STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676208	A. Building B. Wing	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eagle Crest Rapid Recovery	9602 Huffmeister Rd Houston, TX 77095

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - 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** 46561 Based on observation, interview, and record review, the facility failed to provide adequate supervision and assistance devices to prevent accidents for one (Resident #1) of six residents whose records were reviewed for falls in that: Resident #1 rolled off the bed during incontinent care with x1 assistance. This failure could place fall risk residents at risk for harm and serious injury. Findings included: Record review of Resident #1's face sheet revealed a sixty-four-year-old woman who had been admitted to the facility on [DATE]. Her diagnoses were noninfective gastroenteritis and colitis (conditions that cause inflammation of the digestive tract), acute kidney failure, chronic obstructive pulmonary disease (COPD, lung disease), spinal stenosis (when the space inside the backbone is too small and places pressure on nerves), morbid (severe) obesity, reduced mobility, and need for assistance with personal care. Record review of Resident #1's care plan revealed that Resident #1 was at risk for falls related to muscle weakness, initiated on 07/29/22. Resident #1 also had an ADL self-care performance deficit related to muscle weakness and the last revision prior to 03/12/24 was on 02/16/24. Interventions at the time of 02/16/24 revealed that Resident #1 was an extensive x2 assist for bed mobility and an extensive x1-2 for toileting. On 03/12/24, the care plan indicated that Resident #1 had a fall on 10/06/23 from a hoyer lift and on 03/12/24 from the bed. The intervention initiated on 03/12/24 were falls mats to the bedside and mobility bars x2 to assist with bed mobility. Record review of Resident #1's MDS 3.0 (minimum data set, a standardized collection of demographic and clinical information that described a person's overall condition) completed 03/05/24, Section GG- Functional Abilities and Goals subsection GG0170 Mobility revealed: a. Roll left and right, the ability to roll from lying to back to left and right side and return back lying on bed: score 01. Dependent b. Sit to lying, the ability to move from sitting on side of bed to lying flat on bed: score 01. Dependent (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: 676208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/15/2024
NAME OF PROVIDER OR SUPPLIER Eagle Crest Rapid Recovery		STREET ADDRESS, CITY, STATE, ZIP CODE 9602 Huffmeister Rd Houston, TX 77095	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. Lying to sitting on side of the bed, the ability to move from lying on back to sitting on the side of the bed and with no back support: score 01. Dependent Section GG- Functional Abilities and Goals subsection GG01115- Functional Limitation in Range of Motion: a. Upper extremity (shoulder, elbow, wrist, hand): score 2. Impairment on both sides b. Lower extremity (hip, knee, ankle, foot): score 2. Impairment on both sides Record review of Resident #1's BIMS score (a test used to measure cognitive decline in resident) revealed a score of 10 (moderately impaired) on a scale that ranged from 00-15. Record review of Resident #1's fall risk evaluation dated 02/13/24 revealed a score of 11.0. This document stated If the total score is 10.0 or greater, the resident should be considered HIGH Risk for potential falls. Prevention protocols should be initiated immediately and documented on the care plan. Record review of Resident #1's progress note written by RN A on 03/12/24 at 23:58 (11:58 pm) documented: At 10:30pm heard a screaming this writer ran down 600 hall CNA came out and said, Resident #1 fell . Observed resident laying left face on the floor between her bed and roommate's bed. Her bedside table was pushed over to roommate's side. Resident complained of pain to both of her legs my knees, my knees hit the bedside table. No abrasion or laceration noted. A golf size green discoloration noted on right lower leg. Did not move resident to determine any fracture. Her left leg observed equally straight to her right leg. Asked if she ok, she screamed No, I'm not. She pushed me too far to the edge of the bed. I fell hard, I need ambulance. Resident's speech was clear and coherent. Resident pupils were equal round and reactive to light and accommodation. Certified nurse assistant (CNA) reported resident flipped over during incontinent care. Called Director of Nursing (DON), put her on the phone with resident. Offered pain medication and in house x-ray but resident insisted hospital. Followed DON instruction, this writer and her assigned CNA applied the hoyer sling, she was able to bend her legs, turned her body over gently then hoyered her back to bed. This writer stayed