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	01/14/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 5 residents (Resident #6) reviewed for care plans .The facility failed to ensure a care plan was developed to address Resident #6's need for an escort to appointments.This failure could place residents at risk of not receiving appropriate care and interventions to meet their needs. Findings include :Record review of Resident #6's face sheet, reflected a [AGE] year-old male who was originally admitted to the facility on [DATE] and last re-admitted on [DATE]. Resident #6 had medical diagnoses which included unspecified dementia (mild, with agitation) (declining brain function related to thinking and judgement that is severe enough to impact daily life without behavioral disturbance, psychotic disturbance, mood disturbance), hypertension (high blood pressure), dysphagia (difficulty swallowing), hemiplegia and hemiparesis following cerebral infarction affecting left dominant side (left-side paralysis after a stroke), depression (prolonged periods of sadness and hopelessness), Human Immunodeficiency Virus Disease (HIV being a virus that attacks cells that help the body fight infections making a person more vulnerable to other infections and diseases), cognitive communication deficit and blindness in one eye.Record review of Resident #6's Annual MDS , dated 12/09/2025, reflected he was rarely or never understood and a BIMS assessment for cognitive intactness was not conducted. Resident #6 was totally dependent on staff for toileting, showering, and footwear and required total assistance with mobility in bed. Resident #6 was coded for short-term and long-term memory problems and was severely impaired related to daily decision making and having a wheelchair.Record review of Resident #6's care plan, dated 01/14/2026, reflected he had an ADL self-care performance deficit with interventions which included resident being totally depending on 1-2 staff to provide 2-3 baths weekly and as necessary and requiring mechanical lift with 2 staff members assistance for transfers. Resident #6 had impaired cognitive function/dementia or impaired thought processes with interventions which included cuing, reorienting and supervising as needed and keeping the resident's routine consistent and trying to provide consistent caregivers as much as possible in order to decrease confusion. Resident #6 had a seizure disorder r/t unspecified convulsion with interventions which included giving medications as ordered and post-seizure treatment including turn on side with head back, hyper-extended to prevent aspiration, keep airway open, after seizure take vital signs and neuro check, monitor for aphasia , headache, altered LOC , paralysis, weakness, pupillary changes.Record review of Resident #6's care plan meeting dated 01/08/2026 reflected that the RP was invited and attended. No concerns, issues or changes from last care plan was documented.Record review of Resident #6's medical records, reflected there was no documentation of Resident #6's clinic visit on 12/31/2025 in the (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	progress notes, assessments or uploads . Observation and attempted interview with Resident #6 on 01/14/2026 at 10:00 AM, revealed he was in a low bed facing the wall and appeared to be resting with his eyes closed. Resident #6 appeared to be well-groomed, with dry flakes on his face. There were no odors or clutter in Resident #6's room. Resident #6 did not respond to questions.Interview with Clinic Staff A on 1/12/2026 at 3:44 PM, she said she worked at the clinic and that NP F reported to her that Resident #6 seemed out of it when he arrived at the facility and he did not have his health information with him. It was reported to Clinic Staff A that NP A called Resident #6's RP, who said a facility staff should have gone with Resident #6. Clinical Staff A stated Resident #6's appointment was 12/31/2025 at 2:30 PM. Observation and interview with Resident #6's RP on 1/14/2026 at 10:49 AM, she said she was aware Resident #6 had an appointment, and the facility did not tell her she needed to attend the clinic with Resident #6. The facility told the RP they would get him to the appointment. The RP said Resident #6 was unable to talk about what was going on with him and she brought this to the facility's attention on 1/8/2026 during a care plan meeting and now the facility just started to consistently send someone out with Resident #6 to appointments. Interview with Resident $6's RP at 12:30 PM , she said she never went to any recent appointments and on 12/31/2025 the clinic called the RP because Resident #6 could not recite his birthday and social security number at his appointment, and the clinic also told her they tried to call the facility but were unable to reach anyone. Resident #6 was being fed by the RP, and he did not respond to any questions from the RP.Interview with LVN C on 1/14/2026 at 11:20 AM, she said Resident #6's RP was usually informed of his appointments, but a staff member could go with him if needed.Intreview with LVN C on 1/14/2026 at 3:01pm , LVN C said she remembered seeing Resident #6 going out to an appointment on 12/31/2025. LVN C thought Resident #6's RP would have been there and LVN C was unsure if the RP went with Resident #6 to his appointments all the time . Interview with the SW on 1/14/2026 at 11:26 AM, she said he role of escorts was to relay information