STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455815	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fallbrook Rehabiliation and Care Center	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455815	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fallbrook Rehabiliation and Care Center	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the resident has a right to a dignified existence and maintain good grooming at resident request in a timely manner for two out of four residents (Resident#2 and Resident #1) reviewed residents rights. The facility failed to provide timely incontinent care for Resident #2 and Resident #1 and it affected the resident's feelings. This deficient practice could place residents at risk of skin breakdown and reduced feelings of self-worth Record review of Resident #2's face sheet revealed a [AGE] year-old female who was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #2 had diagnoses which included morbid (severe) obesity (A BMI of 40 plus), diabetes mellitus (high blood sugar), hypertension (high blood pressure), and need assistance with personal care. Record review of Resident #2's Quarterly MDS assessment, dated 06/28/25, revealed a BIMS score of 14 of 15, which indicated intact cognition. Resident #2 needed extensive to total care with ADL assistance with one staff assist. Record review of Resident #2's care plan, revision dated 09/05/25, read in part . [Resident #2] had incontinent of bladder and bowel. Intervention: clean peri area with each incontinence episode, check on resident every two hours and assist with toileting as needed. resident had self-care performance deficit related to impaired mobility. was on antibiotic therapy for UTI on Cipro 500mg PO BID for 5 days . During an observation on 09/04/325 at 2:15 p.m., the Treatment nurse and CNA M provided a head-to-to-skin assessment for Resident #2. When CNA M opened the resident's incontinent brief, it revealed Resident #1's brief was saturated with urine, and the inside of the brief was brown in color. During an interview on 09/04/25 at 2:07 p.m., Resident #2 said she was provided incontinent once today around 10:15 a.m. or 10:30 a.m., when she had a bowel movement, and nobody had come to ask her if she was wet. Resident #2 said the staff did not change her often, and that contributed to her having UTIs often. Resident #2 stated she told the aide she was wet before lunch, and the aide said she was coming to change her, but she did not come back, and her shift had ended, and she had gone home without changing her. Resident #2 said she felt uncared for because she was left in a dirty incontinent brief for hours. During an interview on 09/04/25 at 2:32 p.m., LVN P said CNA O was Resident #2's aide. LVN P said the aide should check the resident and see if the resident was wet at least every two hours. She said Resident #2's brief was soaked, and the resident would have redness, an open area, and a UTI. LVN P said CNA O did not tell her Resident #2 had not been changed when she asked if she had provided incontinent care for Resident #2. During an interview on 09/04/25 at 2:45 p.m., the Treatment Nurse said Resident #2's incontinent brief was soaking wet with urine, and it appeared Resident #2 was not changed recently. The Treatment Nurse said Resident #2's skin could break down, develop rashes, pressure ulcers, and UTI if the aide did not provide timely incontinent care for the resident. She said the aides were responsible for checking on the resident during rounds at least every two hours. She said the floor nurse was responsible for monitoring the aides throughout the shift to ensure the aides were providing care for the residents. The Treatment Nurse said she had an in-service on incontinence care during the all-staff meeting last week, Thursday (08/28/29), and she educated the staff on the importance of making rounds every two hours, changing the residents' incontinent briefs, and making sure the residents were kept dry to prevent skin breakdown and UTI. During an interview on 09/05/25 at 2:52 p.m., CNA M said Resident #2's incontinent brief was very wet, and the inside of the brief was brown, which showed Resident #2 had not been changed for more than two hours. CNA M said the aides made rounds every two hours and as needed. She said Resident #2 could get a bed sore, redness or infection. CNA M said she had a skills check, and it included ADLs, and the treatment nurse educated aides to make rounds every two hours and change the resident to prevent skin breakdown or UTI. During an interview on 09/08/25 at 10:05 p.m., the Corporate Nurse said the aides were responsible for providing incontinent care and were supposed to make rounds every two hours per standard of care. She said if Resident #2 was not changed promptly, the resident's skin could get red, and there was potential for UTI. The Corporate Nurse stated if she was a resident, she would not feel good if she were left on a wet incontinent brief for hours. During a telephone interview on 09/08/25 at 3:54 p.m., CNA O said she did not work with Resident #2 on 09/04/25 because she no longer worked at the facility. She said she had not worked in the facility at all in September 2025. During an interview on 09/08/25 at 5:10 p.m., the DON stated he would go and verify if he had given CNA O's name in error, because they had another aide with the same first name but a different last name. The DON did not provide the other aide's name before the state