with her the entire time. 911 called. RP notified of the incident. Resident took Norco 5/325mG and Zofran 4mG by mouth prior to leaving facility. Resident was awake alerted oriented to person, place, time and situation at time of leaving. Resident left facility at 11:25pm per stretcher with two Emergency Medical Technicians. Record review of Resident #1's Hospital Discharge summary dated 03/13/24 at 01:49 am revealed that impressions were completed on the right and left knee, head/brain, and cervical spine. No abnormalities were found. Resident was prescribed PRN hydrocodone (opioid pain medication) and acetaminophen (mild to moderate pain reliever). Condition was stable and resident was discharged back to the facility the same day. In an observation on 03/15/24 at 11:58 am Resident #1's door to her room was closed. One aide (name unknown at the time), walked out of the room and told the surveyor that she was giving ADL care. Two gray fall mats and small bedside rails were placed at both sides of the bed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/15/2024
NAME OF PROVIDER OR SUPPLIER: Eagle Crest Rapid Recovery		STREET ADDRESS, CITY, STATE, ZIP CODE: 9602 Huffmeister Rd Houston, TX 77095	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/15/24 at 12:06 pm with Resident #1, she stated that she rolled out of the bed a few days ago and she still felt sore. She stated staff were made aware of aches and she was prescribed pain medications. She explained that during incontinent care, the CNA pushed her over too far and she went off the side of the bed. Resident #1 recalled that the fall occurred in the morning but said she was unsure. She also recalled that there was only one CNA in the room and there were no fall mats in place at that time. Since the incident, Resident #1 stated her legs hurt, had begun to bruise and she overall felt sore. The surveyor attempted to ask Resident #1 additional questions but after a long pause, she explained that she was tired, and the surveyor exited the room. Record review of the schedule book at the nursing station revealed that on 03/12/24, CNA A worked from 10pm-6am as the aide for Resident #1, CNA B was scheduled from 10pm - 6am on a different hall, and RN A was the night nurse. In an interview on 03/15/24 at 1:30 pm with CNA A, she stated that she had worked at the facility for 4-5 months on the 10 pm- 6 am shift. She stated that on the night of 03/12/24, she entered Resident #1's room to answer the call light. Upon entry, CNA A saw feces smeared all over Resident #1's sheets and she left the room to gather fresh linen so that she could perform incontinent care and a complete bed change. She explained that Resident #1 was flat on her back when she began the care, and she stood on the left side of the bed so that she could turn the resident on her right side. Once on the right, she grabbed the fitted sheet on the bed and removed it from one side and pulled it underneath the resident's body. Then she laid the resident back flat and went around to the right side of the bed so that she could roll her over on her left side. When she was on her right side, she stated that she was rocking her body and told her to keep her body composed. She continued to remove the soiled linen from the bed and before she could bring the resident back to lying flat, Resident #1 rolled off of the left side of the bed towards the roommate's bed. In further detail, CNA stated that during this time, the bed was at the height or her hips and that she had worked with Resident 1 in the past. Resident #1 was usually a one person assist and CNA A stated that she does not normally rock, but she does not hold her weight. She explained that to her, Resident #1 was in the middle of the bed and not the edge. CNA A stated that when the resident fell , her upper body fell first and she immediately got RN A, who was working the 6 pm- 6 am shift that night. When Resident #1 fell there was no blood, but she yelled out in pain and said it was coming from both of her legs. Eventually the resident was sent out to the hospital but initially, she said that she did not want to and then she changed her mind later during the conversation. CNA A stated that the last in-service she attended on falls was 2 months prior. On 03/15/24 at 1:48 pm, an attempted call was made to RN A. The attempt was unsuccessful and a voicemail requesting a call back was left. In an interview on 03/15/24 at 1:50 pm with the DON, she stated the statement she got from CNA A explained that Resident #1 had fallen out of the bed while she was being changed because the resident was rocking. While on the ground, RN A assessed the resident, and no bruising or hematomas were noted. Resident #1 had complete motion of her legs and arms and initially requested pain medication. She eventually was sent out to the hospital for further analysis. The DON stated that Resident #1 was a 2 person assist for the hoyer life and 1 person assist for bed mobility. At night, the nurses oversee the care staff, however, she is on call 24/7. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676208	A. Building B. Wing	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eagle Crest Rapid Recovery	9602 Huffmeister Rd Houston, TX 77095