to the facility regarding changes and to be there for safety precautions. Resident #6's appointment was either 12/30/2025 or 12/31/2025 but she did not have a record to be sure so she would request it from the clinic. The SW said the facility typically sent someone with Resident #6 to appointments and he should have been with someone during his December 2025 appointment and the SW forgot to put escort in his record on the main page with updates so nurses knew to send someone with a resident to appointments. The SW said it was an oversight and that was why the facility changed their system of locating escorts for residents to reviewing resident off-site appointments at the start of each week. The SW said the facility implemented a new system recently to review appointments in the morning meeting to ensure escorts were sent out with residents to their appointments and that was the way the facility was going to track this process for escorts going forward. Resident notes were requested on 1/14/2025 at 11:26 AM from the SW for the 12/31/2026 and no documentation was received as of exit.Interview with the Administrator on 1/14/2026 at 12:05 pm, he said some residents could go to their appointments on their own and some had an aide go with them and there was no specific policy on having an escort to off-site appointments. He said if residents needed an escort , the facility would coordinate. Sometimes families made the appointment and let the facility know so they could schedule an aide to follow the resident to their appointment. If the facility called the RP and they could not go, the facility would look at the residents' BIMS and call extra staff in for that day. Starting 01/05/2026, the facility's procedure was during every morning meeting the IDT team which included the SW and Nursing team would review appointments and schedule. The Administrator said there was an issue with one of the residents who went to a doctor's appointment and there was no one there to help stand him up for his injection. The resident's RP brought up the (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	concerns. The Administrator said the SW was the person who always called the RP to check on the resident's appointment. The Administrator did not think there was any negative outcome because someone loaded the resident into the transport van and brought their face sheet and a list of medical records to the clinic. Interview with the Administrator on 1/14/2026 at 2:20pm , he said there was a communication breakdown and even if the family usually accompanied the resident, the facility should have communicated and ensured they had an escort go with the resident even if it was a doctor's appointment. The Administrator said having an escort should have been documented somewhere in the resident record . The Administrator said there was no policy on accompanying residents to appointments. Resident #6's notes for the 12/31/2025 clinic visit were requested from the administrator on 1/14/2026 and no documentation was received as of exit.Interview with the MDS Nurse on 1/14/2026 at 1:14 PM revealed she was aware Resident #6 had an appointment at a clinic, and an aide was supposed to be with him, but she did not know who that was. Nursing would be able to schedule an escort if residents needed one. Nurses should still know how to tell the staff to prepare an escort. The MDS Nurse said she did not think there'd be a need to have an escort documented in residents' care plans since all the staff were aware which residents needed an escort, but she would do so for residents who required it. The MDS Nurse said Resident #6 had a BIMS of 00 and was rarely or never understood so he should have been accompanied and there was always a risk of going on his own, but she could not specify what the risk was. Interview with the DON and Administrator on 1/14/2026 at 4:39 PM, the DON said if Resident #6 was going to a clinic, he would have been supervised by the driver on the way to the clinic and at the clinic there should be staff to assist him as needed. The Administrator said the RP cancelled Resident #6's appointment and rescheduled it for 12/31/2025 and even if it was a holiday the facility should have made sure to accommodate that.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation. interview and record review the facility failed to ensure the resident environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistance devices to prevent accidents for 1 of 3 residents (Resident #6) reviewed for adequate supervision and accident hazards.The facility failed to ensure Resident #6 had an escort to a clinic visit on 12/31/2025 at 2:30 PM.This failure could place residents at risk of injury and lack of support during off-site visits. Findings include:Record review of Resident #6's face sheet, reflected a [AGE] year-old male who was originally admitted to the facility on [DATE] and last re-admitted on [DATE]. Resident #6 had diagnoses which included unspecified dementia (mild, with agitation) (declining brain function related to thinking and judgement that is severe enough to impact daily life without behavioral disturbance, psychotic disturbance, mood disturbance), hypertension (high blood pressure), dysphagia (difficulty swallowing), hemiplegia and hemiparesis following cerebral infarction affecting left dominant side (left-side paralysis after a stroke), depression (prolonged periods of sadness and hopelessness), Human