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	12/18/2024

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38073 Based on observation, interview, and record review, the facility failed to protect the resident's right to reside and receive services in the facility with reasonable accommodation of needs and preferences for 1 of 8 residents (Resident #1) reviewed for accommodation of needs. The facility failed to ensure Resident #1 could access his call button on 12/18/24. This failure placed residents at risk of not being able to call for help if they need it. Findings included: Review of the undated face sheet for Resident #1 reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included history of traumatic brain injury, muscle wasting and atrophy (loss of muscle mass and tissue), cognitive communication deficit, and contracture of muscle in both upper arms. Review of the annual MDS assessment for Resident #1 dated 12/09/24 reflected a BIMS score of 14, indicating intact cognitions. It reflected he was completely dependent on staff for transfers from bed to chair. Review of the care plan for Resident #1 dated 10/25/24 reflected the following: Category: Falls [Resident #1] is at risk for falling R/T impaired mobility, TBI, medications. Resident will remain free from major injury until next review. Scoop mattress place due to fall. Keep bed in lowest position with brakes locked. Keep call light and reach at all times. Observation and interview on 12/18/24 at 11:03 AM revealed Resident #1 calling out from his room Hey! Hey! Upon entering his room, he stopped calling out. He was lying in bed, and both hands and arms had severe contractures (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to restricted joint mobility). His elbows were bent and hands resting on both shoulders. His call button was not visible on the bed. The call button, which was a flat pad as opposed a small button, was hanging towards the floor at the head of the bed. The cord was wrapped around the mobility bars at the head of the bed several times. Resident #1 stated he could not move his arms to reach the call pad, but it would not matter, because it did not work. A test of the call pad revealed the light outside Resident #1's room did not go on. (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: 676382	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2024
NAME OF PROVIDER OR SUPPLIER Falcon Ridge Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 149 Klattenhoff Lane Hutto, TX 78634	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/18/24 at 11:11 AM, LVN A stated she did not know why the call button was not in reach and did not know that it was not working. LVN A stated it she was the nurse in charge of Resident #1, but it was not her who wrapped the cord around the mobility rails. LVN A stated she was trying to untangle the call pad from the mobility rails, but it was difficult and was taking some time. She stated the call pad should have always been placed in reach of Resident #1's hands. She stated Resident #1 was able to use the call pad and regularly used it. She stated there was no definite way that she ensured the call system was working and that aides placed the call buttons within reach of residents when they left resident rooms. Observation on 12/18/24 at 11:15 AM revealed an alarm emitting from a telephone/call system switchboard at the nurse's station closest to Resident #1's room. A display on the telephone/call system switchboard had the words Cord Out [Resident #1's room]. During an interview on 12/18/24 at 01:30 PM, CNA B stated the call button not being accessible to Resident #1 was her fault, because she liked to get it way out of the way when she repositioned him, which she did once an hour. She stated he used the call pad frequently, but he also hollered out her name often to get her attention. She stated she wrapped the cord around the mobility rails to get it out of the way, and then while she was helping him, someone called out to her that one of her other residents was trying to get out of bed, so she ran out, intending to come back and finish setting Resident #1 up with all his accommodations but forgot. CNA B stated she and Resident #1 had a good relationship, and she felt very bad that she did not put the call pad back within reach. During an interview on 12/18/24 at 03:28 PM, the DON stated it was her expectation that call buttons would be given to the residents when staff left the rooms. She stated a potential negative outcome was that a resident could fall trying to get up when no one came to help them. She stated another potential negative outcome might be pain not being addressed. During an interview on 12/18/24 at 03:53 PM, the ADM stated call buttons should have been within reach at all times especially for residents with reach issues and mobility issues such as Resident #1. The Adm stated a potential negative outcome was needing incontinent care and having skin breakdown. Review of facility policy dated 05/05/23 and titled Call Lights, Responding To reflected the following: Policy: the staff will respond to call lights or other requests for assistance to meet the patient's/resident's needs. Procedures: 6. When leaving the patient or resident room, ensure the call light is placed within the patient's/resident's reach.