STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676412	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fall Creek Rehabilitation and Healthcare Center	14949 Mesa Dr Humble, TX 77396

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47277 Based on observations, interviews, and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident medical, nursing, mental, and psychosocial needs, for 1 (CR #1) of 5 Residents reviewed for care plans in that: The facility failed to develop a comprehensive person-centered care plan for CR #1 to address the risk for falls. This failure placed residents who were fall risk at risk of serious harm and injury. An Immediate Jeopardy (IJ) was identified on 1/16/2025. The IJ template was provided to the Administrator and DON on 1/16/2025 at 3:45pm. While the IJ was removed on 1/18/2025 at 1:11 p.m., the facility remained out of compliance at a severity of no actual harm with potential for more than minimal harm that is not an immediate jeopardy and a scope of pattern, due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at an increased risk of decline, and diminished quality of life. Findings included: Record review of CR#1's face sheet dated 12/14/24 reflected a [AGE] year-old female with an original admitted [DATE] and re-admission 1/12/25. Her diagnoses included: Alzheimer's/Dementia (Mental Decline), Hypertension (blood pressure is high) and coronary artery disease (the heart is not receiving enough oxygen and could lead to heart attack). Record review of CR#1's Orders dated 1/1/25 - 1/31/25 revealed CR#1's Meclzine HCI oral tablet 12.5 mg given in the morning for dizziness and was discontinued 1/14/25; Lactulose Encephalopathy Oral Solution 20 GM-Give 30ml by mouth one time a day for maintain ammonia levels**Do not hold for loose stools** order date 9/5/2024 at 1:07pm and D/C Date 1/8/2025 at 2:36pm; Lactulose Encephalopathy Oral Solution 20 GM-Give 30ml by mouth two times a day for maintain ammonia levels**Do not hold for loose stools** order date 1/8/2025 at 2:36pm and D/C Date 1/11/2025 at 5:06am Lactulose Encephalopathy Oral Solution 20 GM/30ML (Lactulose) Give 30ml by mouth three times a day for elevated Ammonia Level- Order date -Date 1/11/2025 at 5:08am and D/C Date 1/14/2025 (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

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR#1's completed Quarterly MDS assessment dated [DATE] and completed 11/11/24, reflected CR#1 had a BIMS of 6 which suggest severe cognitive impairment. She used a walker for mobility. CR#1 requires supervision or touching to sit to stand, chair/bed-to-chair transfer, toilet transfer, tub/shower transfer, walk 10 feet, walk 50 feet with two turns, walk 150 feet. B1000 [Vision] - revealed CR#1 has adequate vision - see fine detail, such as regular print in newspapers/books. J1900 - revealed CR#1 had two or more falls since admission with no injury. Record review of CR#1's care plan dated 11/13/24 revealed the following care areas: Problem: [CR#1] is cognitively impaired and has problems with short term, long term, impaired ability to understand others, and impaired ability to make daily decisions Alzheimer's, Dementia. Goal: [CR#1] staff will assist daily due to cognitive loss during the next 90 days. Target Date: 11/18/2024. CR#1 needs will be met and dignity will maintained through the next review. Target Date: 11/18/2024 Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. Ask yes/no questions in order to determine the resident's needs, Cue, reorient and supervise as needed. Identify yourself at each interaction. Face the resident the resident when speaking and make eye contact. Reduce any distractions-turn off TV, radio, close door etc. The CR#1understands consistent, simple, directive sentences. Provide the resident with necessary cures-stop and return if agitated. Keep my routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. Problem: [CR#1] has impaired visual function r/t Other: (Age related). Goal: [CR#1] will show no decline in visual function through the review date. Target Date: 11/18/2024. Interventions: Anticipate and assist with all visual needs. Identify/record factors affecting visual function including Physiological (glaucoma, crohn's, macular degeneration, cataracts, color discrimination, light sensitivity, dry eyes); Environmental (poor lighting, monochromatic, color scheme), Choice (refuses to wear glasses, use mag glass, turn on lights) etc. Keep both eyes clean and free from matter. Monitor both eyes for redness, drainage, swelling, s/s of infection, notify MD as needed. Monitor/document/report PRN any s/sx of acute eye problems: Change in ability to perform ADLs, Decline in mobility, Sudden visual loss, Pupils dilated, gray or milky, c/o halos around lights, double vision, tunnel vision, blurred or hazy vision. Problem: [CR#1] is at risk for falls and is at risk for increased falls and injury r/t Dementia, Deconditioning, Gait/Balance problems. Goal: Dignity will be maintained. Incident of falls will be reduced, and no occurrence of injury will occur through next review. Target Date: 11/18/2024. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interventions: Anticipate needs, provide prompt assistance with ADLs and other special needs. Be sure The resident's call light is within reach and encourage the [CR#1] to use it for assistance as needed. The [CR#1] needs prompt response to all requests for assistance. Bed in the lowest position. Coordinate with appropriate staff to ensure a safe environment with floors free of clutter, adequate glare free light, call light accessible, bed in lowest position, handrails on walls, and personal items within reach. Problem: [CR#1] has had an actual fall on 7/10/24 with no injury; 9/20/24 with no injury, and 10/17/24 with no injury. Goal: [CR#1] will resume usual activities without further incident through the review date. Target Date: 11/18/2024. Interventions: [CR#1] 10/17/24-Send to ER. 7/10/24: Transfer to ER for eval and treatment. 9/20/24-Safety rounds. Administer pain medications prn per MD order for any pain or discomfort. Anticipate needs, provide prompt assistance with ADLs and other special needs. Call MD and RP for any changes in condition. Monitor/document/report PRN x 72h to MD for s/sx: Pain, bruises, change in mental status, New onset: confusion, sleepiness, inability to maintain posture, agitation. Participate in Falling Star/Fall Prevention Program per facility protocol: Call Light and other personal items within easy reach Position bed to the lowest level Provide 1:1 activities if bedbound. Record review of CR#1's Fall Risk Evaluations and Chart dated 1/25/2025 at 7:17am revealed the following: Effective Date: 10/21/22 at 6:14pm a score of 12 of 28 - Risk Category: At Risk Effective Date: 10/28/22 at 2:20am a score of 12 of 28 - Risk Category: At Risk Effective Date: 10/28/22 at 6:14pm a score of 5 out of 28 - Risk Category: No Category Effective Date: 11/5/22 at 9:27pm a score of 14 out of 28 - Risk Category: At Risk Effective Date: 2/5/23 at 6:30pm a score 14 out of 28 - Risk Category: At Risk Effective Date: 5/5/23 at 5:34pm a score of 12 out of 28 - Risk Category: At Risk Effective Date: 7/10/24 at 4:14pm a score of 10 out of 28 - Risk Category: At Risk Effective Date: 8/19/2024 at 4:14pm a score of 13 