STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455714	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northwest Health and Rehabilitation Center	17600 Cali Dr Houston, TX 77090

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46561 Based on observation, interview, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, for 1 of 5 residents (Resident #1) reviewed for dignity. The facility did not change the linen on Resident #1's bed after it had been soiled and stained with dark brown matter for the duration of the 6am-2pm shift on 05/08/24. This failure could put residents who are incontinent and require ADL assistance at risk for a diminished quality of life, loss of dignity, and self-worth. Findings included: Record review of Resident#1's face sheet dated 05/08/24 revealed a [AGE] year-old man who was admitted to the facility on [DATE]. His admitting diagnoses were multiple fractures to the ribs, Parkinson's disease (a condition that affects the brain and causes problems with movement, balance, and coordination), and hypertension (high blood pressure). Record review of Resident #1's MDS assessment dated [DATE] revealed a BIMS Summary Score of 12 indicating he was moderately impaired . Record review of Resident #1's care plan, last review dated 05/03/24 revealed he had an ADL self-care deficit and was at risk for further decline in ADL functioning. Resident #1's goal for the focus area reflected that he would be well dressed, groomed, cleaned, dignity maintained, and have no further decline in ADL functioning over the next 90 days. Further review of the care plan reflected that Resident #1 had bowel and bladder incontinence and was at risk for skin break down. The goal for the focus area reflected that Resident #1 would remain clean, dry, odor free, and no occurrence of skin break down. In an observation on 05/08/24 at 11:05 am, Resident #1 was sitting in his wheelchair and he was hunched over asleep. The sheets on his bed were wet and there was a large brown tinged stain that was in the middle of the pull sheet (sheet used to adjust the resident in bed) and on the resident's top sheet. A smudge of dark brown matter was also left on the pull sheet and a faint smell of urine lingered in the air. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455714	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northwest Health and Rehabilitation Center	17600 Cali Dr Houston, TX 77090

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/08/24 at 11:22 am with Resident #1, he stated that he required a lot of briefs, and the staff changed him when he needed to be changed. When asked about the linen on his bed, he explained that he had been out of bed since 9:30 am and had wet himself during the middle of the night. He did not know if staff were aware that his linen was wet, but he said that the CNA brought him his breakfast tray and removed it once he was finished. He explained that he had fallen asleep in his wheelchair after breakfast and did not request staff to change his linen. He could not recall if anyone checked on him. When asked if he was currently wet, he stated that the urine in his brief had dried up at that time due to the brief's absorbency. He could not recall if staff had preformed incontinent care for him when they helped him out of bed that morning. In an observation on 05/08/24 at 1:15 pm, Resident #1 was sitting in the same position in his wheelchair next to his bed. He was wearing a different shirt and indicated that he changed it himself. The sheets still had a brown tinged stain that had begun to dry and a dark brown smudge. In an interview with CNA A on 05/08/24 at 1:59 pm, she stated that she had worked at the facility for 2 years. Her shift on 05/08/24 was from 6am-2pm and she was working with Resident #1 on that day. She followed the investigator into Resident #1's room and she stated that she did not know he was up out of bed and she did not know that his sheets looked like that. She explained that linens were to be changed every time the residents were showered or on a as needed basis. She described as needed to be if the linens were dirty, had blood on them, or they were soiled. She agreed that his linens needed to be changed and she did not do it herself because she did not know that he was up . She could not recall when the last time she checked on him after breakfast, but stated that rounds were to be done every 2 hours. CNA A explained that the harm in not changing dirty linen when needed was that Resident #1 could get skin tears. In an observation on 05/08/24 at 3:15 pm, the linen on Resident #1's bed had been changed. In an interview with the DON on 05/08/24 at 3:32 pm, she stated the CNA's duties were to provide ADL care, incontinent care, help feed residents, and make up beds. She explained that a med aide was assigned to give Resident #1 his shower that day and she got him up out of the bed. The CNAs often gave showers to residents, but because the shower aide got the resident up that morning, she believed the linen change was overlooked by CNA A. She stated that the harm in not having clean linens on the bed was infection control and the risk for skin breakdowns. Record review of the facility's Policies and Procedures titled Resident Rights revised 04/24 reflected that: The facility staff will uphold the resident's dignity and individuality, providing care that fosters their quality of life in a respectful environment. Procedure stated that the facility would provide a clean, safe, comfortable, and home-like environment.