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455815	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fallbrook Rehabiliation and Care Center	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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455815	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fallbrook Rehabiliation and Care Center	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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure a resident who was unable to carry out activities of daily living received necessary services to maintain good nutrition, grooming, and personal and oral hygiene for two of 4 residents (Resident#2 and Resident #1) reviewed for ADLs. The facility failed to provide timely incontinent care for Resident #2 and Resident #1. This deficient practice could place residents at risk of skin breakdown and reduced feelings of self-worth.Findings include: 1. Record review of Resident #2's face sheet revealed a [AGE] year-old female who was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #2 had diagnoses which included morbid (severe) obesity (A BMI of 40 plus), diabetes mellitus (high blood sugar), hypertension (high blood pressure), and need assistance with personal care. Record review of Resident #2's Quarterly MDS assessment, dated 06/28/25, revealed a BIMS score of 14 of 15, which indicated intact cognition. Resident #2 needed extensive to total care with ADL assistance with one staff assist. Record review of Resident #2's care plan, revision dated 09/05/25, read in part . [Resident #2] had incontinent of bladder and bowel. Intervention: clean peri area with each incontinence episode, check on resident every two hours and assist with toileting as needed. resident had self-care performance deficit related to impaired mobility. was on antibiotic therapy for UTI on Cipro 500mg PO BID for 5 days . During an observation on 09/04/325 at 2:15 p.m., the Treatment nurse and CNA M provided a head-to-to-skin assessment for Resident #2. When CNA M opened the resident's incontinent brief, it revealed Resident #1's brief was saturated with urine, and the inside of the brief was brown in color. During an interview on 09/04/25 at 2:07 p.m., Resident #2 said she was provided incontinent once today around 10:15 a.m. or 10:30 a.m., when she had a bowel movement, and nobody had come to ask her if she was wet. Resident #2 said the staff did not change her often, and that contributed to her having UTIs often. Resident #2 stated she told the aide she was wet before lunch, and the aide said she was coming to change her, but she did not come back, and her shift had ended, and she had gone home without changing her. Resident #2 said she felt uncared for because she was left in a dirty incontinent brief for hours. During an interview on 09/04/25 at 2:32 p.m., LVN P said CNA O was Resident #2's aide. LVN P said the aide should check the resident and see if the resident was wet at least every two hours. She said Resident #2's brief was soaked, and the resident would have redness, an open area, and a UTI. LVN P said CNA O did not tell her Resident #2 had not been changed when she asked if she had provided incontinent care for Resident #2. During an interview on 09/04/25 at 2:45 p.m., the Treatment Nurse said Resident #2's incontinent brief was soaking wet with urine, and it appeared Resident #2 was not changed recently. The Treatment Nurse said Resident #2's skin could break down, develop rashes, pressure ulcers, and UTI if the aide did not provide timely incontinent care for the resident. She said the aides were responsible for checking on the resident during rounds at least every two hours. She said the floor nurse was responsible for monitoring the aides throughout the shift to ensure the aides were providing care for the residents. The Treatment Nurse said she had an in-service on incontinence care during the all-staff meeting last week, Thursday (08/28/29), and she educated the staff on the importance of making rounds every two hours, changing the residents' incontinent briefs, and making sure the residents were kept dry to prevent skin breakdown and UTI. During an interview on 09/05/25 at 2:52 p.m., CNA M said Resident #2's incontinent brief was very wet, and the inside of the brief was brown, which showed Resident #2 had not been changed for more than two hours. CNA M said the aides made rounds every two hours and as needed. She said Resident #2 could get a bed sore, redness or infection. CNA M said she had a skills check, and it included ADLs, and the treatment nurse educated aides to make rounds every two hours and change the resident to prevent skin breakdown or UTI. During an interview on 09/08/25 at 10:05 p.m., the Corporate Nurse said the aides were responsible for providing incontinent care and were supposed to make rounds every two hours per standard of care. She said if Resident #2 was not changed promptly, the resident's skin could get red, and there was potential for UTI. The Corporate Nurse stated if she was a resident, she would not feel good if she were left on a wet incontinent brief for hours. During a telephone interview on 09/08/25 at 3:54 p.m., CNA O said she did not work with Resident #2 on 09/04/25 because she no longer worked at the facility. She said she had not worked in the facility at all in September 2025. During an interview on 09/08/25 at 5:10 p.m., the DON stated he would go and verify if he had given CNA O's name in error, because they had another aide with the same first name but a different last name. The DON did not provide the other aide's name before the state