out of 28 - Risk Category: At Risk Effective Date: 9/20/24 at 11:59 a score of 26 out of 28 - Risk Category: At Risk (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Effective Date: 10/17/24 a score of 21 out of 28 - Risk Category: At Risk Effective Date: 1/11/25 at 3:00pm score of 18 out of 28 - Risk Category: At Risk Effective Date: 1/12/25 at 7:17am a score of 11 out of 28 - Risk Category: At Risk Record Review of Discharge Summary dated 1/16/2025 at 3:12pm revealed the following: Discharge Diagnosis: Intraparenchymal hemorrhage of brain (CMA/HCC) (HCC). Hospital Course: [CR#1] female with PMH of Alzheimer's, dementia, who presented for a bifrontal contusions, and a R SDH s/p fall (unwitnessed) found down on the floor. Patient endorses R shoulder & arm pain, right flank pain and headache. Patient noted to have laceration to R eyebrow. Initial CTH unremarkable. Repeat CTH demonstrated [NAME] acute R frontal lobe IPH, acute R SHD, trace R frontal SAH, acute hemorrhage in L frontoparietal IPH. CT Maxillocial demonstrated acute inferior R orbital & maxillary sinus fracturs and possible 0.2 cm thickness R intraorbital hematoma. CT C-spine & x-ray of R humerus, negative for acute abnormalities. No AC/AP use. NSGY consulted requiring no acute interventions. Opthal consulted for R orbital fracture, with no acute interventions. Patient should cont. Augmentin x7 more days for sinus fx ppx per face team. Patient should cont 3 more days of Keppra for total of 7d sz ppx. Patient is tolerating PO diet and ambulation, vital signs and labs are stable. Medically clear for discharge to SNF. Record review of facility nursing notes dated 8/15/24 at 2:00pm by LPN revealed, CR#1 found on knees in her room after lunch, small scrape noted on R finger, CR#1 C/O pain in her hands. Assessment completed. Record review of facility nursing notes dated 9/20/24 at 7:24pm by LPN revealed, nurse notified by CR#1's roommates' visitor that CR#1 had fallen. Upon Entering, LPN observed CR#1 sitting on the floor at bedside. CR#1 did not remember falling. CR#1 assessed, and neuro checks completed. Record review of facility nursing notes dated 10/17/24 at 3:04pm by LVN revealed, CR#1's found sitting on the floor. CR#1 informed LVN she just fell but cannot recall how she fell . CR#1 assessed and sent to hospital. Record review [CR#1] Lab Results Report dated 1/8/2025 revealed Ammonia is critically high (85.0). Record review [CR#1] Lab Results Report dated 1/10/2025 revealed Ammonia is critically high (128.0) Record review of facility nursing notes dated 1/11/2025 at 2:17pm by LVN A [Un-witnessed fall 1/11/2025 1:36pm] revealed, Head to toe assessment, ROM performed and injuries skin teat to rt lower arm and bruises to rt eyebrow lower lt forearm. Alert and confused x2-3 able to make needs known and VS 139/78 97. 5 71 20 97% on RA Neuro VSS no c/o pain or discomfort. Will cont to monitor. FM, DON and on-call called. Record review of facility nursing notes dated 1/11/2025 at 2:17pm by LVN A [Un-witnessed fall 1/11/2025 1:36pm] revealed, CR#1 fell again in room and was found on her butt and has a bruise to her rt side of head by eyebrow. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of facility nursing notes dated 1/11/2025 at 3:21pm by RN A revealed, CR#1 will be transferring to local hospital for CT (x-ray) scan of the head s/p un-witnessed fall, family informed of findings. Record review of facility's Neurological (15 minute) Assessment Flow Sheet revealed the following: 1/11/25 at 1:45pm - Completed by LVN A 1/11/25 at 2:00pm - Completed by LVN A 1/11/25 at 2:15pm - Completed by LVN A 1/11/25 at 2:30pm - Completed by LVN A 1/12/25 at 3:40am- Completed by LVN A Record review of nursing notes on 1/12/25 at 3:33am by LVN B reveal CR#1 returned from hospital - S/P unwitnessed fall due to unsteady gait. CR#1 denied pain or discomfort. Report received from hospital RN indicated CR#1 has no broken bones and no bleeds. Record review of nursing notes on 1/12/25 effective at 7:25am by LVN A revealed effective at 7:37am CR#1 will be transferring to local hospital for CT scan of the head and X-ray to Lt arm s/p un-witnessed fall, family, MD, and DON notified. Record review of nursing notes on 1/12/25 effective at 7:25am by LVN A revealed Head to toe assessment, ROM performed c/o pain to her head Lt arm offered pain meds and refused. Alert and confused x3 not able to make needs known and VS 136/79 97.4 71 20 97% on RA, Neuro VS cont. Will cont monitor. CR#1CR#1 will be transferring to local hospital. Record review of nursing notes on 1/16/2025 effective at 7:30pm by BT revealed, CR#1 readmitted to facility around 7:30pm via stretcher under care of PCP with DX: Bifrontal contusion and R SDH. CR#1 has a history of Dementia and is a high fall risk. Sitter at bedside for safety. Medication reconsolidated with MD. Residents to continue ABT X 7 days and Keppra x 3 days more days. Head to toe assessment completed. Vitals: B/P 157/78 P:64 Temp:97.3 R:18 Resident has bruise on right eye with 4 sutures, forehead and on right arm w/contracture but denies pain. Night medication administered. Family and DON notified of arrival. Record review of the facility's Comprehensive Care Plans policy dated 04/2023 revealed the following: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with 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 resident's comprehensive assessment. 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	6. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed. Interview on 1/14/25 at 10:39am with CI - it was revealed that the concerns were the continuous unwitnessed falls and the appearance of a lack of staff supervision. Indicated CR#1 had unwitnessed falls 3 times over the weekend, twice in one day on 1/11/24 (2:17pm & 2:39pm), which was less than 30 minutes apart; the second fall resulted in injuries and a trip to the hospital. Confidential continued concern ignited with CR#1 returned from the hospital on 1/12/25 at 3:30am and at 7:30am had to be taken back to the hospital with multiple injuries and bruises, being a broken jaw, brain bleed, bruises and a fractured arm. There has not been meetings concerning interventions for CR#1's falls. Observation on 01/14/25 at 11:50am of CR#1's room, revealed bed not in a low position, no floor mates, no stars on the door and no star on the wall, which according to the facility, would notify all staff of a fall risk. Telephone Interview on 1/14/2025 at 1:48pm CNA B - Stated she is familiar with CR#1. She stated she is a floater in the facility and is not directly assigned to any one area. She stated CR#1 always walking a lot in the facility. States the CR#1 was walking perfectly fine about a week ago. CNA B stated she could not remember if resident was a fall risk and she had not seen a star on her door that would indicate CR#1 was a fall risk. She stated there was nothing in the care plan that required more frequent rounds. Interview on 1/14/2025 at 2:38pm with DON stated she was aware CR#1 had fallen twice on 1/11/2025. The DON was informed during the initial fall CR#1 was assessed and LVN A was directed to call the PCP. DON further stated CR#1 ambulates by herself. CR#1 likes to get in her closet and attempt to get clothes because CR#1 tells staff she is leaving so she packs her clothes. DON states that staff