

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455815	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/02/2025
NAME OF PROVIDER OR SUPPLIER  Fallbrook Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  10851 Crescent Moon Dr Houston, TX 77064	

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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation for 1 (CR #1) of 7 residents reviewed for controlled drugs in that:</p> <p>-The facility failed to appropriately store CR #1's Norco oral tablet 5-325mg (Hydrocodone -Acetaminophen-medication classified as a schedule II drug (high potential for addiction and abuse) used to treat pain and also used as a cough suppressant) in the DON's office under double lock when CR #1 was discharged to the hospital on [DATE] and returned to the facility 06/21/24. It was discovered on 06/29/24 that the medication was missing after CR #1 requested pain medication.</p> <p>-The facility Nursing staff failed to have completed signatures on their Controlled Drugs-Count Record for the month of June 2024 regarding 7am oncoming nurse and 7pm off going nurse for 6/18/24, 6/20/24, 6/24/24, 6/25/24, and 6/28/24.</p> <p>This failure could place residents at risk for unwanted discomfort, pain, and further decrease in quality of life.</p> <p>Findings include:</p> <p>Record review of CR #1's face sheet dated 03/31/25 revealed a [AGE] year-old male admitted to the facility on [DATE]. CR #1's diagnoses included the following: COPD (a group of lung diseases that block airflow and make it difficult to breathe), muscle weakness, lack of coordination, cognitive deficit, spondylosis(age-related wear and tear of the spine) with radiculopathy lumbar region (a condition that affects the nerve roots in the lower back), anxiety, malignant neoplasm of bronchus or lung (a type of cancer that originates in the airways or lung tissue), malignant pleural effusion (cancer causing an abnormal amount of fluid to collect in the thin layers of tissue lining the outside of the lung), and respiratory failure with hypoxia (lack of oxygen in the tissue to sustain bodily functions) . Further review of the face sheet revealed that resident was discharged from the facility on 07/05/24 to the hospital.</p> <p>Record review of CR #1's admission MDS dated [DATE] reflected a BIMS score of 15 indicating that resident cognition was intact. Section N (Medication) of CR #1's MDS reflected that CR #1 was receiving and opioid (pain-relieving medicine that work with the brain cells).</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
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of CR #1's Comprehensive Care Plan dated 06/14/24 reflected CR #1 was being care planned for pain r/t lung cancer with interventions that included to administer analgesics as per ordered. Give &amp;frac12; hour before treatments or care.</p> <p>Record review of CR #1's Physician Order Summery Report for the month of June 2024 reflected the following orders:</p> <p>-Dated 06/13/24 Norco oral tablet 5-325mg (Hydrocodone-Acetaminophen) give 1 tablet by mouth every 6 hours as needed for pain.</p> <p>-Dated 06/29/24 Tylenol with Codeine #4 tablet 300-60mg (Acetaminophen-Codeine) give 1 tablet by mouth every 6 hours as needed for pain do not give with Norco.</p> <p>Record review of CR #1's MAR for the month of June 2024 reflected the medication Norco 5-325mg (Hydrocodone-Acetaminophen) was given twice on the following days: June the 14th and June the 17th by RN B. Further review reflected that Tylenol with Codeine #4 tablet 300-60mg (Acetaminophen-Codeine) was administered to CR #1 on June the 29th.</p> <p>Record review of an E-INTERACT (interventions used to improve the identification, evaluation, and management of changes in resident's condition to reduce unnecessary hospital transfer) was done on CR #1 on 06/17/25 for urinary retention with pain (severe pain) uncontrolled with pain medication and CR #1 was sent to the hospital.</p> <p>Record review of the facility- self report revealed CR #1's medication Norco oral tablet 5-325mg (Hydrocodone) went missing after resident was discharged to the hospital 06/17/24. CR #1 returned to the facility 06/21/24 and on 06/29/24 CR #1 requested pain medication. The Unit Manager called pharmacy to reorder the medication. The pharmacy informed the facility the medication Norco 5-325mg 120 tablets was delivered to the facility on [DATE] and signed by LVN G. The Police Department was called, and the investigation was ongoing.</p> <p>Record review of the facility Pharmacy drug delivery receipt dated 06/16/24 revealed 120 tablets of Norco 5-325mg (Hydrocodone) was delivered to the facility for CR #1 with the Unit Manger signing for the medication.</p> <p>Record review of the facility investigation dated 07/01/24 of statement taken from Unit Manger said after he received the medication Norco 5-325mg (Hydrocodone 120 tablets) on 06/16/24 he did not work on the hall after that.</p> <p>Record review of the facility's June 2024 Controlled Drugs-Count Record revealed the following:</p> <p>-6/18/24 no signature for 7pm off going nurse.</p> <p>-6/19/24 no signature for the 7pm off going nurse.</p> <p>-6/20/24 no signature for the 7am off going nurse.</p> <p>-6/24/24 no signature for the 7am oncoming and 7am off going nurses.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-6/25/24 no signature for the 7am oncoming and 7am off going nurses.</p> <p>-6/26/24 7am oncoming and 7am off going was RN B signature.</p> <p>-6/26/24 7am oncoming was RN B signature. The off going signature was not legible.