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455815	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fallbrook Rehabiliation and Care Center	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)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455815	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fallbrook Rehabiliation and Care Center	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)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 3 residents (Resident #1) reviewed for incontinent care. The facility failed to ensure CNA L and CNA D properly cleaned Resident #1 during incontinent care. This failure could place residents at risk for pain, infection, injury, and hospitalization. Findings include: Record review of Resident #1's face sheet revealed a [AGE] year-old female who was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1 had diagnoses which included morbid (severe) obesity (A BMI of 40 plus), diabetes mellitus (high blood sugar), hypertension (high blood pressure), and cerebral infraction (brain attack caused by a blockage in a blood vessel). Record review of Resident #1's Quarterly MDS assessment, dated 07/31/25, revealed a BIMS score of 13 of 15, which indicated moderately impaired cognition. Resident #1 needed total care with ADL assistance with two staff assist. Record review of Resident #1's care plan, revision dated 08/11/25, read in part . [Resident #1] was frequently incontinent of bladder and bowel. Intervention: monitor for incontinent often and PRN, change promptly and apply a protective barrier to the skin. Observation on 09/04/25 at 4:00 p.m., revealed incontinent care was provided for Resident #1 by CNA L and CNA T. CNA T did not separate Resident #1's labia while she provided incontinent care. CNA T cleaned Resident #1 four times by putting her hand between the resident's closed peri area, without looking at or visualizing the labia. Resident #1 said ouch it hurts and the incontinent wipes had bright red blood. During an interview on 09/04/25 at 4:09 p.m., LVN P said CNA T was supposed to separate Resident #1's labia and wipe from front to back. She said CNA T should have separated the labia to make sure the area was cleaned and see if there was any open area to prevent infection and skin impairment. LVN P said CNA T was supposed to tell her that Resident #1 had blood from the labia area so she could assess Resident #1. She said the blood could be coming from irritation in the labia from sitting on the urine-soaked incontinent brief for an extended period of time. During an interview on 09/04/25 at 5:02 p. m., CNA L said CNA T should have separated Resident #1's labia and cleaned the sides and center. CNA L said Resident #1's labia should be separated so CNA T could see if Resident #1 had an open area where the blood on the wipes was coming from and made sure she cleaned the resident properly to prevent the resident from getting an infection. CNA L said CNA T should have stopped and called LVN P when Resident #1 said it was hurting and there was blood on the wipes. During an interview on 09/04/25 at 5:38 p.m., CNA T said she was supposed to open Resident #1's labia and wipe each side and then the middle, but she did not because she forgot. CNA T said she just wiped the middle without separating Resident #1's labia. She said she wiped out blood three or four times when she cleaned Resident #1's labia area. CNA T said Resident #1 could get an infection if the resident's labia area were not cleaned thoroughly. LVN T said she would tell LVN P after she had provided incontinent care for Resident #1. During an interview on 09/05/25 at 9:31 a.m., the DON said he expected CNA T to stop providing incontinent care and call LVN P when Resident #1 said, ouch, it hurts, and she also wiped-out blood from Resident #1's vagina area. The DON said CNA L and CNA T were educated to spread the labia and wipe one side, discard the wipe, use another wipe and wipe the other side, then discard it, and finally use another wipe and wipe in the middle. The DON said CNA L and CNA T should see the labia area and make sure there were no changes to the skin, and if CNA T did not clean the labia area properly, Resident #1 could have a UTI. The DON said Resident #1 had not had a UTI since she was admitted to the facility on [DATE]. Record review of the facility's, undated, policy on perineal care read in part . it is the practice of this facility to provide perineal care to all incontinent residents.and needed in order to promote cleanliness and comfort, prevent infection.facility explanation and compliance guideline. Female. 11.c.separate the resident's labia with one hand and cleanse perineum with the other hand by wiping in direction from front to back.