STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675663	A. Building B. Wing	04/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fort Bend Healthcare Center	3010 Bamore Rd Rosenberg, TX 77471

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47709 Based on interviews and record review, the facility failed to ensure the comprehensive person-centered care plan was reviewed and revised after a change in condition and or falls for 1 (Resident #1) of 4 residents reviewed for care plan revision/timing. 1. The facility failed to ensure Resident #1's care plan was revised to include interventions and services to decrease the risk of falls in the facility's dining room after suffering a fall on 12/31/24. Resident #1 had similar falls in the facility's dining room on 09/29/23 and 09/21/24 with no injuries. 2. The facility failed to ensure Resident #1's care plan included interventions and services to appropriately assess and monitor the resident's chronic pain. These failures could place residents at risk of not receiving the appropriate care, services, or treatments needed to achieve highest quality of life. Findings included: Record review of Resident # 1's face sheet, dated, 03/12/25, reflected a [AGE] year-old female who was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses which included: Unspecified dementia (memory loss, confusion, difficulty thinking or making decisions), unspecified severity, without behavioral disturbance, psychotic disturbance (mental condition where a person has trouble knowing what is real), mood disturbance, anxiety (feeling of worry, fear or nervousness), Alzheimer disease (disease that slowly damage memory and thinking skills), major depressive disorder, cognitive communication deficit (difficulty with thinking and language), unspecified lack of coordination (having trouble controlling movements, making actions unsteady), fracture of unspecified part of neck of right femur (a broken bone in an unknown part of the upper right thigh), subsequent encounter for closed fracture with routine healing (follow-up visit for a broken bone that is healing normally). Record review of Resident #1's Quarterly MDS assessment, dated 12/14/24, revealed the resident had a BIMS score of 5, indicating a severe cognitive impairment. Functional abilities substantial/maximal assistance (help does more than half the effort), eating, oral hygiene, toileting hygiene, shower/bath, lower body dressing and personal hygiene. Resident# 1 was not coded for pain or falls. (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's Incident by Incident Type, dated 12/1/24-3/14/25 revealed Resident #1's fall dated 12/31/24 at 7:00 pm, in the dining room, the resident slid out of the wheelchair while attempting to pick up something on the floor. The nurse observed a skin tear to the right forearm. Record review of Resident#1's Comprehensive Care Plan, updated on 1/25/25, did not reveal goals or interventions related to preventing falls in the dining room. However, the care plan did indicate Resident #1 was at risk for falls. Interventions included staff anticipating and meeting the resident's needs. ensuring Resident #1's call light was within reach and encouraging the resident to call for assistance as needed. Educate the resident/family/ caregivers about safety reminders and what to do if a fall occurs. Ensure Resident #1 wears appropriate footwear when ambulating or mobilizing in wheelchair. Physical therapy to evaluate and treat as ordered or as needed. Record review of Resident #1's Care Plan dated 11/25/20 did not reveal the dates the care plan was updated after the resident's falls on 9/29/23 and 9/21/24. Further review of the care plan indicated Resident #1 was at risk for falls r/t history of falls and suffered falls in the facility's dining room on 9/29/23 and 9/21/24. The resident was noted to be found sitting on the dining room floor with no injuries after each fall on 9/29/23 and 9/21/24. Interventions included: place call bell/light within easy reach, respond promptly to calls for assist to toilet, foot ware will fit properly and have non-skid soles, provide reminders to use ambulation and transfer assist devices, keep area free of obstructions to reduce the risk of falls or injury, resident is on the fallen leaf program to indicate she is at high risk for falls. A red band will be placed on her wheelchair and leaf next to her name on the door to indicate to staff that she is a high risk for falls, PT (physical therapy) and OT (occupational therapy) to evaluate and treat as indicated. Assist resident to the dining room and have resident sit at a table, resident has been re-educated on the importance of using the call lights and waiting for help. Call light education done, bed in lowest position and brake extender on wc (wheelchair). Record review of a Physical Therapy Evaluation, dated 12/11/24, revealed the reason for the resident's physical therapy referral was due to decline in strength, dynamic balance, functional ambulation, functional mobility .The resident felt unsteady when standing, when walking; had a fear of falling, and worried about falling. The evaluation indicated the resident unable to communicate pain; and lack of pain was determined based upon the resident's behavior. The resident exhibited slow, unsteady gait with forward lean of trunk, inadequate hip extension and inadequate trunk extension which are associated with the underlying causes of muscle weakness, reduced functional activity tolerance and impaired coordination. The resident also exhibited the wide base of support, decreased rotation of hips and shoulders, decreased speed and amplitude of automatic movements, decreased step length (<15), waddling, and pushing her walker far ahead of her. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the evaluation revealed weak trunk and lower extremity muscles, reduced reactive balance and reduced recognition of unsafe situations as fall predictors for the resident. The resident's Gross Motor Coordination was also noted as impaired. The resident was referred to physical therapy due to decline in functional mobility and her ability to ambulate due to muscle weakness, decreased balance and coordination and decreased functional endurance. The resident was noted to have cognitive impairment and poor safety awareness. However, she was cooperative. The resident was noted to benefit from physical therapy interventions to improve safety, decrease level of assistance in functional mobility and improve her ability to ambulate. The resident required skilled physical therapy services to increase lower extremity strength, improve dynamic balance, increase coordination, increase functional activity tolerance, minimize falls, facilitate independence with all functional mobility, increase