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/15/24 at 4:05 pm with CNA B, she stated that she worked at the facility for 2 years and worked from 6 pm- 6 am on 03/12/24. CNA B said that after Resident #1 fell , she came to the resident's room to assist. She entered the room [ROOM NUMBER] minutes after the initial fall and she that Resident #1 was lying parallel on the floor on her stomach, in between Bed A and Bed B. She stated that from her understanding of the fall, Resident #1 came forward to the side of the bed too much, lost control, and fell off the bed. CNA B had worked with Resident #1 in the past as her aide and she was a resident who relied on staff quite a bit. She stated that Resident #1 was a bigger woman, and she was a hard resident to work with for a change due to her size. She described her as a little bit of deadweight during the change, but also, if aides were trying to guide her a certain way, she did not think that she could always track them. CNA B explained that she thought she could rock somewhat, but it was not to where she was incapable being changed. CNA B expressed that she felt Resident #1 was a harder resident during incontinent care and she would make sure she was extra careful whenever she provided care. When asked to describe the amount of assistance Resident #1 needed during ADL care, she stated that aides were completely in control of her lower body, but she would move her arms to an extent and would consider her to have full range of motion. In an interview on 03/15/24 at 04:23pm with CNA C, she explained that she when she had to provide incontinent care for Resident #1, she was cooperative, but she normally would ask another aide for assistance. She explained that Resident #1 was dead weight, and she would have to physically push her on her side to change her. As of lately, Resident #1 would hold on the rails attached to her bed, but before they were added this week, she would not hold on to anything. In an observation on 03/15/24 at 4:29pm, CNA C put on a pair of gloves and laid Resident #1 down flat in the bed. CNA C told the resident what she was going to do, and she turned the resident to her left side on the bed. CNA C stated, you have to hold her up with one hand to change her and Resident #1 grabbed the rail on the left side of the bed with both hands for stability. In a follow up interview on 03/15/24 at 4:33 pm with Resident #1, she stated that the CNA had her too far on the edge of the bed and when she pushed her over, she fell off. She stated she did not tell the CNA that she was too far over because everything happened so fast and before the fall, she did not have side rails to hold onto and would hold onto nothing. In an interview on 03/15/24 at 4:33 pm with CNA D, she explained that Resident #1 could sometimes be dead weight, but it depended on her mood. She stated that she advised all new employees to perform incontinent care with 2 people because she was kind of difficult to work with during ADL's. When asked if Resident #1 moved around during incontinent care, she stated that she did not move around a lot because she was scared of falling, however, she did move around a lot in the past, but it had been several months since then. When asked if she was in the center of the bed, how could she roll herself off the bed, CNA D stated that there would be no way. Resident #1 could move her arms, but she could not move her back. In an interview on 03/15/24 at 5:01 pm with the DON, she stated that Resident #1 needs were dependent on her mood. If she would like to sit up, she would need two people, for bed mobility, she only required one person. She stated that the harm in a staff member no providing proper assistance with ADL care could be staff causing harm to themselves or to the resident. CNA A had been retained by the therapy department and was written up after this incident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676208	A. Building B. Wing	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eagle Crest Rapid Recovery	9602 Huffmeister Rd Houston, TX 77095

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility all staff in-service on Falls dated 01/25/24revealed that CNA A was in attendance. Record review of facility's in-service on bed mobility and transfers dated 03/13/24, revealed CNA A was the only aide in attendance. Record review of CNA A's Nurse aide Orientation dated 10/09/23, revealed CNA A was checked off to have successfully completed training on falls, transfers, and facility policy. No policy's provided were suitable for use in this tag.