are informed to keep CR#1's clothes within reach because it prevents CR#1's attempts to get into the closet and risk falling. DON stated CR#1 is impulsive and CR#1's elevated Ammonia levels played a part in contributing to confusion and falling. DON stated fall precautions were in place in CR#1 care plan and MDS. DON stated staff were always checking on resident. DON stated CR#1 was on isolation at this time. DON states staff are informed to do frequent rounds, which is every two hours for CNA's and Nurses. States she will check with her staff to get the rounding requirements for CNA's and Nurses. DON stated Neuro checks were in place. CR#1 was sent out to local hospital after the second fall returned to the facility and again had an unwitnessed fall the third time, which she was sent back to the local hospital. Telephone Interview on 1/14/2025 at 2:49pm with LVN A stated on 1/11/2025, a CNA called out for help and she and she responded with the CNA. LVN A could not remember the CNA who called out. LVN A observed CR#1 on the floor. LVN A Completed head to toe assessment and ensured CR#1's ROM was Ok. LVN A observed CR#1 had a little skin tear on her arm and cleaned the area up, put a band-aid on the arm. LVN A stated the other arm sustained a small bruise. Stated she contacted PCP and CR#1's representative. She stated CR#1 told her she was putting on her shirt and she fell . LVN A stated the CNA helped CR#1 put her shirt on. LVN A still could not recall the name of the CNA who assisted her. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	LVN A stated on the second fall, CR#1 was found by a CNA and the CNA called and stated, she's on the floor again. This time CR#1 had other injuries in the facial area (eyebrow) and this time CR#1's representative was called and told CR#1 sent out to hospital. While waiting for EMS, LVN A stated CR#1 was placed in her wheelchair, stayed by nurses' station until EMS came. LVN A stated when the EMS came to pick CR#1 up, they were informed CR#1 had high levels of Ammonia. LVN A observed CR#1 has been up in about, but with an unsteady gait. LVN A stated CR#1 eats in dining area with other residents. CR#1 walks on a walker. LVN A stated she has observed CR#1 has really been unsteady and in the last few months has been required to use her walker continuously. LVN A further stated CR#1 was getting therapy. LVN A stated CR#1 refused to comply to verbal direction to walk with her walker. Telephone Interview on 1/14/2025 at 3:22pm CNA C stated she worked a double shift (6a-2p and 2p -10p). CNA C stated she worked with CR#1 on the 1/11/25. During the 2pm - 10pm she was informed CR#1 had fallen but did not witness the fall. She stated she was not in the area at that time. CNA C stated she could not remember who told her CR#1had fallen. CNA C stated she is required to make rounds every 2 hours and she makes more rounds more frequently if the resident is at risk. CNA C stated CR#1 is a fall risk, but she is not aware of the care plan requiring more frequent rounds. CNA C stated she is always redirecting CR#1 to use her wheelchair or walker because CR#1 doesn't like to all the time. Telephone Interview on 1/14/2025 @ 4:35pm with LPN B - Stated she was working when resident returned from the hospital 3:30am 1/12/2025. Stated when CR#1 returned from the hospital she was at her baseline as CR#1 was giving thank you's to the EMS personnel who transferred her from their stretcher to her bed. LPN B stated CR#1 stated she wanted to go to sleep. She stated CR#1 already had on her gown and CNA A went to the room to ensure CR#1 had fresh water and ensuring she was safe, then completed her rounds. LPN B stated CR#1 preferred her room the door closed, but she left it slightly cracked opened. LPN B stated CR#1 was under her care, and she completed neuros and documented in her chart (nursing notes) neuros back in place and updated care plan. LVN B stated she did not document on the neurological assessment flow sheet. She stated the care plan did not require additional or more frequent rounds than what was required by nursing staff (every two hours). LVN B stated she went into CR#1's room before her last round about 5:30am and CR#1 was still sleeping, she stated she completed other rounds then left the facility around 6:00am. Follow-Up Telephone interview on 1/14/2025 at 4 :49pm with LVN A - She mentioned she started the Neuro checks on CR#1 after her first fall. She stated those checks are completed on the neurological assessment flow sheet and a note in the PCC. LVN A stated it is a responsibility of the nurses to update the care plans for the residents. She stated the care plan did not require additional or more frequent rounds that what was required by nursing staff. Telephone interview with CNA A on 1/14/2025 at 5:07pm-She stated she worked the 10p-6am shift on 1/11/25. States the ambulance brought CR#1 to facility early morning 1/12/2025. She stated the ambulance put CR#1 in the bed. CNA A stated she checked on CR#1 during her last rounds and CR#1was still sleeping. She stated CR#1's door was cracked open a little. States CR#1 did not get up during her shift. Stated she would have completed rounds more often had she known CR#1 was a fall risk. Stated when she left the facility CR#1 was in bed sleep. Stated she received training in the form of orientation. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with PT on 1/14/2025 at 5:27pm- stated she has been treating CR#1on and off for a few years. PT stated CR#1 has bad dementia. PT stated CR#1 should use her walker or wheelchair to get around the facility. PT stated CR#1 had a significant decline in motor skills after having Covid around February 2024. PT stated CR#1was in therapy from 7/13/24 - 9/20/24. PT stated CR#1 was evaluated for additional therapy on 1/6/24. PT stated she went to check on CR#1 in her room and was informed by nursing staff CR#1 had had a fall and went to the hospital. Interview with R#2 on 1/14/2025 at 5:58pm stated she witnessed the second fall on 1/11/25 because she was in CR#1's room. Stated CR#1 was trying to get up from a seated position and fell backwards. She stated staff does not check on CR#1 often; however, when CR#1 is in the common area, and she try to stand up staff will redirect. Observation on 1/15/25 at 10:50am revealed CR#1 lying in bed in the local hospital room. CR#1 appeared to have a black and blue eye on the right side and stitches above the brow area. CR#1's arm was bruised from the upper arm to the wrist area. The nurse assisted me by lifting the comforter and showing where CR#1 sustained bruising on her right thigh area upper thigh area a tear on her thigh her leg and a very swollen black and blue in color kneecap. Follow-Up Interview with DON on 1/15/2025 at 4:10pm - Who stated there wasn't enough time to put in additional interventions for the CR#1 as the falls were frequent and resulted in hospitalization . DON stated when CR#1 returned to the facility it was 3:30am and then CR#1 fell again and was taken to the hospital 7:30am. DON stated the interventions that will be in place when CR#1 returns to the facility will be a conference with CR#1's representative to see if CR#1 is a good fit for the facility. DON stated CR#1 has previously fallen, been placed on fall preventions, given physical and occupational therapy. Telephone Interview with CNA D on 1/16/2025 at 8:00am -Stated she worked the morning of 1/12/2025 on the 6am - 2pm shift. She stated she was the CNA assigned to CR#1. Stated she was assisting another resident who was in a contaminated room and did not witness the CR#1 fall nor hear a scream. CNA D stated she was informed afterwards and did see resident CR#1 before she went to the hospital. She stated CR#1 appeared to be disoriented and really confused. Stated CR#1 is usually independent and walks on her own and she sometimes has a wheelchair she uses but not often. CNA D stated she doesn't know why CR#1 was falling so much. CNA stated CR#1 did not have a yellow star on her door that she can remember. CNA D stated residents who are considered high fall risk also wear a wrist band. She stated she never observed CR#1 with a wrist band. She stated it was only 2 nurses and 2 CNA's working that shift. She stated there was no indication in CR#1's chart that indicated more frequent rounds should be completed. Interview with CNA E on 1/16/2025 at 10:00am-Stated she was working 6:00am - 2:00pm shift on 1/12/2025. She stated there were only two CNAs working the entire shift. Stated LVN A called her to CR#1's room to assist regarding CR#1's fall. CNA E she stated when she arrived in CR#1's room she witnessed LVN A was asking CR#1 questions. CNA E stated she yelled for the assigned CNA D and when CNA D arrived, she left the room and returned to her section to care for residents assigned to her. CNA E stated her last training was two weeks ago and residents who are fall risk has a star on their door. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fall Creek Rehabilitation and Healthcare Center	14949 Mesa Dr Humble, TX 77396

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with PCP on 1/16/25 at 11:50am stated she is notified on incidents regarding residents through NP or the on-call services. PCP Stated she has had concerns about CR#1's repeated falls. Stated the interventions tried were challenging to CR#1 because the interventions would have limited her functions. PCP stated most of CR#1's function related falls were attributed to her cognitive ability. PCP stated she has seen a significant decline in CR#1's cognitive area in the last year. Stated CR#1 was to use her wheelchair, but because CR#1 was so independent a lot of times she wouldn't. The skilled nursing is under the therapy department and occurs after hospitalization , which CR#1 has had in the past. CR#1's Cognitive area was limited and declining because the dementia has progressed this past year. PCP stated memory care could be more appropriate; however, there has not been a conversation in the past even though the progressive decline in CR#1 cognitive area and constant falls were occurring. PCP stated that there are many factors to resident placement in a memory care facility. One factor having to be Financial and if the insurance would pay for that type of care. PCP stated that once CR#1 returns to the facility and after a review of hospital documentation, PCP stated that that would be an intervention to address. Clarification Interview with DON on 1/16/2025 at 3:20pm-DON stated she is ultimately responsible for updating and developing the care plans. However, the nursing staff must update during the time of the incident (ex. Falls, etc). During the morning staff meetings, there are staff report on falls, etc. Based on the morning reports, care plans are reviewed during the meeting and given a finalization as long as the update doesn't restrict the resident's ability to function. An Immediate Jeopardy (IJ) was identified due to the above failures. The ADMIN and DON were notified and provided with the IJ template on 1/16/2025 at 3:45 p.m. Observed and Interviewed CR#1 in her room on 1/17/2025 at 11:10am -CR#1's personal appearance was clean, HOB raised and she was watching television and talking with her 1:1 aide, CNA F. CR#1 appeared to be alert, responding, and giving eye contact. When asked how things were going CR#1 stated she was feeling better then gave surveyor a compliment on hair and clothing items. CR#1 began rambling while attempting to speak, but there was no understanding. Interviewed CNA F on 1/17/2025 @ 11:20am who stated she is very familiar with CR#1 and her fall issues. She stated she is doing 1:1 with resident until further notice. Stated she and CR#1 had a good relationship, then CR#1 interrupted and stated she loved CNA F. The following Plan of Removal submitted by the facility was accepted on 01/17/2025 at 1:11 p.m. and included: Name of facility: Fall [NAME] Rehabilitation and Healthcare Center Date: 1/16/25 F 656 Care Plan Problem: The facility failed to develop and implement a comprehensive person-centered care plan for CR#1, which included measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility failed to implement preventive measures for CR#1's continuous falls, which resulted in severe injuries. On 1/11/2025 CR#1 fell at 2:17pm with minor injuries and again 22 minutes later at 2:39pm resulting in serious injuries requiring hospitalization . CR#1 was returned to the facility on [DATE] at 3:33am and at 7:37am CR#1 transferred to hospital for another unwitnessed fall. The facility failed to ensure CR#1, was provided the needed care and services to decrease the risk of falls through a person-centered care plan. CR#1 readmitted to facility this evening. Immediate action: 1. 1/13 /25 The facility administrator completed a self-report incident to HHSC due to unwitnessed fall with major injury. 2. 1/16/25The facility conducted an audit of residents with fall risk assessment with no risk scores 0-4 and at-risk scores 5-30 to ensure their comprehensive person-centered care plans are appropriate and meet their individual needs. No additional concerns were identified. Completed 1/17/25 3. On 1/16/25 The Don/Designee immediately initiated an audit of residents' currently residing in the facility comprehensive care plans who have had falls in the last 16 days, 6 residents with 8 falls where reviewed, to ensure fall prevention interventions are objective, measurable and timely. No additional concerns noted. Completed 1/16/25. 4. On 1/16/25 The Corporate nurse conducted a 1:1 in-service with the DON on the facility Fall Prevention Program Policy focusing on timely implementation of person center care plans to include adding measures that objectively meet the resident's needs. Interventions: 5. On 1/16/25 the DON/Designee initiated an in-service with the facility Licensed nursing staff on The Fall Prevention program. This included an explanation of Risk Assessments indicating fall risk and or no risk and the different interventions based on Fall risk assessment as well as the licensed nurse responsibility to immediately implement interventions to prevent or further prevent residents falls and injuries. Projected completion 1/17/25 6. On1/16/25 the DON/Designee initiated an in-service with the facility staff on the Fall Prevention Program Policy to include the Falling Star Program. A gold Star is added to the Resident name on the door, on their wheelchair/Walker and above their bed to alert Staff, the resident has had a fall and is at risk for additional falls. Projected completion on 1/17/25 7. On 1/16/25 the DON/Designee initiated an in-service with licensed nurses on immediately reporting all resident falls to the DON and or Administrator to seek guidance and ensure appropriate interventions are put in place following a residents fall. Projected completion 1/17/25 (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	8. On 1/16/25 the Regional Corporate nurse/Designee initiated and in-service with the nurse managers and licensed nurses on the Facility Policy for Comprehensive Care Plans focusing on promptly updating resident plan of care following each fall with interventions to meet the residents' individualized needs, DON/MDS nurse and Designee will monitor care plans for appropriateness and completion. Completion date 1/17/25 Ongoing Projected completion 1/17/25 Any staff member not present or in service, will not be allowed to assume their duties until in-serviced. Ongoing In-service will be completed by DON/ADON/WC NURSE/or weekend nurse supervisor, until all staff, weekend, prn, and agency staff in completed. Monitoring 9. On 1/16/25 The DON/designee began a questionnaire to validate the effectiveness of the training. The questionnaire is conducted with facility staff. Immediate re-education will be completed by the DNS/designee if any staff is unable to answer appropriately to the questions on the questionnaire. Staff will not be allowed to work until after completion of the questionnaire. Projected completion 1/17/25. 10. Starting on 1/17/25 the facility Adm/Don and designee will review prior day falls and comprehensive care plans to ensure interventions chosen are individualized, appropriate and effective. Any interventions noted to be inadequate will be changed at that time. Completed 1/17/25. 11. An impromptu QAPI meeting was conducted with the facility's Medical Director, Dr. [NAME] on 1/16/25 to notify of the potential for non-compliance and the action plan implemented for approval. Plan approved on 1/16/25. The surveyor confirmed the facility implemented their plan of removal and Monitoring began on 1/18/2025. Interviews on 1/18/2025 at 1:00 a.m. - 1/18/2025 6:44 p.m. with Admin, DON, LVN's A, B, C, D, E, and F (shifts 6a-6p, 6p-6a); CNA's G, H, I and J (shifts 6a-2p, 2p-10p, and 10p-6a said they were reeducated on the policy for comprehensive care plans. Inservice training on facility's Fall Prevention Program, Risk Assessments, Interventions based on fall risk, the Falling S [TRUNCATED]

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 47277 Based on observation, interview and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 5 residents (CR#1) reviewed for free of accidents, hazards, supervision, and devices., in that: The facility failed to ensure precautionary interventions in place CR #1, who was a known fall risk that resulted in falls with serious injuries and multiple hospitalization . An Immediate Jeopardy (IJ) was identified on 1/16/2025. The IJ template was provided to the Administrator and DON on 1/16/2025 at 3:45pm. While the IJ was removed on 1/18/2025 at 4:29 p.m., the facility remained out of compliance at a severity of no actual harm with potential for more than minimal harm that is not an immediate jeopardy and a scope of pattern, due to the facility's need to evaluate the effectiveness of the corrective systems. This failure placed facility residents who were fall risk at risk of serious harm and injury. Findings included: Record review of CR#1's face sheet dated 12/14/24 reflected a [AGE] year-old female with an original admitted [DATE] and re-admission 1/12/25. Her diagnoses included: Alzheimer's/Dementia (Mental Decline), Hypertension (blood pressure is high) and coronary artery disease (the heart is not receiving enough oxygen and could lead to heart attack). Record review of CR#1's Orders dated 1/1/25 - 1/31/25 revealed CR#1's Meclzine HCl oral tablet 12.5 mg given in the morning for dizziness and was discontinued 1/14/25; Lactulose Encephalopathy Oral Solution 20 GM-Give 30ml by mouth one time a day for maintain ammonia levels**Do not hold for loose stools** order date 9/5/2024 at 1:07pm and D/C Date 1/8/2025 at 2:36pm; Lactulose Encephalopathy Oral Solution 20 GM-Give 30ml by mouth two times a day for maintain ammonia levels**Do not hold for loose stools** order date 1/8/2025 at 2:36pm and D/C Date 1/11/2025 at 5:06am Lactulose Encephalopathy Oral Solution 20 GM/30ML (Lactulose) Give 30ml by mouth three times a day for elevated Ammonia Level- Order date -Date 1/11/2025 at 5:08am and D/C Date 1/14/2025 Record review of CR#1's completed Quarterly MDS assessment dated [DATE] and completed 11/11/24, reflected CR#1 had a BIMS of 6 which suggest severe cognitive impairment. She used a walker for mobility. CR#1 requires supervision or touching to sit to stand, chair/bed-to-chair transfer, toilet transfer, tub/shower transfer, walk 10 feet, walk 50 feet with two turns, walk 150 feet. B1000 [Vision] - revealed CR#1 has adequate vision - see fine detail, such as regular print in newspapers/books. J1900 - revealed CR#1 had two or more falls since admission with no injury. Record review of CR#1's care plan dated 11/13/24 revealed the following care areas: Problem: [CR#1] is cognitively impaired and has problems with short term, long term, impaired ability to understand others, and impaired ability to make daily decisions Alzheimer's, Dementia. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Goal: [CR#1] staff will assist daily due to cognitive loss during the next 90 days. Target Date: 11/18/2024. CR#1 needs will be met and dignity will maintained through the next review. Target Date: 11/18/2024 Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. Ask yes/no questions in order to determine the resident's needs, Cue, reorient and supervise as needed. Identify yourself at each interaction. Face the resident the resident when speaking and make eye contact. Reduce any distractions-turn off TV, radio, close door etc. The CR#1understands consistent, simple, directive sentences. Provide the resident with necessary cures-stop and return if agitated. Keep my routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. Problem: [CR#1] has impaired visual function r/t Other: (Age related). Goal: [CR#1] will show no decline in visual function through the review date. Target Date: 11/18/2024. Interventions: Anticipate and assist with all visual needs. Identify/record factors affecting visual function including Physiological (glaucoma, crohn's, macular degeneration, cataracts, color discrimination, light sensitivity, dry eyes); Environmental (poor lighting, monochromatic, color scheme), Choice (refuses to wear glasses, use mag glass, turn on lights) etc. Keep both eyes clean and free from matter. Monitor both eyes for redness, drainage, swelling, s/s of infection, notify MD as needed. Monitor/document/report PRN any s/sx of acute eye problems: Change in ability to perform ADLs, Decline in mobility, Sudden visual loss, Pupils dilated, gray or milky, c/o halos around lights, double vision, tunnel vision, blurred or hazy vision. Problem: [CR#1] is at risk for falls and is at risk for increased falls and injury r/t Dementia, Deconditioning, Gait/Balance problems. Goal: Dignity will be maintained. Incident of falls will be reduced, and no occurrence of injury will occur through next review. Target Date: 11/18/2024. Interventions: Anticipate needs, provide prompt assistance with ADLs and other special needs. Be sure The resident's call light is within reach and encourage the [CR#1] to use it for assistance as needed. The [CR#1] needs prompt response to all requests for assistance. Bed in the lowest position. Coordinate with appropriate staff to ensure a safe environment with floors free of clutter, adequate glare free light, call light accessible, bed in lowest position, handrails on walls, and personal items within reach. Problem: [CR#1] has had an actual fall on 7/10/24 with no injury; 9/20/24 with no injury, and 10/17/24 with no injury. Goal: [CR#1] will resume usual activities without further incident through the review date. Target Date: 11/18/2024. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interventions: [CR#1] 10/17/24-Send to ER. 7/10/24: Transfer to ER for eval and treatment. 9/20/24-Safety rounds. Administer pain medications prn per MD order for any pain or discomfort. Anticipate needs, provide prompt assistance with ADLs and other special needs. Call MD and RP for any changes in condition. Monitor/document/report PRN x 72h to MD for s/sx: Pain, bruises, change in mental status, New onset: confusion, sleepiness, inability to maintain posture, agitation. Participate in Falling Star/Fall Prevention Program per facility protocol: Call Light and other personal items within easy reach Position bed to the lowest level Provide 1:1 activities if bedbound. Record review of CR#1's Fall Risk Evaluations and Chart dated 1/25/2025 at 7:17am revealed the following: Effective Date: 10/21/22 at 6:14pm a score of 12 of 28 - Risk Category: At Risk Effective Date: 10/28/22 at 2:20am a score of 12 of 28 - Risk Category: At Risk Effective Date: 10/28/22 at 6:14pm a score of 5 out of 28 - Risk Category: No Category Effective Date: 11/5/22 at 9:27pm a score of 14 out of 28 - Risk Category: At Risk Effective Date: 2/5/23 at 6:30pm a score 14 out of 28 - Risk Category: At Risk Effective Date: 5/5/23 at 5:34pm a score of 12 out of 28 - Risk Category: At Risk Effective Date: 7/10/24 at 4:14pm a score of 10 out of 28 - Risk Category: At Risk Effective Date: 8/19/2024 at 4:14pm a score of 13 out of 28 - Risk Category: At Risk Effective Date: 9/20/24 at 11:59 a score of 26 out of 28 - Risk Category: At Risk Effective Date: 10/17/24 a score of 21 out of 28 - Risk Category: At Risk Effective Date: 1/11/25 at 3:00pm score of 18 out of 28 - Risk Category: At Risk Effective Date: 1/12/25 at 7:17am a score of 11 out of 28 - Risk Category: At Risk Record Review of Discharge Summary dated 1/16/2025 at 3:12pm revealed the following: Discharge Diagnosis: Intraparenchymal hemorrhage of brain (CMA/HCC) (HCC). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Hospital Course: [CR#1] female with PMH of Alzheimer's, dementia, who presented for a bifrontal contusions, and a R SDH s/p fall (unwitnessed) found down on the floor. Patient endorses R shoulder & arm pain, right flank pain and headache. Patient noted to have laceration to R eyebrow. Initial CTH unremarkable. Repeat CTH demonstrated [NAME] acute R frontal lobe IPH, acute R SHD, trace R frontal SAH, acute hemorrhage in L frontoparietal IPH. CT Maxillocial demonstrated acute inferior R orbital & maxillary sinus fracturs and possible 0.2 cm thickness R intraorbital hematoma. CT C-spine & x-ray of R humerus, negative for acute abnormalities. No AC/AP use. NSGY consulted requiring no acute interventions. Opthal consulted for R orbital fracture, with no acute interventions. Patient should cont. Augmentin x7 more days for sinus fx ppx per face team. Patient should cont 3 more days of Keppra for total of 7d sz ppx. Patient is tolerating PO diet and ambulation, vital signs and labs are stable. Medically clear for discharge to SNF. Record review of facility nursing notes dated 8/15/24 at 2:00pm by LPN revealed, CR#1 found on knees in her room after lunch, small scrape noted on R finger, CR#1 C/O pain in her hands. Assessment completed. Record review of facility nursing notes dated 9/20/24 at 7:24pm by LPN revealed, nurse notified by CR#1's roommates' visitor that CR#1 had fallen. Upon Entering, LPN observed CR#1 sitting on the floor at bedside. CR#1 did not remember falling. CR#1 assessed, and neuro checks completed. Record review of facility nursing notes dated 10/17/24 at 3:04pm by LVN revealed, CR#1's found sitting on the floor. CR#1 informed LVN she just fell but cannot recall how she fell . CR#1 assessed and sent to hospital. Record review [CR#1] Lab Results Report dated 1/8/2025 revealed Ammonia is critically high (85.0). Record review [CR#1] Lab Results Report dated 1/10/2025 revealed Ammonia is critically high (128.0) Record review of facility nursing notes dated 1/11/2025 at 2:17pm by LVN A [Un-witnessed fall 1/11/2025 1:36pm] revealed, Head to toe assessment, ROM performed and injuries skin teat to rt lower arm and bruises to rt eyebrow lower lt forearm. Alert and confused x2-3 able to make needs known and VS 139/78 97. 5 71 20 97% on RA Neuro VSS no c/o pain or discomfort. Will cont to monitor. FM, DON and on-call called. Record review of facility nursing notes dated 1/11/2025 at 2:17pm by LVN A [Un-witnessed fall 1/11/2025 1:36pm] revealed, CR#1 fell again in room and was found on her butt and has a bruise to her rt side of head by eyebrow. Record review of facility's Neurological (15 minute) Assessment Flow Sheet by LVN A revealed the following: 1/11/25 at 1:45pm - Completed by LVN A 1/11/25 at 2:00pm - Completed by LVN A 1/11/25 at 2:15pm - Completed by LVN A 1/11/25 at 2:30pm - Completed by LVN A (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1/12/25 at 3:40am- Completed by LVN A Record review of nursing notes on 1/12/25 at 3:33am by LVN B reveal CR#1 returned from hospital - S/P unwitnessed fall due to unsteady gait. CR#1 denied pain or discomfort. Report received from hospital RN indicated CR#1 has no broken bones and no bleeds. Record review of nursing notes on 1/12/25 effective at 7:25am by LVN A revealed effective at 7:37am CR#1 will be transferring to local hospital for CT scan of the head and X-ray to Lt arm s/p un-witnessed fall, family, MD, and DON notified. Record review of nursing notes on 1/12/25 effective at 7:25am by LVN A revealed Head to toe assessment, ROM performed c/o pain to her head Lt arm offered pain meds and refused. Alert and confused x3 not able to make needs known and VS 136/79 97.4 71 20 97% on RA, Neuro VS cont. Will cont monitor. CR#1CR#1 will be transferring to local hospital. Record review of nursing notes on 1/16/2025 effective at 7:30pm by BT revealed, CR#1 readmitted to facility around 7:30pm via stretcher under care of PCP with DX: Bifrontal contusion and R SDH. CR#1 has a history of Dementia and is a high fall risk. Sitter at bedside for safety. Medication reconsolidated with MD. Residents to continue ABT X 7 days and Keppra x 3 days more days. Head to toe assessment completed. Vitals: B/P 157/78 P:64 Temp:97.3 R:18 Resident has bruise on right eye with 4 sutures, forehead and on right arm w/contracture but denies pain. Night medication administered. Family and DON notified of arrival. Record review of the facility's Fall Prevention Program policy dated 01/2023 revealed the following: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. Policy Explanation and Compliance Guidelines revealed the following: 1. The facility utilizes a standardized risk assessment for determining a resident's fall risk. a. The risk assessment categorizes residents according to low, moderate, or high risk b. For program identification purposes, the facility utilizes high risk and low/moderate risk, using the scoring method designated on the risk assessment. 2. Upon admission the nurse will complete a fall risk assessment along with the admission assessment to determine the resident's level of fall risk. 3. The nurse will indicate on the fall risk assessment the resident's fall risk and initiate interventions on the resident's baseline care plan. 4. The nurse will refer to the facility's High Risk or Low/Moderate Risk protocols when determining primary interventions. 6. High Risk Protocols: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	C. Provide interventions that address unique risk factors measured by the risk assessment tool: medications, it's psychological, cognitive status, or recent change in functional status. D. Provide additional interventions as directed by the resident's assessment, including but not limited to: i. System devices ii. Increase frequency of rounds iii. Sitter, if direct if indicated iv. Medication regimen review v. Low bed vi. Alternate call system access vii. Schedule ambulation or toileting assistance viii. Family/caregiver or resident education ix. Therapy services referral x. Place Fall Prevention Indicator (Star) on the name plate to residence room xi. Place Fall Prevention Indicator (Star) on residents wheelchair. Interview on 1/14/25 at 10:39am with CI - it was revealed that the concerns were the continuous unwitnessed falls and the appearance of a lack of staff supervision. Indicated CR#1 had unwitnessed falls 3 times over the weekend, twice in one day on 1/11/24 (2:17pm & 2:39pm), which was less than 30 minutes apart; the second fall resulted in injuries and a trip to the hospital. Confidential continued concern ignited with CR#1 returned from the hospital on 1/12/25 at 3:30am and at 7:30am had to be taken back to the hospital with multiple injuries and bruises, being a broken jaw, brain bleed, bruises and a fractured arm. There had not been meetings concerning interventions for CR#1's falls. Observation on 01/14/25 at 11:50am of CR#1's room, revealed bed not in a low position, no floor mates, no stars on the door and no star on the wall, which according to the facility, would notify all staff of a fall risk. Telephone Interview on 1/14/2025 at 1:48pm CNA B - Stated she is familiar with CR#1. She stated she is a floater in the facility and is not directly assigned to any one area. She stated CR#1 always walking a lot in the facility. States the CR#1 was walking perfectly fine about a week ago. CNA B stated she could not remember if resident was a fall risk and she had not seen a star on her door that would indicate CR#1 was a fall risk. She stated there was nothing in the care plan that required more frequent rounds. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 1/14/2025 at 2:38pm with DON stated she was aware CR#1 had fallen twice on 1/11/2025. The DON was informed during the initial fall CR#1 was assessed and LVN A was directed to call the PCP. DON further stated CR#1 ambulates by herself. CR#1 likes to get in her closet and attempt to get clothes because CR#1 tells staff she is leaving so she packs her clothes. DON states that staff are informed to keep CR#1's clothes within reach because it prevents CR#1's attempts to get into the closet and risk falling. DON stated CR#1 is impulsive and CR#1's elevated Ammonia levels played a part in contributing to confusion and falling. DON stated fall precautions were in place in CR#1 care plan and MDS. DON stated staff were always checking on resident. DON stated CR#1 was on isolation at this time. DON states staff are informed to do frequent rounds, which is every two hours for CNA's and Nurses. States she will check with her staff to get the rounding requirements for CNA's and Nurses. DON stated Neuro checks were in place. CR#1 was sent out to local hospital after the second fall returned to the facility and again had an unwitnessed fall the third time, which she was sent back to the local hospital. Telephone Interview on 1/14/2025 at 2:49pm with LVN A stated on 1/11/2025, a CNA called out for help and she and she responded with the CNA. LVN A could not remember the CNA who called out. LVN A observed CR#1 on the floor. LVN A Completed head to toe assessment and ensured CR#1's ROM was Ok. LVN A observed CR#1 had a little skin tear on her arm and cleaned the area up, put a band-aid on the arm. LVN A stated the other arm sustained a small bruise. Stated she contacted PCP and CR#1's representative. She stated CR#1 told her she was putting on her shirt and she fell . LVN A stated the CNA helped CR#1 put her shirt on. LVN A still could not recall the name of the CNA who assisted her. LVN A stated on the second fall, CR#1 was found by a CNA and the CNA called and stated, she's on the floor again. This time CR#1 had other injuries in the facial area (eyebrow) and this time CR#1's representative was called and told CR#1 sent out to hospital. While waiting for EMS, LVN A stated CR#1 was placed in her wheelchair, stayed by nurses' station until EMS came. LVN A stated when the EMS came to pick CR#1 up, they were informed CR#1 had high levels of Ammonia. LVN A observed CR#1 has been up in about, but with an unsteady gait. LVN A stated CR#1 eats in dining area with other residents. CR#1 walks on a walker. LVN A stated she has observed CR#1 has really been unsteady and in the last few months has been required to use her walker continuously. LVN A further stated CR#1 was getting therapy. LVN A stated CR#1 refused to comply to verbal direction to walk with her walker. Telephone Interview on 1/14/2025 at 3:22pm CNA C stated she worked a double shift (6a-2p and 2p -10p). CNA C stated she worked with CR#1 on the 1/11/25. During the 2pm - 10pm she was informed CR#1 had fallen but did not witness the fall. She stated she was not in the area at that time. CNA C stated she could not remember who told her CR#1had fallen. CNA C stated she is required to make rounds every 2 hours and she makes more rounds more frequently if the resident is at risk. CNA C stated CR#1 is a fall risk, but she is not aware of the care plan requiring more frequent rounds. CNA C stated she is always redirecting CR#1 to use her wheelchair or walker because CR#1 doesn't like to all the time. (continued on next page)

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	676412	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fall Creek Rehabilitation and Healthcare Center	14949 Mesa Dr Humble, TX 77396