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455815	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fallbrook Rehabiliation and Care Center	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455815	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fallbrook Rehabiliation and Care Center	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 2 residents (Resident #1) reviewed for infection control. The facility failed to ensure CNA L and CNA T followed appropriate infection control, hand hygiene and PPE procedure during incontinent care for Resident #1. This failure could place residents at risk for infection. Findings include: Record review of Resident #1's face sheet revealed a [AGE] year-old female who was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1 had diagnoses which include morbid (severe), obesity (A BMI of 40 plus), diabetes mellitus (high blood sugar), hypertension (high blood pressure), and cerebral infraction (brain attack caused by a blockage in a blood vessel). Record review of Resident #1's Quarterly MDS assessment, dated 07/31/25, revealed a BIMS score of 13 of 15, which indicated moderately impaired cognition. Resident #1 needed total care with ADL assistance with two staff assist. Record review of Resident #1's care plan, revision dated 08/11/25, read in part . [Resident #1 was frequently incontinent of bladder and bowel. Intervention: monitor for incontinent often and PRN, change promptly and apply a protective barrier to the skin. During an observation on 09/04/25 at 4:00 p.m., revealed incontinent care was provided for Resident #1 by CNA L and CNA T. The aides did not wash their hands, and they took gloves from their uniform pockets and donned gloves, which they used to provide incontinent care for the resident. CNA L and CNA T used the same gloves throughout incontinent care. CNA L and CNA T used the same gloves and applied a clean incontinent brief on Resident #1. CNA L used the peri wipe and cleaned the urine on the air mattress, and did not disinfect the air mattress. During an interview on 09/04/25 at 4:20 p.m., LVN P said CNA L and CNA T should introduce themselves to Resident #1 and wash or sanitize their hands before they donned their gloves. LVN P said the aides should not have taken the gloves from their uniform pockets because it was cross-contamination. LVN P said CNA L and CNA T should not have used the dirty gloves to apply the clean incontinent brief on Resident #1 because of cross-contamination; they had just transferred back the germs to the clean brief. She said CNA L should have clean the mattress with disinfectant wipes not peri wipes because the peri would not kill the germs on the mattress. During an interview on 09/05/25 at 5:07 p.m., CNA L stated she was supposed to obtain all the necessary supplies for incontinent care, which included gloves, but she did not because she had gloves in her uniform pocket. CNA L said she forgot to wash her hands, which meant she could transfer the germs from her hands and the germs from her uniform pocket because she donned gloves from her uniform pocket to Resident #1. CNA L said she forgot to take off the dirty gloves, wash her hands, and don a clean pair of gloves to prevent cross-contamination. She said she was educated to wash her hands before she donned clean gloves, took off the dirty gloves, wash her hands, and then put on clean gloves before transitioning from dirty to clean. CNA L stated she was supposed to wipe the air mattress with disinfectant wipes instead of peri-wipes. During an interview on 09/04/25 at 5:21 p.m., CNA T said she did not wash her hands before she donned gloves, which she took from her uniform pocket. CNA T said she forgot to wash her hands before she donned the glove from her pocket and it was cross-contamination. She said she should have taken off the dirty gloves and washed her hands, then donned clean gloves before touching the clean incontinent brief. She said she applied the clean incontinent brief with the dirty glove she used to clean Resident #1, which could have resulted in cross-contamination. During an interview on 09/05/25 at 9:40 a.m., the DON said CNA L and CNA T were supposed to wash or sanitize their hands before they donned clean gloves. The DON stated CNA L and CNA T should not have used gloves from their uniform pockets because it would lead to cross-contamination and the spread of germs. The DON stated CNA L and CNA T should have removed the dirty gloves used to clean Resident #1, washed or sanitized their hands, and then donned clean gloves before applying a clean incontinent brief to decrease the spread of germs. The DON stated CNA L should have disinfected the low-loss air mattress instead of wiping it with a peri wipe, which was an infection control issue because the germs were still present on the mattress. During an interview on 09/05/25 at 1:12 p.m., the Administrator said CNA L and CNA T should have washed their hands before they donned clean gloves and provided care for Resident #1. He said CNA L and CNA T should have taken gloves from the glove box on their incontinent care setup, not from their uniform pockets, because of infection control, and they could spread germs from one resident to another. The Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455815	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fallbrook Rehabiliation and Care Center	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)
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455815	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fallbrook Rehabiliation and Care Center	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)