independence with gait in order to enhance patient's quality of life by improving ability to increase performance skills with functional tasks, and perform functional mobility with reduced risk of falls. The recommended level of skilled therapy services also included the need for durable medical equipment for condition and Patient with dementia requiring repetition of structured task to facilitate new learning. Further review of the evaluation indicated, due to the documented physical impairments and associated functional deficits, without skilled therapeutic intervention, the patient is at risk for: falls, decreased participation with functional tasks and further decline in function . Record review of Physical Therapy Evaluation & Plan of Treatment, dated 1/8/25, revealed the resident was diagnosed with a fracture of unspecified part of neck of right femur (right hip); generalized muscle weakness; unsteadiness on feet; unspecified abnormalities of gait and mobility; other lack of coordination; and other reduced mobility with an onset date of 1/2/25. The resident's treatment approaches may have included therapeutic exercises; neuromuscular reeducation; gait training therapy; physical therapy evaluation: moderate complexity; therapeutic activities; and wheelchair management training to occur 20 times between 1/8/25 and 3/6/25. Further review of the Evaluation & Treatment Plan reflected a goal to safely perform functional transfers with moderate assistance with ability to right self to achieve/maintain balance in order to increase performance skills with functional tasks and decrease level of assistance from caregivers. The plan indicated the resident's transfers level of function prior to 1/2/25 was contact guard assist and her baseline on 1/8/25 was total dependence with attempts to initiate. A goal to complete sit to stand transfers with moderate assistance with ability to right self to achieve/maintain balance in order to increase performance skills with functional tasks, perform mobility with reduced risk of falls and decrease level of assistance from caregivers. The plan indicated the resident's sit to stand level of function prior to 1/2/25 was contact guard assist and her baseline on 1/8/25 was total dependence with attempts to initiate. A goal to increase dynamic standing balance to Poor+ spontaneously righting self when needed in order to decrease loss of balance during functional mobility, improve ability to safely ambulate within environment and reduce the risk for falls. The plan also indicated the resident's sit to stand level of function prior to 1/2/25 was contact guard assist and, her baseline on 1/8/25 was total dependence with attempts to initiate. The plan also indicated the resident's dynamic standing level of function prior to 1/2/25 was fair and her baseline on 1/8/25 was poor. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the Evaluation & Treatment Plan indicated the resident was referred to physical therapy due to decline in strength, dynamic balance, functional ambulation, functional mobility .status post hospitalization for an accidental fall and sustaining a right hip femoral neck fracture. The resident was noted to be status post right hip hemiarthroplasty (half of a hip joint replacement). The resident required skilled physical therapy services to increase lower extremity strength, improve dynamic balance, increase coordination, increase functional activity tolerance, minimize falls, facilitate improvement with all functional mobility and increase ability to ambulate in order to enhance patient's quality of life by improving ability to increase performance skills with functional tasks and perform functional mobility with reduced risk of falls. Level of Skilled Services also included need for durable medical equipment for condition and Patient with dementia requiring repetition of structured task to facilitate new learning. Record Review of Physical Therapy Discharge Summary revealed dates of service of 1/8/25-1/31/2025. The summary indicated the resident was discharged from physical therapy per physician or case manager. The resident's transfers level of function prior to 1/2/25 was contact guard assist; baseline on 1/8/25 was total dependence with attempts to initiate; on 1/28/25 was maximum assistance; and on discharge 1/31/25 was maximum assistance. The resident's sit to stand level of function prior to 1/2/25 was contact guard assist; baseline on 1/8/25 was total dependence with attempts to initiate; on 1/28/25 was maximum assistance; and on discharge 1/31/25 was maximum assistance. The resident's dynamic standing level of function prior to 1/2/25 was fair; baseline on 1/8/25 was poor; on 1/28/25 was poor; and on discharge 1/31/25 was poor. The discharge summary also indicated the resident had reached maximum potential with skilled services. Interview with the MDS coordinator on 3/13/25 at 3:44 pm, she said when she tried different interventions for residents, she referred residents to therapy. She said the Unit Manager was responsible for putting therapy services into a resident's care plan. She said facility management spoke about care plan interventions and updates during the daily morning meeting and scheduled care plan meetings. She said she was not familiar with Resident #1's current care plan. She said the risk of a resident when a care plan does not meet her needs could be another fall or injury. Several unsuccessful attempts to interview contracted Physical Therapy Director were made 3/12/25 and 3/13/25. Interview with the DON on 3/13/25 at 2:38 pm, she said she had worked at the facility for 4 weeks. She said she was not aware Resident #1 suffered 3 falls in the facility's dining room. She said the facility would consider trying different interventions if the falls indicated a pattern. She said since Resident #1 had 3 similar incidents she considered the resident's falls in the dining room a pattern. She said the risk associated with a care plan not meeting the needs of a resident was the facility not providing the care a resident required. Interview with the Administrator on 3/14/25 at 4:16 pm, she said she referred to a care plan as a 'plan of care. ' She said she was not aware the resident suffered 3 falls in the facility's dining room. She said she had only been employed with the facility for one month. She said the risk associated with a resident not having an appropriate care plan was the facility not providing adequate, appropriate care and preventative measures. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with CNA B on 3/25/25 at 10:50 AM, she said Resident# 1 could stand up and walk on her own. She said the resident rolled herself around in her wheelchair. She said the resident's physical capabilities really depended on her mood. She said the resident slept during the day and was usually awake at night. She said during the day, the resident was sometimes less responsive. She said when the resident was not in the mood during the day, she required 2 persons assist. She said when the resident was in a good mood, she was able to do most things with little to no assistance. She said since the resident came back from the hospital after she broke her hip, the resident seemed fine. She said the resident was able to stand up on her own. She said nothing had changed regarding the care she provided to the resident since she returned to the facility. She said the resident did not have any new assistive devices either. In an interview with the Unit Manager, on 3/25/25 at 11:07 AM, she said the Unit Manager and the MDS nurse was responsible for updating resident care plans. She said every time a resident fell , a new intervention was added to their care plan. She said she was familiar with Resident #1. She said the resident's baseline behavior was pleasantly confused. She said the resident had the ability to speak but did not speak very often. She said sometimes, if you asked the resident a question, she would reply with 'yes' or 'no.' She said she could not recall exactly how many times the resident suffered a fall. She said she thought the resident had suffered a fall in the facility dining room once in the past. She said she did not know how long it had been but there was a long span of time between the fall on 12/31/24 and the previous fall in the dining room. She said the resident had not suffered as many falls as others considered fall risks. She also said she knew residents had the right to fall. She said the resident was still receiving the same care as before she was sent to the hospital. She said one change that occurred since the resident fell on [DATE] was staff always had to monitor the dining room while residents were present. She said when the resident returned from the hospital, she was working with PT and OT. She said she did not know the resident had suffered three falls in the dining room. She said she did not know whether the resident's three falls in the dining room were considered a pattern due to the timeframe between each fall. She said she would have to look at the care plan to determine whether the care plan was appropriate and met the residents' needs. She said she knew the residents' previous care plan was appropriate. She said the resident's current plan did not have interventions that would prevent the resident from falling in the dining room. She said she needed to tweak the resident's care plan. She said she was not sure whether the facility was able to utilize Geri Chairs for residents. She said a Geri Chair with a tabletop was considered a restraint. She said the resident's falls were related to the resident bending down while sitting in her wheelchair and attempting to pick items up off the floor. She said she was considering getting some sort of grabber device for the resident, but the resident had one contracted hand. She said the risk associated with the resident's care plan not meeting the resident's needs was potentially another fall. In an interview with Family Member on 03/25/25 at 11:31 AM, she said she was not aware of any changes to the resident's care plan after the resident fell on [DATE]. She said the social worker would call and do a meeting when updates to the care plan were needed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the Interim Administrator, DON, and Regional Nurse on 3/25/25 at 3:17 PM, the DON said if a resident was nonverbal or unable to regularly make their needs known, she would observe the residents' facial expressions to assess for pain. She said she would consider the resident falling in the dining room three times a pattern. The DON, Interim DON and Regional Nurse all said the resident's current care plan did not meet the resident's needs by appropriately addressing the resident's pattern of falling in the facility's dining room. The DON said the care plan should have been updated on 12/31/24 with interventions to prevent future falls in the dining room. The DON said all facility nurses had been educated on all resident care plans since she began working at the facility a month ago. The Regional Nurse said facility management staff (the DON, Unit Manager, ADON if on staff, MDS Coordinator) were all responsible for reviewing resident care plans. She said if an incident occurred, the nurse responsible for providing care to the resident at the time of the incident would also be responsible for updating the resident's care plan to include the incident. The Regional Nurse said the nurse responsible for providing care at the time of the incident would be responsible for notifying facility management, so they can follow up on updates to the care plan. The Regional Nurse said care plans were also discussed during daily morning meetings, and morning meetings were standard and nothing new to facility staff. The Interim Administrator and DON said the expectation would have been for the Unit Manager and the MDS Coordinator to ensure the resident's care plan had been updated. The Interim Administrator and DON said there were interventions such as, adjusting the resident's wheelchair, the use of non-skid pads, or fall mats that the facility could put in place to appropriately address the resident's needs. 2. Record review of Resident #1's Care Plan, dated 01/25/25, revealed the resident had chronic pain. The care plan did not reveal methods to be used to assess or screen the resident for pain. However, the care plan did reveal a goal for the resident to actively participate in assessment of the resident's pain, pain management goals, and plan. Interventions included nursing staff assessing for presence of pain at frequent routine intervals; screening the resident for pain daily; assessing to determine if the resident was experiencing pain. If pain was present, conduct and document pain assessment particularly location, nature, intensity, and duration of pain. Record review of Resident#1's December 2024 Medication Administration Record (MAR) dated 12/01/2024 - 12/31/2024 revealed Resident#1 was assessed for pain: 12/31/24: pain level 0 Record review of Resident#1's January 2025 Medication Administration Record (MAR) dated 01/01/2025 - 01/31/2025 revealed Resident#1 was assessed for pain: 01/01/25: pain level 3 O1/04/25 - 01/06/25 on hold by physician 12/12/25: pain level 3 Record review of Resident #1's Order details dated 11/21/24, revealed Acetaminophen Tablet 325 MG (milligrams). Give 2 tablet by mouth every 6 hours as needed for general discomfort. Record review of a Physical Therapy Evaluation, dated 12/11/24, revealed the resident was unable to communicate pain. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with CNA B on 3/25/25 at 10:50 AM, She said the resident never verbalized pain, displayed, or indicated when she was in pain based on her behavior. She said laughter was the resident's response to verbal cues, conversation from anyone, and everything was laughter. She said the resident laughed at everything. In an interview with RN B on 3/25/25 at 12:02 PM, she said no one would know when the resident was in pain because the resident was nonverbal. She said she was not familiar with the resident's care plan. She said the resident's care plan was on the computer. She said she thought she was notified about the resident's care plan by the DON last week. She said she did not know what goals or interventions the resident was care planned for. She said she knew how to provide care to her assigned residents based on her familiarity of the resident and information she received from other nursing staff during shift report. She said she provided care to the resident as long as she had worked at the facility, so she knew how to meet the resident's needs. She said she was not aware the resident was care planned for chronic pain. She said she did not know nursing staff were responsible for assessing and documenting the residents for pain frequently. RN B was not able to provide an explanation on how she was able to tell when the resident was in pain. She said best practice for assessing pain of nonverbal residents was based on their facial expressions. She said the nursing staff may not have been specifically following the resident's care plan since she returned from the hospital, but nursing staff were closely monitoring the resident, and trying to know how the resident was feeling. She said the purpose of resident care plans was to ensure appropriate management of the resident's needs. She said there might be difficulty with nursing staff appropriately managing resident needs without care plans. She said the risk associated with not following or being familiar with a resident's care plan was a potential decline in health. In an interview with CNA A on 3/25/25 at 2:13 PM, she said she was not ever able to tell when the resident was in pain. She said it would be difficult for anyone to tell when the resident was in pain. She said the resident was a happy person and laughed at everything. She said the resident did not seem like she was in pain after she fell but was still lying on the dining room floor on 12/31/24. She said the resident did not appear to be in pain the next day either. She said the day shift CNA told CNA A the resident was not in pain and was lying in bed when CNA A began her shift. In an interview with the MD on 3/25/25 at 3:03 PM, he said the resident was prescribed pain medication due to her Arthritis diagnosis. He said the condition could have caused chronic pain for the resident. He said he was not aware of what goals or interventions the facility had care planned for the resident's chronic pain. He said if a resident was not able to verbalize pain, nursing staff should assess for pain based on facial expressions and grimacing. He said the risk associated with a resident not having an appropriate care plan was the resident not having their needs met. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the Interim Administrator, DON, and Regional Nurse on 3/25/25 at 3:17 PM, the DON said the resident's care plan appropriately addressed the resident's chronic pain. She said the resident was being assessed and monitored for pain according to the care plan. She said the resident also had a PRN order for pain medication, and if the medication was not effective, the nursing staff would notify the resident's doctor. The DON said the resident was not completely nonverbal because she randomly spoke. She said she was not aware staff responsible for providing care to the resident were not able to tell when the resident was in pain. She said if the staff were accustomed to working with the resident, they should have been able to at least recognize when something was wrong with the resident. She said nurses should also use their best judgment and use PainAd Scale to assess pain for a nonverbal resident or resident unable to verbalize their pain. She said the PainAd Scale was a pain assessment based on facial expressions. She said the facility recently began using a new electronic health record database management system. She said the new system included a PainAd scale assessment for the nurses to use for documentation purposes. She said the nurses were recently reeducated on risk management, which included training on using the PainAd scale within the electronic health record. Record review of policy titled Care Plans, Comprehensive Person-Centered, revised March 2022, revealed 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 . Policy Interpretation and Implementation: 3. The care plan interventions are derived from a thorough analysis of the information person-centered care plan: a. includes measurable objectives and timeframes; .10. When possible, interventions address the underlying source (s) of the problem area(s), not just or triggers.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46678 Based on observation, interviews, and record review, the facility failed to ensure a resident received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for 1 (Resident #1) of 4 residents reviewed for quality of care. The facility failed to perform an appropriate assessment on Resident #1 after report of an unwitnessed fall on 12/31/24 that resulted in a hip fracture that required hip surgery. The facility failed to initiate neuro checks for Resident #1 after report of unwitnessed fall. An Immediate Jeopardy was identified on 4/4/25. The Immediate Jeopardy template was provided to the facility on [DATE] at 11:26 a.m. While the Immediate Jeopardy was removed on 4/7/25, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. These failures could place residents at risk for a delay in treatment or diagnosis, a decline in the resident's condition and/or the need for hospitalization and prolonged treatment. Findings included: Record review of Resident #1's face sheet dated 3/12/25, revealed a [AGE] year-old female admitted to the facility with an initial admitted [DATE] and readmitted on [DATE]. Diagnoses included: unspecified dementia (a group of symptoms affecting memory, thinking and social abilities), Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), lack of coordination, bilateral macular keratitis (inflammation of the clear, dome-shaped tissue on the front of the eye that covers the pupil and iris), and muscle weakness. Record review of the quarterly MDS assessment dated [DATE] indicated Resident #1 had a BIMS score of 5 which indicated severe cognitive impairment. Further review of the quarterly MDS assessment indicated Resident #1 did not have pain presence in the last five days and no falls since reentry . Functional abilities substantial/maximal assistance (help does more than half the effort) for eating, oral hygiene, toileting hygiene, shower/bath, lower body dressing and personal hygiene. Record review of the discharge MDS assessment dated [DATE] indicated Resident #1 had pain presence in the last five days. The discharge MDS assessment indicated Resident #1 did not have any falls since reentry. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's care plan dated 11/25/24 did not reveal goals or interventions related to preventing the resident from falling in the facility's dining room. However, the care plan did indicate Resident #1 suffered a fall and was noted to be found sitting on the facility's dining room floor with no injuries on 9/29/23 and 9/21/24. Further review of the care plan indicated interventions included: place call bell/light within easy reach; respond promptly to calls for assist to toilet; foot ware will fit properly and have non-skid soles; provide reminders to use ambulation and transfer assist devices; keep area free of obstructions to reduce the risk of falls or injury; resident is on the fallen leaf program to indicate she is at high risk for falls. A red band will be placed on her wheelchair and leaf next to her name on the door to indicate to staff that she is a high risk for falls; PT and OT therapy to evaluate and treat as indicated. Assist resident to the dining room and have resident sit at a table; resident has been re-educated on the importance of using the call lights and waiting for help. Call light education done, bed in lowest position and brake extender on w/c. Record review of a Physical Therapy Evaluation, dated 12/11/24, revealed the reason for the resident's physical therapy referral was due to decline in strength, dynamic balance, functional ambulation, functional mobility . The resident felt unsteady when standing, when walking, had a fear of falling, and worried about falling. The evaluation indicated the resident was unable to communicate pain; and lack of pain was determined based upon the resident's behavior. The resident exhibited slow, unsteady gait with forward lean of trunk, inadequate hip extension and inadequate trunk extension which are associated with the underlying causes of muscle weakness, reduced functional activity tolerance and impaired coordination. The resident also exhibited the wide base of support, decreased rotation of hips and shoulders, decreased speed and amplitude of automatic movements, decreased step length (<15), waddling, and pushing her walker far ahead of her. Further review of the evaluation revealed weak trunk and lower extremity muscles, reduced reactive balance and reduced recognition of unsafe situations as fall predictors for the resident. The resident's Gross Motor Coordination was also noted as impaired. The resident was referred to physical therapy due to decline in functional mobility and her ability to ambulate due to muscle weakness, decreased balance and coordination and decreased functional endurance. The resident was noted to have cognitive impairment and poor safety awareness. However, she was cooperative. The resident was noted to benefit from physical therapy interventions to improve safety, decrease level of assistance in functional mobility and improve her ability to ambulate. The resident required skilled physical therapy services to increase lower extremity strength, improve dynamic balance, increase coordination, increase functional activity tolerance, minimize falls, facilitate independence with all functional mobility, increase independence with gait in order to enhance patient's quality of life by improving ability to increase performance skills with functional tasks, and perform functional mobility with reduced risk of falls. The recommended level of skilled therapy services also included the need for durable medical equipment for condition and patient with dementia requiring repetition of structured task to facilitate new learning. Further review of the evaluation indicated, due to the documented physical impairments and associated functional deficits, without skilled therapeutic intervention, the patient is at risk for: falls, decreased participation with functional tasks and further decline in function . Record review of the incident/accident report dated 3/14/25 did not reveal details of Resident#1's unwitnessed fall. However, the report indicated the resident had a witnessed fall on 12/31/24 at 7:00 pm. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's progress note dated 12/31/24 at 7:56 PM by RN A, reflected the following: in the dining room, the resident slid out of the wheelchair while attempting to pick up something on the floor. The nurse observed a skin tear to the right forearm. The head-to-toe assessment was done, noting a skin tear to the right forearm. The vital signs were 117/64, p 87, SpO2 93%, 96.9, and r 18. The MD was notified, and an order to clean the skin tear and apply a sterile strip was received. The resident denies pain. The RP and unit manager were made aware. The order was carried out to clean the skin tear with normal saline and apply a sterile strip with the dressing. PRN Tylenol was administered to avoid any complaint of pain. The resident was educated to seek assistance when in need. Safety measure in place. The plan of care remains. Record review of the progress notes dated 1/1/25 at 4:45 AM and labeled as a late entry, RN B noted the following: Resident c/o pain to her rt lower extremity. She was relieved of her pain with prn Tylenol 325 mg 2 tabs. She slept thereafter. She was kept in bed, was not taken out of bed, ate her meals in bed too. Text message sent to her MD on a new year day that evening. When am about leaving, his text message came in. Which read, X-ray of the hips and knees. Same handed over to the next shift. Record review of the progress notes dated 1/1/25 at 10:52 AM by the Unit Manager reflected the following: Vitals: T 98.1- 1/1/25 10:54 Route: Forehead (non-contact), BP 126/60- 1/1/25 10:54 Position: Sitting r/arm, P 76- 1/1/25 10:54 Pulse Type: Regular, R 18- 1/1/25 10:54, O2 98%- 1/1/25 10:54 Method: Room Air. Pain: Pain assessment interview should not be conducted. Resident is rarely/never understood. Indicators of pain: none. Pain Note: Fall of 12/31/24. Record review of the progress notes dated 1/1/25 at 2:26 PM by RN B reflected the following: Acetaminophen Tablet 325 mg, given 2 tablet by mouth every 6 hours as needed for general discomfort. Given. c/o pain at 03 level. Record review of the progress notes dated 1/2/25 at 12:57 AM by LVN B reflected the following: Per day shift nurse