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	10/10/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm 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. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(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 - 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 immediately consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there was a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) for 1 (CR #1) of 6 residents reviewed for resident rights. - Nurse A did not immediately notify CR #1's physician when he had a change in condition and was sent out to the hospital via 911 on 09/14/25. -Nurse A did not notify CR #1's family member/RP/emergency contact when he had a change in condition and was transported to the hospital on [DATE]. The failures could place residents at risk of not receiving appropriate care and required notifications being made when there is a change in their condition. Findings included: Record review of CR #1's admission Record, dated 09/16/25, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included type 2 diabetes mellitus (high levels of blood sugar in the blood) with chronic kidney disease, degenerative disease of nervous system (conditions that affect the nerve cells in the brain and spinal cord), other chronic pancreatitis (long-standing inflammation of the pancreas), depression, and muscle weakness. Further review revealed resident was listed as RP, family member was listed as RP/emergency contact #1, and another family member was listed as POA-Care/emergency contact #2 (no phone number listed). Record review of CR #1's Quarterly MDS Assessment, dated 08/28/25, revealed a BIMS score of 13, indicating intact cognition. Record review of CR #1's progress notes, dated 09/14/25 at 20:50 (8:50 p.m.), entered by Nurse A, revealed in part CNA called 911 resident complaining of vomiting and chest pain.Blood pressure 143/84, pulse 81, respiration 18, temp 102.2 [degrees Fahrenheit], and O2 sat 99. As nurse was leaving room EMT and police coming in hallway with CNA stating she called them. 2105 [9:05 p.m.] time on stretcher to ambulance. No other documentation/notes were found that indicated doctor or RP was notified. Record review of hospital record, dated 09/14/25, revealed in part .presented from [nursing facility name] with complaints of flu-like symptoms, nausea, vomiting, chest pain associated with vomiting, and abdominal pain. The patient reports the abdominal pain as severe, rated 10/10 [pain scale used for assessing pain intensity, where 0 indicates no pain and 10 represents the worst pain imaginable] and similar to his previous h/o pancreatitis.On exam the patient is AAOx4 [patient is fully aware of their identity, location, time, and situation, reflecting a high level of cognitive function], in no apparent distress. During a telephone interview on 09/16/25 at 7:27 a.m., CNA A said she did not know what time she told Nurse A to check on CR #1 on 09/14/25 but when she told her, she said okay she was going to get to him, but she never checked on him. She said CR #1 was normally grumpy and aggressive but on this day, 09/14/25, he was doubled over, his skin color was grayish, he looked tired and just did not look like himself at all. She said she also heard CNA B, and Residents #2 and #3 tell Nurse A about CR #1 not feeling well while she was helping other residents in the hallway. She said she heard Resident #2 tell Nurse A that CR #1 was asking for her to come to his room because he was not feeling well, but she said she told Resident #2 not to worry about it and that she would take care of it. She said she went back to his room, and CR #1 was on his bed, sitting up but slouched all the way over and throwing up. She said she took his temperature with her personal thermometer, and he had a fever of 103 F. She said CR #1 was saying his chest hurt, and to please call the ambulance. She said he told her his pain level was a 10 out of 10. She said over an hour had passed and she never saw Nurse A go into his room to check on him. She said she called 911 from her cell phone at 8:46 p.m. and yelled out for Nurse A. She said Nurse A went to CR #1's room and asked him how he was feeling. She said the resident could barely talk, and that he just kept saying to call the ambulance. She said she left CR #1's room and went to the hallway to give 911 the address to the facility, and they arrived maybe within 5 minutes. She said Nurse A denied being told that something was wrong with CR #1. During an observation and interview on 09/17/25 at 10:09 a.m., revealed CR #1 was at the hospital lying in bed, watching television. He said he did not remember what time he started feeling bad on Sunday, 09/14/25. He said he was in a lot of pain from his waist down, he was vomiting, his chest was also hurting, and his pain level was at a 10. He said he told the nurse aide he was feeling bad but said he did not remember when he told her. He said he did not get a chance to ask the nurse for anything because she never came and checked on him. He said he pressed his call light, waited for about an hour, but the nurse did not go to his room until about 2-3 minutes before the ambulance got to the facility. He said the nurse aide said she was