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure they were adequately equipped to allow residents to call for staff assistance through a communication system which relayed the call directly to a staff member or to a centralized staff work area from each resident's bedside, and toilet and bathing facilities for 1 of 5 residents (Resident #1) reviewed for call light systems. The facility failed to ensure Resident #1' s call light was properly functioning. These failures could place residents at risk of not being able to call for assistance when needed. Findings include: Record review of Resident #1's face sheet revealed a [AGE] year-old female who was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1 had diagnoses which included morbid (severe) obesity (A BMI of 40 plus), diabetes mellitus (high blood sugar), hypertension (high blood pressure), and cerebral infraction (brain attack caused by a blockage in a blood vessel). Record review of Resident #1's Quarterly MDS assessment, dated [DATE], revealed a BIMS score of 13 of 15, which indicated moderately impaired cognition. Resident #1 needed total care with ADL assistance with two staff assist. Record review of Resident #1's care plan, revision date [DATE], read in part . [Resident #1] required assistance with ADL functions: Goal resident would maintain a sense of dignity by being clean, dry odor free and well groomed. There was intervention for call light. During an observation and interview on [DATE] at 3:35 p.m., Resident #1 said her call light was not working, and the State Surveyor asked her to push her call light. When the resident pushed the red button on the call light, the light was not blinking at the insertion site in the room or above the resident's door. Resident #1 said her call light worked sometimes, and sometimes it would not work, and she could not remember how long the call light had not been working correctly. Resident #1 said her aides and the nurses knew about it. Resident #1 said LVN P gave her the call light when she came to her room between 10:00 a.m. and 11:00 a.m. and she did not know if the call was working or not During an observation and interview on [DATE] at 3:39 p.m., LVN P came into Resident #1's room, pushed the call light, and it was not working. LVN P pulled the call light cord out of the wall insertion, and the light came on. She pushed the call light back into the wall insertion and pushed on the red knob on the call light, but the light did not come on in the room or above the door. LVN P said the call light was not working properly, and she was not aware the call light was malfunctioning. LVN P said she was going to notify the maintenance director. During an observation and interview on [DATE] at 3:41 p.m., LVN P came back to Resident #1's room with another call light cord, which she inserted into the wall outlet and pushed the red button on the cord, and the call light lit up in the room at the wall and above the resident's door. LVN P said she would still put the repair order in the log. She said if the call light was not working, Resident #1 would not be able to reach the staff for any assistance until a staff member came into the resident's room. She said Resident #1 would have delayed care, and if the resident tried to get up to call for assistance, the resident could fall and sustain injury. She said she handed the call light to Resident #1, but did not check if the call light was functioning properly. LVN P said she forgot to check if the call light was functioning, before she handed the call light to Resident #1. She stated the maintenance director was responsible for making sure the call light was functioning correctly. During an interview on [DATE] at 9:48 a. m., the DON said the call light connected Resident #1 to the staff to make her needs known when the staff were not in the room. The DON said maintenance was responsible for maintaining the call light, and the nursing staff were supposed to notify maintenance, by writing, that the call light was not functioning in the maintenance log. The DON said the aides were supposed to check and ensure the call light was working before the staff handed the call light to Resident #1. The DON said Resident #1 would not get the assistance she needed until the staff made the next round. The DON said there would be a variable negative outcome for Resident #1 and did not respond to what types of variables. During an interview on [DATE] at 12:58 p.m., the Administrator said the maintenance director was responsible for making sure all the call lights were working. He said he did the audit of all the call lights last night when he became aware Resident #1's was not working. The Administrator said the call light was what Resident #1 used to communicate her needs to the staff. The Administrator said Resident #1 could have delayed care because the resident's call light was not functioning correctly. The Administrator said the staff should have checked and made sure the call light was working before she gave the call light to Resident #1. The Administrator stated he performed a call light audit on [DATE], and the maintenance director should have documented it. During a telephone interview on [DATE] at 3:13 p.m., the Maintenance Director stated the entire maintenance team conducted monthly