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	12/20/2024

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37059 Based on observations, interviews, and record review, the facility failed to ensure personnel provided basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel for 1 of 77 residents (CR #1) reviewed for CPR. 1. RN A failed to call a code blue and obtain assistance from available staff when CR #1 was found unresponsive. This led to a delay of approximately ,d+[DATE] minutes before CPR was started on CR #1. 2. RN A initiated CPR with improper chest compressions and depth during CPR on CR #1 on [DATE]. 3. LVN A failed to place the mask over the resident's nose and mouth, ensuring a good seal. 4. Staff failed to ensure the crash cart had AED pads and was ready for use during CPR on CR #1. This led to a delay of approximately ,d+[DATE] minutes before CPR was started on CR #1. An IJ was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 9:45 a.m. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated with the severity level of actual harm that was not immediate jeopardy because all staff had not been trained on [DATE]. These failures placed residents at risk of experiencing worsening of condition, extended pain, and death from possible delays in the initiation of an emergency response and improper implementation of CPR. Findings included: Record review of CR #1's face sheet dated [DATE] revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. CR #1's diagnoses included respiratory failure, Crohn's disease (swelling and irritation of the tissues in the digestive tract), Asperger's syndrome (neurodevelopment disability that affects the ability to effectively interact and communicate with people), cirrhosis of the liver (liver damage from conditions such as hepatitis B or C, or chronic alcohol use), gastroesophageal reflux (condition in which stomach acid moves up into the esophagus, causing heartburn), pneumonia, and malnutrition. She was discharged to a medical examiner after she died on [DATE]. (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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR #1's 5-day MDS dated [DATE] revealed she had a BIMS score of 00 (severe cognitive impairment); CR #1 ambulated via wheelchair; and CR #1 was dependent for ADL's (eating, toileting, shower, oral hygiene, and dressing). Record review of CR #1's care plan meeting, dated [DATE] revealed the following in part: .[CR#1] will remain full code. [CR #1] does not have a POA . Record review of progress notes dated [DATE] at 10:50 a.m. by MA A revealed the following: cant [can't] swallow notified nurse [RN A] Record review of progress notes dated [DATE] at 12:34 p.m. by RN A revealed the following in part: .Change of Condition Identified: leukocytosis (above the normal range of white blood cells) . [PCP] present and visited resident [CR #1] . What do you think is going on with the resident: Resident lab results show WBC 22.1. [PCP] present and visited resident. New orders received as follows: 1) CXR 1-V & UA w/ C&S 2) Ceftriazone (antibiotic that is used to treat many kinds of bacterial infections, including severe or life-threatening)1gm IV QD x7 days 3) May place midline for ABX therapy 4) Levothyroxine (used to treat hypothyroidism - underactive thyroid) 50mg PO QD (RP) notified of new orders and gave verbal consent for midline placement. Physician Notified: [PCP], [DATE] 12:00 PM Record review of CR #1's progress notes dated [DATE] by RN A revealed the follow in part: [CR #1] was observed unresponsive sitting in wheelchair. [CR #1] was confirmed full code, transferred to bed, and CPR was called. 911 was called @1321 [1:21 p.m.] which EMS arrived to room shortly after. EMS continued life saving measures. [Family member] was notified of resident's condition [CR #1] was pronounced deceased @1351 [1:51 p.m.] per EMS personnel. Resident was last seen alive between , d+[DATE]:30 [12:00 p.m. - 12:30 p.m.] during lunchtime sitting in wheelchair . (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR #1's EMS Report dated [DATE] revealed: . Primary Impression: Cardiac - Cardiac Arrest . Call Received - 1:22 p.m. Dispatched - 1:23 p.m. On Scene - 1:24 p.m. At Patient - 1:42 p.m. Narrative: History - Nursing home staff stated they walked into the patient's room and found her unresponsive. The last time they saw . Assessment - On arrival, The pt was in bed in her room and nursing staff was doing very poor, slow CPR, and ventilating the pt on high flow oxygen via BVM . She was not conscious, not breathing, and without a pulse. There were no signs of rigor mortis. Her alive was one hour prior. The nursing home nurse states she has not been sick and does not know what could have caused it . Her airway appeared clear. Eyes appeared fixed, dilated, and non-reactive. Breath sounds: absent bi laterally. ABD: soft/nondistended. Skin: cool/dry. Rx/Treatment - Nursing home staff started CPR prior to arrival. 