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety 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 that residents received treatment and care in accordance with professional standards of practice for 1 (CR #1) of 6 residents reviewed for quality of care. -On 09/14/25, CNA A failed to tell Nurse A specifically what was wrong with CR #1. Nurse A failed to assess or provide medical care for CR #1 for approximately two hours, after CNA A asked her to check on CR #1 around 6:30 p.m. CNA A called 911 on 09/14/25 around 8:46 p.m. after CR #1 was noted to have a fever of 103 F, nausea/vomiting, doubled over with pain of 10/10, and was grayish in color. CR #1 was diagnosed at the hospital with fever, left heel wound infection, complicated UTI, and AKI. An Immediate Jeopardy (IJ) was identified on 10/07/25. The IJ Template was provided to the facility on [DATE] at 2:05 p.m. While the IJ was removed on 10/09/25, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal (POR). This failure could place residents at risk of not receiving necessary medical care, a decline in health, and/or experiencing emotional and physical distress. The findings included: Record review of CR #1's admission Record, dated 09/16/25, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included type 2 diabetes mellitus (high levels of blood sugar in the blood) with chronic kidney disease, degenerative disease of nervous system (conditions that affect the nerve cells in the brain and spinal cord), other chronic pancreatitis (long-standing inflammation of the pancreas), depression, and muscle weakness. Record review of CR #1's Quarterly MDS Assessment, dated 08/28/25, revealed a BIMS score of 13, indicating intact cognition. Further review revealed the resident required the assistance of 2 or more helpers with toileting and chair/bed-to-chair transfer, and partial assistance with showering/bathing. Record review of CR #1's Care Plan, undated, revealed he had an ADL self-care performance deficit and required hands on assistance bathing/showering, bed mobility, dressing, and transferring. Record review of CR #1's progress notes, dated 09/14/25 at 20:50 (8:50 p.m.), entered by Nurse A, revealed in part CNA called 911 resident complaining of vomiting and chest pain.Blood pressure 143/84, pulse 81, respiration 18, temp 102.2, and O2 sat 99. As nurse was leaving room EMT and police coming in hallway with CNA stating she called them. 2105 [9:05 p.m.] time on stretcher to ambulance. Record review of the hospital report, ADM DT: 09/15/25, Note Date: 00:34 (12:34 a.m.), admission Date: 09/14/2025, revealed in part .presented from [nursing facility name] with complaints of flu-like symptoms, nausea, vomiting, chest pain associated with vomiting, and abdominal pain. The patient reports the abdominal pain as severe, rated 10/10 (pain scale used for assessing pain intensity, where 0 indicates no pain and 10 represents the worst pain imaginable) and similar to his previous h/o pancreatitis.On exam the patient is AAOx4 [patient is fully aware of their identity, location, time, and situation, reflecting a high level of cognitive function], in no apparent distress. Record review of hospital report, ADM DT: 09/15/25, note dated 09/15/25 at 15:24 (3:24 p.m.), revealed in part .Assessment: #Fevers, #L heel wound, #complicated UTI w/ suprapubic catheter, #AKI. Further review, note date: 09/21/25 22:16 [10:16 p. m.], revealed in part .09/19/2025: Echogram with pelvic angiogram [diagnostic procedure that uses X-ray images to visualize blood vessels and identify any blockages or narrow spots], bilateral lower extremity angiogram, spur retrieval stent of left peroneal artery [self-expanding stent with integrated balloon dilation technology, allowing for temporary support of the artery and improved blood flow], IVUS [minimally invasive procedure that uses sound waves to assess blood vessels from the inside]. During a telephone interview on 09/16/25 at 7:27 a.m., CNA A said she did not know what time she told Nurse A to check on CR #1 on 09/14/25 but when she told her she said okay she was going to get to him, but she never checked on him. She said CR #1 was normally grumpy and aggressive but on this day, 09/14/25, he was doubled over, his skin color was grayish, he looked tired and just did not look like himself at all. She said she also heard CNA B, and Residents #2 and #3, tell Nurse A (did not know what time) about CR #1 not feeling well while she was helping other residents in the hallway. She said she heard Resident #2 tell Nurse A (did not know what time) that CR #1 was asking for her to come to his room because he was not feeling well, but she said she told Resident #2 not to worry about it that she would take care of it. She said she went back to his room, and CR #1 was on his bed, sitting up but slouched all the way over and throwing up. She said she took his temperature with her personal thermometer, and he had a fever of 103 F. She said CR #1 was saying my chest hurts, my chest hurts, please call the ambulance. She said he told her his pain level was a 10 out of