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	01/05/2026

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 - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents, who was dependent on assistance for activities of daily living, received necessary and timely care and services, including repositioning, incontinence care, and bathing, in accordance with professional standards of practice for 1 of 5 residents reviewed (Resident #1).On 01/13/2026, the facility failed to ensure Resident #1 received repositioning, incontinence care, or a scheduled bed bath.This failure could place residents at risk of not receiving timely hygiene care and demonstrated inadequate oversight of staff responsibilities related to activities of daily living.Record review of Resident #1's face sheet, dated 01/03/2026, reflected the resident was a 57 -year-old female who was admitted to the facility on [DATE], with diagnoses of acute respiratory failure with hypoxia (inadequate oxygenation of the blood), morbid (severe) obesity due to excess calories (having a body mass index of 40 or higher)., paralytic syndrome following cerebral infarction (condition that result in loss of motor function, often due to damage to the nervous system).Record review of Resident #1's MDS assessment, dated 10/02/2025 revealed a BIMS score of 14 indicating cognition was intact (thinking is normal). Resident #1 was dependent - (helper does all the effort. Residents do none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity) with all activities of daily living, including repositioning, incontinence care, and bathing. Section H - Bladder and Bowel: Resident #1 as coded 3, indicating Urinary /Bowel Continence Always incontinent (no episodes of continent voiding/ bowel movements). Section M - Skin Conditions - indicated Resident #1 was resident at risk of developing pressure ulcers/injuries. Record review of Resident #1's care plan, dated 12/23/2025, reflected: Focus Area: Resident is frequently incontinent of Bladder and Bowel. Goal: Resident will remain clean, dry and odor free and dignity will be maintainedover next 90 daysInterventions /Tasks: Monitor for incontinent, often/PRN, change promptly and apply a protective skin barrier to skin. Focus Area: Residents require assistance with ADLGoal: Will maintain a sense of dignity by being clean, dry, odor free and well-groomed over next 90 days.Interventions /Tasks: Toileting: Total assistance of two staff members. Personal Hygiene: Total assistance of two staff members. Bed Mobility: Extensive assistance of 2 staff members. Dressing: Extensive assistance of 2 staff members.Focus Area: The resident has an ADL self-care performance deficit. Goal: The resident will maintain/improve level of functioning.Interventions /Tasks: BATHING/SHOWERING: Provide sponge bath when a full bath or shower cannot be tolerated. BED MOBILITY: The resident requires extensive assistance by two person staff to turn and reposition in bed. DRESSING: The resident is dependent on staff to dress.Record review of the Shower/bathing schedule revealed that Resident #1 was scheduled to receive a bed bath on Tuesday/Thursday/Saturday- Days (6:00 AM-2:00 PM) shift. Schedule also indicated showers were to be done according to assignment and shift time.Review of CNA J's ADL documentation, on 01/13/2026 for the 6:00 AM-2:00 PM shift failed to demonstrate that Resident #1 received repositioning, (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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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incontinence care, or a scheduled bed bath.Interview on 01/03/2026 at 2:56 PM, Resident #1 while lying in bed in the supine (on back) position stated she requested assistance to have her soiled brief changed and a bed bath earlier during the morning shift (6:00 AM to 2:00 PM). Resident #1 stated the care was not provided. Resident #1 further stated she later informed CNA E that she required soiled brief change and continued to wait for assistance. Resident #1 reported there were days when she called for assistance and no staff came to her, and there were days when no one checked on her until approximately 6:00 PM. Resident #1 stated that she had not been repositioned even once during the morning shift. She stated that staff (Nurse G, DON, CNA J and CNA E) had checked in on her throughout the day, but no one had repositioned her. She stated she was supposed to get a bed bath during the morning shift but was not offered a bath this morning. She stated she had communicated the need to have her brief changed to CNA J hours prior and again within the past hour to CNA E who started his shift at 2pm. She stated she had not communicated the need to Nurse G and the DON. Resident # 1 denied skin breakdown