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	02/27/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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 that residents received adequate supervision and assistance devices to prevent accidents for 1 of 3 residents reviewed for accidents (Resident #1). The facility failed to ensure CNA G implemented safe transfer measures on 02/13/2026 at 4:00 a.m. when she attached the lift sling to the handling strap, instead of the sling attachment loop. Resident #1 experienced a fall and sustained a fractured clavicle during a mechanical lift transfer. On 02/22/2024 at 8:22p.m. an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 02/25/2026, the facility remained out of compliance at a severity level of at a potential for more than minimal harm that is not immediate jeopardy and a scope of isolated due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. This failure could place resident at risk of not receiving appropriate supervision leading to injuries, hospitalization, or death.Findings included:Record review of Resident #1's face sheet, dated 02/22/2026, revealed a [AGE] year-old female admitted [DATE], diagnosis included cerebral palsy (is a group of conditions that affect movement and posture caused by brain damage before birth) other abnormalities of gait and mobility, muscle wasting and atrophy, muscle weakness (generalized), contracture, unspecified joint.Record review of Resident #1's MDS, dated [DATE], indicated a BIMS score of 14, indicating no cognition impairment. Record review of fall risk assessment for Resident #1, dated 02/13/2026, indicated a score of 22.0 indicating high risk for falls.Record review of Resident #1's care plan, dated 01/18/2026, reflected:Focus Area: Resident #1 is at raise 4 falls related to limited mobility weakness and altered mental status.Goal: Resident #1 We'll be free of falls are injuries related to falls through the next review date.Interventions /Tasks: Ensure mechanical lift straps are secure and not broken, All straps in place, mechanical live is charged before transferring Resident#1 with two person assist.Focus Area: Resident #1 has an ADL self-care performance deficit related to limited mobility and weakness.Interventions /Tasks: Resident #1 one requires mechanical lift with two-person staff assistance for transfer. Record review of Resident #1 ‘s X- Ray results (performed at the facility) of left shoulder, dated on 02/13/2026 with evaluation time 2:55 p.m. and reported time of 3:06p.m., revealed a fractured clavicle.Record review of Resident #1 hospital documentation for Resident #1, dated 02/13/2026, revealed:Resident #1's clavicle X- Ray at 8:21 p.m., suspected mid fractured clavicle, mildly displaced.CT scan at 9:58 p.m. of shoulder confirmed findings of a fractured distal end of the left clavicle (a break near the shoulder end of the collarbone). During an interview on 02/21/2026 at 5:15 p.m., Resident #1 stated she was being transferred by CNA G using a mechanical lift when she fell from the lift. Resident #1 stated she immediately experienced pain and reported pain to Nurse K. She stated there was only one staff member who implemented the mechanical lift transfer but CNA S arrived and assisted by getting the nurse after the fall occurred. Resident #1 stated she was not moved prior to Nurse K's assessment. Resident #1 stated there was usually two person (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	assisting when being transferred with the mechanical lift. She stated CNA G was attempting to get her out of bed early and she did not believe CNA G asked for another person to assist. She stated pain was being managed with medication prior to being transferred to the hospital. She stated she was later transferred to the hospital as she was informed of left fractured clavicle. She stated the pain was managed with medication. She stated the facility replaced the sling after the incident, but the new sling being used after the incident caused pain, described as a knife stabbing to her right leg during each transfer. She stated since the incident on 02/13/2026, two staff members started transferring her with the mechanical lift. Resident #1 reported she did not feel safe when the new sling was used. Resident #1 stated that she had not notified the facility of concern related to the sling. During an interview on 02/21/2026 at 10:19 a.m. , the Administrator stated he and the DON were notified by Nurse K of the incident at 5:30 a.m. on 02/13/2026 by Nurse K. He stated he was informed the sling strap (handle) broke during transfer. The administrator was the abuse coordinator. He stated he is responsible for conducting facility incident investigations. He stated and investigation was initiated on 