STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676382	A. Building B. Wing	08/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Falcon Ridge Rehabilitation	149 Klattenhoff Lane Hutto, TX 78634

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 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** 42949 Based on record review and interview, the facility failed to develop a base line care plan that included the instructions needed to provide effective and person-centered care of the resident, for one Resident (Resident #2) of four residents reviewed for base line care plans. The facility failed to timely and accurately assess resident's care plan needs. 1. Resident #2's baseline care plan problem start dates and approach dates for Residents #2's were dated 22 days and 21 days, respectively, prior to her admission to the facility. 2. Resident #2's care plan failed to address her preferred language, incontinent care, delirium, cognitive loss/dementia, activity preferences, and communication needs. 3. The care plan failed to address that Resident #2's functional abilities and goals reflected the use of the mobility device walker, and not a wheelchair. These failures could affect all residents by placing them at risk for not receiving care and services to meet their needs. Findings included: Review of the undated face sheet for Resident #2 reflected an [AGE] year-old female admitted to the facility on [DATE] with diagnosis of wedge compression fracture of first lumbar vertebra, need for assistance with personal care, unsteadiness on feet, abnormalities of gait and mobility, repeated falls, chronic pain syndrome, and cognitive communication deficit. Review of the admission MDS assessment for Resident #2 dated 07/05/24 reflected a BIMS score of 0, indicating severe cognitive impairment. MDS revealed the following information: Resident #1's preferred language was Spanish. Section B hearing, speech, and vision revealed unclear speech slurred or mumbled words. Resident #1 makes herself understood, is usually understood, has difficulty communicating some words or finishing thoughts, but is able if prompted or given time. (continued on next page)

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Acute onset mental status change reflected behavior usually present that does not fluctuate - disorganized thinking and altered level of consciousness. Section F - preferences for customary routine and activities reflected Resident #1 had preferences for her routine and activities. Section GG - Functional Abilities and Goals reflected mobility device - walker. Bowel incontinence reflected Resident #1 was frequently incontinent. Section V Care Area Assessment triggered the following care areas: Delirium Cognitive loss/dementia Communication Urinary Incontinence and indwelling catheter and Mood State Review of the baseline care plan, category problem, for Resident #2 dated 06/05/24 reflected the following: resident was a new admission, admitted from a local hospital status post fall. The resident's baseline care plan would be developed within 48 hours. Edited 07/27/24. Review of Resident #2's approach to problem start dated: 06/05/24 reflected dehydration risk - provide adequate fluids, determine likes/dislikes; created 06/06/24. Review of Resident #2's approach to problem start dated: 06/05/24 reflected no elopement risk; created 06/06/24. Review of Resident #2's approach to problem start dated: 06/05/24 reflected minimize falls, encourage use of call light, orient to room, and safety devices; created 06/06/24. Review of Resident #2's approach to problem start dated: 06/05/24 reflected pain management monitor pain, verbal/descriptor, location: back treatment - see physicians orders; created 06/06/24. Review of Resident #2's approach to problem start dated: 06/05/24 reflected ambulation device: wheelchair; created 06/06/24. Review of Resident #2's approach to problem start dated: 06/05/24 reflected activity preference - activity preferences were left blank; created 06/06/24. Review of Resident #2's approach to problem start dated: 06/05/24 reflected continent of bowel and bladder; created 06/06/24. Review of facility fall incident detail report dated 06/25/24 - 08/25/24 reflected: (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	07/05/24 location - patient's room, type of incident - fall witnessed, secondary injury - no apparent injury, physician notified - no, transfer to hospital/emergency - no, care planned - no 08/20/24 location - TV room, type of incident - found on floor, secondary injury - no apparent injury, physician notified - no, transfer to hospital/emergency - no, care planned - yes 08/22/24 location - patient's room, type of incident - found on floor, secondary injury - no apparent injury, physician notified - no, transfer to hospital/emergency - no, care planned - yes Review of Resident #2's care plan revealed no revised care plan for the resident's falls on 08/20/24 and 08/22/24. In an interview on 08/25/24 at 2:56 pm, Resident #2's family member was asked if it was alright to speak with Resident #2. The family member replied, do you speak Spanish? In an attempted interview on 08/25/24 at 4:17 pm with HHSC contractor interpreter via phone with Resident #2 revealed resident was not interviewable. Observation on 08/25/24 at 4:17 PM revealed a fall mat was not next to Resident #2's bed. An interview on 08/25/24 at 4:54 pm with the Administrator revealed Resident #2's care plan was not up to date. The care plan was in place to document and to know the resident's specific needs. It was the outline of all the facility's needs to do to care for the resident. The Administrator stated that they were short staffed and did not currently have an MDS coordinator, the MDS coordinator would be the person in charge of making sure assessments were accurate and the care plan was dated correctly. Review of the facility's care plan process, person-centered care, dated 2023, reflected the facility will develop and implement a baseline and comprehensive care plan for each resident that includes the instructions needed to provide effective and person-centered care for the resident that meet professional standards and quality of care. Person centered care means the facility focuses on the resident as the center of control and supports each resident in making his or her own choices. Person centered care includes trying to understand what each person is communicating, verbally and nonverbally, identifying what is important to each resident with regard to daily routines and activities, and understanding the resident's life before coming to reside in the nursing home. Procedures; Develop and implement the baseline person centered care plan within 48 hours of residence admission. The baseline person centered care plan will include the minimum health care information necessary to properly care for the resident including, but not limited to initial goals based on admission orders, resident goals, position orders, dietary orders, therapy services, social services and PASARR recommendation, if applicable the baseline person centered care plan summary includes immediate resident needs. The person-centered care plan includes date, problem, resident goals at admission and desired outcomes, time frames for achievement, interventions, discipline specific services and frequency.