</p> <p>-6/27/24 7am oncoming nurse was LVN F signature. The off going signature was not legible.</p> <p>-6/28/24 7am oncoming nurse had an illegible signature; no signature for the 7am off going nurse.</p> <p>-6/29/24 7am oncoming was LVN A signature.</p> <p>Record review of statement from LPN D dated 07/01/24 said she was approached by the previous ADON that RN B would be leaving the facility at 2:00PM and that LPN D along with orientee LVN F would be responsible for the floor. LPN D reported that she got report from RN B and while counting the narcotics with RN B she observed there were some medications wrapped on a sheet with a rubber band. LPN D said she enquired about it and RN B told her don't do not worry about those, CR #1 was transferred to the hospital. LPN D said she suggested that the medication should be given to the ADON, but RN B insisted that she should not worry about the wrapped pack of medications and walk away. LPN D said LVN F was given the key to the narcotic cart throughout the shift and handed it to the oncoming nurse.</p> <p>Interview on 04/01/25 at 12:08PM via phone with LPN D said she worked at the facility PRN on the morning or evening shift. LPN D said she remembered the incident regarding CR #1 Norco medication missing. LPN D said she did not remember what day it was but that she was orienting a new nurse when around 12PM the previous ADON came to her to tell her another nurse on the hall was going to have to leave at 2pm who name she could not recall. LPN D said she counted the narcotic count with the nurse. LPN D said she remembered counting Norco medication, but did not remember who the medication belonged to. LPN D said when they approached her later about Norco medication missing. She said 120 pills were missing and that was not what she remembered counting. LPN D said when a resident receiving narcotics had to be transferred to the hospital, the narcotic was supposed to be counted and given to the DON. LPN D said she could not remember what medication belonged to who. LPN D said when she finished counting the narcotic with the nurse, she was told by the previous ADON to give the narcotic key to the nurse she was orienting, and she did.</p> <p>Record review of statement from RN B dated 07/01/24 indicated on 06/21/24 she was scheduled to work from 7AM-1PM. RN B said CR #1 was scheduled to be re-admitted to the facility on [DATE]. RN B said she counted the narcotic cart with LPN D and gave report. RN B said when she counted the narcotic with LPN D among the narcotics was CR #1 Norco wrapped with 2 count sheets. RN B said she gave the narcotic key to LPN D.</p> <p>Interview on 04/01/25 at 9:43AM via phone with RN B said she used to work at the facility full time on the morning shift from 7a-7p. RN B said she stopped working at the facility in August 2024. RN B said she heard there was a problem with the narcotic count on the hall that CR #1 resided on. RN B said she was called to come to the facility to take a drug test which she did. RN B said she tested negative for the drug test. RN B said there was a male nurse that worked on the same hall that refused to take the drug test but did not remember his name. RN B said whenever she counted the narcotic cart, the count was correct.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 04/01/25 at 1:00PM RN B said she was not sure if CR #1's narcotics were on the cart when she counted with LPN D. RN B said it was the facility protocol to count the narcotics and give to the DON when the resident was transferred to the hospital to ensure the medication remained secured. RN B said the narcotics could have been left on the cart because the DON was not at the facility and if not in the facility, the medication must stay on the narcotic cart until the medication can be delivered to the DON.</p> <p>Record review of statement from LVN F said on 06/21/24 said she was on orientation with LPN D. LVN F said RN B left the facility at 2:00PM after counting the narcotic cart with LPN D. LVN F said she thought everything was okay.</p> <p>Interview on 04/01/25 at 3:33PM via phone with LVN F said on 06/21/24 she was in training with nurse LPN D and did not count the narcotic medication cart. LVN F said she was never given the key to the narcotic cart. LVN F said she was one of the nurses that done a drug test and tested negative for drugs in her system.</p> <p>Interview on 03/31/25 at 3:05PM via phone with LPN A said she remembered last year of a resident medication gone missing but did not remember CR #1. LPN A said she worked at the facility on a PRN basis 6a-6p but last year the shift time was from 7a-7p. LPN A said she only worked at the facility on the weekends PRN morning shift. LPN A said when a resident that was receiving narcotics and had to be transferred to the hospital on the weekends, the narcotic had to be counted at the end of each shift with the oncoming nurse following up to that following Monday. After counting the narcotic on that Monday ensuring the count was correct, the narcotic would then be given to the DON to lock the medication away until the resident returned to the facility.