Immunodeficiency Virus Disease (HIV being a virus that attacks cells that help the body fight infections making a person more vulnerable to other infections and diseases), cognitive communication deficit and blindness in one eye.Record review of Resident #6's AnnualMDS, dated [DATE], reflected he was rarely or never understood and a BIMS assessment for cognitive intactness was not conducted. Resident #6 was totally dependent on staff for toileting, showering, and footwear and required total assistance with mobility in bed. Resident #6 was coded for short-term and long-term memory problems and was severely impaired related to daily decision making and having a wheelchair.Record review of Resident #6's care plan, dated 01/14/2026, he had an ADL self-care performance deficit with interventions which included resident requiring mechanical lift with 2 staff members assistance for transfers. Resident #6 had impaired cognitive function/dementia or impaired thought processes with interventions which included cuing, reorienting and supervising as needed and keeping the resident's routine consistent and trying to provide consistent care givers as much as possible in order to decrease confusion. Resident #6 had a seizure disorder r/t unspecified convulsion with interventions which included giving medications as ordered and post-seizure treatment which included turn on side with head back, hyper-extended to prevent aspiration, keep airway open, after seizure take vital signs and neuro check, monitor for aphasia (difficulty speaking), headache, altered LOC, paralysis, weakness, pupillary changes.Record review of Resident #6's medical records, reflected there was no documentation of Resident #6's clinic visit on 12/31/2025 in the progress notes, assessments or uploads.Observation and attempted interview with Resident #6 on 01/14/2026 at 10:00am, he was in a low bed facing the wall and appeared to be resting with his eyes closed. Resident #6 appeared to be well-groomed, with dry flakes on his face. There were no odors or clutter in Resident #6's room. Resident #6 did not respond to questions.Interview with Clinic Staff A on 1/12/2026 at 3:44pm, she said she worked at the off-site clinic and that NP F reported to her that Resident #6 seemed out of it when he arrived to the facility and he did not have his health information with him. It was reported to Clinic Staff A that NP A called Resident #6's RP who said a facility staff should have gone with Resident #6. Clinical Staff A confirmed that Resident #6's appointment was 12/31/2025 at 2:30pm.Interview with NP F on 1/12/2026 on 3:55pm, she said she was the NP in the room during Resident #6's appointment on 12/31/2025 at 2:30pm. Resident #6 was not responsive and was not oriented and he was by himself. Resident #6 was able to answer a little bit but NP A had to call Resident #6's RP. Resident #6 was soiled when he arrived. Medical assistants at the facility were unable to assist (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #6 in a standing position to change him. NP F did not know the name of the person who picked up and dropped off Resident #6. NP F said the driver told her Resident #6's RP was supposed to be coming but the RP told NP A no one relayed this information to her.Interview with Resident #6's RP on 1/14/2026 at 10:49am, she said she was aware Resident #6 had an appointment, and the facility did not tell her she needed to attend the clinic with Resident #6. The facility told the RP they would get him to the appointment. The RP said Resident #6 was unable to talk about what is going on with him and that she brought this up to the facility's attention on 1/8/2026 during a care plan meeting.Observation and interview with Resident #6 and his RP on 1/14/2026 at 12:30pm, she said she never went to any recent appointments and that on 12/31/2025 the clinic called the RP because Resident #6 could not recite his birthday and social security number at his appointment, and the clinic also told her they tried to call the facility but were unable to reach anyone. Resident #6 was being fed by the RP, and he did not respond to any questions from the RP.Interview with LVN C on 1/14/2026 at 11:20am, she said Resident #6's RP was usually informed of his appointments, but a staff could go with him if needed. In a later interview at 3:01pm, LVN C said she remembered seeing Resident #6 going out to an appointment on 12/31/2025. LVN C thought Resident #6's RP would have been there at the appointment and LVN C was unsure if the RP went with Resident #6 to his appointments all the time.Interview with the SW on 1/14/2026 at 11:26am, she said the role of escorts was to relay information to the facility regarding changes and to be there for safety precautions. Resident #6's appointment was either 12/30/2025 or 12/31/2025 but she did not have a record to be sure so she would request it from the clinic. The SW said the facility typically sent someone with Resident #6 to appointments and he should have been with someone during his December 2025 appointment and that the SW forgot to put escort in his record on the main page containing updates so nurses knew to send someone, which was the old process. The SW said it was an oversight and that was why the facility changed their system of locating escorts for residents to reviewing resident off-site appointments at the start of each week. The SW said the facility implemented a new system recently to review appointments