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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** 46708 Based on interview and record review, the facility failed to ensure the residents environment remained as free of accident hazards as is possible and ensure each resident received adequate supervision for one (Resident #1) of three residents reviewed for accidents and hazards. 1. The facility failed to ensure Resident #1's care plan, which called for floor mats to be on the floor at her bedside, was followed. No fall mat was observed beside Resident #1's bed. 2. The facility failed to prevent Resident #1 from sustaining a fall in her room and fracturing her left wrist. This deficient practice could affect residents by contributing to falls with injury, hospitalization , and death. The findings were: Review of the undated face sheet for Resident #1 reflected a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of fracture of unspecified part of neck of right femur, subsequent encounter for closed fracture with routine healing, metabolic encephalopathy (a problem in the brain), anxiety disorder due to known physiological condition, dementia, mild, with agitation, anorexia, fracture of the lower end of right radius (part of two joints: the elbow and the wrist), initial encounter for closed fracture, and repeated falls. Review of the admission MDS assessment for Resident #1 dated 05/19/24 reflected: BIMS score of 3, indicating severe cognitive impairment. Section GG - Functional Abilities and Goals reflected impairment on both sides - lower extremity (hip, knee, ankle, foot). Mobility Devices - wheelchair. Any Falls Since Admission/Entry or Reentry or Prior Assessment, whichever is more recent - No Recent Surgery Requiring Active SNF (skilled nursing facility) Care - yes, repair fractures of the pelvis, hip, leg, knee, or ankle Review of Resident #1's care plan reflected the following: Problem start date: 03/07/24 category pain - Resident #1was at risk for pain related to fall with fracture, impairment mobility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Problem state date: 03/07/24 edited 08/16/24 category falls - Resident #1 is at risk for falling related to impaired mobility, vascular dementia, and history of falls. Approach - low bed with floor mat on both sides dated 03/21/24. Review of facility's fall incident detail reports for Resident #1 dated 06/25/24 - 08/25/24 reflected: 07/07/24 location - patient's room, type of incident - found on floor, secondary injury - abrasion skin tear, location of injury - back of right elbow, physician notified - no, transfer to hospital/emergency - no, care planned - no 07/12/24 location - patient's room, type of incident - witnessed fall, secondary injury - skin tear, location of injury - lower left arm, left upper leg, and right lower leg, physician notified - no, transfer to hospital/emergency - yes, care planned - no 08/16/24 location - patient's room, type of incident - found on floor, secondary injury - fracture, location of injury - left wrist, physician notified - no, transfer to hospital/emergency - yes, care planned - yes Review of Resident #1's progress note dated entered by LVN A dated 08/16/24 reflected resident's roommate notified this nurse that her roommate was on the floor. Upon entering resident room, resident observed on floor in her supine position by the roommate bed. Resident stated 'I came back from the bathroom, and I was trying to transfer from chair to bed and fell on the floor'. Wheelchair was next to the bed lock. Call light was within reach. Head to toe assessment done, noted small laceration on left hip and left wrist swollen. Assisted resident to the bed. Range of motion done to all extremities. Resident complained of pain on left wrist. Administered as needed pain medication. Notified hospice nurse and neuro check initiated. Attempted interview on 08/25/24 at 4:05 pm with Resident #1 revealed she was not interviewable. An interview on 08/25/24 at 4:15 pm with LVN A revealed she was notified by resident's roommate that Resident #1 fell . Resident #1 said she went to the restroom then tried to transfer from the wheelchair to the bed and fell . LVN A revealed Resident #1's wheelchair was not locked. LVN A revealed there was no floor mat on the floor, and they needed a floor mat. She revealed Resident #1 fell by her bed and a floor mat would have helped her during her fall. LVN revealed she did not see any floor mat; Resident #1 had never had a floor mat in her room. Observation on 08/25/25 at 4:15 pm revealed LVN A looked all around and in the closets, and in Resident #1's room, but did not locate a mat. An interview on 08/25/24 at 4:07 pm with LVN B revealed she often took care of Resident #1 and Resident #1 was next to the bed when she fell . She revealed Resident #1 had fall interventions, but she did not see the fall mat in the room when Resident #1 fell and could not recall the last time she saw the fall mat. She revealed it was a problem that that intervention was not there because Resident #1 tried to get up, and she was not in the right mind to know her limitations. LVN B thought the fall mat was a great thing when Resident #1 was in the bed because she had a history of falls and a history of injury, so it was important for interventions to be in place. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 08/25/24 at 4:45 pm with the Administrator revealed Resident #1 was care planned for a mat beside her bed. The care plan was in place to document and to know the resident's specific needs. It was the outline of all the facility needed to do to care for the resident. Review of the facility's Fall Management policy dated 2023 reflected the facility will identify each patient/resident who is at risk for falls and will plan care and implement interventions to manage falls. Qualified staff will complete the fall risk evaluation to determine if patient/resident is a fall risk. The fall management program includes education for staff and creative, functional strategies while recognizing patient/rights and highest practicable level of function. The care plan reflects individualized interventions that are reassessed and revised as needed.