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	05/30/2025

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 - Minimal harm or potential for actual harm 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** Based on interview, and record review, the facility failed develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives and time frames to meet a residents' mental, nursing and mental and psychosocial needs that were identified in the comprehensive assessment for 2 of 12 Residents (CR #1 and Resident #26) reviewed for care plans. The facility failed to identify CR #1's diagnosis of Ventriculoperitoneal Shunt (a small plastic tube that is used to drain the cerebrospinal fluid from the brain into the space of the abdomen) in her care plan. The facility also failed to ensure that Resident #26's care plan included information regarding his oxygen that was ordered 5/7/25. The failure could place residents at risk of not having their needs met or inability of staff to identify a change of condition. Findings include: Record review of CR #1's Medication Review Report generated on 5/30/25 revealed CR #1 was admitted to the facility on [DATE] with diagnoses of dementia (a neurodegenerative disease that causes a decline in mental abilities including memory), end stage renal disease (a condition where the kidneys have permanently lost their ability to filter waste and excess fluid from the blood), hydrocephalus (a buildup of fluid in the cavities deep within the brain, putting pressure on the brain) and diabetes (a condition in which the body has trouble controlling blood sugar and using it for energy, resulting in high blood sugar). She was [AGE] years of age. Record review of a CR #1's Progress Note written by NP A dated 3/28/23 revealed she had a history of ventricular intracranial shunt (a devise used to treat hydrocephalus). It further revealed she was transferred from another nursing home. Record review of CR #1's Nursing Progress Note dated 7/30/24 revealed CR #1 was taking antibiotics for a urinary tract infection. The nurse noted that the resident's family was concerned that her ventricular intracranial shunt was malfunctioning due to increased confusion. The resident's family requested that she go to the hospital to check her shunt, and NP A approved. Record review of CR #1's hospital records dated 7/30/24 revealed the resident had a CT scan of her head and a radiological exam of her chest. Both tests revealed the Ventriculoperitoneal shunt was intact and in place. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of CR #1's hospital discharge instructions dated 7/30/24 revealed the resident was provided with education materials for Ventriculoperitoneal Shunt Home Guide. The education explained the warning signs of shunt malfunction, including headache, vomiting, feeling sleepier than usual, loss of appetite, low energy, irritability, personality change or confusion, vision changes, trouble walking, urinary incontinence and seizures. The education stated to get help right away if CR #1 experienced the following: .Are sleepier than usual or have trouble waking up, vomit for no reason, have a fever, noticed redness or swelling along shunt path, have a headache that is getting worse, start to twitch or shake, develop vision problems, lose coordination or balance, become irritable or start to behave abnormally. Record review of CR #1's care plan report dated 7/10/24 revealed she had a focus area of alteration in neurological status related to hydrocephalus and seizures. The goal was for CR #1 to be able to communicate needs daily, with a target dated of 10/8/24. Interventions included assess for effects of psychotropic medications, if seizure activity occurs, place on side and maintain open airway, monitor/report signs of tremors, rigidity, dizziness, changes in level of consciousness and slurred speech, and complete a skin inspection daily. Further review of CR #1's care plan revealed there was no information regarding a ventriculoperitoneal shunt. Record review of Resident #26's face sheet dated 5/28/2025, revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including Hemiplegia (one sided weakness or paralysis) and Hemiparesis (weakness in one leg, arm, or side of the face) following Nontraumatic Intracerebral Hemorrhage affecting Right Non-dominant side. Record review of Resident #26's quarterly MDS dated [DATE] revealed a BIMS score of 15 that indicated cognition was intact. Record review of Resident #26's Order Summary Report with active orders as of 5/28/25 revealed Oxygen at 3 L/min via NC continuously DX:_SOB_ every night shift every Sun for O2 Change and label water humidification and nasal cannula tubing weekly every Sunday night shift with order date of 5/7/25. Record review of Resident #26's May MAR and TAR printed 5/28/25 revealed Change and label water humidification and nasal cannula tubing weekly every Sunday night shift. Record review of Resident #26's care plan printed 5/28/25 revealed no information regarding oxygen. Record review of Resident #26's care plan printed 5/29/25 revealed he required the use of oxygen via nasal cannula with intervention to apply oxygen via nasal cannula as ordered. Observation on 5/28/25 at 9:32 a.m. revealed Resident #26 was wearing oxygen at 3 liters via nasal cannula. During interview on 5/29/25 at 11:50 a.m., the DON said it depended on who updated the care plans. The DON said the MDS nurse did the overall or chronic issues from the MDS and the DON, wound care nurse, and the unit manager did the acute issues. The surveyor asked the DON to check Resident #26's care plan regarding oxygen and the DON said No, I don't see it regarding oxygen being on Resident #26's care plan. The DON said the MDS nurse was responsible for adding oxygen to Resident #26's care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 5/29/25 at 1:28 p.m., the MDS Nurse said the IDT was responsible for updating care plans. The MDS Nurse said the DON, the ADON, dietary, social worker and the MDS nurse were the IDT team. The MDS nurse said if nursing put in an order for oxygen, then they would put it in the care plan. The MDS nurse said the ADON would be responsible for adding a new order for oxygen to the care plan. During interview on 5/29/25 at 1:34 p.m., the ADON said usually the MDS nurse or one of the managers would add new orders to the care plan. The ADON said the unit manager reviewed new orders and would be the first one to add it to the care plan. The ADON said they worked together as a team and her and the DON also reviewed orders and could add to the care plan with MDS overseeing everything. During interview on 5/29/25 at 1:49 p.m., LVN H said the nurses did add interventions regarding falls on the care plan but otherwise most things were added by management. During interview on 5/29/25 at 4:43 p.m., the DON said technically staff would not know how to care for the resident if information was not on the care plan but if there was something needed for the resident they would have had an order. During interview on 5/30/25 at 9:28 a.m., the Unit Manager said the DON or MDS was responsible for adding new orders like for oxygen to the care plan. In an interview on 5/30/25 at 12:45pm, LVN E said she could not remember caring for CR #1. She said for any change of condition, including a change of condition involving a shunt, she would complete an SBAR assessment and notify the doctor, follow-through with any orders and monitor the resident closely. In an interview on 5/30/25 at 2:20pm, Unit Manager said to monitor a brain shunt, nursing staff should look at them closely if they noticed signs of leg pain, hunchback, or one-sided weakness. In an interview on 5/30/25 at 2:40pm, the ADON said if a resident had a brain shunt, the nurses should monitor for changes of condition, including changes to neurological status. In an interview on 5/30/25 at 3:30pm, the MDS Specialist said the facility's MDS nurse was not at the facility. She said the MDS nurse was responsible for completing the nursing care plan. When asked about CR #1's diagnosis of a ventricular intracranial shunt, she said a diagnoses like that should be on a resident's care plan. She said nurses should monitor for seizures, blood pressure elevation, headache, pain, and dilation of the eyes. She said the nurses would need to know about a shunt placement. She said without this knowledge, a nurse could overlook a headache as a common headache, or a blood pressure medication could be prescribed for high blood pressure not knowing the shunt was in place. She said the MDS nurse should have reviewed the resident's admission and readmission medical records. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy for Comprehensive Care Plans dated 4/2023 read in part, 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 . the comprehensive care plan will be prepared by an interdisciplinary team, that includes, but is not limited to: a. the attending physician or non-physician practitioner designee involved in the resident's care . a registered nurse with responsibility for the resident .other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. Examples include, but are not limited to: i. The MDS nurse .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents who were unable to carry out Activities of Daily Living received the necessary services to maintain grooming and personal hygiene for 2 (Residents #377 and #378) of 10 residents reviewed for Activities of Daily Living. The facility failed to provide Residents #377 and #378 with adequate services to maintain personal hygiene. This failure could place residents at risk of diminished quality of life, decreased self-esteem or skin breakdown. Findings included: Record review of Resident #377's face sheet dated 6/2/2024, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including Myocardial Infarction (Heart Attack) and Muscle Weakness. Record review of Resident #377's admission MDS dated [DATE] revealed a BIMS score of 9 that indicated moderate cognitive impairment. Record review also revealed ADL performance code of 02 for bathing and showering that indicated Resident #377 required substantial/maximal assistance. Record review of Resident #377's care plan with last review date of 5/28/24 revealed Resident #377 required substantial/maximum assistance with 1-2 staff for showering or bathing. Record review of Resident #377's Documentation Survey Report v2 for May of 2024 revealed no bathing documentation for Resident #377 from when she was admitted to the facility on [DATE] through 5/16/24. There was no documentation that Resident #377 refused or was unavailable for bathing from 5/10-5/16/24. Record review of Resident #378's face sheet dated 5/29/2024, revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including Acute Respiratory Failure with Hypoxia (low blood oxygen levels), Unspecified Dementia (group of symptoms affecting memory, thinking and social abilities) and Muscle Weakness. Record review of Resident #378's admission MDS dated [DATE] revealed a BIMS score of 8 that indicated moderate cognitive impairment. Record review also revealed ADL performance code of 02 for bathing and showering that indicated Resident #378 required substantial/maximal assistance. Record review of Resident #378's care plan with last review date of 5/31/24 revealed resident required substantial/maximum assistance with 1-2 staff for showering or bathing. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #378's Documentation Survey Report v2 for May of 2024 revealed no bathing documentation from 5/3/24 when Resident #378 was admitted to the facility through 5/8/24 when Resident #378 was transferred to the hospital. Resident #378 returned to the facility on 5/20/24 and a bed bath was documented on Wednesday 5/22/24 and the next bed bath was documented on Wednesday 5/29/24 which was an interval of a week. Resident #378 was documented as having refused bathing on Friday 5/24/24. Record review of Resident #378's Progress Notes revealed no documentation regarding bathing or refusal to bathe from 5/3-5/8/24 or from 5/23-5/28/24. Review of an email from Resident #377's family stating Resident #377 had passed away in October of 2024 with no further information given. During interview with Resident #378's family member they said Resident #378 had passed away in October of 2024. The stated it took a long amount of time for staff to provide care when requested and care was lacking. The family member said they were devastated by the fact he was unclean. The family member said Resident #378 was dirty every time they saw him and that they tried to go to the facility at least every other day. During interview on 5/29/25 at 11:50 a.m., the DON said she started at the facility in March of 2025 therefore she was not at the facility when Resident #377 or Resident #378 were admitted . During interview on 5/29/25 at 4:43 p.m., the DON said there would not be any other place the aides would document bathing other than the electronic medial record. During interview on 5/30/24 at 8:44 a.m., the DON said staff was previously not documenting showers right as showers were popping up as a task on their schedule every day. The DON said the shower task had since been changed to only pop up as a task on the resident's shower day. The DON said she could not answer to what the NA meant on the Documentation Survey Report v2 and assumed it meant bathing was not completed. The DON said CNAs had retraining about completing showers about a month ago after she arrived at the facility and had told them they have to document properly. The DON said CNAs received training during orientation, yearly and as needed regarding showering. The DON said if a resident refused to bathe the CNAS were to re-ask the resident and then notify the nurse who would notify the resident's family. The DON said the nurses were responsible for making sure the showers were completed. The DON said since she became the DON, she had the CNAs complete shower sheets which were turned into the nurses and then to the unit manager and then to the DON. The DON said if a resident was not bathed the effect could be skin breakdown to the resident. During interview on 5/30/24 at 9:20 a.m., the ADON said CNAs were responsible for bathing residents and the nurses were who oversaw that the CNAs completed their baths. The ADON said if a resident refused then the CNAs asked again and if the resident continued to refuse then notified the nurse who notified the resident's family. The ADON said CNAs were trained regarding bathing during orientation, yearly check offs and as needed if there were issues with bathing. The ADON said if a resident was not getting bathed appropriately then the resident could have an odor or sadness. The ADON said about three weeks ago they started having the CNAs complete shower sheets which was given to the nurse to sign off and then given to the DON to monitor that showers were being completed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 5/30/24 at 9:28 a.m., the Unit Manager said she did not remember Resident #377 or Resident #378. The state surveyor viewed the shower sheets that the Unit Manager had in her office that had been completed and turned into her. The Unit Manager said the CNA documented on the shower sheets regarding skin issues or breakdown and if the resident had a shower, bed bath or refusal. The Unit Manager said skin breakdown or skin infections could occur if residents were not getting showers appropriately. During interview on 5/30/24 at 9:32 a.m., the Administrator said she did not remember any specific information regarding Resident #378. During interview on 5/30/24 at 3:05 p.m., the Administrator said she had a grievance from Resident #377's family regarding her not being changed every two hours, the facility being short staffed and the resident having a blister in her private area. The Administrator said she addressed the issues with the family and gave them her personal cell phone number for any further concerns which she did not remember them calling. Record review of facility's policy Activities of Daily Living (ADLs) reviewed/revised 1/2025 revealed a resident who was unable to carry out activities of daily living would receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.