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	09/13/2024

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** 38644 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 promoted maintenance or enhancement of his or her quality of life for 1 (Resident #8) of 5 residents reviewed for resident rights. -The facility failed to allow Resident #8 to exercise her right to refuse her soiled linen to be changed. This failure could place residents at risk for decreased feelings of self-worth and dignity. Findings: Record review of Resident #8's face sheet dated 9/12/24 revealed an [AGE] year-old female who admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included dementia, major depressive disorder, and persistent mood disorders. Record review of Resident #8's quarterly MDS assessment dated [DATE], revealed a BIMS score of 8 out of 15, which indicated moderate cognitive impairment. She required assistance from staff with ADL care including toileting hygiene. Record review on of Resident #8's care plan revised on 9/9/24 indicated she had a behavior problem related to new environment as evidenced by resident is withdrawn and agitated easily. Resident noted by family to exaggerate the truth or give misleading information. Resident will curse and refuse when she does not want to do something. Interventions were to allow choices within individuals decision making abilities (initiated 8/21/21) and explain all procedures to the resident before starting and allow the resident time to adjust to changes (initiated 9/22/22). The resident also had impaired cognitive function and impaired thought processes related to dementia. Interventions were in part to provide the resident with necessary cues and stop and return if agitated (revised 10/4/22). (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #8's nursing note dated 9/8/24 written by RN S read in part, .Charge nurse reported that resident was upset and wanted to speak with me. Upon entry to the room, resident lying in bed visibly upset and shaking, blankets on the floor. Resident stated she was hit with a pillow, blankets thrown on floor, and head banged on the wall. Resident could not identify staff member by name. Resident stated that her head was hurting. Complete skin assessment performed with no new bruises or injuries noted. Administrator/DON notified. MD notified with order to send to (local hospital) for CT scan, dx: suspected head trauma. (Family member) notified and wanted a further update after hospital report. 911 notified. Dispatcher stated that Sheriff will also be notified due to the nature of the incident. Resident was comforted, cleaned, and put to bed. No signs of any distress noted. Resident pending further hospital evaluation . Record review of CNA S's witness statement dated 9/8/24 read in part, .I [CNA S] went in to change [Resident #8] she was wet and her bottom sheet was even wet and she did not want me to change her sheet because she said that she was comfortable but I explained to her that her sheet was wet and I had to change it and she was upset so I changed her sheet and I changed her and I left out of the room . Record review of LVN A's witness statement dated 9/8/24 read in part, .[Resident #8] was yelling for help as I was rounding on the hall. The resident was visibly upset, crying, shaking, inconsolable. Resident stated she was thrown into bed by CNA, which resulted in resident hitting head on wall. Resident was assessed by Supervisor, Nurse [LVN C], and me. We assisted resident with ADL, repositioning, and with clean linens, as hers were on the floor. Resident was calmed, resting in bed waiting on EMS to transfer her to ED department for further evaluation . Record review of Resident #8's hospital record dated 9/9/24 revealed her CT spine showed no acute abnormality. CT of the head/brain showed no acute abnormality. Xray of left hand should no fracture or dislocation and no acute abnormality. Xray of the shoulder revealed no acute displaced fracture. Xray of the hip showed no definite acute displaced periprosthetic fracture. Record review of the provider investigation report dated 9/10/24 revealed Resident #8 alleged that The CNA threw me in the bed while she was changing me and hit my head on the wall. The Provider action taken post investigation revealed that the allegation against CNA S was not able to be confirmed. In-services were completed with staff on abuse and neglect and resident rights. Resident was sent to the ER and returned with no new orders. CNA S was counseled on residents right to refuse care and returned to work on 9/10/24. Resident #8's care plan was updated, and CNA S's assignment was changed to not provide care to Resident #8 out of abundance of caution. Record review of CNA S's disciplinary action form dated 9/10/24 revealed CNA S was provided with a final warning. The account of circumstances leading to this action revealed on incident date, 9/8/24, the aide continued to provide care to a resident after the resident refused the care. The corrective action indicated the residents have the right to refuse care. Should this occur, charge nurse should be notified and then another attempt to assist be made 5-10 minutes later. If resident refuses, charge nurse should be notified of the continued refusal of care. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation and interview on 9/10/24 at 11:21 a.m., Resident #8 was in her wheelchair in her room with a family member. She said she had a bad problem with an aide last night. She said the aide came in her room and got mad because she wanted her diaper changed. She said suddenly it lit a fuse; the aide attacked her and beat the (expletive) out of her. She said the aide held her and kept hitting her and might have killed her. This Surveyor did not notice any visible injuries to the resident but noted a red area on her finger. She said the incident occurred around 6 p.m. last night and the facility called an ambulance. In an interview on 9/10/24 at 11:17 a.m., Resident #8's family member said he was aware of the incident that recently occurred. He said the resident was in a depressed state and could not sleep at night since the incident occurred. In a telephone interview on 9/10/24 at 2:16 p.m., Resident #8's family member said she was notified of the incident. She said there was no laceration or bleeding, just a headache and extreme agitation. She said Resident #8 might have been sundowning. She said Resident #8 had shown signs of agitation and un-cooperation in the past and psychiatry was seeing her. In an interview on 9/10/24 at 2:47 p.m. CNA S said around 9:30 p.m. on the day of the incident, Resident #8 had her light on and wanted to be changed. She said she pulled her covers back and noticed her sheet was wet. She told the resident would go get a brief and that the sheet underneath was wet. She said Resident #8 told her she only wanted her brief changed; not the sheet. CNA S said she told Resident #8 she could not leave her like that, so she left and obtained her supplies and a draw sheet. CNA S said she returned to the room and turned resident over and took the sheet off one side. She said Resident #8 asked her, what are you doing? CNA S said she explained to Resident #8 that she could not just change her brief and not the sheet. She said Resident #8 told her, No, no, you're a (expletive), you are being mean, you are hurting me. CNA told the resident she was not hurting her; she was just trying to get her clean and dry, and get her sheets on. She said she did not stop providing care because she was almost finished. She said she pushed the resident toward the wall and the resident started cursing and calling her names. She said she turned the resident toward her and put the sheet on. CNA S said Resident #8 thought she was going to push her out of the bed, and the CNA said she continued to change her and did what she needed to do so the resident could be comfortable. CNA S said the resident was upset because she changed her sheets. She said she should have gotten the nurse to diffuse the situation. She said normally if a resident said you are hurting me, she would tell the resident what she was doing, step out, and let the nurse know. She said she did not tell LVN C that the resident said was hurting her, but said she should have. She said she assumed the resident was ok, the resident was still cursing and calling her expletives. She said residents had the right to not have their soiled linen changed. She said the facility in-serviced her on abuse/neglect and residents right. In an interview on 9/10/24 at 3:17 p.m. CNA S said, during the incident, Resident #8 did not hit any parts of her head or body on the wall. In an interview on 9/10/24 at 3:55 p.m., the Administrator said she did not believe there was any intent during the incident between CNA S and Resident #8. She said CNA S did not want to leave Resident #8 on a soiled bed. She said the aide changed the sheet, Resident #8 got upset and made accusations when mad. She said CNA S should have only changed the resident's brief and notified the nurse so she could reapproach the resident. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An attempted interview on 9/13/24 at 9:31 a.m. with LVN A was unsuccessful. In a telephone interview on 9/13/24 at 11:27 a.m., LVN C said she was the charge nurse the night of the incident. She said she conducted a head-to-toe assessment on Resident #8 with no visible injuries. She said she observed the resident shaking and she was not normally shaking before. LVN C said CNA S did not report anything about pain or refusal of care to her from Resident #8. She said if a resident refused care, they should not be touched, and it should be reported to the charge nurse. She said all residents should be treated with dignity and respect. Record review of the facility's policy titled Resident Rights revised on 4/24 read in part . The facility protects and promotes the rights of each resident. The facility staff will uphold the resident's dignity and individuality, providing care that fosters their quality of life in a respectful environment . The facility staff will assist the residents in exercising their rights. The facility staff will not interfere, hamper, coerce, compel by force, treat different/otherwise discriminate against, or retaliate against a resident for exercising their rights .

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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 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** 47722 Based on observation, interview, and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received necessary services to maintain good personal hygiene for 1 (Resident #1) out of 9 residents reviewed for ADL care. - The facility staff failed to provide timely incontinence care to Resident #1. This failure could place residents who were unable to carry out ADLs independently, at risk of skin breakdown, pain, and infection. Findings include: 1. Record review of Resident #1's undated face sheet, revealed a [AGE] year-old female admitted on [DATE], with an original admitted [DATE]. She had diagnoses of muscle wasting and atrophy (decrease in size and wasting of muscle tissue), unspecified convulsions (rapid, involuntary muscle contractions causing shaking and limb movement), heart failure (heart does not pump effectively), type 2 diabetes (body does not produce insulin or is resistant to it), muscle weakness, and cerebral infarction (stroke). Record review of Resident #1's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 15 out of 15, which indicated normal cognition. She had impairment on one side of her upper extremities and used a wheelchair. According to the MDS, she was substantial/max assist with all of her ADLs and mobility. She was frequently incontinent of bowel and bladder. Record review of Resident #1's care plan, dated 3/7/23, revealed a focus: Resident had current skin concerns- a rash to right and left inner thighs (Initiated: 3/7/23 Revised: 8/22/24). Goal: Resident's skin irritation will be resolved