MD ordered a bilateral knee and hip x-ray. Due to sp fall. Record review of the progress notes dated 1/2/25 at 6:43 am by RN B reflected the following: Acetaminophen Tablet 325 mg, give 2 tablet by mouth every 6 hours as needed for general discomfort. PRN administration was: effective. Follow-up pain scale was: 1. Record review of progress notes dated 1/2/25 at 11:28 am by the Unit Manager reflected the following: x-ray company here to do x-rays to both hips. Awaiting results. Record review of the progress notes dated 1/2/25 at 1:37 pm by the Unit Manager reflected the following: X-rays results here. MD was notified of results. Orders received to be transfer to Hospital. RP aware. Record review of physician orders dated 12/1/24 reflected the following: Pain Monitoring-Assess for pain every shift with a start date of 12/1/24. Acetaminophen Tablet 325 mg-Give 2 tablets by mouth every 6 hours as needed for general discomfort with a start date of 12/1/24. Record review of Resident #1's electronic health records dated 12/31/24 to 1/2/25 did not reveal neuro checks . (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Further review of the electronic health record revealed x-ray results dated 1/2/25 indicated Resident #1 had an acute right hip fracture. Record review of the hospital clinical report dated 1/3/25 indicated Resident #1's hip x-ray showed a closed displaced fracture of right femoral neck, orthopedic surgery consulted. Observation on 3/13/25 at 2:17 PM, Resident #1 was sitting in her wheelchair in the hallway. This surveyor asked her how she was, and she smiled and started laughing. RN B came by and started speaking to her and she started laughing. Resident #1 started self-propelling herself down the hallway. Interview with [NAME] A on 3/12/25 at 2:16 pm, she said on 12/31/24 she was rolling silverware in the dining room. Resident #1 was sitting in her wheelchair facing her. [NAME] A did not see Resident #1 fall, she said she heard her fall. [NAME] A said Resident #1 hit the floor hard, it sounded like a thump. She said Resident #1 was lying on her right side and said call the ambulance family member repeatedly. [NAME] A said she could not tell if Resident #1 was in pain. [NAME] A stayed with Resident #1 in the dining room and yelled for help. She said CNA A came to the dining room and saw Resident #1 on the floor. CNA A left to get the nurses. [NAME] A could not recall the names of the nurses. [NAME] A told the nurses she did not see Resident #1 fall but heard her fall. After [NAME] A told the nurses what happened she went home. Interview with [NAME] A on 3/25/25 at 2:47 pm, she said she was at the table that was in front of the kitchen and Resident #1 was at table near the Administrator's office (approximately 15 feet). [NAME] A said she turned around saw Resident #1 on the floor. She said Resident #1 was lying on her right said, she was not crying, she kept on saying call the ambulance family member. [NAME] A said there was no one else in the dining room at that time. [NAME] A said she did not see any nurses around, so she called for help and CNA A came to the dining room. She told CNA A that Resident #1 fell . [NAME] A said for an unwitnessed fall she was trained to stay with the resident and holler for help. She said they were not allowed to leave the resident alone after a fall. Interview with CNA A on 3/12/25 at 1:57 pm, she said on the evening of 12/31/24, she heard [NAME] A calling out for help. When CNA A went to the dining room, she saw Resident #1 on the floor and [NAME] A was beside her. CNA A said she got RN A and another nurse; she could not remember who the other nurse was to look at Resident #1. She said after the nurses did their assessments, she and the two nurses got Resident #1 off the floor into her wheelchair. CNA A said she took Resident #1 to her room and put her in bed. CNA A said the resident did not show any signs of pain at that time. CNA A said when a resident had an unwitnessed fall, she was trained to get the nurse. Interview with CNA A on 3/25/25 at 2:13 pm, she said on the evening when Resident #1 had her fall she was coming from the 200 hall towards the kitchen. She heard [NAME] A calling for help. She said she saw Resident #1 on the floor by the cabinets in the dining room, lying on her right side. [NAME] A told her Resident #1 fell . CNA A said she saw a skin tear on the resident's arm. CNA A could not remember if vitals were taken. CNA A said RN A told her it was ok to get Resident #1 off the floor. CNA A said RN A and the nurse from 300 hall grabbed underneath the resident arms and she held onto the resident's pants, and they put the resident in the wheelchair. CNA A said she, RN A, and the nurse from 300 hall transferred Resident #1 to her bed. CNA A said she does not remember if Resident #1 was in pain. She said if a resident was on the floor by themselves, she would holler for help and wait for someone to respond. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview with CNA B on 3/12/25 at 2:50 pm, she said on the morning of 1/1/25, she read the morning report and saw that Resident #1 had a fall the previous night and a skin tear on her hand. CNA B said she went to Resident #1's room to get her out of bed that morning. CNA B proceeded to get Resident #1 dressed for the day. CNA B said when she put Resident #1's right leg in the pants Resident #1 said Family Member, Family Member, Family Member repeatedly and fast. CNA B said the resident sounded like she was in pain. CNA B left Resident #1 in bed and notified RN B. CNA B said she came back the next day (1/2/25) and Resident #1 was still in bed. CNA B attempted to take Resident #1 out of bed and called CNA C for assistance. CNA B said they tried moving her but Resident #1 rolled back onto her left side away from the pain. CNA B and CNA C left Resident #1 in bed and CNA C notified the Unit Manager. Interview with CNA B on 3/25/25 at 10:50 am, she said she went to Resident #1's room and said to her it's time to get up. CNA B said she put Resident #1's left leg in the pants first, then when she tried to put her right leg in the pants Resident #1 said, no Family Member, no Family Member, no Family Member. CNA B told RN B Resident #1 was in pain. CNA B thought RN B assessed Resident #1 but was not sure. CNA B said RN B told her to leave Resident #1 in bed. CNA B said Resident #1 had her meals in bed that day and checked on Resident #1 every 2 hours. CNA B said the next day on the morning of 1/2/25 she tried to get Resident #1 dressed again. CNA B said she had CNA C help her. CNA C said there was something wrong with Resident #1's leg. CNA C notified the Unit Manager. CNA B said that was the day Resident #1 had an x-ray on her leg. CNA B said for an unwitnessed fall, she was trained to stay with the resident