen therapy. Record of Resident #1's care plan initiated on 11/07/2022 and revised on 02/02/2023 revealed the following: Focus: I have as needed oxygen therapy r/t hospice services. Goal: I will have no s/sx of poor oxygen absorption though the review date. Interventions: oxygen settings: 2-4 L as needed per standing hospice orders. (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record of Resident #1's physician order dated 11/13/22 revealed an order to change O2 concentrator tubing every night shift every Sunday. Record review of Resident #1's Treatment Sheet for the month of January 2023 revealed: nurses made an entry that the tubing was changed and dated 01/22/2023 and 01/29/2023. [tubing is changed every Sunday]. Record of Resident #1's physician order dated 02/02/2023 created by LVN A revealed an order for O2 via NC 2-4L/min prn every 1 hours as needed for SOB or sats below 92% room air. Attempted interview and observation on 02/02/23 at 9:40a.m., of Resident #1 revealed he was lying in his bed. He had a nasal cannula in place and an oxygen concentrator at his bedside. The concentrator was on and set to deliver 4 LPM (liters per minute). The oxygen tubing was dated 01/16/23. Record of Resident #1's nurses notes created by LVN A on 2/2/2023 9:42 a.m. read in part: . Note Text: notified [hospice company] of residents change in condition. Resident had episode of paleness along with clammy skin. Resident taken to his room by cna and cna notified nurse. Nurse assessed resident- at that time resident was not pale and clammy. o2 sat at84-85% on room air. o2 at 2l/min via NC applied and sats remained the same. Nurse then administered 4l/min o2 via nc- sats at 85% after 3 mins of administration. Resident assisted to bed x 2 staff. Resident doesn't appear sob and is acting as usual self. Will cont to monitor for any changes. [hospice company]to notify rp . Observation and interview on 02/02/23 at 10:03 a.m., LVN A said the oxygen tubing was dated 01/16/23. She said oxygen tubing were changed weekly by night shift nurses on Sunday. She said Resident#1 had a change of condition this morning. She said resident had standing orders from hospice. She said there was an oxygen concentrator in the resident's room not being used with tubing connected. She said she did not check the date on the tubing prior to administering the oxygen therapy this morning. She said tubing should be changed weekly to avoid infection control issues and to let the nursing staff know when the tubing was changed. In an interview and record review on 02/02/23 at 10:11 a.m., with LVN A, LVN A reviewed Resident #1's Physician's orders with this Surveyor. LVN A said she did not see an order for oxygen. Resident#3 Record review of Resident #3's face sheet undated revealed the resident was a [AGE] year-old female admitted [DATE] and readmitted on [DATE] with diagnoses that included Parkinson's disease, Acute respiratory failure with hypoxia, restlessness and agitation Record review of the Resident #3's MDS dated [DATE] revealed a BIMS score of 00 out of 15 indicating severely impaired cognitive skills. Further review of the MDS revealed that she required extensive assistance from staff for dressing, toilet use and personal hygiene. The resident was incontinent of bowel and bladder. Section C0100. Special treatment, procedures and program was coded for receiving oxygen therapy. Record review of Resident#3's Care Plan initiated 9/23/2019 and revised on 10/8/2019 revealed the following: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Focus: Resident #3 has Oxygen Therapy r/t O2 via N/C at 3L/min at night as needed Goal: Resident#3 will have no s/sx of poor oxygen absorption through the review date. Interventions: OXYGEN SETTINGS: Resident #3 has O2 via nasal cannula @ 3L continuously at night as needed. Record review of Resident #3's physician order dated 02/20/22 revealed an order to Change O2 tubing Q week on Sunday every night shift every Sun related to ACUTE RESPIRATORY FAILURE WITH HYPOXIA. Record review of Resident #3's physician order dated 9/30/22 revealed an order for 02 @ 2-4L CONTINUOUS TO KEEP SATS >90%. every shift for TO KEEP 02 SATS > 90%. Record review of Resident #3's MAR/TAR for the month of January 2023 revealed nurses made an entry that the tubing was changed and dated 01/29/2023 [tubing is changed every Sunday]. Attempted interview and observation on 02/02/23 at 9:56a.m., revealed Resident #3 was in the dining room sitting on a W/C receiving continuous oxygen from a portable concentrator. The concentrator was on and set to deliver 4 LPM (liters per minute). The oxygen tubing was dated 01/23/23. Observation and interview on 02/02/23 at 10:06 a.m., LVN B stated Resident #3's oxygen concentrator tubing was labeled 01/23/23. LVN B stated not changing the tubing could be an infection control issue. She said tubing were changed weekly by night nurses on Sunday. She said she knew resident was on oxygen therapy but did not check the tubing this morning. Record review and interview on 02/02/23 at 12:00p.m., the DON reviewed Resident #1 and #3's physician orders and MAR/TAR with the Surveyor. The DON said the tubing and humidifier were checked on Sunday by the night shift nurse. The DON said nurses were responsible for ensuring the procedures involving oxygen therapy and the dating/changing of tubes were completed. She said she had no explanation of why the changing of the oxygen equipment was not done. She said the nurses documented that tubing were changed. She said LVN A brought it to her attention that Resident #1 had a change of condition this morning and there was a set-in resident's room. LVN A told her that she did not check the date on the tubing before administering oxygen. The DON said her expectation was to follow physician order and have a clean set available in case of emergency. She said not changing the oxygen equipment could have the potential outcome of the residents experiencing breathing issues and possible infections. In an interview on 02/02/23 at 12:14p.m., with the DON and the Administrator, the Administrator said the facility did not have a policy on dating/replacing oxygen therapy equipment.