related to delayed care. In an interview conducted on 01/03/2026 at 3:06 PM, Nurse E stated he reminded CNA J multiple times (10:30AM, 12:30PM, and 1:30PM) during the morning shift to provide Resident #1 with a bed bath and helped. Nurse E stated CNA J assured him she would complete the care prior to shift ending. Nurse E stated when he spoke with CNA J at approximately 2:15PM she later stated she had arranged for CNA E to help her with Resident #1's bed bath. He stated residents should be repositioned at least every two hours. Nurse E stated he was not informed that Resident #1 did not receive repositioning, incontinence care, or a bed bath during the shift. Nurse E stated that there were adequate staff available if help was needed. Nurse E stated he was immediately arranging for two other staff members to implement care as he could not locate CNA J and did not want to delay care longer. Nurse E stated it was the care staff responsibility to ensure resident needs were met timely. Nurse E stated the delay in care placed Resident #1 at risk for skin breakdown. Interview on 01/03/2026 at 3:21 PM, CNA J stated that during her scheduled shift from 6:00 AM to 2:00 PM, she did not reposition Resident #1, did not provide incontinence care (soil brief change), and did not provide a bed bath. She stated Resident #1 was scheduled to have a bed bath during the morning shift. She stated that Resident #1 informed her that she needed to be changed but she required help in providing care to Resident #1 as Resident #1 required 2-3 staff assistance when providing care. She stated she had not asked for assistance during her scheduled shift from 6:00 AM to 2:00 PM but was scheduled to work an additional shift, the evening shift (2:00PM - 10:00). She stated she went to lunch and had planned to provide care after lunch with CNA E during the evening shift. She stated residents should be repositioned at least every two hours. She did not explain why she did not request help, and why care was delayed. She stated the facility had provided training on incontinence care, repositioning, and bed baths. She stated that when a resident care is delayed it could place Resident #1 at risk of harm and neglect. In an interview conducted on 01/03/2026 at 4:48 PM, the DON stated it was the facility's expectation that staff reposition dependent residents at least every two hours and as needed, and that staff had been trained on incontinence care, repositioning, and ADL care. The DON stated he checked on Resident #1 at varies between 10:00 AM and 2:00 PM on 01/13/2026; however, he was not made aware that the required care had not been provided. The DON stated it was the responsibility of all staff to ensure the residents' needs were met timely. He stated the DON and Administrator were responsible for overseeing residents' satisfaction related to quality of care. He stated quality of care satisfaction is monitored during daily safety rounds conducted by the DON, the Administrator and Leadership Staff. He stated delayed care placed Resident #1 at risk for skin breakdown.Observation on 01/03/2026 at 4:13 PM, of care provided to Resident #1, soiled (wet) brief was (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	removed. No foul odors were noted at the time of observation. Resident #1's bed bath revealed intact skin with no observed pressure injuries or areas of skin breakdown. Resident #1 Record review of the facility policy implemented 09/01/2021 and reviewed/revised 08/01/2025, titled Bathing a Resident, revealed that it is the practice of the facility to assist residents with bathing to maintain proper hygiene and help prevent skin issues.Record review of facility policy implemented 09/01/2021 and reviewed/revised 04/23/2025, titled Activities of Daily Living (ADLs), revealed that the facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable.Care and services will be provided for the following activities of daily living:1. Bathing, dressing, grooming and oral care;2. Transfer and ambulation;3. ToiletingRecord review of facility policy implemented 09/01/2021 and reviewed/revised 09/01/2021, titled Turning and Repositioning, revealed that the facility will, implement turning and repositioning as part of our systematic approach to pressure injury prevention and management. This policy establishes responsibilities and protocols for turning and repositioning.Turning and repositioning is a primary responsibility of nursing assistants. However, all nursing staff are expected to assist with turning and repositioning. The facility has established routine turning and repositioning schedules consisting of every 2-4 hours, on the even hour. A maximum of thirty minutes before or after the scheduled time will be allotted for compliance with the schedule.