and call for help. She said the fall would need to be reported to the nurse. Interview with RN B on 3/13/25 at 3:00 pm, she said on 1/1/25 Resident #1'a demeanor was very calm and alerted, other times she would be quiet and just look at you. CNA B told her Resident #1 was in pain. RN B took Resident #1's vitals and administered pain medication. RN B notified the MD, and the MD sent a text that evening for an order to do x-rays for Resident #1. RN B instructed the CNAs to keep Resident #1 in bed until the results of the x-rays came in. RN B said she did not know if neuro checks were conducted on Resident #1 because she was not at the facility the evening of the fall. RN B said when a resident has a fall, she would need to conduct a head-to-toe assessment, take vitals. She said she would use pen and paper to jot down anything concerning from the assessment. She said if the resident was not sensible enough to say anything, she may use illustrations like touching her arm and see if resident responds. She said she would need to notify the DON, MD, family. She said the risk to the resident if they were not properly assessed was, they could go into neurogenic shock. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview with RN B on 3/25/25 at 12:02 pm. She said on the morning of 1/1/25, CNA A told her Resident #1 had pain. RN B said she went to Resident #1's room to look at her. RN B said when she touched her leg Resident #1 looked at her. RN B said Resident #1 was lying on her back and she was not crying, she was just lying in bed. RN B said she seemed normal. She told CNA A not to move her and leave her in bed. RN B said she gave Resident #1 PRN medication for pain and tried to notify the MD by texting. RN B said she got a response back from the MD to do an x-ray of the suspected leg that evening. RN B said she handed over the order to the night shift nurse. RN B said when a resident has an unwitnessed fall, she was trained to do the assessment on the floor where the resident has fallen. She would conduct ROM by moving the arms and legs. She said if the resident had obvious pain from ROM, she would dial 911. RN B said she was trained to document incidents, assessments, ROM. RN B said when she was notified Resident #1 had pain, she did not take vitals or conduct ROM. RN B said she did not want to lift Resident #1 out of bed. She said when a resident has pain it was considered a change in condition and that was the reason why she called the doctor. RN B said she should have done a head-to-toe assessment and ROM on Resident #1 and notified the DON, family, and MD. She said the risk to the resident when ROM was not documented was not recognizing potential injury or knowing the extent of the injury. Interview with CNA C on 3/14/25 at 11:56 am, he said on the morning of 1/2/25 he went to Resident #1's room to check on her. He said when he touched Resident #1's leg she looked like she was in pain. CNA C told the Unit Manager the resident was in pain. When the Unit Manager touched Resident #1's leg Resident #1 said Family Member, Family Member, Family Member. The Unit Manager told CNA C x-rays were ordered for Resident #1. CNA C said if a resident had an unwitnessed fall, he was trained to stay with the resident and call out for help. Interview with CNA C on 3/25/25 at 12:56 pm, he said on the morning of 1/2/25 he went to Resident #1's room and said to her time to get you up. Resident #1 said no Family Member, no Family Member, no Family Member. CNA C said Resident #1 was usually not like that. He said Resident #1 normally laughs, but that day she was not laughing. He left Resident #1 in bed and told the Unit Manager there was something wrong with the resident. CNA C said the Unit Manager went to look at Resident #1. He did not know if the Unit Manager took vitals because he had to leave and take care of residents in the dining room. Interview with the Unit Manager on 3/25/25 at 11:07 am, she said she was not in the facility the day Resident #1 had her fall. She said the progress note she entered on 1/1/25 that indicated Resident #1 did not have pain was entered while she was at home and received this information form RN A's nursing note. The Unit Manager said she received a text from RN A on the evening of 12/31/24 notifying her of Resident #1's fall. The Unit Manager said she returned to the facility on [DATE] and CNA C told her Resident #1 had pain in her leg. The Unit Manager said she went to check on Resident #1 and palpated her right said and she saw the resident in pain. The Unit Manager said she called in a stat x-ray at approximately 8:30 AM. The Unit Manager said if a resident had an unwitnessed fall, she expected nursing staff to assess them right where the resident fell and not move them. She said the nurses should assess ROM by moving their arms and legs and do a head-to-toe assessment and look for skin tears. The Unit Manager said the progress note entered by RN A showed a head-to-toe assessment was documented but, RN A could have put more information in the progress note. The Unit Manager said she spoke to RN A and RN B regarding Resident #1's fall and pain. She said the Administrator probably talked to [NAME] A. The Unit Manager said she was not sure if ROM was conducted on Resident #1 because it was not documented in the progress note. She said the risk to the resident when ROM was not conducted was the resident would be bruised or fractured. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview with Resident #1's RP on 3/12/25 at 11:31 am, she said RN A notified her of Resident #1's fall in the dining room, on the evening of 12/31/24. After the fall she said CNA A and CNA B told her Resident #1 would make noises when they provided care for her or messed with her leg. The RP said a couple of days later, on 1/1/25, she was notified by the Unit Manager Resident #1's hip was broken and was getting transferred to the hospital. The RP said Resident #1 ended up having surgery at the hospital that same day. RP said an x-ray was not conducted on the night of the fall. The RP said Resident #1 had fallen out of her wheelchair at least 2 to 3 times. The RP said if Resident #1 saw an object on the floor she would lean down to pick up the object. Interview with the DON on 3/13/25 at 1:06 pm, she said if a resident had an unwitnessed fall, the nurse would need to conduct a head-to-toe assessment, ROM, anticipate whether there was a possible fracture, move the arm and pay attention for facial expressions. The DON said if the resident was unable to communicate, she would initiate calling 911. The MD, DON, and family would need to be notified and the nurse would need to complete an incident report. The DON said she asked RN A about this incident two weeks ago. The DON said the incident was reported to the