STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455800	A. BUILDING _____ B. WING _____	03/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESTCHASE HEALTH AND REHABILITATION CENTER	8820 TOWN PARK DR HOUSTON, TX 77036

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 0580 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to immediately consult with the physician and notify the resident representative when there was a change in condition for 1 of 8 residents (CR #1) reviewed for notification of changes . -The facility staff failed to consult CR #1's physician of numerous breathing treatment refusals when he was diagnosed with [REDACTED]. -The facility failed to update the CR #1's physician and RP of continued change in condition and deterioration and did not inform his responsible party of chest x-ray results and treatments. -The facility staff failed to immediately notify CR #1's physician of abnormal labs (complete blood count) on [DATE]. - CR #1 was found unresponsive on [DATE] with unreadable [MED]gen saturation level and was pronounced dead one hour later in the facility. An immediate Jeopardy (IJ) was identified on [DATE]. While the IJ was lowered on [DATE], the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope of isolated because the facility continuing to educate their staff and monitor the effectiveness of the Plan of Removal. These failures could affect any resident who experiences a change in their condition in the facility placing them at risk complication from delay in medical intervention. Findings include: CR #1 Record review of CR #1's face sheet dated [DATE] revealed a [AGE] year-old male admitted to the facility on [DATE]. His [DIAGNOSES REDACTED]. He was a full-code. Record review of CR #1's Quarterly MDS dated [DATE] revealed a BIMS score of 3 indicating severe cognitive impairment. He required extensive assistance of one staff for toileting and hygiene, limited assistance of one staff for dressing, and was independent of all other ADLs. He ambulated without any devices. He was always incontinent of bowel and bladder. He was not on hospice. Further review of MDS revealed the resident was not coded as having any behaviors. Record review of CR #1's care plan dated [DATE] revealed he had a respiratory infection related to [MEDICATION NAME] pneumonia. The goal was he would be free of signs and symptoms of infection by the review date. interventions included antibiotics and treatments per the physician orders, recording vitals, documenting side effects, and changing positions at regular and frequent intervals especially if in bed. Record review of CR #1's chest x-ray dated [DATE] revealed Bilateral perihilar fullness, nonspecific in nature, possibly due to perihilar [CONDITION] (Collapse of lungs) , adenopathy (disease of the lymph nodes), developing [MEDICATION NAME] (acute inflammation of the bronchi, accompanied by inflamed patches in the nearby lobules of the lungs). Consider central venous congestion or [MEDICAL CONDITION] arterial hypertension if indicated by symptomatic presentation, other testing or medical history. Continued follow-up recommended. Minimally worse compared to [DATE]. During an interview on [DATE] at 4:05 pm CNA A said she worked with CR #1 frequently and knew his usual behaviors/care needs. She said in February he was breaking out in sweats, and she asked the nurse to check his vitals. She said CR #1's physician ordered a chest x-ray. She said he was diagnosed with [REDACTED]. She said he was getting antibiotics and got better, but the sweating returned the week of ,[DATE] and got progressively worse than the previous time. Record review of CR #1's physician's orders [REDACTED]. Record review of CR #1's MAR/TAR dated February 2020 revealed he refused breathing treatments on ,[DATE] at 6 am, ,[DATE] at 6 am, ,[DATE] at 10 pm, ,[DATE] at 2 pm, ,[DATE] at 6 am and 2 pm, ,[DATE] at 6 am, and ,[DATE] at 6 am. Record review of CR #1's nursing notes for February 2020 revealed no documentation indicating his physician was notified of the missing breathing treatments. During an interview on [DATE] at 11:53 am, the Physician said she was the point of contact for any changes in condition regarding CR #1's care. She said when he was receiving breathing treatments in February due to [MEDICATION NAME] she was never informed of any treatment refusals. During an interview on [DATE] at 2:28 pm, CR #1's guardian said he last visited [DATE]th, 2020 and CR #1 was in bed sleep. When asked if he was aware of the pneumonia and treatments from a month prior he said he was not made aware of the [DIAGNOSES REDACTED].#1's SBAR dated [DATE] 2:07 pm revealed Patient alert with coughing noted. Upon auscultating lungs sounds, wheezing is noted. (Physician) notified and assessed resident and gave order for STAT chest X RAY and [MEDICATION NAME] Treatments- (Breathing inhalation treatment) V/S BP ,[DATE] P 78 RR 18 O2 SAT 98% at RA T 98.6. RP notified. The respirations were dated ,[DATE] and the blood pressure, O2 SATs and pulse were dated ,[DATE]. The statement This condition, symptom, or sign has occurred before was coded with no. He had no mental status changes and no functional status changes including needing more assistance, decreased mobility, or weakness. Under respiratory, abnormal lung sounds, wheezing and a productive cough were documented. There were no urine changes indicated including decreased urine output. It was documented that CR #1's RP was notified at 2:10 pm. The assessment was signed by RN A. During a telephone interview on [DATE] at 11:25 am RN A said she was new to the facility. When asked about CR #1's SBAR she completed on [DATE] she said, I don't remember that person. She said she was shadowing a nurse (LVN C) who was showing her how to enter the information, but she could not recall if she did the assessment or notified the Physician and responsible party. During an interview on [DATE] at 4:05 pm CNA A said around [DATE] CR #1 was sweating needing more assistance with ADLs when he usually followed cues. She said when changing his brief, he would not roll like usual and she would have to assist him. She said he was also slow with eating and drinking which was abnormal. She said she informed the nurses for several days of his changes in condition, and kept asking and kept asking for CR #1 to be assessed (LVN C and LVN Z) . She said there was never any follow up from the nurses. She said she reported changes again to the charge nurse on an unknown date and took his temperature and she said, well he doesn't have a fever. On ,[DATE] The physician was in the building and ordered another chest x ray. The results came back that he had [MEDICATION NAME]. She said the nurse LVN Z informed her he would be started on antibiotics and breathing treatments. She asked LVN Z what about IV fluids, because he hasn't been drinking much. She said LVN Z responded, Oh so you're a doctor now? She said the Wound Care Nurse was present during this and told LVN Z Sometimes when these CNAs tell yall something, they know what they're talking about. During an interview on [DATE] at 12:45 pm the Wound Care Nurse said she was responsible for treating CR #1's wound. She said on ,[DATE] she noticed he did not look good. She said he had been sleeping more, talking less, and did not ask for a soda as he usually did. She said CNA A told her LVN Z was already informed of the changes. She said LVN Z Took CR #1's vitals and said they looked good. She said CNA A again told LVN Z that CR #1 was still not looking like himself although his vitals were not abnormal. She said she told LVN Z that the vital signs were not the only indicator that something was wrong and the CNAs knew the residents best . She said the physician was called and new orders were received. She said she did not notice any other changes on ,[DATE] and ,[DATE]. Record review of CR #1's physician notes revealed the following: [DATE] I was asked to evaluate patient with wheezing. Today seen patient resting in bed in no acute distress. She noted he had scattered wheezes all throughout . Further review revealed Later in the evening around 6 pm I was called with chest x ray results that reported [MEDICATION NAME] and was started on [MEDICATION NAME]. The note was signed by the Physician. [DATE] Today seen patient resting in bed no acute distress. Received first dose of [MEDICATION NAME] -antibiotic today. The note indicated he had wheezing and cough, but also said clear to auscultation without wheezes or rhonchi. The last labs that were reviewed were from [DATE]. The note was signed by the Physician. Record review of CR #1's physician orders [REDACTED].

