

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/28/2026
NAME OF PROVIDER OR SUPPLIER  Eagle Crest Rapid Recovery		STREET ADDRESS, CITY, STATE, ZIP CODE  9602 Huffmeister Rd Houston, TX 77095	

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)
<p>F 0578</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews and record reviews, the facility did not ensure that the resident's requests, refusals, discontinuations, and advance directives were honored for 1 of 1 (CR#1) resident's DNR. LVN A provided CPR to CR #1 prior to determining if the resident had advanced directives in place resulting in CR #1 receiving life-saving intervention from LVN A and then emergency responders. Emergency responders did restore CR #1's pulse and CR#1 was transported to the hospital where CR#1 expired. The noncompliance was identified as Past Non-Compliance. The IJ began on [DATE] and ended on [DATE]. The facility corrected the noncompliance before the survey began. This deficient practice could place residents at risk of harm and injury due to inadequate care. Findings include: Review of CR #1's face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included Cerebral infraction, Muscle weakness, Hyperlipidemia, Type 2 diabetes without complications, Quadriplegia, acute posthemorrhagic Anemia, and Hypotension. Record Review of CR #1's Care Plan dated [DATE] revealed he was care planned for DNR. Intervention dated [DATE] required staff to check resident file for DNR before calling a code. Review of CR #1's progress note dated [DATE] shows that the following entry was made by RN B. During routine rounding, the nurse observed the resident gasping for air, sweating profusely, and then becoming unresponsive. A code was called, life-saving measures were initiated, and 911 was contacted. Upon EMS arrival, life-saving efforts were transferred to them, and the Do Not Resuscitate (DNR) documentation was subsequently located and confirmed as active. At that point, EMS successfully restored the resident's pulse and blood pressure, and the resident was transported to the hospital. The Nurse Practitioner (NP) was notified and informed about the events. The responsible party (RP) was also contacted and made aware of the situation, including the life-saving measures performed before the DNR was retrieved. The RP expressed understanding and requested the address of the hospital's emergency room where the resident was taken. Record review on [DATE] at 12:00p.m. of facilities in-service documents reflected that on [DATE], the facility conducted an audit of its long-term care and skilled nursing units. The purpose of the audit was to review the list of residents with Do Not Resuscitate (DNR) orders. This list was compiled by the facility's social worker, and the Assistant Director of Nursing (ADON) is responsible for checking it daily for accuracy. In an interview with the ADON On [DATE] at 12:22p.m. she stated that on [DATE], the facility created two binders to expedite the identification of residents with a DNR. The binders were placed on the crash carts and at the nurses' station. Record review on [DATE] at 12:24 p.m. reflected that on [DATE], the facility conducted an in-service training for nursing staff. The training focused on the importance of checking all patients' code status before initiating any life-saving measures. If a Do Not Resuscitate (DNR) order is in place, cardiopulmonary resuscitation (CPR) should not be initiated, as this would contradict the selected end-of-life measures and orders. In an interview on [DATE] at 11:50 a.m., the Administrator</p> <p>(continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  Facility ID: 676208	If continuation sheet Page 1 of 2

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<p>F 0578</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>stated that, before CPR was performed on CR #1, it was essential to verify the patient's code status. He noted that LVN A's failure to check CR #1's code status violated policy and required the initiation of life-saving measures for CR #1. In an interview on [DATE] at 12:25 p.m., the ADON stated that, before LVN A called a code and initiated Life-Saving Measures on CR #1, the DNR status should have been verified. She indicated that LVN A's failure to check CR #1's DNR status constituted a violation of policy. An unsuccessful attempt was made to contact LVN A on [DATE], at 12:26 p.m., at 10:30 a.m. on [DATE] and 1:00pm on [DATE]. In an interview on [DATE] at 12:55 p.m., LVN B stated that she believed LVN A had already confirmed the code status for CR #1. LVN B mentioned that, per their policy, anyone who calls a code is responsible for verifying the DNR status before initiating the code. LVN B stated that she had been in-serviced to check a resident's code status before initiating life-saving measures. In an interview on [DATE] at 1:17 p.m., with LVN C, she stated that she had received training on [DATE] to check a resident's code status before initiating life-saving measures. She mentioned that the training emphasized checking the DNR binder on the crash carts, as it was faster than looking it up in the PCC system. In an interview on [DATE] at 2:30 p.m., with CNA A, she stated that she had been trained to check a resident's DNR status. She explained that a book located on the crash carts indicated whether a resident had a DNR. Additionally, she mentioned that the facility offers CPR classes for all CNAs. In an interview on [DATE] at 2:35 p.m., with CNA B, she stated that she had been trained to check a resident's DNR status. In an interview on [DATE] at 2:40 p.m., with CNA C, she stated that she had been trained to check a resident's DNR status. In an interview on [DATE], at 2:45 p.m., with CNA C, she stated that she had been trained to check a resident's DNR status. In a phone interview on [DATE], at 3:30 p.m., with the Regional Director of Nursing for facilities, she stated that on [DATE], she instructed the facility to create a binder to help staff easily identify which residents have a DNR order. Record review of the facility's DNR policy (undated) on [DATE] at 4:00 p.m., revealed that, before any life-saving measures are taken, staff must first determine whether the resident has a DNR in place. Record review of the facility provider report dated o[DATE] reflected that CR#1 received life-saving measures during a medical episode despite having a DNR in place. The nurse on duty failed to comply with CR#1's DNR by calling a code and initiating life-saving measures. If a Do Not Resuscitate (DNR) order is in place, cardiopulmonary resuscitation (CPR) should not be initiated, as this would contradict the selected end-of-life measures and orders. In an interview with the administrator on [DATE], the facility management team suspended LVN A and LVN B because of providing Life Saving Measures to CR #1. CR #1 had a DNR in place, and the nurses failed to confirm the DNR before performing CPR. In an interview on [DATE] at 3:25 p.m., the Medical Director stated that he did participate in a QAPI regarding DNR. He also stated that the negative outcome of not checking for a code status could be unnecessary trauma to the resident's body. In an interview with the facility administrator on [DATE], at 3:25 p.m., the facility held a Quality Assurance and Performance Improvement (QAPI) meeting. The Medical Director confirmed his participation in discussions regarding Do Not Resuscitate (DNR) orders during this meeting. Record review of facility in-service dated [DATE], reflected that the facility held a CPR course that was open to all staff. The course also covered the facility policy on when to initiate and when not to initiate Life-Saving Measures. Record review of LVN_A disciplinary form dated 01/23/26, the facility management terminated LVN A for failing to verify whether CR #1 had a DNR before calling code and EMS. The noncompliance was identified as Past Non-Compliance. The IJ began on [DATE] and ended on [DATE]. The facility corrected the noncompliance before the survey began.</p>		