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	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fallbrook Rehabilitation 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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32422 Based on observation, interview and record review, the facility failed to accommodate the needs and preferences reviewed for accommodation of needs. for one resident (Resident #28) of 15 residents. The facility failed to ensure Resident #28's call light was within reach of the resident. This failure could place residents at risk of being unable to obtain assistance for activities of daily living or in the event of an emergency. Findings included: Observation and interview on 4/8/25 at 10:18 AM revealed Resident #28's call light was under his dresser on the right side of his bed. Resident #28 was observed lying in bed, he said that he just woke up and his leg hurts. The surveyor asked him to press his call-light for assistance and he said he did not even know he had a call-light. Surveyors searched for the call-light which was found under the dresser. The DON came to assist, he removed the call-light from beneath the dresser and attached the call-light to Resident #28's blanket. Resident #28 pressed the call-light to make sure it worked. An interview with the DON on 4/8/25 at 10:25 AM, when asked what a negative outcome could have been if the resident could not be able to reach and press his call-light. The DON said he could have fallen and hurt himself by getting up to get what he needed. The DON said that he would address Resident 328's pain and conduct in-services on call-lights with the staff. He said that all staff were responsible for having call-light placement. An interview on 4/10/25 at 10:14 am with the Administrator he said that the call-lights being withing reach of the resident were important because the call-light notified staff of the residents needs so they could address them. He said that all staff were responsible for having call-light placement. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #28's facility admission record in the facility medical record system revealed that Resident #28 was admitted on [DATE]. Resident #28 was a [AGE] year-old male with diagnoses that included facial weakness following other cerebrovascular (facial weakness can develop following other cerebrovascular diseases, such as stroke, subarachnoid hemorrhage, or cerebral venous thrombosis. These conditions disrupt the normal blood flow to the brain, resulting in damage to the facial nerve disease.) and attention and concentration deficit following cerebral infarction (concentration deficit refers to a person's ability to filter out distractions and maintain their focus on a particular task. Attention and concentration deficits are common following cerebral infarction). Record review of Resident #28's Admission MDS dated [DATE], revealed a BIM score of 12 out of 15 indicating a moderate cognitive impairment. Resident #28 was documented to have lower extremity impairment and was documented to require total to substantial/maximum assistance from staff for ADL's. He required set-up to or clean-up assistance with eating. He was always continent with bladder and bowel. Record review of Resident #28's care plan revealed a care plan to address ADL self-care performance deficit and requires hands on assistance. Date Initiated: 01/29/2025. Revision on: 02/12/2025 Goals included to maintain/improve level of Functioning, bed mobility with assist of 1. Date Initiated: 02/12/2025 and a care plan to address a prescribed an anticonvulsant medication for behaviors and is at risk for side effects, abnormal labs, skin reaction and falls. Interventions included will be free of side effects/adverse reactions related to anticonvulsant use throughout the next review. Date Initiated: 02/12/2025. Revision on: 02/24/2025, Monitor for Side effects of headache, fatigue, dizziness, blurred vision, nausea, weight changes and mood changes. Date Initiated: 02/12/2025. Review of the facility's policy and procedure entitled Answering the Call-light, dated revised September 2022 read in part . The purpose of this procedure is to ensure timely responses to the resident's requests and needs .Explain to the resident that a call system is also located in his/her bathroom .Be sure that the call light is plugged in and functioning at all times . Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor.

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35822 Based on observation, interview, and record review the facility failed to respect the resident's right to personal privacy during care, for 1(Resident # 777) of 6 residents reviewed for privacy, in that: -LVN F failed to lock her computer during medication pass on 04/09/25, leaving Resident #777's medical records disclosed on the hallway. This failure could place resident at risk for economic harm, embarrassment, and not maintaining their individual autonomy and individuality. The findings included: Record review of Resident # 777's face sheet dated 04/11/25 revealed a [AGE] year-old female admitted to the facility on [DATE]. Resident # 777 diagnoses included the following: staphylococcal (bacteria) arthritis (swelling or tenderness in one or more joints causing pain or stiffness) of the right knee, chronic pain, anemia (low count of red blood cells {cells that carry oxygen from the lungs to the rest of the body}), hypertension (high blood pressure), heart failure, and kidney disease stage 3 (moderate loss of kidney function). Record review of Resident #777's Admission MDS dated [DATE] reflected a BIMS score of 15 indicating that resident cognition was intact. Record review of Resident #777's Physician Order Summary Report for the month of April 2025 reflected the following order: -Dated 03/25/25 Cefazolin (antibiotic) 2gm intravenously every 8 hours for infection until 04/30/25. Record review of Resident #777's Comprehensive Care Planned dated 03/26/25 reflected that resident was being care planned for receiving IV antibiotics for infection. The intervention included to monitor for signs and symptoms of infiltration (when a substance move into a space not normally found). Record review of Resident #777's MAR for the month of April 2025 revealed that the facility was administering the medication Cefazolin 2gm IV as ordered. Observation on 04/09/25 at 7:45AM during medication pass for Resident #777, LVN F retrieved the IV medication Cefazolin 2mg from her medication cart. LVN F left her computer screen open exposing Resident #777's medical records for medication administration and walked away from the cart entering resident room to administer the medication. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/09/25 at 7:47AM with nurse LVN F said she forgot to close Resident #777 medical record before going into the resident's room. LVN F said this placed the residents medical information at risk of being exposed to anyone and this was a HIPPA violation. LVN F said she had been in-serviced on resident privacy and HIPPA (a federal law designed to protect the privacy and security of patient health information. Record review of the facility policy on Resident Rights revised February 2021 reflected in part: .Employees shall treat all residents with kindness, respect, and dignity .privacy and confidentiality . Record review of the facility policy on Confidentiality of Infection and Personal revised October 2017 reflected in part: .The facility will safeguard the personal privacy and confidentiality of all residents personal and medical records .

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32422 Based on interview and record review, the facility failed to develop a person-centered baseline admission care plan for 2 of 6 residents (Resident #45 and Resident #31) reviewed for baseline care plans in that: -The facility failed to develop a 48-hour baseline care plan with goals, interventions, treatments, and psychosocial needs addressed in a resident specific care plan for Resident #45. - The facility failed to develop a 48-hour baseline care plan with goals, interventions, treatments, and psychosocial needs addressed in a resident specific care plan for Resident #31. This failure could affect new admissions residents reviewed for 48-hour baseline care plans of not having their individual, medical, functional, and psychosocial needs identified and cause a physical or psychosocial decline in health. Findings included: Resident #45 Record review or Resident #45's admission record dated 4/11/25 revealed a [AGE] year-old male admitted to the facility on [DATE]. Resident #45's diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (both conditions that can occur after a cerebral infarction, or stroke, and are characterized by weakness or paralysis on one side of the body) and brief psychotic disorder (psychiatric condition characterized by sudden and temporary periods of psychotic behavior, such as delusions, hallucinations, and confusion). Record review of Resident #45's admissions MDS dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 13 out of 15 revealing he was cognitively intact. The MDS assessment revealed that Resident #45 was coded for ranges substantial/maximal assistance to setup or clean-up assistance with ADL's. Resident #43 was coded to be frequently incontinent of bladder and always incontinent of bowel. Record review of Resident #45's medical record revealed there was no baseline care plan. Record review of Resident #45's comprehensive care plan revealed care plans to address ADL self-care performance deficit and altered cardiovascular status, no date provided. During an interview on 4/10/25 at 5:03 pm the DON said that Resident #45 should have had a baseline care plan and comprehensive care plan to provide the continuum of care that the resident needs. The DON said that the negative outcome could be the resident not having the care he needs provided. He said that the MDS Coordinator would be responsible for creating the care plans. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/11/25 at 1:15 pm with the MDS Coordinator, she said she was the one responsible for completing the care plans, she said that the care plans were important to help take care of the resident and provide care for the resident. She said that she used the RAI manual for the policy for care plans. The MDS Coordinator added that she had only worked at the facility for 2 weeks and was doing an audit of the care plans. Resident #31 Record review of Resident #31's face sheet dated 04/10/25 revealed a [AGE] year-old male was admitted to the on 03/05/25. Resident #31 diagnosis included: end stage renal disease (kidneys have stopped working well enough to support the body), hypertension (force of blood against the walls of the arteries is consistently too high), atrial fibrillation (an irregular heartbeat) and coronary artery disease (arteries that supply blood to the heart become narrowed or blocked due to build up of plaque). Record review of Resident #31's admission assessment dated [DATE] revealed BIMS of 13 indicating intact cognition. Further review revealed Resident #31 was depended on staff with ADL care with one to two staff assist. Record review of Resident #31's medical record revealed there was no baseline care plan. During an interview on 04/11/25 at 2:42 p.m., the MDS Coordinator said the baseline care plan should be initiated upon admission and completed within 48 hours. The MDS Coordinator said if Resident #31 did not have a baseline care plan, Resident #31 might not get all the appropriate care from the staff. During an interview on 04/11/25 at 2:57 p.m., the ADON said a baseline care plan should initiated on admission, and she was not sure how it is done in this facility. The ADON said she would check with the corporate nurse and update the surveyor. During an interview on 04/11/25 at 3:05 p.m., the DON said the admitting nurse was responsible for starting the bassline care plan within 24 hours and completed within 72 hours. The DON said he becomes involved with the baseline care plan when he reviews the admission the following day unless the admission is over the weekend, and then he will review it on Monday. The DON did not respond when he was asked why Resident #31 did not have a baseline care plan. The DON said the staff would care for Resident #31 based on the report received from the hospital and the discharge summary report from the hospital. The DON said if Resident #31 had any order that was not in the discharge summary report, then the order and care would not be provided for Resident #31. During an interview on 04/11/25 at 4:09 a.m., the Corporate Nurse said the bassline care plan should be started on admission by the admitting nurse and completed within 48 hours. During an interview on 04/11/25 at 4:22 p.m., LVN F said the nurse did not initiate the 48-hour care plan, and she thought the MDS was responsible for the 48-hour care plan. LVN F said she was the admitting nurse for Resident #31. She said she reviewed the hospital orders, notified the physician about the resident medications, and carried out the physician's orders. LVN F said she had no skill check-off or training for a baseline care plan. LVN F said the DON and ADON monitored the nurse during rounds and reviewed the admission paperwork for new residents. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy entitled; Care Plans-Baseline dated revised March 2022 read in part . Policy Statement: A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission. The baseline care plan is used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered comprehensive care plan (no later than 21 days after admission). The baseline care plan is updated as needed to meet the resident's needs until the comprehensive care plan is developed. 36918

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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	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** 32422 Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 2 of 7 residents (Resident #53, Resident #31) reviewed. The facility failed to ensure that Resident #53's status of hospice were a focus area in the resident's comprehensive care plan and no intervention was in place. The facility failed to ensure Resident #31 status on ADL care were a focus area in the resident's comprehensive plan and intervention was in place. This deficient practice could affect residents by contributing to inadequate care. The findings included: Resident #53 Record review of Resident #53's facility Admission Record dated 4/10/25 revealed that Resident #53 was a [AGE] year-old male admitted on [DATE]. Resident #53's diagnoses included unspecified Dementia, unspecified severity, without behavioral disturbances (Dementia is a term used to describe a group of symptoms affecting memory, thinking, and social abilities, which interfere with daily life) (used to classify cases of dementia where the specific type and severity are not specified, and the condition is not accompanied by behavioral disturbances, psychotic disturbances, mood disturbances, or anxiety) and hyperlipidemia (an excess of lipids or fats in your blood. This can increase your risk of heart attack and stroke because blood cannot flow through your arteries easily). Record review of Resident #53's Admission MDS dated [DATE] revealed Resident #53 had a BIMS score of 2 out of 15 indicating severe impairment cognitively. Resident #53 required was coded to be dependent, requiring total to substantial/maximal assistance with of his ADL's excluding eating which was coded to require supervision or touch assistance. Record review of Section O (special treatments, procedures, and programs), the area for hospice was selected. Record review or Resident #53's comprehensive care plan revealed no care plan to address his hospice status. Record review of Resident #53's base line care plan summary dated 1/2/25 revealed Resident #53 had outside coordination with hospice . Physician orders for Resident #53 were requested on 04/10/2025 at 3:12 pm via email to the Administrator and verbally at 4/10/25 at 5:03 pm to the DON but were not received to reflect the physician order for hospice services created by the Administrator. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/10/25 at 5:03 pm the DON said that Resident #53 should have a comprehensive care plan for hospice. The comprehensive care plan was important to provide the continuum of care that the resident needs. The DON said that the negative outcome could be the resident not having the care he needs provided. He said that the MDS Coordinator would be responsible for creating the care plans. The DON said that he would add the comprehensive care plan for hospice. During an interview on 4/11/25 at 1:15 pm with the MDS Coordinator, she said she was the one responsible for completing the care plans, she said that the care plans were important to help take care of the resident and provide care for the resident. She said that she used the RAI manual for the policy for care plans. The MDS Coordinator added that she had only worked at the facility for 2 weeks and was doing an audit of the care plans. Resident #31 Record review of Resident #31's face sheet dated 04/10/25 revealed a [AGE] year-old male was admitted to the on 03/05/25. Resident #31 diagnosis included: end stage renal disease (kidneys have stopped working well enough to support the body), hypertension (force of blood against the walls of the arteries is consistently too high), atrial fibrillation (an irregular heartbeat) and coronary artery disease (arteries that supply blood to the heart become narrowed or blocked due to build up of plaque). Record review of Resident #31's admission assessment dated [DATE] revealed BIMS of 13 indicating intact cognition. Further review revealed Resident #31 was depended on staff with ADL care with one to two staff assist. Record review of Resident #31's care plan dated 03/06/25 revealed Resident #31was not completed with ADL care. During an interview on 04/11/25 at 2:42 p.m., the MDS Coordinator said Resident #31 ADL was not care planned in the comprehensive resident-centered care plan, and the MDS coordinator should complete it within 21 days after she finished the MDS. She said if Resident #31 did not have a complete comprehensive care plan, the resident may not get all the appropriate care from the staff. During an interview on 04/11/25 at 3:05 p.m., the DON said Resident #31 comprehensive care plan was due within 21 days, and the MDS nurse were responsible for completing the care plan. The DON said the staff would care for the resident based on what was done for Resident #31 in the hospital and by knowing the resident. He stated a person-centered care plan was required in the facility so that staff would provide continuity-focused care for Resident #31. He said if Resident #31 had orders and it was not care planned, the resident would not get the care. During an interview on 04/11/25 at 4:09 a.m., the Corporate Nurse said the MDS coordinator should complete a compressive-centered care plan for Resident #31 within 21 days. The Corporate Nurse said Resident #31 would get the care the resident deserved because they would continue what the hospital provided for the resident, from the resident progress notes and information from the nurse. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy and procedure entitled Care Plans, Comprehensive Person-Centered, dated revised March 2022 read in part . Policy Statement .A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission . The comprehensive, person-centered care plan: includes measurable objectives and timeframes; describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including .which professional services are responsible for each element of care; includes the resident's stated goals upon admission and desired outcomes; builds on the resident's strengths; and reflects currently recognized standards of practice for problem areas and conditions. 36918

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36918 Based on observation, interview, and record review the facility failed to ensure a resident who was unable to carry out activities of daily living (ADLs) received the necessary services to maintain nutrition, grooming and personal and oral hygiene for 2 of 4 residents (Resident #21and Resident #31) reviewed for ADLs. - The facility failed to ensure Resident #21was provided personal grooming (dry patches and flaky skin) by facility staff. - The facility failed to ensure Resident #31 was provided personal grooming (brown substance in the resident fingernails) by facility staff. These failures could place residents at risk for not receiving the assistance needed for daily care and services. Findings included: RESIDENT #21 Record review of Resident #21's face sheet dated 04/09/225 revealed a [AGE] year-old male was admitted to the on 02/17/25. Resident #21 diagnosis included: cerebral infraction (blockage in blood vessel stops blood flow to the brain), hypertension (force of blood against the walls of the arteries is consistently too high), atrial fibrillation (an irregular heartbeat) and diabetes mellitus (abnormally high blood sugar levels) Record review of Resident #21's admission assessment dated [DATE] revealed on BIMS of 09 indicating moderately impaired cognition. Further review revealed Resident #21 needed extensive ADL care with one staff assist. Record review of Resident #21's care plan dated 02/27/25 revealed Resident #21 had ADL self - care performance deficit. Interventions bathing/showering: check nails length and trim and clean on bath and as necessary. Report any changes to the nurse. During an observation and interview on 04/08/25 at 11:25 a.m., it revealed Resident #21's fingernails on both hands had a dark brown substance. Resident #21 said his fingernails were dirty, and the staff had not offered to clean his nails even when he had asked. Resident #21 said he felt bad because his fingernails were dirty. During an observation and interview on 04/08/25 at 11:30 a.m., CNA P said Resident #21's fingernails were dirty, and she was not Resident #21 aide. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/08/25 at 11:33 a.m., LVN H said she observed Resident #21's fingernails, which were dirty and needed to be cleaned. LVN H said all nursing staff could clean Resident #21's fingernails. LVN H said if the resident's fingernails were not clean and he ate with them, the resident would get an infection. LVN H said the nurses monitored the aides during the shift, and the DON and ADON monitored the nurses during random rounds. LVN H said she had not had any in-service or skills check-off on ADL, which included fingernail care. During an interview on 04/08/25 at 11:37 a.m., CNA T said Resident #21 was up when she came to work today (04/08/25) at 6:30 a.m. She just saw Resident #21 now, and his fingernails were dirty. CNA T said all nursing staff were responsible for cleaning Resident #21 fingernails. She stated that if Resident #21's fingernails were filthy and the resident ate with them, the resident could get an infection. CNA T said the charge nurse monitored the aides throughout the shift, and the ADON monitored the charge nurse during random rounds. CNA T said she would check and see if she had any skill check-off or in-service on ADL. During an interview on 04/09/25 at 2:41 p.m., the DON said Resident #21's fingernails are cleaned on Sundays and as needed. He said the aides are responsible for cleaning residents' fingernails. The DON said if the aides did not clean the resident's fingernails, it would be poor hygiene. The DON said she would check if the aides had skill check off and in service and get back to the surveyor. The DON said during in-service, the IP would educate the aides to ensure residents' fingernails are cleaned to prevent infection. During an interview on 04/09/25 at 4:35 p.m., the ADON said Resident #21's fingernails are part of ADL care, and the aide should clean Resident #21's fingernails. The ADON said Resident #21 could get an infection from eating with dirty fingers. She said the staff are responsible for providing nail care for the residents. She said the charge nurses monitored the aide throughout the shift, and the ADON OR DON monitored the change nurse during random rounds. During an interview on 04/10/25 at 10:08 a.m., the Administrator said all the nursing staff should clean Resident #21 fingernails daily and as needed. He said it was for Resident #21 safety and to prevent potential infection. He said for alert residents, it would be dignity issues. The Administrator said the aides should have training on nail care before they started working on the floor. He said the charge nurse monitored the aides throughout the shift, and the nurse managers monitored the nurses during [NAME] rounding. RESIDENT #31 Record review of Resident #31's face sheet dated 04/10/25 revealed a [AGE] year-old male was admitted to the on 03/05/25. Resident #31 diagnosis included: end stage renal disease (kidneys have stopped working well enough to support the body), hypertension (force of blood against the walls of the arteries is consistently too high), atrial fibrillation (an irregular heartbeat) and coronary artery disease (arteries that supply blood to the heart become narrowed or blocked due to build up of plaque). Record review of Resident #31's admission assessment dated [DATE] revealed BIMS of 13 indicating intact cognition. Further review revealed Resident #31 was depended on staff with ADL care with one to two staff assist. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fallbrook Rehabilitation and Care Center	10851 Crescent Moon Dr Houston, TX 77064

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #31's care plan dated 03/06/25 revealed Resident #31 ADL care was not completed in his care plan. Record review of Resident #31's weekly skin checks date: 03/19/25, 03/25/25, 04/1/25, and 04/08/25 did not reveal Resident #31's skin was ashy Patches of dry skin. During an observation on 04/09/25 at 11:00 a.m. revealed Resident #31 was scratching the left side of his back with a scratcher. Further observation revealed Resident #21 had dry, ashy skin all over his body. Resident #31 had ashy, dry patches of skin on his right foot and the top of the partially amputated left foot. During an interview on 04/09/25 at 11:13 a.m., Resident #31 said the staff gave him a bed bath, and he could not remember how often, but they did not put lotion on his skin after the bed bath. Resident #31 said his skin was dry, and he scratched all the time. That was why he had the back scratcher, and he was scratching his right hand on the bedside table during the interview. During an observation and interview on 04/09/25 at 11:24 a.m., LVN H said she saw Resident #31 today but did not check the resident's skin. She said he saw dry skin all over the resident skin. LVN H said the wound care nurse did the skin assessment for Resident #31. She said that when the aide provided daily care for Resident #31, the aide should have told the nurse if the resident had dry skin. LVN H said the aides should apply cream or lotion on the resident on shower days and as needed. LVN H said the resident should not have to ask for lotion before the aide applied the cream on the resident's skin because it was part of the daily ADL care. LVN H said if a resident's skin was dry, it could cause the skin to break down and open the area when the resident starched, and it could cause infection. LVN H said she had no training, skin check-off -or in-service on skin assessment or mentoring skin. She said the floor nurse monitored the aides during rounding, and the DON and ADON monitored the nurses during random rounding. During an interview on 04/09/25 at 2:47 p.m., the DON said the aides should apply cream or lotion on Resident #31 on shower days and during daily ADL care. The DON said Resident #31 should not have asked staff to apply lotion because it was part of ADL care. The DON said if the aides did not apply lotion or cream on Resident #31, the skin would be dry, crake, or break open. He said the charge nurse monitored the aides throughout the shift, and the DON and ADON monitored the nurses during random rounds. The DON said that the staff is educated to ensure the residents' skin is hydrated by applying daily lotion during in-service. During an interview on 04/09/25 at 4:40 p.m., the ADON said the aide showers Resident #31 three times a week and as needed. She stated aides are supposed to apply lotion on residents daily. The ADON said Resident #31 could have skin tears if lotion were not applied on the residents daily or as needed. She said the charge nurse monitored the aides throughout the shift, and the ADON and DON monitored the nurse during random rounding. She said she would have to review the facility policy, see the training provided for the staff on skincare and integrity, and get back to the surveyor on skin care. During an interview on 04/09/25 at 5:06 p.m., the surveyor requested training, skills check off, and in-service for LVN H, Wound care nurse, and CNA T for skin care and nail care from DON. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/10/25 at 10:16 a.m., the Administrator said the aides should apply lotion on Resident #31, and the staff should apply the cream daily and as needed. The Administrator said many things would happen to the skin. He said Resident #31 would be uncomfortable and had a high chance of skin breakdown. The Administrator said the aides should have done a skills check-off before working on the floor. He said the charge nurses monitored the aides, and the nurse managers monitored the nurses during random rounding. The Administrator said the aides and the nurses were competent in carrying out their duties for the resident but did not know why the staff did not provide the care. He stated he would QAAPI it and see if the staff needed more training and provide whatever training they required. During an interview on 04/10/25 at 10:44 a.m., the DON said he could not find any training or skill-check 0ff for LVN H, the Wound care nurse, and CNA T. The DON still expects the nurses and the aides to provide care competently based on their school training. He said they are putting training in place as of yesterday. The DON said competent meant the nurse or aide had the skills to perform the care to the resident, which the staff was hired, and if the staff was not able to perform their duties, then the staff would be trained. During an interview on 04/10/25 at 11:10 a.m., CNA T said she did not notice that Resident #31 skin was dry, and his right foot was very dry and had patches of dry skin. CNA T said LVN H gave her cream to apply on Resident #31 after she saw Resident #31 skin with the surveyor. CNA T stated that Resident #31's skin could start to break down and become irritated if the staff did not apply lotion to the resident's skin. CNA T said the charge nurse monitored the aides throughout the shift. CNA T said she could not remember if she had any skills checked off and would check with the DON and get back to the surveyor. During an interview on 04/10/25 at 3:05 p.m., the Wound care nurse said she was responsible for Resident #31's skin assessment, and she did his skin assessment on Tuesday (04/08/25). The wound care nurse said that if she was not mistaken, she told Resident #31's aide that the resident's skin was dry. She said Resident #31's skin could break down if aides did not apply lotion to the resident's skin. The wound care nurse said she was surprised that Resident #31 had that much ashy, dry skin all over his body and that he did not have any skin breakdown. She said any nursing staff could apply the cream to Resident #31, but the aide would be the first line of care, and it should be done on shower days and daily. She said the resident should not have to ask for the lotion to be applied before the staff would apply the cream on the resident because it was part of the daily ADL. The Wound care nurse said the nurse monitored the aides throughout the day, and the DON and ADON monitored the nurses during random rounding. She said she did not know of any skill check-off on skin or training provided by the facility, but it was taught in school, and we also apply lotion daily, and the staff should apply cream on the resident's skin. Record review of the facility policy on fingernails care dated2001 MED - PASS, Inc. (Revised February 2018) read in part . the purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections .

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35822 Based on observation, interview, and record review the facility failed to ensure that a resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion for 1 (Resident #158) of 6 residents reviewed for range of motion. -Resident #158 did not receive preventive care measures to prevent further contractures of the resident's hands. This failure placed resident at risk for impaired skin integrity, of further decline and decrease in their quality of life and quality of care. Findings include: Record review of Resident #158's face sheet dated 04/09/25 revealed a [AGE] year-old-female admitted to the facility on [DATE]. Resident diagnoses included the following: bipolar disorder (mood swings ranging from depressive lows and elevated energy), seizures, quadriplegia (loss of function in arms legs that could include the chest, abdomen, pelvis, and back). Record review of Resident #158's annual MDS dated [DATE] reflected a BIMS score of 3 indicating that resident's cognition was severely impaired. Section GG (Functional Abilities) reflected resident with limited range of motion to upper and lower extremities (hip, knee, ankle, foot, shoulder, elbow, wrist, and hands). Record review of Resident #158's Physician Order Summary Report for the month of April 2025 reflected the following order: -Dated 03/20/25 Occupational Therapy evaluate and treat as indicated. Record review of Resident #158 Occupational Evaluation and Plan of Treatment with a certification period from 02/20/25-04/05/25 reflection in part: .It is recommended that patient wear a resting hand splint and palmar guard on right and left hand for 4 hrs on/4hrs off in order to reduce pain caused by joint deformity and improve PROM for adequate hygiene . -Record review of Resident #158's Comprehensive Care Plan dated 01/16/23 contractures and is at risk for skin breakdown, increase pain from infected areas and injury. Resident has contractures bilaterally to hands and lower extremities. Further review of care plan reflected that resident care plan had been updated on 04/10/25 for resident to have pressure reducing products (i.e. hand rolls .) to decrease further skin breakdown .PT/OT to evaluate and treat as needed for contractual management. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 04/08/25 at 9:46AM of Resident #158 resting in bed. Resident hands bilaterally were contracted with fingernails long and dirty underneath the nails. Resident did not have device in hands to prevent further contracting or injury to hands. Further observations of resident having no hand device to prevent further contractures at these times: 12:00PM, 1:00PM, 2:30PM, 2:245PM and 4:00PM. , Observation 04/09/25 at 8:00AM of resident having no hand contracture device. Further observation of no hand device at the following times, 10:00am, 10:58AM, 1:00PM, 1:20PM, 3:00PM and 3:57PM. Interview on 04/09/25 at 3:57PM with LVN F after observing Resident #158 right and left hands (no skin breakdown observed) said resident hands were contracted and that resident nails needed to be clipped because they were long. LVN F said resident needed to have a device in her hands to prevent further contracture. LVN F said she was the nurse for Resident #158 and the Physical Therapy Department did not provide any suggestion for resident contractures to her hands. Interview on 04/09/25 at 4:04 PM the Director of Rehab Services said the last time Resident #158 was on rehab services was 02/20/25 with the recommendations for hand rolls with skin checks to the palm of the hands. The Rehab Director said the facility did not have a restorative care program at this time, but it would have been the nurse's responsibility to ensure that resident had hand rolls in place to prevent resident hands from further contracting. LVN F said it was the responsibility of the CNA's to keep the resident nails clipped if the resident was not a diabetic. LVN F said if the resident was a diabetic, the nurses would clip resident fingernails or the podiatrist. Interview on 04/09/29 at 4:16PM the DON said it was the nurse's responsibility as well as the CNA's to ensure a resident with hand contractures were being provided with intervention such as hand rolls to prevent further contractures to the hand. The DON said if this was not being done the resident was being placed at risk for skin breakdown due to their nails penetrating the skin. Record review of the facility policy on Resident Mobility and Range of Motion revised July 2017 reflected in part: Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in range of motion .

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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** 36918 Based on observations, interviews, and record reviews, the facility failed to ensure the resident environment remained as free of accident hazards as was possible for 1 of 3 residents (Resident #45) reviewed for accident hazards, in that: The facility failed to ensure there was no unattended container micro - kill germicidal wipes on top of the housekeeper's cart in 100 hall. These deficient practices could place residents at risk of an accidental injury. The findings were: Record review of Resident #45's face sheet dated 04/09/25 revealed a [AGE] year-old male was admitted to the on 02/15/25. Resident #45 diagnosis included: hemiplegia (paralysis that affects only one side of the body), hypertension (force of blood against the walls of the arteries is consistently too high), atrial fibrillation (an irregular heartbeat) and diabetes mellitus (body cannot regulate blood sugar levels properly). Record review of Resident #45's admission assessment dated [DATE] revealed BIMS of 13 indicating intact cognition. Further review revealed Resident #45 needed extensive with ADL care with one staff assist. Record review of Resident #45's care plan dated 04/11/25 revealed Resident #45 had had impaired decision-making skills, safety awareness judgement and exhibits inattention and disorganized thinking at intervals. Intervention: Check on resident at routine intervals to assess needs and monitor for safety issues and provide assistance as needed. During an observation on 04/08/25 at 9:43 a.m., Resident #45 propelled himself to housekeeper K on 100 halls and took germicidal wipes (10) from the container, which was left unattended on top of the housekeeper's cart. Housekeeper K was cleaning inside a resident's room, and her cart was out of site. Resident #45 wiped his hands and both sides of his mouth and propelled himself to his room. During an interview on 04/08/25 at 9:50 a.m., Housekeeper J interpreted for Housekeeper K. Housekeeper J said Housekeeper K said she was supposed to store the germicidal wipes container in the lock compartment of her cart to prevent residents from getting into it. She said she left the container on the cart because she was using it. She said Resident #45 was not supposed to touch or take it. Housekeeper K did not answer when asked what could happen to a resident if the resident came in contact with the germicidal wipe. Housekeeper K said she had training on infection control and hazard materials. Housekeeper K said she did not remember what was taught during the training. During an interview on 04/08/25 at 10:03 a.m., Resident #45 said he went and took some wipes from the housekeeper's cart and pointed to the cart. He said he wiped his hands, both sides of his mouth, and wiped his mattress, and then he placed it in the trash can and pointed to the trash can. Resident #45 said he takes the wipes from the cart all the time. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 04/08/25 at 10:07 a.m., CNA F said she saw the wipes in Resident #45's trash can in his room. CNA F said Resident #45 was not supposed to use the germicidal wipes because it could cause eye irritation for the resident. CNA F said the housekeepers should lock the wipes in their carts when not in use. During an interview on 04/09/25 at 12:12 p.m., the Housekeeping Supervisor said Housekeeper K should lock the disinfectant to prevent what happened yesterday when Resident #45 took wipes from on top of the housekeeper's cart. She said the disinfectant could cause harm to the resident, such as skin irritation. She said she made daily rounds with the housekeeper, and the housekeeper was in service on storing chemicals. During an interview on 04/10/25 at 9:46 a.m., the Administrator said the disinfectant whips should be in a locked compartment out of reach of residents. The Administrator said the wipes should be locked in the compartment for the safety of the residents. He said he did not know what the chemicals in the wipes could do to the resident. The Administrator said the housekeeper supervisor monitored the housekeeper during rounds, and he also monitored the cart when he made random rounds. The Administrator said the housekeepers are trained on how to secure the cleaning chemicals before and while working on the floor. During an interview on 04/10/25 at 10:38 a.m., the DON said the staff told him on Tuesday that Resident #45 went and took some disinfectant wipes from the housekeeper's cart. The DON said the housekeepers should put the wipes in the lock compartment when not used. He said that the nursing staff did not use that type of wipes but did not know what could happen to Resident #45's skin, and he did not know the chemical compound of the wipes. The DON said he did not see any reactions on Resident #45's face and would follow up on Resident #45. Record review of the facility in service on daily routine dated 04/01/25in part read please clean carts daily after shift. Leave all chemicals in your lock cart . and Housekeeper K signed the in - service. The facility policy for accident/hazard was requested on 04/1024 at 9:27a.m., and it was not provided upon exit.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35822 Based on observation, interview and record review, the facility failed to ensure that a resident who enters the facility with an indwelling catheter received appropriate treatment and services to prevent urinary tract infections for 2 (Resident #17, Resident #158) of 6 residents reviewed for catheters, as evidenced by: -Resident #17 did not have a STATLOCK to secure Foley catheter. -Resident #158 did not have a STATLOCK to secure Foley catheter. These failures placed the residents at risk of their Foley catheters getting dislodged, unwanted pain, trauma, infections, and decreasing their quality of life. Findings included: Resident # 158 Record review of Resident #158's face sheet dated 04/09/25 revealed a [AGE] year-old-female admitted to the facility on [DATE]. Resident diagnoses included the following: acute (illness that develops quickly) and chronic (lasting for a long time) respiratory failure with hypoxia (lack of oxygen to sustain bodily functions), neuromuscular (affecting the nerves controlling the muscles) dysfunction of the bladder, sepsis (infection in the blood. Record review of Resident #158's annual MDS dated [DATE] reflected a BIMS score of 3 indicating that resident's cognition was severely impaired. Further review section H (Bowel bladder) reflected that resident had an indwelling catheter. Record review of Resident #158's Physician Order Summary Report for the month of April 2025 reflected the following order: -Dated 03/30/25 Foley catheter size_16Fr and balloon size_30 cc change PRN. Record review of Resident #158's Comprehensive Care Plan dated 01/25/25 and revised 02/11/25 reflected that resident was being care planned for indwelling catheter with an intervention to change Foley tubing securement device weekly and PRN if loose or soiled. Observation 04/08/25 at 9:46AM of Resident #158 resting in bed. Resident had an indwelling Foley catheter without a Statlock (catheter stabilization device that secures a catheter in place, helps to minimize catheter movement and accidental removal) to prevent Foley tubing from accidently being dislodged or pulling on the tube. Observation on 04/09/25 at 10:58AM Observation of Resident #158 with a stat loc attached to her right thigh. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #17 Record review of Resident #17's face sheet dated 04/11/25 reflected a [AGE] year-old female admitted to the facility on [DATE] and again on 02/13/25. Resident diagnoses include the following: sepsis (infection in the blood), obstructive and reflux uropathy (blockage in the urinary tract that hinders urine flow), cognitive deficit, hemiplegia (paralysis on one side of the body after a stroke), hemiparesis (weakness on one side of the body, and cerebral infarction (an area in the brain where there is tissue death due to the blood vessel blockage). Record review of Resident #17's quarterly MDS dated [DATE] reflected a BIMS of 3 indicating that resident cognition was severely impaired. Record review of section H (Bowel and Bladder) in the MDS reflected that resident had an indwelling catheter. Record review of Resident #17's Physician Orders for the month of April 2025 reflected the following order: -Dated 04/07/25 change Foley catheter size 20Fr and balloon size 10 cc PRN. Record review of Resident #17's Comprehensive Care Plan dated 04/18/24 reflected that resident was being care planned for an indwelling catheter with an intervention that included to observe for potential complications involving catheter occlusion, catheter migration (catheter movement) and provide catheter care every shift. Observation on 04/08/25 at 10:04AM of Resident #17 resting in bed. Resident had an indwelling Foley catheter. Resident foley catheter did not have a Statlock in place to secure the tubing to prevent dislodgement or pulling on the tubing. Observation on 04/09/25 at 10:31AM of Resident #17 having a Statlock on right thigh area . Interview on 04/09/25 at 10:52AM with LVN F said it was the responsibilities of the nurse to assess residents that had a Foley catheter to ensure that a Statlock was in place to prevent the Foley catheter from being pulled out. LVN F said if this happens, it placed the resident at risk for pain, bleeding, and infections. LVN F said she was Resident #17's and Resident #158 nurse. Interview on 04/09/25 at 11:05AM with the DON said residents with an indwelling Foley catheter should have a statlock/secure strap in place to prevent pulling the Foley tubing out. The DON said it was the nurses that were supposed to ensure that this device was in place. The DON said the nurses should be assessing the resident at least once a shift. The DON said if the resident Foley tubing is dislodged with the bulb still inflated, the incident could cause the resident discomfort as well as more discomfort in inserting a new Foley catheter. The DON said ultimately fell on him to ensure that the nurses were carrying out this task. Interview on 04/09/25 at 11:20AM with CNA G said she had been working at the facility full time for [AGE] years. CNA G said whenever a resident had a Foley catheter it was the responsibility of the CNA to provide care for the catheter by cleaning the resident properly and if the Stalock came off the resident, the CNA should inform the nurse to prevent the Foley tube from being pulled out. CNA G said the CNAs did not place the Stalock on the residents, but the nurses did. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy on Catheter Care, Urinary revised August 2022 reflected in part: The purpose of this procedure is to prevent urinary tract infections .secure catheter with catheter securement device .

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	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fallbrook Rehabilitation 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.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 35822 Based on observation, interview and record review, the facility failed to ensure that drugs and biologicals used in the facility were stored properly in accordance with professional standards of practice in one of two medication rooms (Hall 100), reviewed for labeling and storage of drugs and biologicals, in that: -Medication room on hall 100 had expired medications. These failures placed residents on Hall 100 at risk of receiving expired medications and adverse reactions. Findings Include: Observation on 04/09/25 at 7:15AM on Hall 100 medication storage room revealed there were 3 expired hydrocortisone acetate 25mg suppositories. The expiration date on the medication was dated 03/2025. Interview on 04/09/25 at 7:25AM with LVN H said it was the DON that was supposed to be checking the medication rooms for any expired medications. LVN H said if a resident is administered an expired medication, it placed the resident at risk of not receiving the full intended dose of the medication or it could place the resident at risk for unwanted adverse side effects. Interview on 04/09/25 at 9:54AM with the DON said he was responsible for checking the medication storage room for expired medications. The DON said if a resident received a medication that had expired, it placed the resident at risk for complications and the efficacy (to produce a desired or intended result) of the medication. The DON said the facility had two medication rooms. The DON said he checked the medication storage rooms every morning and someone must have placed the expired medication in the medication storage room fridge. Interview 04/09/25 at 9:20AM The facility Regional Nurse was asked for the facility policy on Expired medications/Drug Destruction.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 48923 Based on observation, interview and record review, the facility failed to dispose of garbage and refuse properly for 1 out of 3 dumpsters, dumpster A. -On 4/8/2024 at 8:08am, one of the facility's dumpster was observed with no lid attached or on it and was a quarter full. This failure has the potential to affect 54 residents in the facility, staff, and visitors by placing them at risk for infection and a decreased quality of life due to having an exterior environment which could attract pests, rodents and other animals. Findings included: Observation on 4/8/25 at 8:08am, Surveyor A and [NAME] A observed the facility dumpster area, which was in the lot behind the dietary department. The facility stand-alone dumpster was not covered. The lid was detached and placed on the side next to the dumpster. Observation on 4/9/25 at 8:47am, the right lid to the same dumpster was open. It was marked in white chalk 4/09. Interview with [NAME] A on 4/8/25 at 8:08am, she said she did not know why the dumpster was open. [NAME] A said that not closing the lids could attract rodents because of the dumpster being located near a sewage line at the facility. She said she would go to her supervisor about this issue. Interview with the Dietary Manager on 4/8/25 at 8:20am, she said that the trash company said they would deliver a new dumpster on 4/9/25 because the metal rod that connects the lids to the dumpster was broken. She was going to call again to get an update on the time of arrival. Interview on 4/9/25 at 8:47am, the Dietary Manager said she did not know about the white chalk labelled 4/09. She said that if the dumpster was broken it should not be in use. She said the facility had two other dumpsters across from this one that could be used, and she used a mop to close the right lid. Interview with the Administrator on 4/8/25 at 8:24am, he said the trash company called him and said they were going to deliver it that day. In a later interview on 4/10/25 at 5:47pm, the Administrator said the dumpster with the broken lid didn't need to be used as the facility had two other working dumpsters with lids. Record review of facility's policy and procedure of Food-Related Garbage and Refuse last revised October 2017 read in part, Food-related garbage and refuse are disposed of in accordance with current state laws .7. Outside dumpsters provided by garbage pickup services will be kept closed and free of surrounding litter.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36918 Based on observation, interview and record review, the facility failed to maintain an infection control program designed to prevent the development and transmission of infection for 2 of 4 residents (Resident #31 and Resident #14) observed for infection control. The facility failed to ensure EBP sign was posted on Resident #31 door and ensure PPE was set up at the residents door. The facility failed to ensure clean uncovered linen cart with linens was not stored in Resident # 14 room. These failures could place the residents at risk for infection. Findings included: Record review of Resident #31's face sheet dated 04/10/25 revealed a [AGE] year-old male was admitted to the on 03/05/25. Resident #31 diagnosis included: end stage renal disease (kidneys have stopped working well enough to support the body), hypertension (force of blood against the walls of the arteries is consistently too high), atrial fibrillation (an irregular heartbeat) and coronary artery disease (arteries that supply blood to the heart become narrowed or blocked due to build up of plaque). Record review of Resident #31's admission assessment dated [DATE] revealed BIMS of 13 indicating intact cognition. Further review revealed Resident #31 depended on staff with ADL care with one to two staff assistance. Record review of Resident #31's care plan dated 03/06/25 revealed Resident #31ADL care was not completed in his care plan. During an observation on 04/0/25 at 9:15 a.m., revealed Resident #31 was on EBP, and there was no signage on the resident door or PPE set by the resident door. During an interview on 04/08/25 at 10:57 a.m., LVN H said Resident #31 was a dialysis resident, and he was admitted with a wound on his left heel. LVN H said a resident with a wound should be on EBP. She said Resident #31 should have a sign on his door and PPE set up by the door. She said the purpose of the sign and PPE setup was to prevent the spread of germs (infection control). She said she did not have any in service on infection control and was unsure who would post the sign on the door. During an interview on 04/09/25 at 2:35 p.m., the DON said Resident #31 should have the EBP sign posted on his door to alert this staff that they should [NAME] their PPE while providing care for the resident. The DON said that was an infection control issue because if Resident #31 had any organism in his wound and the staff did not know the resident was on EBP and did not use their PPE during care, the staff could spread the germs to other residents. He said the IP nurse was responsible for putting the sign on the door and the PPE set by the resident's door. The DON said he monitors the IP nurse. The DON said he would be the person to provide in-service for the IP nurse. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/09/25 at 4:44 p.m., the ADON said Resident #31 should have an EBP sign on his door and a bin with PPE near the door so the staff could easily reach the PPE. She said the staff could be exposed to germs if the staff provided care for Resident #31 without PPE, who had a wound on his heel, and the staff could transfer the organism to other residents. The ADON said she was responsible for setting up the bin and posting the signage on the resident's door. The ADON said she was waiting to laminate the door signs, and she said she placed a paper sign on the door and did not realize that the paper fell off the door, but it is still an infection control issue. During an observation on 04/08/25 at 10:45 a.m. revealed an uncovered clean linen cart with linens stored in Resident #14's room. During an interview on 04/08/25 at 10:47 a.m., CNA Y said he observed the clean linen cart in Resident #14's room and pulled it out. CNA Y said the staff should not store the clean linen cart in Resident #31's room because of infection control. He said if the linen got contaminated and the staff used the linen on another resident, the germs would be transferred to the other resident. CNA Y said he had in service on infection control, including linen storage. During an interview on 04/08/25 at 11:00 a.m., LVN H said the clean linen care was not supposed to be stored in a resident room because of cross-contamination. She said she did not have any in service on infection control or linen storage. She said the floor nurse monitored the aides throughout the shift, and the nurse managers monitored the nurses during random rounding. During an interview on 04/08/25 at 11:03 a.m., CNA T said Resident #14 was assigned to her and she did not store the linen cart in Resident #14's room. She stated the linen cart was not in the resident's room when she came to work this morning, and when she left the room, the line cart was not in the resident's room. CNA T said the clean linen cart should not be in Resident #14 room because of cross-contamination. CNA T said she had in service on infection control, and it covered clean and dirty linen storage. She stated the nurses monitored the aides throughout the shift. During an interview on 04/09/25 at 2:35 p.m., the DON said the clean linen cart was not supposed to be stored in Resident #14's room because it would be clean to dirty, and it was cross-contamination. He said the charge nurse monitored the aides throughout the shift, and the DON and ADON monitored the nurses during random rounds. During an interview on 04/09/25 at 4:49 p.m., the ADON said the staff should not store the clean linen cart in Resident #14's room because of cross-contamination. She stated that the linen stored in the resident's room could be contaminated, and if the linen was used on another resident, it could cause the spread of germs. The ADON said the floor nurse monitored the aides on their shift while the nurse managers monitored the nurses during random rounds. Record review of the facility policy on clean laundry storage policy dated 2001 MED - PASS, Inc. (Revised September 2022) [NAME] in part . storage#3 . the use of separate room, closet, or other designated space with a closed door are used to reduce the accidental contamination . Record review of the facility policy on enhanced barrier precaution Vertical Health services dated 03.28.2024 read in part . policy interpretation and implementation #16 . Signs are posted on the door or wall outside the resident room indicating the type of precautions and PPE required. #17 . PPE is available outside of the resident rooms .