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

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.

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F 0580 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) Record review of CR #1's lab results dated [DATE] revealed a high white blood count of 10.9(high, indicative of infection) . The normal range was 4.2 - 9.1. Record review of CR #1's MAR/TAR dated [DATE] revealed he started [MEDICATION NAME] on the second shift on ,[DATE] at 9 pm. Further review revealed he had wheezing after receiving the nebulizer after each treatment except the last treatment on [DATE] and the one on [DATE]. During an interview on [DATE] at 11:53 am, the Physician said she was the point of contact for any changes in condition regarding CR #1's care. When asked if she was informed of any recent changes in condition she said she was called when CR #1 had a cough and wheezing. She said his chest x ray came back positive for [MEDICATION NAME] and she started him on [MEDICATION NAME] twice a day and breathing treatments four times a day. She said he had a standing weekly CBC order and she reviewed the labs on Mondays. She said if labs were abnormal the nursing staff would call her, but she was unaware of his abnormal labs on ,[DATE]. She said she last visited on that day and he was his usual self. She said he still had a cough but no wheezing. She said facility staff did not inform her of changes in condition including eating less, drinking less, taking off clothes, sweating, sleeping, and wheezing any time after ,[DATE]. She said had those changes been reported to her she would have changed the treatment, to include IV fluids, broader lab work, and vital checks every 4 hours. Record review of CR #1's care plan dated [DATE] revealed he had [MEDICATION NAME] infection and receiving antibiotics. The goal was he would be free of complications related to the infection through the review date. interventions included antibiotics treatments per the physician order [REDACTED]. Record review of CR #1's point of care documentation completed by aides dated [DATE] revealed his fluid intake on the three shifts as follows: ,[DATE] 480 cc, 480 cc, 240 cc ,[DATE] 480 cc, 240 cc, 120 cc ,[DATE] 240 cc, 240 cc, nothing documented ,[DATE] 480 cc, 360 cc, 240 cc ,[DATE] 240 cc, 240 cc, 240 cc During an interview on [DATE] at 4:05 pm CNA A said the last shift she worked with CR #1 was on ,[DATE] from 6 am 2 pm. She said he usually ate 100% of his meals, but only ate half at breakfast and lunch. She said he also had not been drinking much. She said he usually needed at least two brief changes during a shift but had not had much urine output. She said she reported changes to the Unit Manager some time during the week of ,[DATE] but never received follow up. She said CR #1 was still not looking good and brought the information up to the Administrator because she felt that the nurses were not listening to her. She said, I'm the main one that works with him and this is not him. She said the Administrator said they would just monitor CR #1. During an interview on [DATE] at 4:54 pm, the Unit Manager said he had been in the role since February 20th. He described CR #1 as alert and oriented, independent but needing supervision. He said within the last week CR #1 started developing a cough and wheezing. The physician was notified and ordered a STAT chest x ray. The chest x ray revealed [MEDICATION NAME]. The physician ordered antibiotics and breathing treatments. He said he was not aware of any other symptoms. When asked if staff had reported any changes in condition to him he said he remembered somebody saying he was eating less. He said he did not remember who told him that. He said following the treatments he was getting better and eating more. During a follow up interview on [DATE] at 1:40 pm, Unit Manager said the Administrator told him sometime last week that an aide reported a change in condition (coughing, wheezing, low appetite.) He said he informed the Administrator that a chest x ray was ordered, and CR#1 was confirmed to have [MEDICATION NAME] and had already started antibiotics. He said the physician was aware of the coughing and wheezing and he did not call the physician to report any other changes because he thought CR #1 was getting better. During an interview [DATE] at 3:50 pm, CNA F said she worked on [DATE] on CR #1's hall on the day shift. She said she was not assigned to him but remembered walking past his room around 11:,[DATE] pm and noticed he was lying in bed. When asked if she noticed any changes in his condition she said he had not been screaming for a bag of chips and a coke for a couple of days, which he usually did. She said CNA A also mentioned he had not produced much urine the past couple of days. During an interview on [DATE] at 2:20 pm CNA K said she was assigned to CR #1 on the evening shift of ,[DATE]. She said she did not normally work that wing but came in to cover a shift and no changes of condition were reported to her at shift change. She said CR #1 normally walked around at night, but he did not that night. She said he demanded food at midnight when she was rounding and provided him a snack which he ate. The aides further said not report this to the charge nurse . During an interview on [DATE] at 2:28 pm, LVN Z said she last worked with CR #1 on ,[DATE] and described his condition as good. She said his treatments were effective and his wheezing had calmed down. She said no changes in condition were reported to her that shift. She said she remembered being informed he ate 20% one day but could not recall what day it was. She said the Physician was not notified because for the most part He was eating but Sometimes he wanted you to feed him. She said it had not been reported that he was not drinking fluids. When asked how his change in condition was being monitored she said his O2 SATs and temperature were being checked 2 3 times per shift and documented in his clinical