in the morning meeting to ensure escorts were sent out with residents to their appointments. The SW was requested on 1/14/2025 at 11:26am for Resident #6's notes for the 12/31/2026 and no documentation has been received as of exit.Interview with the Administrator on 1/14/2026 at 12:05pm, he said some residents could go to their appointments on their own and some had an aide go with them and there was no specific policy on having an escort to off-site appointments. He said if residents needed an escort, the facility would coordinate that. Sometimes families made the appointment and let the facility know so they could schedule an aide to follow the resident to their appointment. If the facility called the RP and they could not go, the facility would look at the residents' BIMS and call extra staff in for that day. Starting 01/05/2026, the facility's procedure was during every Morning meeting the IDT team including the SW and Nursing team would review appointments and schedule. The Administrator said there was an issue with one of the residents who went to a doctor's appointment and there was no one there to help stand him up for his injection. The resident's RP brought up the concerns. he said the Social Worker was the person who always called the RP to check on resident's appointment. The Administrator did not think there was any negative outcome because someone loaded the resident into the transport van and brought their face sheet and list of medical records to the clinic.Interview with the Administrator on 1/14/2026 at 2:20pm, he said there was a communication breakdown and even if the family usually accompanied the resident, the facility should have communicated and ensured they had an escort go with the resident even if it was a doctor's appointment. The Administrator said having an escort should have been documented somewhere. The Administrator said there was no policy on (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	accompanying residents to appointments. The Administrator was requested on 1/14/2026 at 12:05pm for Resident #6's notes for the 12/31/2026 and no documentation has been received as of exit.Interview with the MDS Nurse on 1/14/2026 at 1:14pm, she was aware Resident #6 had an appointment at a clinic and that an aide was supposed to know with him, but she did not know who that was. Nursing would be able to schedule an escort if residents needed one. Nurses should still know how to tell the staff to prepare an escort. The MDS Nurse said she did not think there'd be a need to have an escort care-planned since all the staff were aware which residents needed an escort. Resident #6 had a BIMS of 00 and was rarely or never understood so he should have been accompanied and that there was always a risk of going on his own, but she could not specify what the risk was.Interview with the DON and Administrator on 1/14/2026 at 4:39pm, the DON said if Resident #6 was going to a clinic, he would have been supervised by the driver of the van to the facility and at the clinic there would be staff present so he was always supervised. The Administrator said the RP cancelled Resident #6's appointment and rescheduled it for 12/31/2025 and even if it was a holiday the facility should make sure to accommodate that.A policy on supervision was requested from the Administrator and DON on 1/14/2026 at 12:16pm by e-mail, it was not provided as of exit.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain medical records on each resident that are complete and accurately documented for 1 (Resident #68) of 5 residents reviewed for accurate records.-The facility failed to document showers for Resident #6 on 12/30/2025, 1/1/2026, 1/3/2026, 1/6/2026, 1/6/2026, 1/10/2026 and 1/13/2026.-The facility failed to upload documents or have progress notes related to Resident #6's clinic visit on 12/31/2025.This failure could put residents at risk of changes in condition such as skin injury or breakdowns not being detected and treated and resident progress not being tracked. Findings include:Record review of Resident #6's face sheet reflected a [AGE] year-old male who was originally admitted to the facility on [DATE] and last re-admitted on [DATE]. Resident #6 had diagnoses which included unspecified dementia (mild, with agitation) (declining brain function related to thinking and judgement that is severe enough to impact daily life without behavioral disturbance, psychotic disturbance, mood disturbance), hypertension (high blood pressure), dysphagia (difficulty swallowing), hemiplegia and hemiparesis following cerebral infarction affecting left dominant side (left-side paralysis after a stroke), depression (prolonged periods of sadness and hopelessness), Human Immunodeficiency Virus Disease (HIV being a virus that attacks cells that help the body fight infections making a person more vulnerable to other infections and diseases), cognitive communication deficit and blindness in one eye.Record review of Resident #6's Annual MDS, dated [DATE], reflected he was rarely or never understood and a BIMS assessment for cognitive intactness was not conducted. Resident #6 was totally dependent on staff for toileting, showering, and footwear and required total assistance with mobility in bed. Resident #6 was coded for short-term and long-term memory problems and was severely impaired related to daily decision making and having a wheelchair.Record review of Resident #6's care plan, dated 01/14/2026, he had