by next review date (Initiated: 3/7/23, Revised: 9/2/24 Target: 11/29/24). Interventions: Perform treatments as ordered, Low air loss mattress. Focus: Resident has bowel and bladder incontinence and is at risk for skin breakdown AEB impaired bladder function (Initiated: 3/21/23 Revised: 3/21/23). Goal: Resident will remain clean, dry, odor free and no occurrence of skin breakdown will occur over the next 90 days (Initiated: 3/21/23, Revised: 9/2/24, Target: 11/29/24). Interventions: Provide incontinence care after each incontinent episode and PRN. Monitor for s/sx of skin break down-report to MD and RP. Record review of Resident #1's Physician Orders revealed the following orders from MD A: - Zinc Oxide External Ointment (protects skin from urine/stool), Apply to Skin topically for brief change and PRN. Ordered on 4/15/24. - Furosemide (causes increased urination) 20mg, 1 PO QD. Ordered on 4/19/24. - Triamcinolone Acetonide External Ointment, Apply to Rt and Lt inner thigh topically BID for skin irritation for 14 days. Ordered on 8/21/24. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Triamcinolone Acetonide External Ointment, Apply to Rt and Lt inner thigh topically BID for skin irritation for 14 days. Ordered on 9/6/24. - Target Behaviors, Every Shift monitor resident for presence of behaviors (refusal of care). Document Yes or No if behaviors were observed. Ordered on 9/10/24. No refusal of care was documented. Record review of Resident #1's progress note from MD A on 8/28/24, revealed she had a rash on buttocks and between her legs. The doctor ordered anti-fungal cream and to keep it clean and dry. Record review of Resident #1's wound observation sheet from 9/3/24, revealed redness to bilateral inner thighs. Record review of Resident #1's Wound Care Note from NP B on 9/9/24, revealed moisture associated skin damage to the right inner thigh and left buttock. The wound care NP ordered cream and to keep the wound clean and dry. Record review of Resident #1 progress notes for September 2024 revealed no refusals for being changed. In an observation and interview with Resident #1 on 9/10/24 at 11:02am, she was receiving a bed bath by the Shower Tech. Resident #1 said she had not been changed since 5:00 am that morning and that she would not get changed again until 5:00 am the next morning. In an interview with the Shower Tech on 9/10/24 at 12:12 pm, she said she had been with the facility for 1 year and 3 months and worked on the 100 and 200 halls. She said Resident #1's diaper was completely soaked and had not been changed since 5:00 am that day and would not be changed again until the next day at 5:00 am. She said Resident #1 was only changed at 5:00 am and then by herself (the Shower Tech) whenever she was there. She said the CNAs would wait for her to change the resident when she gave them a shower. She said they would sit in Management's office and talk instead of changing the residents. In an interview with CNA C on 9/11/24 at 12:38 am, she said she had worked at the facility for 1 year. She was working the front of the 200 hall from 201-207. She said Resident #1 did not get changed when she was not working, and she knew because the resident told her and because she worked with the staff before and saw that they did not change residents all night. She said she found Resident #1's brief completely saturated every time she came to work. She said she thought Resident #1 sitting in a soiled brief made her wounds on her bottom and in between her legs worse. In an interview with Resident #1 on 9/11/24 at 12:40 am, she said she got changed because CNA C was there, and that particular CNA was the only one who checked on her every 2 hours and changed her. In an interview with CNA D on 9/12/24 at 1:52 pm, she said she checked on residents every 2 hours, but at that facility she had to check/change residents more often than that because there are a lot of residents who were heavy wetter's. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Unit Manager E on 9/12/24 at 2:40 pm, she said she had been at the facility for 5 years and was the Manager over the 100 and 200 halls. She said it was her expectation that staff rounded and change residents every 2 hours and PRN. She said the shower tech gave showers/baths M/W/F and the CNA gave showers if the shower tech was pulled. She said the Shower Techs were not pulled that often and the CNAs should be able to shower and change the residents every 2 hours if they had to. She said if residents were left in soiled diapers, it could cause skin break down and wounds. In an interview with the DON on 9/13/24 at 10:45 am, she said she had been with the facility for 3 years. She said it was her expectation for residents to be checked and changed every 2 hours and PRN. She said if the residents were not changed at least every 2 hours and sat in a soiled brief, they could have skin break down and wounds. She said the CNAs had to shower/bathe residents sometimes, but it was not often because they tried to pull another staff member to the floor like the Staffing Coordinator who was a CNA, or the Restorative Aides. She said when the CNAs gave the showers and had to change residents every 2hrs, she felt like the job load was not too heavy and they were able to handle it. She also said they were not short staffed like they were last year. Record review of the facility's policy and procedure on Activities of Daily Living-Highest Level of Functioning (Revised March 2019) read in part: It is the policy of this facility to provide care and services to ensure that a resident is able to maintain their ability to self-perform their activities of daily living, at their level of functioning prior to facility admission, unless circumstances of the individual's clinical condition demonstrate that diminishment in ability was unavoidable. The facility is responsible to provide necessary care to all residents who are unable to carry out activities of daily living on their own to ensure they maintain proper nutrition, grooming, and hygiene .