chart. During an interview [DATE] at 3:56 pm, CNA J said she worked with CR #1 on ,[DATE] from 6 am 2 pm. She said no changes of condition were reported to her at shift change and she did not observe any changes in CR #1's condition until his breathing was abnormal. She said she saw him around 8 am, changed his brief, and assisted him back to bed. She said around 8:30 am 9:30 am she passed his breakfast tray. When she picked up his tray she noted he ate around 75% of his meal and drank both milk and juice. Around 10 am he was naked in the hallway and she assisted back to his room and put on a new brief. She said while doing rounds around 11 am she was across the hallway caring for another resident and noticed CR #1's breathing was not good. She said she had never seen him breathing that way and immediately called LVN P who checked his O2 sat but they could not be read. She said CPR was started, EMS was called, but he was pronounced dead. Record review of CR #1's nursing note dated [DATE] and written at 5:02 pm revealed At 1030am The pt was seen naked outside the room and I rushed to him with a gown and asked the pt if he is ok and he said he wants to watch TV at the dinning so I walked with him so he wouldn't fall. At 1047am , I saw him walking toward his room and I helped him to his room and I asked if he is ok and he said yes thank you. At 1100am, I told my colleague (LVN P) I was going for break, At 11.10am I heard code blue and I rushed to his room, on getting there CPR was in process and 911 was called. At 12.03pm, he was pronounced dead. The doctor was notified of the situation and the guardian was called and I was given the (phone number) to call for them to come pick him up. At 1245pm the (police department) arrived and asked me questions. The note was signed by LVN C. During an interview on [DATE] at 5:34 pm, LVN C said she alternated between all wings. She said the last time she worked was ,[DATE] from 6 am 2 pm. She said she was familiar with CR #1 and described his condition as okay on ,[DATE]. She said no changes in condition were reported to her. She said when she made her initial rounds that morning he was sleeping. She said around 8 am he was in the restroom. She said she checked his vital signs around 9 am before administering his breathing treatment. When asked if she remembered his vitals she said they were Very stable and around 130 something. She said around 10:30 am she saw him naked and went to put a gown on him and walked him down to the TV room. She said he doesn't have a steady gait and was afraid he was going to fall. She said he had a behavior of walking around naked, but it was the first time she witnessed it. She said she did not do any assessment following that. She said at 10:45 am she saw him coming from the dining room and ran to him and helped him to the room. She said she saw him at 11 am and he said he was okay. She said she told LVN P she was going for a break and heard code blue shortly after. She said she ran to see what happened and saw a nurse perfuming CPR. She said she called CR #1's physician to give an update on his condition and was informed to send him to the emergency room , but he was pronounced dead around 12:03 pm. She said she called CR #1's guardian and was given a phone number to call to have the body picked up. When asked how his change in condition was being monitored she said his vitals were taken before and after breathing treatments. During an interview on [DATE] at 2:28 pm, CR #1's guardian said he last visited [DATE]th, 2020 and CR #1 was in bed sleep. He said he spoke with facility nursing staff who reported he had a [MEDICAL CONDITION] on ,[DATE] and shortness of breath. He said a voicemail was left from a facility staff member that said he died on ,[DATE] from pneumonia. He said, I did not know he had pneumonia. During an interview on [DATE] at 10:07 am, when asked how changes of condition were to be reported , the DON said we would like them to do the stop and watch form and give one to the nurse and unit manager. The nurse should go assess the resident and call the physician with the findings. She said nursing staff were responsible for informing resident's responsible party of any change in condition and updates to the treatment plan and documenting the communication in the clinical chart. Record review of the facility's policy on Changes in Condition dated February 2017 revealed Prompt notification is required when there is an accident involving the resident which results in injury and has the potential for requiring intervention; a significant change in the resident's attending physical, mental, or psychosocial status including a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications; or a need to alter treatment significantly. If the attending physician cannot be reached, nursing attempts to contact the following providers in this order until a physician has been contacted. The facility DON, District Director of Clinical Services, and the Director of Operations were notified on [DATE] at 4:25 pm that immediate jeopardy was identified due to the above failures, a copy of the IJ template was provided at this time and a plan of removal was requested. The final plan of removal was accepted on [DATE] at 4:37 p.m. after several revisions were made. IJ/IT/SQC [DATE] Plan of Removal In services were immediately initiated [DATE] 6 PM by the Director of

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F 0580 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) Nursing on the following topics to include all nursing staff and managers and will be completed [DATE] at 6 pm. Change In Condition (to include what a change in condition is, documentation, physical assessment and notifications of Resident Physician and Responsible Party) Monitoring of Resident's with a recent Change of Condition Laboratory Result Review and Notifications that includes ensuring all changes are communicated accurately and timely to Physician and Responsible Party. Laboratory Results are faxed to facility once results are available. Results are delivered to charge nurse responsible for residents care. Abnormal or Critical results are reported to physician immediately. Results and Interventions are then communicated to the responsible party. Abuse / Neglect Prohibition Interact / Stop and Watch for Resident Care Specialist and Medication Aides to alert Licensed Nurses of Changes in Condition and ensure adequate follow up. Training will include notifying Charge Nurses of changes in behavior, skin, bowel and bladder, mental / physical wellness, refusal of care and meal intakes. Training will also include reporting to Nurse Managers and DON when staff feels appropriate action has not been taken. 24 Hour Summary Reports (Auto Generated) from Point Click Care will be utilized for shift to shift report to ensure continuity of care. *Staff unable to attend by set date will be educated prior to the start of their subsequent shift. DON/Nurse Managers / Designees reviewed all residents in the facility to ensure there were no unidentified changes of condition not appropriately addressed after receiving change in condition education from the District Director of Clinical Services on [DATE]. This will be done by reviewing residents temp, [MED]gen saturation and signs and symptoms of respiratory illness (cough, sore throat, fever). Grand Rounds were conducted by DON and Nurse Managers which included assessing residents for any possible change in condition. This was completed [DATE] 9 pm with no adverse findings. DON/Nurse Managers/Designees will review all lab work performed from [DATE] to present day. Critical/Abnormal results will be reviewed and ensure physician was notified, interventions obtained as indicated and Responsible Party aware. This will be completed by [DATE] 6 PM. Residents with noted changes in condition will be reviewed from [DATE] to present day to ensure the change in condition was appropriately addressed and that the resident's Responsible Party and Physician were notified of the change in condition. This will be completed by [DATE]. ADHOC QAPI meeting with Medical Director held [DATE] at 8 PM to discuss the following processes: DON / Designee will review and log all Changes of Condition. Changes of Condition will be reviewed for accurate assessments including vital signs, physical assessment, interventions and notifications of Responsible Party and Physician. Staff will document findings of a change in condition in an SBAR format. DON / Designee will review all lab results in morning meeting and stand down meeting. Abnormal / Critical lab values will be reported to Physician immediately, interventions will be obtained as indicated and RP will be notified. Residents logged with changes of condition will receive follow up documentation minimally daily until the condition is resolved. Staff will document findings in the progress notes. These findings will be reviewed by the DON/Nurse Managers in the morning meeting and stand down meetings to ensure compliance. Licensed Nurses will utilize 24 Hour Summary Report out of Point Click Care for shift to shift reporting to ensure continuity of care. This 24 hour summary report includes all residents noted with a change in condition, progress notes noted during the reporting time frame and UDAs completed during the reporting time frame. Nurse Managers will utilize 24 hour Summary reports to conduct morning meetings and discuss any residents with changes in condition. Resident Care Specialist will utilize the INTERACT / Stop and Watch Program to alert licensed nurses of changes in condition in residents. Licensed Nurses will follow the Change in Condition Protocols and DON / Nurse Managers will receive a copy of the Stop and Watch to ensure adequate follow up. DON/Designee will conduct ground rounds on residents identified with a change in condition to validate assessment findings and intervention effectiveness. Monitoring Monitoring of the plan to remove the immediate jeopardy was conducted daily at various times from [DATE] until [DATE]. Interviews with 4 CNAs on ,[DATE] and ,[DATE] revealed they were able to identify what a change in condition was and the process for reporting the changes. They were able to state what to do if reported changes had not been followed up with. They were able to state the types of abuse and examples of abuse and neglect. They were able to identify the Abuse Prohibition Coordinator and when he should be notified. Interview with 6 licensed nursing staff on ,[DATE] and ,[DATE] revealed they were able to state their responsibility when a change in condition was reported to them and who to notify. They stated they were responsible for documenting on the SBAR, and nurse's notes when communication with the physician and responsible party were made. They said how they plan to monitor residents with identified changes in condition and communicate to the following shift. They were able to state how lab results are received, documented, and communicated to physicians especially if results are abnormal. They said the 24 hour report was utilized to identify changes in condition and reviewed each shift. Record review of documents provided revealed training in services dated [DATE] and [DATE] were conducted with nursing staff on all shifts which included change in condition, lab results, and abuse/neglect. The lab sheets revealed residents with labs were logged. Those whose labs were already drawn had the proper entities notified and documentation in the resident's clinical chart. Those with upcoming labs were also logged. Residents with identified changes of condition were logged. Their clinical records were reviewed and revealed documentation that there was continued follow up. On [DATE], the facility DON was notified that IJ was lowered but the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope of isolated because the facility continuing to educate their staff and monitor the effectiveness of the Plan of Removal.
F 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice and the comprehensive person centered care plan for one of 8 residents (CR #1) reviewed for quality of care. The facility staff failed to assess CR#1 , obtain and document current vitals when CR #1 was identified to have a change in condition. The facility staff failed to inform CR #1's physician of abnormal lab (Complete blood count) results. The facility staff failed to assess and monitor CR #1 when changes in his condition were reported to the charge nurses, unit manager, and the facility administrator. The changes were not reported to the physician , communicated to in coming staff and were not documented on the residents' change in condition assessment form. CR #1 was found unresponsive on [DATE] with unreadable O2 saturation level and he was pronounced dead one hour late at the facility. An Immediate Jeopardy (IJ) was identified on [DATE]. While the IJ was lowered on [DATE], the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope of isolated because the facility continued to train staff and monitor the effectiveness of the Plan of Removal. These failures could affect any resident who experiences a change in their condition in the facility placing them at risk complication from delay in medical intervention. Findings include: CR #1 Record review of CR #1's face sheet dated [DATE] revealed a [AGE] year-old male admitted to the facility on [DATE]. His [DIAGNOSES REDACTED]. He was a full-code. Record review of CR #1's Quarterly MDS dated [DATE] revealed a BIMS score of 3 indicating severe cognitive impairment. He required extensive assistance of one staff for toileting and hygiene, limited assistance of one staff for dressing, and was independent of all other ADLs. He ambulated without any devices. He was always incontinent of bowel and bladder. He was not on hospice and was not coded as having any behaviors. Record review of CR #1's care plan dated [DATE] revealed he had a respiratory infection related to [MEDICATION NAME] pneumonia. The goal was he would be free of signs and symptoms of infection by the review date. interventions included antibiotics and treatments per the physician orders, recording vitals, documenting side effects, and changing positions at regular and frequent intervals especially if in bed. Record review of CR #1's chest x-ray dated [DATE] revealed Bilateral perihilar fullness, nonspecific in nature, possibly due to perihilar [CONDITION] (Collapse of lungs) , adenopathy (disease of the lymph nodes), developing [MEDICATION NAME] (acute inflammation of the bronchi, accompanied by inflamed patches in the nearby lobules of the lungs). Consider central venous congestion or [MEDICAL CONDITION] arterial hypertension if indicated by symptomatic presentation, other testing or medical history. Continued follow-up recommended. Minimally worse compared to [DATE]. During an interview on [DATE] at 4:05 pm CNA A said she worked with CR #1 frequently and knew his usual behaviors/care needs. She said in February he was breaking out in sweats, and she asked the nurse to check his vitals. She said CR #1's physician ordered a chest x-ray. She said he was diagnosed with [REDACTED]. She said he was getting antibiotics and got better, but the sweating returned the week of ,[DATE] and got progressively worse than the previous time. Record review of CR #1's physician's orders [REDACTED]. Record review of CR #1's MAR/TAR dated February 2020 revealed he refused breathing treatments on ,[DATE] at 6 am, ,[DATE] at 6 am, ,[DATE] at 10 pm, ,[DATE] at 2 pm, ,[DATE] at 6 am and 2 pm, ,[DATE] at 6 am, and ,[DATE] at 6 am. Record review of CR #1's nursing notes for February 2020 revealed no documentation indicating his physician was notified of the missing breathing

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F 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) treatments. During an interview on [DATE] at 11:53 am, the Physician said she was the point of contact for any changes in condition regarding CR #1's care. She said when he was receiving breathing treatments in February due to [MEDICATION NAME] she was never informed of any treatment refusals. During an interview on [DATE] at 2:28 pm, CR #1's guardian said he last visited [DATE]th, 2020 and CR #1 was in bed sleep. When asked if he was aware of the pneumonia and treatments from a month prior he said he was not made aware of the [DIAGNOSES REDACTED].#1's SBAR dated [DATE] 2:07 pm revealed Patient alert with coughing noted. Upon auscultating lungs sounds, wheezing is noted. (Physician) notified and assessed resident and gave order for STAT chest X RAY and [MEDICATION NAME] Treatments- (Breathing inhalation treatment) V/S BP ,[DATE] P 78 RR 18 O2 SAT 98% at RA T 98.6. RP notified. The respirations were dated ,[DATE] and the blood pressure, O2 SATs and pulse were dated ,[DATE]. The statement This condition, symptom, or sign has occurred before was coded with no. He had no mental status changes and no functional status changes including needing more assistance, decreased mobility, or weakness. Under respiratory, abnormal lung sounds, wheezing and a productive cough were documented. There were no urine changes indicated including decreased urine output. It was documented that CR #1's RP was notified at 2:10 pm. The assessment was signed by RN A. During a telephone interview on [DATE] at 11:25 am RN A said she was new to the facility. When asked about CR #1's SBAR she completed on [DATE] she said, I don't remember that person. She said she was shadowing a nurse (LVN C) who was showing her how to enter the information, but she could not recall if she did the assessment or notified the Physician and responsible party. During an interview on [DATE] at 4:05 pm CNA A said around [DATE] CR #1 was sweating needing more assistance with ADLs when he usually followed cues. She said when changing his brief, he would not roll like usual and she would have to assist him. She said he was also slow with eating and drinking which was abnormal. She said she informed the nurses for several days of his changes in condition, and kept asking and kept asking for CR #1 to be assessed (LVN C and LVN Z) . She said there was never any follow up from the nurses. She said she reported changes again to the charge nurse on an unknown date and took his temperature and she said, well he doesn't have a fever. On ,[DATE] The physician was in the building and ordered another chest x ray. The results came back that he had [MEDICATION NAME]. She said the nurse LVN Z informed her he would be started on antibiotics and breathing treatments. She asked LVN Z what about IV fluids, because he hasn't been drinking much. She said LVN Z responded, Oh so you're a doctor now? She said the Wound Care Nurse was present during this and told LVN Z Sometimes when these CNAs tell yall something, they know what they're talking about. During an interview on [DATE] at 12:45 pm the Wound Care Nurse said she was responsible for treating CR #1's wound. She said on ,[DATE] she noticed he did not look good. She said he had been sleeping more, talking less, and did not ask for a soda as he usually did. She said CNA A told her LVN Z was already informed of the changes. She said LVN Z Took CR #1's vitals and said they looked good. She said CNA A again told LVN Z that CR #1 was still not looking like himself although his vitals were not abnormal. She said she told LVN Z that the vital signs were not the only indicator that something was wrong and the CNAs knew the residents best . She said the physician was called and new orders were received. She said she did not notice any other changes on ,[DATE] and ,[DATE]. Record review of CR #1's physician notes revealed the following: [DATE] I was asked to evaluate patient with wheezing. Today seen patient resting in bed in no acute distress. She noted he had scattered wheezes all throughout . Further review revealed Later in the evening around 6 pm I was called with chest x ray results that reported [MEDICATION NAME] and was started on [MEDICATION NAME]. The note was signed by the Physician. [DATE] Today seen patient resting in bed no acute distress. Received first dose of [MEDICATION NAME] -antibiotic today. The note indicated he had wheezing and cough, but also said clear to auscultation without wheezes or rhonchi. The last labs that were reviewed were from [DATE]. The note was signed by the Physician. Record review of CR #1's physician orders [REDACTED]. Record review of CR #1's lab results dated [DATE] revealed a high white blood count of 10.9 (high, indicative of infection) . The normal range was 4.2 - 9.1. Record review of CR #1's MAR/TAR dated [DATE] revealed he started [MEDICATION NAME] on the second shift on ,[DATE] at 9 pm. Further review revealed he had wheezing after receiving the nebulizer after each treatment except the last treatment on [DATE] and the one on [DATE]. During an interview on [DATE] at 11:53 am, the Physician said she was the point of contact for any changes in condition regarding CR #1's care. When asked if she was informed of any recent changes in condition she said she was called when CR #1 had a cough and wheezing. She said his chest x ray came back positive for [MEDICATION NAME] and she started him on [MEDICATION NAME] twice a day and breathing treatments four times a day. She said he had a standing weekly CBC order and she reviewed the labs on Mondays. She said if labs were abnormal the nursing staff would call her, but she was unaware of his abnormal labs on ,[DATE]. She said she last visited on that day and he was his usual self. She said he still had a cough but no wheezing. She said facility staff did not inform her of changes in condition including eating less, drinking less, taking off clothes, sweating, sleeping, and wheezing any time after ,[DATE]. She said had those changes been reported to her she would have changed the treatment, to include IV fluids, broader lab work, and vital checks every 4 hours. Record review of CR #1's care plan dated [DATE] revealed he had [MEDICATION NAME] infection and receiving antibiotics. The goal was he would be free of complications related to the infection through the review date. interventions included antibiotics treatments per the physician order [REDACTED]. Record review of CR #1's point of care documentation completed by aides dated [DATE] revealed his fluid intake on the three shifts as follows: ,[DATE] 480 cc, 480 cc, 240 cc ,[DATE] 480 cc, 240 cc, 120 cc ,[DATE] 240 cc, 240 cc, nothing documented ,[DATE] 480 cc, 360 cc, 240 cc ,[DATE] 240 cc, 240 cc, 240 cc During an interview on [DATE] at 4:05 pm CNA A said the last shift she worked with CR #1 was on ,[DATE] from 6 am 2 pm. She said he usually ate 100% of his meals, but only ate half at breakfast and lunch. She said he also had not been drinking much. She said he usually needed at least two brief changes during a shift but had not had much urine output. She said she reported changes to the Unit Manager some time during the week of ,[DATE] but never received follow up. She said CR #1 was still not looking good and brought the information up to the Administrator because she felt that the nurses were not listening to her. She said, I'm the main one that works with him and this is not him. She said the Administrator said they would just monitor CR #1. During an interview on [DATE] at 4:54 pm, the Unit Manager said he had been in the role since February 20th. He described CR #1 as alert and oriented, independent but needing supervision. He said within the last week CR #1 started developing a cough and wheezing. The physician was notified and ordered a STAT chest x ray. The chest x ray revealed [MEDICATION NAME]. The physician ordered antibiotics and breathing treatments. He said he was not aware of any other symptoms. When asked if staff had reported any changes in condition to him he said he remembered somebody saying he was eating less. He said he did not remember who told him that. He said following the treatments he was getting better and eating more. During a follow up interview on [DATE] at 1:40 pm, Unit Manager said the Administrator told him sometime last week that an aide reported a change in condition (coughing, wheezing, low appetite.) He said he informed the Administrator that a chest x ray was ordered, and CR#1 was confirmed to have [MEDICATION NAME] and had already started antibiotics. He said the physician was aware of the coughing and wheezing and he did not call the physician to report any other changes because he thought CR #1 was getting better. During an interview [DATE] at 3:50 pm, CNA F said she worked on [DATE] on CR #1's hall on the day shift. She said she was not assigned to him but remembered walking past his room around 11:,[DATE] pm and noticed he was lying in bed. When asked if she noticed any changes in his condition she said he had not been screaming for a bag of chips and a coke for a couple of days, which he usually did. She said CNA A also mentioned he had not produced much urine the past couple of days. During an interview on [DATE] at 2:20 pm CNA K said she was assigned to CR #1 on the evening shift of ,[DATE]. She said she did not normally work that wing but came in to cover a shift and no changes of condition were reported to her at shift change. She said CR #1 normally walked around at night, but he did not that night. She said he demanded food at midnight when she was rounding and provided him a snack which he ate. The aides further said not report this to the charge nurse . During an interview on [DATE] at 2:28 pm, LVN Z said she last worked with CR #1 on ,[DATE] and described his condition as good. She said his treatments were effective and his wheezing had calmed down. She said no changes in condition were reported to her that shift. She said she remembered being informed he ate 20% one day but could not recall what day it was. She said the Physician was not notified because for the most part He was eating but Sometimes he wanted you to feed him. She said it had not been reported that he was not drinking fluids. When asked how his change in condition was being monitored she said his O2 SATs and temperature were being checked 2 3 times per shift and documented in his clinical chart. During an interview [DATE] at 3:56 pm, CNA J said she worked with CR #1 on ,[DATE] from 6 am 2 pm. She said no changes of condition were reported to her at shift change and she did not observe any changes in CR #1's condition until his breathing was abnormal. She said she saw him around 8 am, changed his brief, and assisted him back to bed. She said around 8:30 am 9:30 am she passed his breakfast tray. When she picked up his tray she noted he ate around 75% of his meal and drank both milk and juice. Around 10 am he was naked in the hallway and she assisted back to his room and put on a new brief. She said while doing rounds around 11 am she was across the hallway caring for another resident and noticed CR #1's breathing was not good. She said she had never seen him breathing that way and immediately called LVN P who checked

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	455800	A. BUILDING _____ B. WING _____	03/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESTCHASE HEALTH AND REHABILITATION CENTER	8820 TOWN PARK DR HOUSTON, TX 77036

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) his O2 sat but they could not be read. She said CPR was started, EMS was called, but he was pronounced dead. Record review of CR #1's nursing note dated [DATE] and written at 5:02 pm revealed At 1030am The pt was seen naked outside the room and I rushed to him with a gown and asked the pt if he is ok and he said he wants to watch TV at the dinning so I walked with him so he wouldn't fall. At 1047am , I saw him walking toward his room and I helped him to his room and I asked if he is ok and he said yes thank you. At 1100am, I told my colleague (LVN P) I was going for break, At 11.10am I heard code blue and I rushed to his room, on getting there CPR was in process and 911 was called. At 12.03pm, he was pronounced dead. The doctor was notified of the situation and the guardian was called and I was given the (phone number) to call for them to come pick him up. At 1245pm the (police department) arrived and asked me questions. The note was signed by LVN C. During an interview on [DATE] at 5:34 pm, LVN C said she alternated between all wings. She said the last time she worked was ,[DATE] from 6 am 2 pm. She said she was familiar with CR #1 and described his condition as okay on ,[DATE]. She said no changes in condition were reported to her. She said when she made her initial rounds that morning he was sleeping. She said around 8 am he was in the restroom. She said she checked his vital signs around 9 am before administering his breathing treatment. When asked if she remembered his vitals she said they were Very stable and around 130 something. She said around 10:30 am she saw him naked and went to put a gown on him and walked him down to the TV room. She said he doesn't have a steady gait and was afraid he was going to fall. She said he had a behavior of walking around naked, but it was the first time she witnessed it. She said she did not do any assessment following that. She said at 10:45 am she saw him coming from the dining room and ran to him and helped him to the room. She said she saw him at 11 am and he said he was okay. She said she told LVN P she was going for a break and heard code blue shortly after. She said she ran to see what happened and saw a nurse perfuming CPR. She said she called CR #1's physician to give an update on his condition and was informed to send him to the emergency room , but he was pronounced dead around 12:03 pm. She said she called CR #1's guardian and was given a phone number to call to have the body picked up. When asked how his change in condition was being monitored she said his vitals were taken before and after breathing treatments. During an interview on [DATE] at 2:28 pm, CR #1's guardian said he last visited [DATE]th, 2020 and CR #1 was in bed sleep. He said he spoke with facility nursing staff who reported he had a [MEDICAL CONDITION] on ,[DATE] and shortness of breath. He said a voicemail was left from a facility staff member that said he died on ,[DATE] from pneumonia. He said, I did not know he had pneumonia. During an interview on [DATE] at 10:07 am, when asked how changes of condition were to be reported , the DON said we would like them to do the stop and watch form and give one to the nurse and unit manager. The nurse should go assess the resident and call the physician with the findings. She said nursing staff were responsible for informing resident's responsible party of any change in condition and updates to the treatment plan and documenting the communication in the clinical chart. Record review of the facility's policy on Changes in Condition dated February 2017 revealed Prompt notification is required when there is an accident involving the resident which results in injury and has the potential for requiring intervention; a significant change in the resident's attending physical, mental, or psychosocial status including a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications; or a need to alter treatment significantly. If the attending physician cannot be reached, nursing attempts to contact the following providers in this order until a physician has been contacted. The facility DON, District Director of Clinical Services, and the Director of Operations were notified on [DATE] at 4:25 pm that immediate jeopardy was identified due to the above failures, a copy of the IJ template was provided at this time and a plan of removal was requested. The final plan of removal was accepted on [DATE] at 4:37 p.m. after several revisions were made. IJ/IT/SQC [DATE] Plan of Removal In services were immediately initiated [DATE] 6 PM by the Director of Nursing on the following topics to include all nursing staff and managers and will be completed [DATE] at 6 pm. Change In Condition (to include what a change in condition is, documentation, physical assessment and notifications of Resident Physician and Responsible Party) Monitoring of Resident's with a recent Change of Condition Laboratory Result Review and Notifications that includes ensuring all changes are communicated accurately and timely to Physician and Responsible Party. Laboratory Results are faxed to facility once results are available. Results are delivered to charge nurse responsible for residents care. Abnormal or Critical results are reported to physician immediately. Results and Interventions are then communicated to the responsible party. Abuse / Neglect Prohibition Interact / Stop and Watch for Resident Care Specialist and Medication Aides to alert Licensed Nurses of Changes in Condition and ensure adequate follow up. Training will include notifying Charge Nurses of changes in behavior, skin, bowel and bladder, mental / physical wellness, refusal of care and meal intakes. Training will also include reporting to Nurse Managers and DON when staff feels appropriate action has not been taken. 24 Hour Summary Reports (Auto Generated) from Point Click Care will be utilized for shift to shift report to ensure continuity of care. *Staff unable to attend by set date will be educated prior to the start of their subsequent shift. DON/Nurse Managers / Designees reviewed all residents in the facility to ensure there were no unidentified changes of condition not appropriately addressed after receiving change in condition education from the District Director of Clinical Services on [DATE]. This will be done by reviewing residents temp, [MED]gen saturation and signs and symptoms of respiratory illness (cough, sore throat, fever). Grand Rounds were conducted by DON and Nurse Managers which included assessing residents for any possible change in condition. This was completed [DATE] 9 pm with no adverse findings. DON/Nurse Managers/Designees will review all lab work performed from [DATE] to present day. Critical/Abnormal results will be reviewed and ensure physician was notified, interventions obtained as indicated and Responsible Party aware. This will be completed by [DATE] 6 PM. Residents with noted changes in condition will be reviewed from [DATE] to present day to ensure the change in condition was appropriately addressed and that the resident's Responsible Party and Physician were notified of the change in condition. This will be completed by [DATE]. ADHOC QAPI meeting with Medical Director held [DATE] at 8 PM to discuss the following processes: DON / Designee will review and log all Changes of Condition. Changes of Condition will be reviewed for accurate assessments including vital signs, physical assessment, interventions and notifications of Responsible Party and Physician. Staff will document findings of a change in condition in an SBAR format. DON / Designee will review all lab results in morning meeting and stand down meeting. Abnormal / Critical lab values will be reported to Physician immediately, interventions will be obtained as indicated and RP will be notified. Residents logged with changes of condition will receive follow up documentation minimally daily until the condition is resolved. Staff will document findings in the progress notes. These findings will be reviewed by the DON/Nurse Managers in the morning meeting and stand down meetings to ensure compliance. Licensed Nurses will utilize 24 Hour Summary Report out of Point Click Care for shift to shift reporting to ensure continuity of care. This 24 hour summary report includes all residents noted with a change in condition, progress notes noted during the reporting time frame and UDAs completed during the reporting time frame. Nurse Managers will utilize 24 hour Summary reports to conduct morning meetings and discuss any residents with changes in condition. Resident Care Specialist will utilize the INTERACT / Stop and Watch Program to alert licensed nurses of changes in condition in residents. Licensed Nurses will follow the Change in Condition Protocols and DON / Nurse Managers will receive a copy of the Stop and Watch to ensure adequate follow up. DON/Designee will conduct ground rounds on residents identified with a change in condition to validate assessment findings and intervention effectiveness. Monitoring Monitoring of the plan to remove the immediate jeopardy was conducted daily at various times from [DATE] until [DATE]. Interviews with 4 CNAs on ,[DATE] and ,[DATE] revealed they were able to identify what a change in condition was and the process for reporting the changes. They were able to state what to do if reported changes had not been followed up with. They were able to state the types of abuse and examples of abuse and neglect. They were able to identify the Abuse Prohibition Coordinator and when he should be notified. Interview with 6 licensed nursing staff on ,[DATE] and ,[DATE] revealed they were able to state their responsibility when a change in condition was reported to them and who to notify. They stated they were responsible for documenting on the SBAR, and nurse's notes when communication with the physician and responsible party were made. They said how they plan to monitor residents with identified changes in condition and communicate to the following shift. They were able to state how lab results are received, documented, and communicated to physicians especially if results are abnormal. They said the 24 hour report was utilized to identify changes in condition and reviewed each shift. Record review of documents provided revealed training in services dated [DATE] and [DATE] were conducted with nursing staff on all shifts which included change in condition, lab results, and abuse/neglect. The lab sheets revealed residents with labs were logged. Those whose labs were already drawn had the proper entities notified and documentation in the resident's clinical chart. Those with upcoming labs were also logged. Residents with identified changes of condition were logged. Their clinical records were reviewed and revealed documentation that there was continued follow up. On [DATE], the facility DON was notified that IJ was lowered but the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope of isolated because the facility continuing to educate their staff and monitor the effectiveness of the Plan of Removal.

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	455800	A. BUILDING _____ B. WING _____	**03/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESTCHASE HEALTH AND REHABILITATION CENTER	**8820 TOWN PARK DR HOUSTON, TX 77036**

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F 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 5)
F 0773 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to promptly notify the ordering physician or nurse practitioner laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders [REDACTED].#1) reviewed for laboratory services, in that: CR #1's physician was not notified of his abnormal labs result. This failure could affect any resident who has physician ordered labs placing them at risk of delayed medical intervention and decline in health. Findings include: CR #1 Record review of CR #1's face sheet dated 3/23/20 revealed a [AGE] year-old male admitted to the facility on [DATE]. His [DIAGNOSES REDACTED]. He was a full-code. Record review of CR #1's Quarterly MDS dated [DATE] revealed a BIMS score of 3 indicating severe cognitive impairment. He required extensive assistance of one staff for toileting and hygiene, limited assistance of one staff for dressing, and was independent of all other ADLs. He ambulated without any devices. He was always incontinent of bowel and bladder. He was not on hospice. Record review of CR #1's physician notes revealed the following: - 3/17/20 - I was asked to evaluate patient with wheezing. Today seen patient resting in bed in no acute distress. She noted he had scattered wheezes all throughout. Further review revealed Later in the evening around 6 pm I was called with chest x-ray results that reported [MEDICATION NAME] and was started on [MEDICATION NAME]. The note was signed by the Physician. - 3/18/20 - Today seen patient resting in bed no acute distress. Received first dose of [MEDICATION NAME] today. The note indicated he had wheezing and cough, but also said clear to auscultation without wheezes or rhonchi. The last labs that were reviewed were from 3/5/20. The note was signed by the Physician. Record review of CR #1's lab results dated 3/18/20 revealed a high white blood count of 10.9, (normal range was 4.2 - 9.1) , high platelet count of 340 (normal range was 163 - 337), high red cell distribution width of 14.6 (Normal range was 11.6 - 14.4) , high [DIAGNOSES REDACTED]s of 6.8 (normal range was 2.2 - 4.8) , low hemoglobin level of 13.5(normal range was 13.7 - 17.5) , low mean corpuscular hemoglobin concentration of 32.2 (normal range was 32.3 - 36.5) , and low mean platelet volume of 8 (normal range was 9.4 - 12.4.) . Record review of CR #1's physician orders [REDACTED]. Record review of CR #1's clinical chart revealed no documentation that the Physician was notified regarding the abnormal lab results. During an interview on 3/27/20 at 11:53 am, the Physician said she was the point of contact for any changes in condition regarding CR #1's care. She said he had a standing weekly CBC order and she reviewed the labs on Mondays. She said if labs were abnormal the nursing staff would call her, but she was unaware of his abnormal labs on 3/18. She said she last visited on that day and he was his usual self. She said he still had a cough but no wheezing. She said facility staff did not inform her of changes in condition including eating less, drinking less, taking off clothes, sweating, sleeping, and wheezing any time after 3/17. She said had those changes been reported to her she would have changed the treatment, to include IV fluids, broader lab work, and vital checks every 4 hours. During an interview on 3/26/20 at 10:07 am, the DON said she labs were faxed to the facility and it was the charge nurse's responsibility to immediately notify the resident's physician of any abnormal labs. She said if they were not abnormal, they would go in the physician's communication book. Record review of the facility's diagnostic services management policy dated November 2017 revealed If the results are abnormal or show critical values, the attending physician/licensed practitioner will be notified immediately. The date, time, and person notified are documented on the report and signed by the licensed nurse.