an ADL self-care performance deficit with interventions which included the resident being totally depending on 1-2 staff to provide 2-3 baths weekly and as necessary and required a mechanical lift with 2 staff members assistance for transfers. Resident #6 had impaired cognitive function/dementia or impaired thought processes with interventions which included cuing, reorienting and supervising as needed and keeping the resident's routine consistent and trying to provide consistent caregivers as much as possible in order to decrease confusion. Record review of Resident #6's bathing schedule, for the last 30 days reflected Resident #6's bath did not occur or family and/or non-facility staff provided care 100% of the time for that activity: 12/30/2025, 1/1/2026, 1/3/2026, 1/6/2026, 1/6/2026, 1/10/2026, 1/13/2026.Record review of Resident #6's skin checks reflected:-1/5/2026, skin intact. No skin concerns noted at this time. There were no new wounds identified. It was signed by WCN on 1/7/2026.-1/14/2026, skin intact. Dry skin to the face and bilateral feet. Moisturizer applied. It was signed by WCN on 1/14/2025 at 3:21 PM.Record review of Resident #6's medical records reflected there was no documentation of Resident #6's clinic visit on 12/31/2025 in the progress notes, assessments or uploads.Interview with Clinic Staff A on 1/12/2026 at 3:44 PM, she said she worked at the clinic and confirmed that Resident #6 had an appointment on 12/31/2025 at 2:30pm. NP A reported to her that Resident #6 seemed out of it when he arrived at the facility and he did not have his health information with him and they tried calling the facility but no one picked up.Observation and attempted interview with Resident #6 on 01/14/2026 at 10:00 AM, he was in a low bed facing the wall and appeared to be resting with his eyes closed. Resident #6 appeared to be well-groomed, with dry flakes on the sides of his nose. There were no odors or clutter in Resident #6's room.Observation and interview with Resident #6's RP on 1/14/2026 at 10:49 AM, she said she never gave (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #6 a shower because that would be part of the facility's responsibility. The RP uncovered Resident #6's feet which appeared to be dry with flakes on the side of his feet. The RP also said Resident #6 had a clinic visit on 12/31/2025. Resident #6 was being fed by the RP, and he did not respond to any questions from the RP.Interview with the SW on 1/14/2026 at 11:26 AM, she said Resident #6's appointment was either 12/30/2025 or 12/31/2025 but she did not have a record to be sure so she would request it from the clinic. Resident notes were requested from the SW was requested on 1/14/2025 at 11:26 AM from the SW for the 12/31/2026 and no documentation was received as of exit.Interview with CNA G on 1/14/2026 at 11:33 AM, revealed she had not given a shower to Resident #6 yet, and she said showers were documented in the shower sheet.Interview with LVN C on 1/14/2026 at 3:01 PM, LVN C said Resident #6's family did not provide showers and she did not remember signing off on shower sheets. LVN C was unable to locate shower sheets for Resident #6 for December 2025. The last shower sheet was on 11/20/2025 with no skin conditions documented.Interview with the ADON on 1/14/2026 at 3:15 PM, she said Resident #6 received bed baths on Tuesdays, Thursdays and Saturdays and the aides completed shower sheets and nurses would in turn collect those sheets to give to the ADON. The aides were supposed to double-document, meaning once on the physical shower sheet which had space for skin documentation and the second place, they would document was in the resident's medical records. The ADON said there were no reports of Resident #6 refusing showers. The ADON said if shower sheets were not documented then they did not happen, but she knew aides were giving Resident #6 showers or bed baths.Interview with the DON and Administrator on 1/14/2026 at 4:39 PM, the DON said Resident #6 received his showers and it was just not documented. The DON said the aides got busy and did not create a shower sheet, and the showers were done even if they were not documented. The DON denied Resident #6 never received a shower in December 2025 and said it just wasn't documented and said with high staff turnover the facility lagged in documentation. The DON said if Resident #6 was going to a clinic, he would have been supervised by the driver on the way to the clinic and at the clinic there should be staff to assist him as needed. The Administrator said the RP cancelled Resident #6's appointment and rescheduled it for 12/31/2025 and even if it was a holiday the facility should have made sure to accommodate that. Documentation on Resident #6 regarding his appointment on 12/31/2025 was requested on 1/14/2026 at 2:32pm and no documentations was received as of exit.Record review of the facility's policy on Activities of Daily Living, last reviewed or revised on 4/23/2025, read in part, Care and services will be provided for the following activities of daily living; 1. bathing, dressing, grooming and oral care . Refusal of care and treatment by the resident or his/her representative to maintain functional abilities after efforts by the facility to inform and educate about the benefits/risks of the proposed care and treatment; counsel and/or offer alternatives to the resident or representative . A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene .