

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 10/23/2025
NAME OF PROVIDER OR SUPPLIER Falcon Ridge Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 10/23/2025
NAME OF PROVIDER OR SUPPLIER Falcon Ridge Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure each resident received adequate supervision and assistance devices during a mechanical lift transfer for 1 of 5 residents (Resident #1) reviewed for accidents. The facility failed to ensure Resident #1 was transferred per mechanical lift by two people. CNA A transferred Resident #1 from his bed to his motorized wheelchair without the assistance of another person. This failure could place the residents at risk of not receiving the care and services to meet their needs and puts them at risk for injury. Findings included: Review of an undated face sheet for Resident #1 reflected a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included cerebral palsy (a neurological condition that affects movement and posture, caused by abnormal brain development or damage to the brain, often occurring before or during birth.), hemiplegia, affecting the right dominant side (Hemiplegia is a symptom that involves one-sided paralysis. Hemiplegia affects either the right or left side of your body.), and , borderline intellectual functioning (refers to cognitive abilities that fall between average intellectual functioning and intellectual disability, typically characterized by IQ scores ranging from 71 to 84.). Record review of Resident #1's Minimum Data Set, Significant change in status assessment, dated 11/01/25, reflected a previous BIMS score of 15, which indicated no cognitive impairment. Record review of Resident #1's Quarterly Minimum Data Set Assessment, dated 09/05/25, reflected a BIMS score of 15, which indicated no cognitive impairment. Section GG Functional Limitation in Range of Motion reflected an impairment in bilateral (both left and right side) upper and lower extremities. Section GG further reflected Resident #1 used a an electric scooter for mobility and required the assistance of 2 or more helpers to complete activities of daily living, including chair/bed-to-chair transfers. Record review of Resident #1's Care Plan, dated 10/23/25, reflected the following: *Problem: ADLs Functional Status/Rehabilitation Potential - Resident #1 prefers to be out of bed daily by 9:00 AM. Resident #1 requires assistance with activities of daily living related to cerebral palsy, limited mobility, and debility. *Goal: Resident to be out of bed daily by 9:00 AM. He will maintain a sense of dignity by being clean, dry, and odor-free and well-groomed. *Approach: Resident #1 to be transferred from bed-to-chair and chair-to-bed with the assistance of two people and a mechanical lift. An interview on 10/23/25 at 3:19 PM with Resident # 1 revealed in the morning of 10/19/25, CNA A used the mechanical lift by himself to transfer him from his bed to his motorized wheelchair. Resident #1 stated this made him feel unsafe. He stated he knew what the rules were, and that staff were supposed to do mechanical lift transfers with two people assisting. Resident #1 stated he had not fallen from the mechanical lift, nor had he been injured during the one-person mechanical lift transfer on 10/19/25. Resident #1 revealed after breakfast on 10/19/25 he had gone outside, and as he was moving along the sidewalk he fell to the left side onto the pavement and on his face. Resident #1 stated and demonstrated to this writer how the strap of his blue mechanical lift vest had gotten tangled in the left wheel of his motorized scooter. Resident #1 stated he had just returned from an orthopedic appointment, and the doctor told him he no longer needed to wear a left arm sling. He stated he had injured his left shoulder when he slid out of his motorized scooter in the morning of 10/19/25. An observation on 10/23/25 at 3:19 PM of Resident #1 revealed he was clean and well-groomed and was seated in his motorized scooter with his blue mechanical lift vest in the seat underneath him. The straps of the vest were tucked in. An interview on 10/23/25 at 3:49 PM with Resident #1's RP revealed the facility had left a message for her on 10/19/25 around 8:30 AM. She stated they informed her Resident #1 had gone outside after his breakfast and had fallen from his scooter. She further stated if you talk with Resident #1, he will tell you that a strap had gotten caught in the wheel of his power scooter wheel, and that was what made it tip over and he had slid out of it an onto the ground. The RP stated she had not been aware of Resident #1 being transferred in the mechanical lift in the morning of 10/19/25 by one staff member. Review of a progress note dated 10/19/25 at 9:15 AM reflected LVN A was informed Resident #1 had fallen outside the building at approximately 8:15 AM. Upon arrival to the scene, LVN A observed Resident #1 lying face down on the ground with his scooter next to him with his right arm positioned next to his right side and his left arm was pinned across his chest. A small amount of blood was noted on the right hand. Resident #1 sustained skin tears on tip of his right hand and facial area. He was alert and oriented times 4. EMS was called; advised not to move resident until EMS arrival due to possible fracture. The ADM, the DON, and the ADON were notified via text and phone calls. The RP was notified and LVN A spoke to the RP. Resident #1 was sent to the hospital on [DATE] at</p>		

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 10/23/2025
NAME OF PROVIDER OR SUPPLIER Falcon Ridge Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals are stored in locked compartments and only authorized persons have access to the keys for 1 of 3 medication carts (MC #1) reviewed for drug storage and labeling. The facility failed to ensure MC #1, was locked, medications secured, and not accessible to other staff, residents, or visitors. This failure could place residents at risk of having unauthorized access to medications, decreased effectiveness of medication, or missing medications. Findings included: During an observation on 12/11/2025 at 8:24a.m., MC #1, was on 100-hall and unlocked. RN A was not on the hall while the medication cart was unlocked. MC #1 contained residents' prescription drugs, over the counter medications, and narcotics in a locked box in the medication cart. During an interview with RN A on 12/11/2025 at 10:02a.m., she said she had been trained on medication storage. She said the policy was staff must lock the medication carts any time the medication cart was out of the staff member's sight. She said if staff stepped away or turned their back the staff member was supposed to lock the medication cart. She said the person who was assigned to the medication cart at that time was responsible for ensuring it was locked. She said if left unlocked and unattended another nurse can get into the medication cart, or a resident and family member could get into the cart and take medications. She said everyone monitored to ensure that the medication carts were locked. She said staff monitored the medication carts through observation. She said she left the medication cart unlocked because a resident's lips were turning blue in the dining room and she ran to get her blood pressure cuff and forgot to lock the medication cart. During an interview with the ADON on 12/11/2025 at 1:19p.m., she said she had been trained on medication storage. She said the policy was if the medication cart was out of sight of staff it should be locked. She said the person who was on the medication cart was responsible for ensuring the medication cart was locked. She said all staff monitored to ensure staff were locking the medication cart. She said staff monitored by doing observations. She said if the medication cart was left unlocked and unattended anyone could get into the medication cart and access the medications. She also said the medication could get into the wrong hands and cause a drug diversion. She said all managers monitor to ensure the medication carts were locked. She said the managers monitored day to day by observations. She said that RN A had a situation in the dining room and forgot to lock the medication cart when she got her blood pressure cuff. During an interview with the ADM on 12/10/2025 at 1:30p.m., she said she had been trained on medication storage. She said the policy on the medication cart was that the medication cart should be locked any time staff walk away from the cart. She said the person on the cart was responsible for locking the cart. She said if the medication cart was left unlocked and unattended someone could get into the medication cart and steal medications, or a resident can get into the cart and have an adverse reaction. She said all the managers monitored to ensure staff were locking the carts. She said the managers monitored through observation. She said RN A did not lock the medication cart due to having an emergency and forgot because she was rushing back to the resident. Record review of Medication Labeling and Storage Policy dated 4/2019, revealed The facility stores all drugs and biologicals in a safe, secure, and orderly manner. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light, and humidity controls. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals are locked when not in use.</p>		