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38073 Based on observation, interview, and record review, the facility failed to ensure a resident received care, consistent with professional standards of practice, to prevent pressure ulcers for 1 of 8 residents reviewed for prevention of pressure ulcer. The facility failed to ensure Resident #2 received weekly skin assessments in accordance with his care plan. This failure placed residents at risk of pressure ulcers going untreated. Findings: Review of the undated face sheet for Resident #2 reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included spastic quadriplegic cerebral palsy (a form of cerebral palsy that affects both arms and legs and often the torso and face), unspecified contracture of muscle, and muscle wasting and atrophy (loss of muscle mass and strength). Review of the admission MDS assessment for Resident #2 dated 10/07/24 reflected a BIMS score of 12, indicating moderately impaired cognition. It reflected he was frequently incontinent of bladder. There were no skin issues identified in the MDS. Review of the care plan for Resident #2 dated 10/15/24 reflected the following: Category: Pressure Ulcer/Injury [Resident #2] is at risk for Pressure Injury related to: impaired mobility, incontinence. Resident's skin will remain free from major injury until next review. Encourage fluids to maintain hydration. Licensed Nurse to complete skin assessment weekly. Registered Dietician to assess nutritional status and make recommendations. Reposition resident as needed per tolerance. Review of weekly skin check assessments for Resident #2 from 10/07/24 to 12/18/24 reflected one conducted on 10/10/24 and no subsequent assessments. Review of the most recent shower sheet for Resident #2 dated 12/11/24 reflected he received a bed bath and had no new skin problems. Review of nursing progress notes for Resident #2 dated 12/17/24 at 02:36 PM and documented by the TXN reflected the following: Noted circular rash with crusts on the edges to chest, notified NP, received verbal order from Np to apply antifungal ointment to affected area Q shift. RP notified. Observation and interview on 12/18/24 at 11:52 AM revealed Resident #2 in a customized manual wheelchair (a highly personalized mobility device designed to meet the specific needs, preferences, and lifestyle of the user) talking with the DON. He introduced himself and stated he loved it here and everyone treated him well. He stated he was not in any pain and had no skin problems to his knowledge. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/18/24 at 03:01 PM, the TXN stated she was responsible for the skin breakdown prevention program at the facility. She stated individual charge nurses were responsible for weekly skin assessments. She stated she had just learned the weekly skin assessments were not conducted for Resident #2, and the assessments should have been conducted. She stated she was not sure of the system in place to monitor to ensure that skin assessments were done. She stated she assessed Resident #2's skin yesterday and did catch a rash on his chest which now had treatment in place. She stated they tracked the shower sheets very closely and had recent shower sheets for Resident #2 that showed no new skin issues. She stated the weekly skin assessments were important because they were conducted by a licensed nurse, unlike the shower sheets which were conducted by CNAs. The TXN stated she had done the skin assessment on Resident #2 the day prior as part of her program to oversee incontinent care. She stated she had been observing the CNAs perform incontinent care on Resident #2, noticed a rash, and did a complete skin assessment. She stated the rash was the only problem she noted. She stated a potential negative outcome of not doing the skin assessments over two months was they could fail to find skin problems on time, and they could develop to something more serious. During an interview on 12/18/24 3:28 pm, the DON stated the nursing team was heavily involved with Resident #2. She stated the staff were trained on the policy and procedure, and the skin assessments should have been conducted weekly after the first one 10/10/24. She stated they also relied on shower sheets, which were entered into the EMR and tracked by licensed nurses. She stated potential negative outcomes of not doing skin checks were tissue breakdown and unknown skin tears or bruising. During an interview on 12/18/24 at 03:53 PM, the ADM stated skin assessments should have happened at least weekly. He stated his team were freaking out about Resident #2's skin assessments not being done and wondering how it could have fallen through the cracks. The ADM stated a potential negative outcome of skin assessments not being done was skin breakdown. Review of facility policy dated 06/01/15 and titled licensed nurse skin checks reflected the following: all patients/residents will have a thorough weekly skin evaluation performed by a licensed nurse. Weekly, the licensed nurse performs a head-to-toe check of the patient's/resident's skin, paying particular attention to: a. The surfaces of the skin that come in contact with the bed and chair; b. Bony prominences (heel, tailbone, shoulder blades, elbows, back of the head, etc.); c. The surfaces of the skin that come in contact with our orthotic device, tube, brace or positioning device, d. Skin folds.