303 [EMS] arrived prior to 409 [FD] and started ALS resuscitation. Upon contact, the nursing staff was doing low quality compressions and was corrected on proper rate and depth . After 20 minutes of high quality ALS resuscitation the family and POA called back and stated they wanted resuscitation terminated. Transport - The patient was not transported as resuscitation was terminated at 13:51 pm. Call complete. In service. Record review of RN A's cell phone call history dated [DATE] revealed 911 was called at 1:21 p.m. Record review of crash cart check list dated [DATE]st -18th 2024 revealed AED - function and ready. Observation and interview of the facility's crash carts, with the DON and LVN E, on [DATE] at 4:11 p.m. revealed it was located at the front 300 hall, approximately ,d+[DATE] yards away from the nurse's station. The AED was in a case on the outside of the crash cart, after unlocking case mild pitch siren and blue light. The code status binder was on the cart. There were no pads located in the AED machine, but pads were in a zipped side pocket of the bag the AED was in. No extra pads were observed in the drawers of the crash cart. A second crash cart on 100 hall was observed and had a pad in the AED machine and extra pad in the bottom drawer of the crash cart. The DON said LVN E was responsible for checking the crash carts daily. The DON said if a resident was found unresponsive, the staff should call out code blue, direct another staff to call 911, and verify code status to start CPR as soon as possible. She said she was not at the facility on [DATE]. She said she would have preferred for the AED to be used because it would instruct the staff what to do if there was no pulse or heartbeat. She said RN A was not able to locate the AED pads. The DON said RN A should have stayed with CR #1. She said he could have directed CNAs and Nurses to call 911, get the crash cart, which she thought he had done. She said this was a part of the delegation process during a code blue. LVN E said she checked the carts daily and remembered seeing AED pads. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 9:11 a.m., with RN A said he worked the 6:00 a.m. - 2:00 p.m. on [DATE] when CR #1 expired. He said he was notified by CNA B who came and told him, CR #1 was unresponsive. He said he went to CR #1's room (on 500 hall) and checked her pulse and she did not have one. He said he left the room, went to get the crash cart (on 300 hall adjacent to the 500 hall). He said CNA B was left in the room with CR #1. RN A said on his way back with the crash cart, he looked at CR #1's code status in the binder on the crash cart and called 911. RN A said he left CNA B in the room with CR #1. RN A said when he returned to the room, CNA B assisted and placed CR #1 in the bed from her wheelchair. He said he did not yell out for help or code blue after CR#1's pulse was taken or instruct CNA B to get the crash cart. RN A said he told, CR #1's assigned CNA B, to get help. RN A said he placed the backboard under the resident. He said he attempted to use the AED and could not locate the pads. RN A said he started chest compressions. RN A said RT A and LVN A came in and assisted with the bag valve mask. He said he was not sure of the time when they both came in, but it was within a minute. RN A said he continued chest compressions until EMS arrived. He said he did not recall if EMS or the FD gave him direction on his CPR technique. He said he was CPR certified and was trained by the facility on the Code Blue protocol. He said code blue was called when a resident was unresponsive, without a pulse, and needed CPR . Interview on [DATE] at 9:55 a.m. with CNA B said she worked 6:00 a.m. - 2:00 p.m. on [DATE]. She said she had not worked with CR #1 before. She said she saw therapy worked with CR #1 in the morning when they took her for a swallow test at approximately 7:00 a.m. CNA B said she was working on the hall next to CR #1's room, when HK A came to tell her CR #1 was not okay. CNA B went to CR #1's room, saw her sitting in her wheelchair. CNA B said she touched CR #1's leg, and CR #1 did not move. CNA B said CR #1's eyes were open, and her head faced toward the hallway. She said she left immediately and notified RN A. CNA B said RN A went to CR #1's room, checked for CR #1's pulse, and left to get the crash cart. CNA B said she waited with CR #1 until RN A came back with the crash cart. CNA B said she could not remember how much time past, but she said it was approximately a few minutes when RN A returned to the room. She said RN A opened the AED and a siren started. She said, less than a minute RT A and LVN A came in to assist and she left out of the room. She said she did not see if RN A used the AED and did not see CPR performed on CR #1. She said EMS arrived quickly but could not remember how long it took. He said he was CPR certified . He said his CPR trained him to complete 30 chest compression and two breaths. In an interview on [DATE] at 12:58 p.m. CNA A said she had not worked with CR #1 prior to [DATE]. She said she recalled CR #1 had a swallow test around 7:00 a.m. on [DATE]. She said therapy assisted CR #1 with her meal. She said she saw CR #1 around 11:45 a.m. and assisted her with her lunch. She said CR #1 did not eat much. CNA A said she brought CR #1's roommate back to the room at approximately 12:30 p.m. CNA A said CR #1 was in her wheelchair looking out into the hallway. She said she saw staff running to CR #1's room and she stood at CR #1's door but left shortly after RN A and CNA A started to assist CR #1. She said EMS arrived approximately 5 minutes after the staff went in to assist CR #1. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a telephone interview on [DATE] at 1:47 p.m. PCP A said she saw CR #1 on [DATE] at approximately 10:00 a.m. She said CR #1's vitals were within normal limits. PCP A described CR #1 as chronically ill, lungs were clear, sounds reduced, heart was regular, very pale, and malnourished. She said there were no acute care issues. She said the b/p was on the low side but no interventions were needed. In a further interview, PCP A said when a code blue was called the staff should response as a team. She said the staff who found the unresponsive resident should yell out for help from the other staff by asking them the resident code status, get the crash cart, call 911, and immediately start CPR. She said if one staff completed all of the task, a delay in CPR could happen. In a telephone interview on [DATE] at 3:41 p.m. RT A said she was on another hall when she and LVN A were asked by (unknown CNA) to assist with CR #1. She said she could hear the AED siren as she ran down the hall. She said she did not hear anyone yell out code blue. She said she grabbed the O2 tank as she entered CR #1's room, LVN A grabbed the Ambu bag (manual resuscitator). She said LVN A placed the bag over CR #1's mouth without securing a tight seal. She said without a tight seal around the mouth and nose the resident would not get the full benefit of the manual breaths. RT A said she took over bagging CR #1 while RN A continued chest compressions until EMS took over. She said she did not remember if RN A said there were no pads for the AED or if she saw him search for them at some point and could not locate them. She said she saw a pulse oximeter on CR #1's finger but did not remember what the reading was. She said she did not remember if the paramedics educated RN A on the depth of his compressions. She said the facility had provided mock code blue trainings where the staff had to act out the code. She said she was CPR certified . She said a delay in CPR and use of the AED could negatively affect the resident. In a telephone interview on [DATE] at 3:48 p.m. LVN A said he rushed down with RT A to assist with CR #1. He was asked how he assisted, and he continued to repeat I did what needed to be done as a team. He later said he initially placed the Ambu bag on CR #1 and then RT A took over. He said RT A connected the bag to the oxygen, he said he did not know why, and he left before EMS arrived, to get the paperwork ready for EMS. He said he was CPR certified . In a second telephone interview at [DATE] at 8:59 a.m. PCP A said it should be a team effort when a code blue was called. She said the staff that found an unresponsive resident should have called out for help from several staff to bring the crash cart (which had the code status binder on it), get oxygen, call 911, and begin CPR. He should not have left the resident . In a telephone interview on [DATE] at 1:42 p.m. the EMS Supervisor said the verbiage low quality chest compression and depth indicated in the EMS Run sheet indicated the CPR provided for CR #1 did not get the full effect or benefit of the chest compression to aid in life sustaining efforts He said the chest compressions should be ,d+[DATE] inches as referenced by the American Heart Association. He said he would have to get permission for this state surveyor to interview the paramedics that responded to CR #1. Record review of American Heart Association dated [DATE] (https://cpr.heart.org/en/resources/what-is-cpr) revealed the following in part: Automated External Defibrillators (AED) AEDs can greatly increase a cardiac arrest victim's chances of survival . (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	For healthcare providers and those trained: conventional CPR using chest compressions and mouth-to-mouth breathing at a ratio of 30:2 compressions-to-breaths. In adult victims of cardiac arrest, it is reasonable for rescuers to perform chest compressions at a rate of 100 to 120/min and to a depth of at least 2 inches (5 cm) for an average adult, while avoiding excessive chest compression depths (greater than 2.4 inches . Hands-Only CPR consists of two easy steps: Call [DATE] (or send someone to do that) Push hard and fast in the center of the chest . About High-Quality CPR High-quality CPR should be performed by anyone - including bystanders. There are five critical components: Minimize interruptions in chest compressions, Provide compressions of adequate rate and depth . Record review of the facility's Policies and Procedures for CPR - Cardiopulmonary Resuscitation policy, revised [DATE] revealed, Policy The Facility will administer CPR per American Heart Association Guidelines and regulatory expectations for residents with a Full Code status, Procedure, In the event of a medical emergency 2. Check the resident for responsiveness. 3. Validate the resident's code status. a. If the resident is a Full Code, proceed with step #4. 4. Activate the Emergency Response System Code Blue and staff call 911. 5. Assess respirations/pulse simultaneously (within 10 seconds). a. If NO respirations (or only gasping) and NO pulse i. Start CPR. ii. Apply AED as soon as available and follow the prompts. iii. Perform cycles of 30 compressions and 2 breaths via ambu-bag. iv. Continue until EMS providers take over, the resident regains pulse, or receives a Physician Order to cease rescue efforts. 