STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676170	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Dominic Village Rehabilitation and Nursing Cent	2409 E Holcolm Blvd Houston, TX 77021

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 4 out of 5 residents (Resident #2, Resident #3, Resident #4, and Resident #5), reviewed for care plans. - The facility failed to document Resident #2's fall from 8/29/25, and interventions put in place, which included a low bed, and a clutter free area.- The facility failed to document Resident #3's falls from 11/17/25 and 11/27/25, and interventions put in place, which included a low bed.- The facility failed to document Resident #4's falls from 10/22/25, 11/18/25, 11/27/25, and 12/3/25, and interventions put in place which included increased rounding, ordering labs, work up for tachycardia, a low bed, and a clutter free area.- The facility failed to document Resident #5's falls from 9/23/25 and 9/24/25, and interventions put in place which included increased toileting, HS snack, a low bed, and a clutter free area. These failures could place residents at risk for receiving delayed treatment and not obtaining/maintaining their highest practicable wellbeing. Findings included: 1. Record review of Resident #2's undated face sheet revealed he was a [AGE] year-old male, admitted on [DATE] with diagnoses of cerebral infarction (stroke), lack of coordination, dysarthria after stroke (slurred, slow, soft, or monotone speech), hemiplegia and hemiparesis affecting right side after stroke (paralysis and weakness), aphasia (trouble speaking), unsteadiness on feet, type 2 diabetes (body unable to produce insulin or resists it), muscle weakness, muscle wasting and atrophy, muscle weakness, and lack of coordination. Record review of Resident #2's Annual MDS assessment dated [DATE] revealed a BIMS score of 12 out of 15, which indicated moderately impaired cognition. The resident had an impairment on one side of his upper and lower extremities and used a wheelchair for mobility. Resident #2 was dependent (helper does all the effort and resident does none) for all ADLs and was always incontinent of bowel and bladder. The assessment indicated the resident had 1 fall since admission/entry or the prior assessment, but he did not have any injuries. He was not receiving therapy services. Record review of Resident #2's Care Plan dated 1/23/24 revealed the resident had an actual fall r/t impaired mobility on 3/27/25 with no injuries, and 8/29/25 with no injuries (Initiated 5/1/25 Revised 11/24/25. The goal was to resume usual activities without further incident through the review date (Initiated 5/1/25 Revised 12/4/25). Interventions included: continue interventions on the at-risk plan (Initiated 5/1/25), for no injuries determine/address causative factors of fall (Initiated 5/1/25), monitor/document/report PRN x 72hr to MD s/sx of pain, bruises, change in mental status, new onset confusion, sleepiness, or agitation (Initiated 5/1/25), neuro checks as ordered (Initiated 5/1/25), PT consult for strength and mobility (Initiated 5/1/25). The resident also had a low bed and a clutter free area that was not updated for the fall on 8/29/25. Record review of Resident #2's Progress Notes dated 8/29/25 at 9:13pm revealed the resident fell from his wheelchair to the floor after his shower. A CNA was in the room and witnessed it. The resident said he was trying to get his clothes that were on the sink, and he slid from his wheelchair to the floor. He did not hit his head. The charge nurse found the resident lying on his left side on the floor, facing the sink, with his gown on. Neuro checks were started, and no visible injuries were noted. Resident was assisted back to bed. Record review of Resident #2's Progress Notes dated 8/30/25 at 1:02pm revealed the resident was s/p fall day 2 and he was in his w/c propelling himself around the unit. Record review of Resident #2's Physician Orders reviewed on 12/16/25 from MD R revealed the following orders: - Falls monitoring: Keep bed low in locked position- Falls monitoring: Keep resident area clutter free In an observation on 12/16/25 at 1:58pm, Resident #2 had a low bed and a fall mat to the side of his bed. The resident was not in the room. 2. Record review of Resident #3's undated face sheet revealed she was an [AGE] year-old female admitted on [DATE] with diagnoses of Alzheimer's disease, type 2 diabetes, complete traumatic amputation at level between left hip and knee (missing left leg at thigh level), gastrostomy (tube into stomach for nutrition), muscle weakness, contracture of right ankle, muscle wasting and atrophy, lack of coordination, and atrial fibrillation (irregular heart beat). Record review of Resident #3's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 3 out of 15, which indicated severely impaired cognition. The resident was dependent for all ADLs and had an impairment on one side of her upper and lower extremities. The assessment revealed she was always incontinent of bowel and bladder. The assessment indicated the resident had had 1 fall since admission/entry or the prior assessment, with an injury that was