02/13/2026. He stated during the investigation Resident #1 was assessed and reported no pain. He stated Resident#1's medical provider was notified of the fall immediately by Nurse K. He stated he was informed by Nurse K that no order was given as Resident #1 denied pain and it was witnessed fall. He stated Resident #1 report pain at approximately 9:50 a.m. and was assessed with skin bruising near the left shoulder. He stated Nurse M administered pain medication to manage Resident#1's pain. He stated Nurse M notified the medical provider of the onset of pain and bruising, and an order was given to obtain an X- Ray of the left shoulder. He stated X -Ray results was received by the facility at approximately 3:00 p.m., and revealed that Resident #1 sustained a fractured clavicle as a result of the fall. The Administrator stated the medical provider was notified of the results by Nurse M, and orders were given for additional pain medication and transfer Resident #1 to the hospital for further evaluation. He stated medical transport was requested and Resident #1 was transferred to the hospital at approximately 4:00 p.m. on 02/13/2026. The Administrator stated that the facility immediately removed the mechanical lifts sling from Resident #1's room and the facility clinical area mechanical lifts sling. He stated that the outcome of his investigation determined the root cause of the incident was due to staff error of transferring. He stated CNA G attached the mechanical lift sling to the handling strap, instead of the sling attachment loop. He stated staff had been trained on safe mechanical lift transfer. He stated during his investigation CNA G was suspended for three days. He stated he was informed that there were two staff members who implemented the transfer, CNA G and CNA S. He stated that CNA G error caused injury to Resident #1. He stated that all direct care staff were responsible for ensuring mechanical lifts sling are safe and used properly. He stated that DON was responsible for ensuring all direct care staff was trained by the DOR. The administrator stated that he was not aware how the DON tracked training and compliance. During an interview on 02/21/2026 at 11:00 a.m. the DON stated the DOR was responsible for training staff but was unable to explain how competencies were validated or tracked and the system for ensuring all direct care staff were trained. The DON stated he was responsible for ensuring all nursing staff were skilled and knowledgeable of mechanical lift safety. He stated he was not aware if the DOR was informed of Resident #1's fall incident. The DON could not explain who was responsible for inspecting the slings and straps to determine if they were worn or safe to use during resident transfers. The DON could not explain how often were mechanical lift and slings was inspected for safety. He stated when staff were not trained properly the residents were placed at risk of harm.During an interview on 02/21/2026 at 3:45p.m., the DOR stated he provided a mechanical lift in-service to direct care staff on (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	02/14/2026. The DOR stated he was not trained by the facility on the mechanical lifts and sling used by the facility. He stated he was unaware of the manufacture models, the different slings used by the facility, and if each sling used for resident transfers were compatible with the facility mechanical lift. DOR stated he was not familiar with the facility Mechanical lifts competency and evaluation checklist. He stated he had not used or implemented the facility competency and evaluation checklist when he trained facility staff. DOR stated he used prior knowledge and experience related to mechanical lift to train staff. DOR stated he was not aware of the facility residents requiring mechanical lift transfers and the documentation could be found in clinical record. DOR could not explain where the information could be found in the clinical record. DOR stated he was informed of Resident #1's fall but was not informed that the fall was due to knowledge deficiency or staff error. He stated no specific trained related to Resident #1 incident was provided to staff. He stated when staff were not trained properly the residents were placed at risk of harm.During interviews on 02/21/2026, between 12:50 p.m. - 6:45 p.m., CNA A and CNA B, CNA C and Nurse M, and Nurse D stated they had been recently in-serviced on resident mechanical lift transfers but denied completing mechanical lift competency and validation. Staff could not explain proper use of the mechanical lift and sling that was required to safely transfer resident. During an attempted telephone interview attempted on 02/21/2026 at 3:15 p.m., CNA G was left a voicemail requesting a return call, but no return call. During an attempted telephone interview on 02/21/2026 at 3:23 p.m., CNA S was left a voicemail requesting a return call, but no return call.During an observation on 02/21/2026 at 12:16 p.m., the DON did not demonstrate proper use of the mechanical lift that was required to safely transfer residents. He did not lock the wheels of the mechanical lift, failed to position mechanical lift sling correctly. He was unable to clearly explain required safety measures during mechanical lift use. He could not clearly explain the facility's system in place to ensure proper use of mechanical lift. During an observation and interview on 02/21/2026 at 4:16 p.m., Resident #1 was transferred by CNA A and CNA B. Observation revealed they did not demonstrate proper use of the mechanical lift that was required to safely transfer resident. CNA A and CNA B did not ensure mechanical lift wheel were not locked prior to attachment of the mechanical lift sling used to transfer Resident #1. CNA A and CNA B did not center the mechanical lift sling under Resident #1 proper to transferring Resident #1 from the chair to the bed. Resident #1 stated she felt pain associated with improper positioning during the transfer. CNA A and CNA B were unable to demonstrate or clearly explain required safety measures during mechanical lift use.During an interview on 02/21/2026 at 12:16 p.m. and 02/22/2026 at 9:13 a.m., the DON was asked for a facility policy and procedure check list regarding mechanical lifts and safe resident transfers but was not provided.During an interview on 02/22/2026 at 1:00 p.m., Nurse M stated that she was the nurse assigned to care for Resident #1 on 02/13/2026 morning post fall. She stated that she was informed during hand off shift report by Nurse K that Resident #1 had fallen a couple hours prior to the start of Nurse M's shift at 6:00 a.m. She stated she was informed that Resident #1 denied pain and discomfort during Nurse K ongoing assessments. She stated she was informed that Resident #1 had not being given pain medication, the medical provider was notified, and no new orders had been given. She stated during her initial assessment of Resident #1 she denied pain. She stated when she assessed Resident #1 at approximately 10:00 a.m. she noticed left should area was bruised and Resident # 1 mild pain noted. Nurse M stated she notified the provider and was given an order for X-Ray. She reported ongoing mild pain pending the X-Ray and pain medication was given approximately at 12:30 p.m. and additional medication at approximately 2:00 p.m. Nurse M stated that Resident #1's pain was alleviated on assessment. Nurse M stated she could not recall what time the X-Ray was imagining (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	but she recalled being notified of the results between 3:00p.m and 4:00 p.m. with findings of a fracture with mild clavicle displacement. She stated she informed the medical provider of the findings and was provided with order for non-emergent transport to local hospital. During an interview on 02/22/2026 at 3:00 p.m., Nurse K stated that she cared for Resident #1 on 02/12/2026 night shift and was the nurse on duty at the time of Resident #1's fall incident. She stated she was informed by CNA S on 02/13/2026 at approximately 4:30 a.m. that Resident #1had fallen during mechanical lift transfer from bed to chair. She stated she found Resident #1 on the floor alert and position on her back. She stated she assessed Resident #1 immediately and Resident #1 denied pain. She stated at the time of her initial assessment there was no discomfort, pain, or skin discoloration observed. She stated mechanical lift sling was under Resident #1's body as she assessed Resident #1. She stated she was informed that the sling strap broke during transfer. She stated another sling was used to transfer Resident #1 back to bed after the incident. She stated she was present in Resident #1's room during the post fall transfer but did not witness the transfer at the time of the fall. She stated Resident #1 informed her that CNA G and CNA S were transferring from bed and she had fallen during the transfer. Nurse K stated she was not informed by Resident #1 that there was only one staff member there during the initial transfer. Nurse K stated when she arrived in Resident #1 room, both CNA G and CNA S were there in Resident #1 room with her. Nurse K stated she was informed that CNA G connected the mechanical lift sling to the mechanical lift. Nurse K stated she did not investigate the mechanical lift, but she did recall the strap being broken. She stated she notified the medical provider of the fall on 02/13/2025 at 4:56 a.m. after completing Resident #1's assessment and ensuring Resident was safe. On 02/22/2026 at 8:22p.m. an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 02/25/2026, the facility remained out of compliance at a severity level of at a potential for more than minimal harm that is not immediate jeopardy and a scope of isolated due to the facility continuing to monitor the implementation and effectiveness of theirThis was determined to be Immediate Jeopardy (IJ) on 02/22/2026 at 8:22p.m. The Administrator was notified. The Administrator was provided with the IJ template on 02/22/2026 at 8:22p.m. The following Plan of Removal submitted by the facility was accepted on 02/23/2026 at 3:14pm. F 689 Quality of Care:The facility failed to ensure that residents received adequate supervision and assistance devices to prevent accidents for 1 of 3 residents reviewed for accidents (Resident #1). The facility failed to ensure CNA G implemented safe transfer measures on 02/13/2026 at 4:00am when she attached the lift sling to the handling strap, instead of the sling attachment loop. Resident #1 experienced a fall and sustained a fractured clavicle during a mechanical lift transfer. The facility identified immediate action to correct the system failures to ensure all residents receive appropriate supervision, and assistance devices to prevent accidents injuries, hospitalization, or death: The Corporate Nurse will provide re-education to nursing staff who were directly involved in the resident's fall prior to their next scheduled shift, prior to them performing direct care on safe resident transfers when utilizing mechanical lifts. An emphasis will be placed on ensuring residents are appropriately secured with mechanical lift pad straps prior to transfer as well as ensuring straps are in proper condition prior to use by inspecting for safety prior to use per manufacturer instructions. Education will be validated via facility mechanical lift competency checklist. Manufacturer instructions for mechanical lift sling inspection will be placed on each mechanical lift for employee reference. The Corporate Nurse will provide re-education to the DON and DOR on safe resident transfers when utilizing mechanical lifts. An emphasis will be placed on ensuring residents are appropriately secured with mechanical lift pad straps prior to transfer as well as ensuring straps are in proper condition prior to use by inspecting for safety prior to (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	use per manufacturer instructions. Education will be validated via facility mechanical lift competency checklist. Residents who use mechanical lifts will have their care plan reviewed by the DON/Designee to ensure appropriate transfer status is identified in their care plan. New admissions will be reviewed by the IDT in the morning clinical meeting to identify their transfer needs and care plan these needs. Residents identified to have had a change in condition affecting mobility status will be discussed by the IDT and changes will be made as appropriate to their transfer status and care plan. Care planned interventions, including transfer status, will also be placed on the resident Kardex to ensure direct care staff are able to view resident specific needs. Actions to Prevent Occurrence/Recurrence: The facility will take the following actions to prevent an adverse outcome from reoccurring. The Corporate Nurse/Consultant Nurse will then educate the DON/ADON on the facility orientation checklist for nursing staff. Education will be validated via facility mechanical lift competency checklist. The Corporate Nurse, DON, DOR or designee will re-educate nursing staff and therapy staff prior to their next scheduled shift, prior to them performing direct care on appropriate transfer and safe handling of residents during mechanical lift transfers. An emphasis will be placed on ensuring residents are appropriately secured with mechanical lift pad straps prior to transfer as well as ensuring straps are in proper condition prior to use by inspecting for safety prior to use per manufacturer instructions. Education will be validated via facility mechanical lift competency checklist. (Anticipated date of education initiation: 2/23/2026) The DON or designee will audit mechanical lift transfers twice weekly x 4 weeks, then weekly x4 weeks then monthly x1 month. A QAPI PIP has been initiated to report on the above monitoring and auditing procedures. All findings from the PIP will be presented at the monthly QAA meeting. Monitoring/auditing and reporting will continue for a minimum of three months.Monitoring of the plan for the removal included the following:Record review of the facility's staff education in-service training and competency record, dated 02/23/2026, 02/24/2026 and 02/25/2024, revealed appropriate transfer and safe handling of residents during mechanical lift transfers was provided to staff. Record review of QAPI sign-in sheetRecord review on 02/25/2026 of census counts was verified and revealed that a census count was completed for residents requiring mechanical lift transfers and signed off on by the Administrator. Record review on 02/25/2026 of facility mechanical lift competency checklist was updated and used to train staff. The record of evaluation and indicated all trained was able to demonstrate safe transfer at a satisfactory level to implement resident transfers. Interviews on 02/23/2026 - 02/25/2026 on both shifts with staff (Housekeeper A, 4 CNAs, 2 Nurses, 1 CMA, ADON, DON, DOR, and Administrator on 6 a.m.-6 p.m. dayshift, and 3 CNAs, 2 Nurse on 6 p.m. - 6a.m, night shift) were able to verify in-services and to validate their understanding of the information presented. Direct care staff were able to explain how to implement safe mechanical lift transfers, where to find the information in the clinical record identifying residents who require mechanical lift transfers. During observations of mechanical lift transfer on 02/25/2026, 4CNAs and 3Nurses confirmed staff were able to demonstrate safe mechanical lift transfers using the steps outlined in the procedure evaluation checklist. The Administrator was informed the Immediate Jeopardy was removed on 02/25/2025 at 4:25 p.m. The facility remained out of compliance at a severity level of potential for more than minimal harm that is not immediate jeopardy and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure nursing staff possessed the appropriate competencies and skill sets necessary to provide safe care for 1 of 3 residents reviewed for nursing services (Resident #1).The facility failed to ensure CNA G implemented safe transfer measures on 02/13/2026 at 4:00 a.m. when she attached the lift sling to the handling strap, instead of the sling attachment loop. Resident #1 experienced a fall and sustained a fractured clavicle during a mechanical lift transfer. The DON was unable to demonstrate proper mechanical lift transfer technique or clearly explain required safety measures.The facility was unable to provide documentation verifying that CNA G, CNA A, CNA B, or other direct care staff had demonstrated competency in mechanical lift transfers prior to performing resident care.On 02/23/2026 at 2:11p.m. an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 02/25/2026, the facility remained out of compliance at a severity level of at a potential for more than minimal harm that is not immediate jeopardy and a scope of isolated due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. The lack of competency validation contributed to improper sling attachment during transfer, resulting in Resident #1 sustaining a fractured clavicle, and placed other residents requiring mechanical lift transfers at risk for serious injury, including fractures, head trauma, internal injury, or death. Findings included:Record review of Resident #1's face sheet, dated 02/22/2026, revealed a [AGE] year-old female admitted [DATE], diagnosis included cerebral palsy (is a group of conditions that affect movement and posture caused by brain damage before birth) other abnormalities of gait and mobility, muscle wasting and atrophy, muscle weakness (generalized), contracture, unspecified joint.Record review of Resident #1's MDS, dated [DATE], indicated a BIMS score of 14, indicating no cognition impairment. Record review of fall risk assessment for Resident #1, dated 02/13/2026, indicated a score of 22.0 indicating high risk for falls.Record review of Resident #1's care plan, dated 01/18/2026, reflected:Focus Area: Resident #1 is at raise 4 falls related to limited mobility weakness and altered mental status.Goal: Resident #1 We'll be free of falls are injuries related to falls through the next review date.Interventions /Tasks: Ensure mechanical lift straps are secure and not broken, All straps in place, mechanical live is charged before transferring Resident#1 with two person assist.Focus Area: Resident #1 has an ADL self-care performance deficit related to limited mobility and weakness.Interventions /Tasks: Resident #1 one requires mechanical lift with two-person staff assistance for transfer.Record review of Resident #1 ‘s X- Ray results (performed at the facility) of left shoulder, dated on 02/13/2026 with evaluation time 2:55 p.m. and reported time of 3:06p.m., revealed a fractured clavicle.Record review of Resident #1 hospital documentation for Resident #1, dated 02/13/2026, revealed:Resident #1's clavicle X- Ray at 8:21 p.m., suspected mid fractured clavicle, mildly displaced.CT scan at 9:58 p.m. of shoulder confirmed findings of a fractured distal end of the left clavicle (a