Administrator, Interim DON, and the Unit Manager. The DON said the progress note regarding Resident #1's fall on 12/31/24 was not appropriately documented. The DON said if the resident was observed on the floor, staff would need to stay with the resident and call for help, and a head-to-toe assessment would need to be conducted. The DON said for all unwitnessed falls, the nurses would need to conduct an assessment and have management staff conduct an investigation to try to determine the cause of the fall. The DON said neuro checks were not conducted after Resident #1's because the fall was documented as a witnessed fall. She said if the fall was unwitnessed, neuro checks should have been conducted. She said the nurses assessed to the best of their knowledge. She said the risk of not properly assessing the resident was not providing the care the resident required. Interview with the Interim Administrator on 3/14/25 at 4:16 pm, she said no one visibly saw the fall with their eyes. She said staff were trained to go to the resident and do the assessment looking them over head-to-toe, vitals, ROM. She said you would not know if ROM was done for the resident if it was not documented, it would have to be documented in the nurse's notes. She said staff should leave the resident right where they are when conducting assessment. She said the risk to the resident when they were not properly assessed was, they could have neuro problems, fractures. She said the expectation of the nurses were to provide care for the residents. She said they should always reach out to the family and communication is the key. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 3/25/25 at 3:17 pm, with the Regional Nurse, Interim Administrator and DON. The DON said an assessment for an unwitnessed fall would have to include asking the resident if they were ok, how much pain did they have. If the resident was non-verbal, she would look at facial expressions, look over head-to-toe for any physical injuries. She said she would perform ROM, vitals, blood pressure, oxygen, temperature, pulse, and respirations. The DON said the progress note entered by RN A did not specify who notified her of the fall, did not indicate the skin tear, and did not document ROM. The progress note stated, Resident #1 denied pain, the DON said that may be possible. The DON said the progress note did indicate for Resident #1 to ask for help. The DON said when a resident has a fall, she expected the nursing staff to call her and tell her what happened so she could have the correct documentation. She said if it was a witnessed fall, she would take statements. The Regional Nurse said an unwitnessed fall is a fall that occurred when no one was present. The Regional Nurse said the risk to the resident when documentation was incorrect was delayed treatment for the resident. The DON said the risk to the resident when assessments were not conducted and the nursing staff are alerted of a resident having pain was delayed treatment, risk of further injury and increased pain. The DON said the risk to the resident when neuros were not conducted after an unwitnessed fall was not establishing a change in their baseline. Record review of the Accidents/Incidents Policy dated 07/2015 read in part . 13. A neurological assessment must be immediately initiated and maintained for at least 72 hours following each accident/incident involving an injury of any kind to the head or any un-witnessed fall . Record review of the Falls-Clinical Protocol dated 09/2012 under Section Assessment and Recognition read in part . 2. the nurse shall assess and document/report the following: vital signs, recent injury, musculoskeletal function, observing for change in normal range of motion, change in condition, neurological status, pain, frequency, and number of falls since last physician visit, details on how fall occurred, all current medications, all active diagnoses . 7. Falls should also be identified as witnessed or unwitnessed events . Further review of the Falls-Clinical Protocol under Monitoring and Follow-up read in part . 1. the staff, with the physician's guidance, will follow-up on any fall with associated injury until the resident is stable and delayed complications such as late fracture or subdural hematoma have been ruled out or resolved . Record review of the Staffing, Sufficient and Competent Nursing under Section Sufficient Staff dated 08/2022 read in part . 1. Licensed nurses and certified nursing assistants are available 24 hours a day, 7 days a week to provide competent resident care services including . c. assessing, evaluating, planning, and implementing resident care plans . Further review of the policy under section Competent Staff read in part . licensed nurses and nursing assistants are trained and must demonstrate competency in identifying, documenting, and reporting changes of condition consistent with their scope of practice and responsibilities . Record review of the Charting and Documentation Policy dated 07/2017 read in part . 7. Documentation of procedures and treatments will include care-specific details, including . c. the assessment data and/or any unusual findings obtained during the procedure/treatment . On 4/4/25 at 11:26 a.m., the Administrator was informed that an Immediate Jeopardy situation was identified due to the above failures. The following Plan of Removal was submitted by the facility and accepted on 4/4/25 at 2:50 p.m.: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675663	A. Building B. Wing	04/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fort Bend Healthcare Center	3010 Bamore Rd Rosenberg, TX 77471

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	04/04/2025 Plan of Removal F684 Impact Statement On 04/04/25, the facility was provided notification that the survey agency had determined that the conditions at the center constitute an immediate jeopardy to resident health. The facility staff failed to ensure residents received treatment and care in accordance with professional standards of practice, and the comprehensive care plan for CR#1 on 12/31/24 after she suffered a fall in the facility's dining room. The resident was reported to have complained of pain on 01/01/25. The resident was also observed to be experiencing pain 01/02/25 and an x-ray was ordered. Xray results showed a right hip fracture. The resident was transferred and admitted to the hospital on 01/02/25 where she was diagnosed with a right hip femoral neck fracture. The resident was treated with a right hip hemiarthroplasty (half of a hip joint replacement) and discharged back to the facility on [DATE]. Immediate Action: Please accept this as our Plan of Removal for the Immediate Jeopardy related to F684 Quality of Care. CR#1 was diagnosed with a right hip femoral neck