</p> <p>Interview on 03/31/25 at 5:32PM via phone with the Unit Manager worked at the facility PRN on the weekends as a supervisor. The Unit Manager said it was the morning nurse who name he could not remember brought it to his attention that CR #1's narcotic Norco was missing. The Unit Manger said when CR #1's Norco could not be located, he notified DON A and previous Administrator. The Unit Manager said the protocol was when a resident receiving narcotics was transferred to the hospital, the narcotic must be counted at the end of each shift until it was picked up by the DON. The Unit Manager said LVN G no longer worked at the facility and had not worked at the facility for approximately a year. The Unit Manager said after DON A and the previous Administrator was notified, he did not know what happen regarding the missing narcotic for CR #1.</p> <p>Interview on 04/01/25 at 10:45AM with the Human Resource Specialist said all the nurses that had access to the narcotic cart on Hall 200 where CR #1 resided done a drug test except RN E who refused. The Human Resource Specialist said all the nurses that tested for drugs were negative. The Human Resource Specialist said RN E no longer worked at the facility after the incident of CR #1's Norco went missing.</p> <p>On 04/01/25 at 11:03AM A call was placed to RN E, no answer. left voicemail with a call back number. RN E did not return the call after making several attempts to contact RN E.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 04/01/25 at 1:10PM with the present DON, DON B said if a resident was admitted to the hospital and was receiving narcotics, the narcotics had to be counted by 2 nurses and delivered to the DON for best practices. DON B said if the resident was gone from the facility over 3 days, he believed the narcotic would have to be destroyed. DON B said if the resident returned to the facility and on the same medications, the medications would have to be re-ordered by the physician. DON B said this was how it was done at the previous facility he worked at. The DON B said when the resident was discharged, the narcotic (s) needed to be given to the DON within 24-hour period. DON B said if the resident discharged from the facility on the weekend, the staff would have to continue to count the narcotic at the end of each shift and given to the DON on the following Monday. DON B said when this protocol was not being followed it placed the narcotic at risk of being misplaced. Further interview with DON B said it was the responsibility of the DON to be checking the narcotics on each cart to ensure there were no discrepancies detected with the narcotics and the count sheet and that all signatures were completed on the narcotic sheet. DON B said he had been working at the facility since February 10th, 2025. DON B said he checked the narcotic carts each morning looking for any discrepancies. The DON said the facility had a total of 4 medication carts.</p> <p>Record review of DON A work schedule when worked at the facility in June 20204 reflected that DON A was at the facility 06/17/24 (Monday) through 06/21/24 (Friday) as well as 06/24/24 (Monday) through 06/28/24 (Friday).</p> <p>Interview on 04/01/25 at 3:18PM via phone with the previous DON, DON A said it was reported that CR #1 Norco was missing when he returned from the hospital. DON A said RN B gave CR #1 his Norco. DON A said it was RN E who refused to be drug tested and resigned. DON A said all the other nurses that had access to the narcotic cart on hall 200 done the drug test and was negative for drugs in their system. DON A said she tried to call RN E later and he never answered. DON A said when a resident on narcotics must be taken to the hospital and gone for more than 24 hours, the narcotics needed to be given to the DON and the drugs are double locked until the resident returned to the facility. DON A said CR #1's narcotic Norco was never located. DON A said whoever counts the narcotic cart was responsible for the narcotic cart. DON A said the facility failed to remove CR #1's medication Norco from the cart and give to the DON so the medication could be double lock for safe keeping. DON A said the staff was in-serviced on the handling of controlled medications.</p> <p>Record review of the facility investigation revealed that an in-service was done on 07/01/24 with the staff on controlled substances, storge of medications, abuse, neglect, misappropriation protocols/response. Further review revealed that the facility had conducted a pain questionnaire with the residents with no negative outcome identified. The Regional Nurse had done an audit of the medication room and storage room on 07/01/24 with all medications including narcotics were stored safely. The medication rooms were locked, and medication carts were observed locked when nurse was away from the cart.</p> <p>Record review of the facility policy on Controlled Substances revised in April of 2019 reflected in part:</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>.The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications .At the end of each shift: controlled medications are counted at the end of each shift. The nurse coming on duty and the nurse going off duty determine the count together .Controlled medications will be counted every shift change (scheduled or incidental) by an authorized staff member (RN, LVN, CMA) reporting for duty with an authorized staff member reporting off duty .</p> <p>Record review of the facility policy on Identifying Exploitation, Theft and Misappropriation of Resident Property dated April 2021 reflected in part:</p> <p>.As part of the abuse prevention strategy, volunteers, employees, and contractors hired by this facility are expected to be able to recognize exploitation of residents and misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without resident's consent .Example of misappropriation of resident property include drug diversion (taking the residents medication) .</p>		