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Telephone Interview on 1/14/2025 @ 4:35pm with LPN B - Stated she was working when resident returned from the hospital 3:30am 1/12/2025. Stated when CR#1 returned from the hospital she was at her baseline as CR#1 was giving thank you's to the EMS personnel who transferred her from their stretcher to her bed. LPN B stated CR#1 stated she wanted to go to sleep. She stated CR#1 already had on her gown and CNA A went to the room to ensure CR#1 had fresh water and ensuring she was safe, then completed her rounds. LPN B stated CR#1 preferred her room the door closed, but she left it slightly cracked opened. LPN B stated CR#1 was under her care, and she completed neuros and documented in her chart (nursing notes) neuros back in place and updated care plan. LVN B stated she did not document on the neurological assessment flow sheet. She stated the care plan did not require additional or more frequent rounds than what was required by nursing staff (every two hours). LVN B stated she went into CR#1's room before her last round about 5:30am and CR#1 was still sleeping, she stated she completed other rounds then left the facility around 6:00am. Follow-Up Telephone interview on 1/14/2025 at 4:49pm with LVN A - She mentioned she started the Neuro checks on CR#1 after her first fall. She stated those checks are completed on the neurological assessment flow sheet and a note in the PCC. LVN A stated it is a responsibility of the nurses to update the care plans for the residents. She stated the care plan did not require additional or more frequent rounds that what was required by nursing staff. Telephone interview with CNA A on 1/14/2025 at 5:07pm-She stated she worked the 10p-6am shift on 1/11/25. States the ambulance brought CR#1 to facility early morning 1/12/2025. She stated the ambulance put CR#1 in the bed. CNA A stated she checked on CR#1 during her last rounds and CR#1was still sleeping. She stated CR#1's door was cracked open a little. States CR#1 did not get up during her shift. Stated she would have completed rounds more often had she known CR#1 was a fall risk. Stated when she left the facility CR#1 was in bed sleep. Stated she received training in the form of orientation. Interview with PT on 1/14/2025 at 5:27pm- stated she has been treating CR#1on and off for a few years. PT stated CR#1 has bad dementia. PT stated CR#1 should use her walker or wheelchair to get around the facility. PT stated CR#1 had a significant decline in motor skills after having Covid around February 2024. PT stated CR#1was in therapy from 7/13/24 - 9/20/24. PT stated CR#1 was evaluated for additional therapy on 1/6/24. PT stated she went to check on CR#1 in her room and was informed by nursing staff CR#1 had had a fall and went to the hospital. Interview with R#2 on 1/14/2025 at 5:58pm stated she witnessed the second fall on 1/11/25 because she was in CR#1's room. Stated CR#1 was trying to get up from a seated position and fell backwards. She stated staff does not check on CR#1 often; however, when CR#1 is in the common area, and she try to stand up staff will redirect. Interview with HN on 1/15/2025 at 10:27am - who stated CR#1 was admitted to the hospital 1/12/2025 at 7:30am. She stated CR#1 was transported to hospital by EMS. HN stated resident had an admitting diagnosis of Intraparenchymal Hemorrhage of the Brain. Current Diagnosis is Right frontal Lobe IPA, Right Subdural, Broken jaw. She stated according to CR#1's labs drawn 1/13/2025 CR#1 has a UTI. She stated resident released a large amount of stool, which decreased her levels of Ammonia. She stated there were no signs of fractures on her right side, just bruising. She also stated based on lab reports the resident did not have sepsis. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation on 1/15/25 at 10:50am revealed CR#1 lying in bed in the local hospital room. CR#1 appeared to have a black and blue eye on the right side and stitches above the brow area. CR#1's arm was bruised from the upper arm to the wrist area. The nurse assisted me by lifting the comforter and showing where CR#1 sustained bruising on her right thigh area upper thigh area a tear on her thigh her leg and a very swollen black and blue in color kneecap. Follow-Up Interview with DON on 1/15/2025 at 4:10pm - Who stated there wasn't enough time to put in additional interventions for the CR#1 as the falls were frequent and resulted in hospitalization . DON stated when CR#1 returned to the facility it was 3:30am and then CR#1 fell again and was taken to the hospital 7:30am. DON stated the interventions that will be in place when CR#1 returns to the facility will be a conference with CR#1's representative to see if CR#1 is a good fit for the facility. DON stated CR#1 has previously fallen, been placed on fall preventions, given physical and occupational therapy. Telephone Interview with CNA D on 1/16/2025 at 8:00am -Stated she worked the morning of 1/12/2025 on the 6am - 2pm shift. She stated she was the CNA assigned to CR#1. Stated she was assisting another resident who was in a contaminated room and did not witness the CR#1 fall nor hear a scream. CNA D stated she was informed afterwards and did see resident CR#1 before she went to the hospital. She stated CR#1 appeared to be disoriented and really confused. Stated CR#1 is usually independent and walks on her own and she sometimes has a wheelchair she uses but not often. CNA D stated she doesn't know why CR#1 was falling so much. CNA stated CR#1 did not have a yellow star on her door that she can remember. CNA D stated residents who are considered high fall risk also wear a wrist band. She stated she never observed CR#1 with a wrist band. She stated it was only 2 nurses and 2 CNA's working that shift. She stated there was no indication in CR#1's chart that indicated more frequent rounds should be completed. Interview with CNA E on 1/16/2025 at 10:00am-Stated she was working 6:00am - 2:00pm shift on 1/12/2025. She stated there were only two CNAs working the entire shift. Stated LVN A called her to CR#1's room to assist regarding CR#1's fall. CNA E she stated when she arrived in CR#1's room she witnessed LVN A was asking CR#1 questions. CNA E stated she yelled for the assigned CNA D and when CNA D arrived, she left the room and returned to her section to care for residents assigned to her. CNA E stated her last training was two weeks ago and residents who are fall risk has a star on their door. Interview with PCP on 1/16/25 at 11:50am stated she is notified on incidents regarding residents through NP or the on-call services. PCP Stated she has had concerns about CR#1's repeated falls. Stated the interventions tried were challenging to CR#1 because the interventions would have limited her functions. PCP stated most of CR#1's function related falls were attributed to her cognitive ability. PCP stated she has seen a significant decline in CR#1's cognitive area in the last year. Stated CR#1 was to use her wheelchair, but because CR#1 was so independent a lot of times she wouldn't. The skilled nursing is under the therapy department and occurs after hospitalization , which CR#1 has had in the past. CR#1's Cognitive area was limited and declining because the dementia has progressed this past year. PCP stated memory care could be more appropriate; however, there has not been a conversation in the past even though the progressive decline in CR#1 cognitive area and constant falls were occurring. PCP stated that there are many factors to resident placement in a memory care facility. One factor having to be Financial and if the insurance would pay for that type of care. PCP stated that once CR#1 returns to the facility and after a review of hospital documentation, PCP stated that that would be an intervention to address. (continued on next page)

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