break near the shoulder end of the collarbone). Record review on 02/22/2026 of staff training and competency records revealed: No documentation of mechanical lift competency validation for direct care staff, including CNA G, CNA A, CNA B. No documented competency validation for nursing staff responsible for supervising transfers, including the DON. No structured system to verify staff competency prior to independently performing mechanical lift transfers. No record provided identifies the number of residents requiring mechanical lift transfers in the facility.CT scan at 9:58 p.m. of shoulder confirmed findings of a fractured distal end of the left clavicle (a break near the shoulder end of the collarbone). During an interview on 02/21/2026 at 5:15 p.m., Resident #1 stated she was being transferred by CNA G using a (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	mechanical lift when she fell from the lift. Resident #1 stated she immediately experienced pain and reported pain to Nurse K. She stated there was only one staff member who implemented the mechanical lift transfer but CNA S arrived and assisted by getting the nurse after the fall occurred. Resident #1 stated she was not moved prior to Nurse K's assessment. Resident #1 stated there was usually two person assisting when being transferred with the mechanical lift. She stated CNA G was attempting to get her out of bed early and she did not believe CNA G asked for another person to assist. She stated pain was being managed with medication prior to being transferred to the hospital. She stated she was later transferred to the hospital as she was informed of left fractured clavicle. She stated the pain was managed with medication. She stated the facility replaced the sling after the incident, but the new sling being used after the incident caused pain, described as a knife stabbing to her right leg during each transfer. She stated since the incident on 02/13/2026, two staff members started transferring her with the mechanical lift. Resident #1 reported she did not feel safe when the new sling was used. Resident #1 stated that she had not notified the facility of concern related to the sling. During an interview on 02/21/2026 at 10:19 a.m. , the Administrator stated he and the DON were notified by Nurse K of the incident at 5:30 a.m. on 02/13/2026 by Nurse K. He stated he was informed the sling strap (handle) broke during transfer. The administrator was the abuse coordinator. He stated he is responsible for conducting facility incident investigations. He stated and investigation was initiated on 02/13/2026. He stated during the investigation Resident #1 was assessed and reported no pain. He stated Resident#1's medical provider was notified of the fall immediately by Nurse K. He stated he was informed by Nurse K that no order was given as Resident #1 denied pain and it was witnessed fall. He stated Resident #1 report pain at approximately 9:50 a.m. and was assessed with skin bruising near the left shoulder. He stated Nurse M administered pain medication to manage Resident#1's pain. He stated Nurse M notified the medical provider of the onset of pain and bruising, and an order was given to obtain an X- Ray of the left shoulder. He stated X -Ray results was received by the facility at approximately 3:00 p.m., and revealed that Resident #1 sustained a fractured clavicle as a result of the fall. The Administrator stated the medical provider was notified of the results by Nurse M, and orders were given for additional pain medication and transfer Resident #1 to the hospital for further evaluation. He stated medical transport was requested and Resident #1 was transferred to the hospital at approximately 4:00 p.m. on 02/13/2026. The Administrator stated that the facility immediately removed the mechanical lifts sling from Resident #1's room and the facility clinical area mechanical lifts sling. He stated that the outcome of his investigation determined the root cause of the incident was due to staff error of transferring. He stated CNA G attached the mechanical lift sling to the handling strap, instead of the sling attachment loop. He stated staff had been trained on safe mechanical lift transfer. He stated during his investigation CNA G was suspended for three days. He stated he was informed that there were two staff members who implemented the transfer, CNA G and CNA S. He stated that CNA G error caused injury to Resident #1. He stated that all direct care staff were responsible for ensuring mechanical lifts sling are safe and used properly. He stated that DON was responsible for ensuring all direct care staff was trained by the DOR. The administrator stated that he was not aware how the DON tracked training and compliance. During an interview on 02/21/2026 at 11:00 a.m. the DON stated the DOR was responsible for training staff but was unable to explain how competencies were validated or tracked and the system for ensuring all direct care staff were trained. The DON stated he was responsible for ensuring all nursing staff were skilled and knowledgeable of mechanical lift safety. He stated he was not aware if the DOR was informed of Resident #1's fall incident. The DON could not explain who was responsible for inspecting the (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	02/27/2026

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 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	slings and straps to determine if they were worn or safe to use during resident transfers. The DON could not explain how often were mechanical lift and slings was inspected for safety. He stated when staff were not trained properly the residents were placed at risk of harm.During an interview on 02/21/2026 at 3:45p.m., the DOR stated he provided a mechanical lift in-service to direct care staff on 02/14/2026. The DOR stated he was not trained by the facility on the mechanical lifts and sling used by the facility. He stated he was unaware of the manufacture models, the different slings used by the facility, and if each sling used for resident transfers were compatible with the facility mechanical lift. DOR stated he was not familiar with the facility Mechanical lifts competency and evaluation checklist. He stated he had not used or implemented the facility competency and evaluation checklist when he trained facility staff. DOR stated he used prior knowledge and experience related to mechanical lift to train staff. DOR stated he was not aware of the facility residents requiring mechanical lift transfers and the documentation could be found in clinical record. DOR could not explain where the information could be found in the clinical record. DOR stated he was informed of Resident #1's fall but was not informed that the fall was due to knowledge deficiency or staff error. He stated no specific trained related to Resident #1 incident was provided to staff. He stated when staff were not trained properly the residents were placed at risk of harm.During interviews on 02/21/2026, between 12:50 p.m. - 6:45 p.m., CNA A and CNA B, CNA C and Nurse M, and Nurse D stated they had been recently in-serviced on resident mechanical lift transfers but denied completing mechanical lift competency and validation. Staff could not explain proper use of the mechanical lift and sling that was required to safely transfer resident. During an attempted telephone interview attempted on 02/21/2026 at 3:15 p.m., CNA G was left a voicemail requesting a return call, but no return call. During an attempted telephone interview on 02/21/2026 at 3:23 p.m., CNA S was left a voicemail requesting a return call, but no return call.During an observation on 02/21/2026 at 12:16 p.m., the DON did not demonstrate proper use of the mechanical lift that was required to safely transfer residents. He did not lock the wheels of the mechanical lift, failed to position mechanical lift sling correctly. He was unable to clearly explain required safety measures during mechanical lift use. He could not clearly explain the facility's system in place to ensure proper use of mechanical lift. During an observation and interview on 02/21/2026 at 4:16 p.m., Resident #1 was transferred by CNA A and CNA B. Observation revealed they did not demonstrate proper use of the mechanical lift that was required to safely transfer resident. CNA A and CNA B did not ensure mechanical lift wheel were not locked prior to attachment of the mechanical lift sling used to transfer Resident #1. CNA A and CNA B did not center the mechanical lift sling under Resident #1 proper to transferring Resident #1 from the chair to the bed. Resident #1 stated she felt pain associated with improper positioning during the transfer. CNA A and CNA B were unable to demonstrate or clearly explain required safety measures during mechanical lift use.During an interview on 02/21/2026 at 12:16 p.m. and 02/22/2026 at 9:13 a.m., the DON was asked for a facility policy and procedure check list regarding mechanical lifts and safe resident transfers but was not provided.During an interview on 02/22/2026 at 1:00 p.m., Nurse M stated that she was the nurse assigned to care for Resident #1 on 02/13/2026 morning post fall. She stated that she was informed during hand off shift report by Nurse K that Resident #1 had fallen a couple hours prior to the start of Nurse M's shift at 6:00 a.m. She stated she was informed that Resident #1 denied pain and discomfort during Nurse K ongoing assessments. She stated she was informed that Resident #1 had not being given pain medication, the medical provider was notified, and no new orders had been given. She stated during her initial assessment of Resident #1 she denied pain. She stated when she assessed Resident #1 at approximately 10:00 a.m. she noticed left should area was bruised and (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	appropriately secured with mechanical lift pad straps prior to transfer as well as ensuring straps are in proper condition prior to use by inspecting for safety prior to use per manufacturer instructions. Education will be validated via facility mechanical lift competency checklist. Residents who use mechanical lifts will have their care plan reviewed by the DON/Designee to ensure appropriate transfer status is identified in their care plan. New admissions will be reviewed by the IDT in the morning clinical meeting to identify their transfer needs and care plan these needs. Residents identified to have had a change in condition affecting mobility status will be discussed by the IDT and changes will be made as appropriate to their transfer status and care plan. Care planned interventions including transfer status will also be placed on the resident Kardex to ensure direct care staff are able to view resident specific needs. Nursing and Therapy staff will be educated prior to their next scheduled shift, prior to all direct care staff performing direct care and reviewing the Kardex to identify resident specific needs.Actions to Prevent Occurrence/Recurrence: The Corporate Nurse/Consultant Nurse will then educate the DON/ADON/Administrator on the facility orientation checklist for nursing staff. Education will be validated via facility mechanical lift competency checklist. Mechanical lift/sling training will take place at orientation for new nurses and nurse aides. Training will be completed prior to staff transferring a resident using the lift/sling. The Corporate Nurse, DON, DOR or designee will then re-educate nursing staff and therapy staff prior to their next scheduled shift, prior to them performing direct care on appropriate transfer and safe handling of residents during mechanical lift transfers. An emphasis will be placed on ensuring residents are appropriately secured with mechanical lift pad straps prior to transfer as well as ensuring straps are in proper condition prior to use by inspecting for safety prior to use per manufacturer instructions. Education will be validated via facility mechanical lift competency checklist. (Anticipated date of education initiation: 2/23/2026) The Administrator or DON will sign off on new nursing staff employees that the completion of the orientation checklist to include validation of competencies completed for nursing staff prior to being moved from their orientation status. The DON or designee will audit mechanical lift transfers twice weekly x 4 weeks, then weekly x4 weeks then monthly x1 month. The Administrator implemented a QAPI PIP as a means to gather and process information from the monitoring rounds. Findings will be reported at the monthly QAA meeting for a minimum of 3 months.Monitoring:Record review of the facility's staff education in-service training and competency record, dated 02/23/2026, 02/24/2026 and 02/25/2024, revealed appropriate transfer and safe handling of residents during mechanical lift transfers was provided to staff. Staff were evaluated at a satisfactory level and determined safe to implement mechanical lift transfers. Record review of QAPI sign-in sheetRecord review on 02/25/2026 of census counts was verified and revealed that a census count was completed for residents requiring mechanical lift transfers and signed off on by the Administrator. Record review on 02/25/2026 of facility mechanical lift competency checklist was updated and used to train staff. The record of evaluation and indicated all trained was able to demonstrate safe transfer at a satisfactory level to implement resident transfers. Interviews on 02/23/2026 - 02/25/2026 on both shifts with staff (Housekeeper A, 4 CNAs, 2 Nurses, 1 CMA, ADON, DON, DOR, and Administrator on 6 a.m.-6 p.m. dayshift, and 3 CNAs, 2 Nurse on 6 p.m. - 6a.m, night shift) were able to verify in-services and to validate their understanding of the information presented. Direct care staff were able to explain how to implement safe mechanical lift transfers, where to find the information in the clinical record identifying residents who require mechanical lift transfers. During observations of mechanical lift transfer on 02/25/2026, 4 CNAs and 3 Nurses confirmed staff were able to demonstrate safe mechanical lift transfers using the steps outlined in the procedure evaluation checklist. Record review of the (continued on next page)

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