6. Document .Progress Notes . (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	AED Considerations The Facility has an AED available for emergency use, is kept in a location easily accessible by staff, and is rescue-ready. Crash Cart Considerations Ensure the crash cart is ready for immediate use during a code situation . Conduct daily checks to ensure all items are present and in working order and document these checks on a log attached to the cart and regularly check . Ambu Bag Considerations Place the mask over the resident's nose and mouth, ensuring a good seal. Hold the mask with your thumb and index finger forming a C around the mask, while the other three fingers lift the jaw. An IJ was identified on [DATE]. The IJ template was provided to the Administrator and the DON on [DATE] at 10:10 a.m. The following Plan of Removal submitted by the facility was accepted on [DATE] at 6:57 p.m.: Allegation: The facility failed to ensure that a resident received CPR in accordance with professional standards of practice. F678 CPR IJ Plan of Removal for F678 [DATE] According to the IJ Template: The facility failed to ensure that a resident received CPR in accordance with professional standards of practice. The Administrator and DON notified the Medical Director of the IJ on [DATE] and held an ADHOC QAPI meeting to review the IJ template and POR . On [DATE], the Director of Nursing conducted a 1:1 education with RN A. Topic: CPR Policies and Procedures highlighting: assessing the resident, calling for assistance code blue which activates the staff to assist and expedites the 911 response, validating the code status by a quick glance of the Code Status Binder, and initiating CPR with effective chest compressions (compression rate of ,d+[DATE] and a depth of 2 inches, Ambu-bag use (providing a seal), and applying the AED for residents with a Full Code status. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The DON initiated education on [DATE] with Nurses, and Respiratory Therapist on the CPR Policies and Procedures highlighting: assessing the resident, calling for assistance code blue which activates the staff to assist and expedites the 911 response, validating the code status by a quick glance of the Code Status Binder, and initiating CPR with effective chest compressions (compression rate of ,d+[DATE] and a depth of 2 inches, Ambu-bag use (providing a seal), and applying the AED for residents with a Full Code status. All Nurses and Respiratory Therapists will not be allowed to work their assigned shift until training is completed. Staff will verbalize understanding at of end of training session and further training will be provided as needed. Education will be provided in orientation for new hires. Completion date of [DATE]. The DON initiated education on [DATE] with CNA role and code blue situation. CNA will immediately report unresponsive residents to the charge nurse, can assist in announcing code blue and can respond with crash cart and AED to the CODE Blue site. CNA will not be allowed to worked their assigned shift until training is completed. Education will be provided in orientation for new hires. Completion date of [DATE]. The Regional RT and Clinical Team conducted a Mock Code on [DATE] with return demonstration with all staff on site during the 2nd shift. The RT and Clinical Team will conduct a Mock Code with return demonstration for the next 3 shifts with return demonstration to ensure understanding. The Regional RT and Clinical Team will conduct routine Mock Codes to ensure education compliance. Findings will be brought to QAPI and the facilities plan to maintain compliance will be updated as indicated. The facility will maintain compliance with professional standards by treating residents who are Full Code and unresponsive (no pulse) by: assessing the resident, calling for assistance code blue which activates the staff to assist and expedites the 911 response, validating the code status by a quick glance of the Code Status Binder, and initiating CPR with effective chest compressions (compression rate of ,d+[DATE] and a depth of 2 inches, Ambu-bag use (providing a seal), and applying the AED. The Facility will update the code status binder with OOH DNRs as DNRs are implemented. Residents without OOH DNR forms will be considered Full Code. The facility inspects and replenish crash cart daily and after code events by DON/designee to ensure crash cart is rescue ready. The Administrator reviewed the facility policy on [DATE] and no changes were required. The plan of completion is [DATE]. Monitoring of the plan of removal included the following: Record review of Education In-Service Attendance Record dated [DATE] - [DATE] revealed all nurses, CNAs (including RN A, LVN A) were provided education by LVN B - unit manager regarding nurses are responsible to ensure crash carts are restocked after code and CPR protocol. Record review of Education In-Service Attendance Record - Mock Code dated [DATE] -[DATE] (2:00 p.m. - 10:00 p.m., 10:00 p.m. - 6:00 a.m., and 6:00 a.m. - 2:00 p.m.) revealed all staff (nurses, CNAs, therapy staff, hk, were provided demonstration and return demonstration education by the Resp. Therapy Manager regarding Resident found unresponsive - What are our duties? (attachment: Policies and Procedures for CPR - Cardiopulmonary Resuscitation policy, revised [DATE]) Mock Code (continued on next page)

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