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	04/01/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect the residents' right to be free from physical abuse for 1 (Resident #1) of 5 residents reviewed for abuse.The facility failed to ensure Resident #2 was free from physical abuse when Resident #1 hit her leg on 3/16/26.This failure could place residents at risk of emotional distress, fear, decreased quality of life, and abuse.Findings included:Record review of Resident #1's face sheet dated 4/1/26 revealed a [AGE] year-old female who readmitted on [DATE]. Her diagnoses included hemiplegia and hemiparesis (hemiparesis is partial weakness on one side of the body, while hemiplegia is complete or near-complete paralysis on one side affecting right dominant side) following unspecified cerebrovascular disease (refers to a group of conditions that affect the blood vessels of the brain, often leading to stroke or other neurological impairments), dementia, mood disorder, bipolar disorder, psychotic disorder with hallucinations, and depression.Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed a BIMS score of 3 out of 15 which indicated severe cognitive impairment. No physical or verbal behaviors toward others were exhibited during the assessment period. She was dependent on staff for ADL care.Record review of Resident #1's care plan last reviewed 3/6/26 read in part, Behavior problem: [Resident #1] has a unwanted behaviors aeb aggressive behavior (throwing roommates clothes on floor) hitting others, revised 6/6/2025. Goal: [Resident #1] will have no evidence of behavior problems by review date. Interventions were to Administer medications as ordered; Monitor/document for side effects and effectiveness, dated 3/10/2025. Give 1:1 assistance (1:1 assistance typically refers to a support system where one individual provides direct assistance to another) to try and calm resident down, as needed, dated 3/10/2025. Hospice was notified of incident, dated 3/10/2025. [Resident #1] was placed in another room, dated 3/10/2025. No interventions for unwanted behaviors were added since 3/10/2025.Record review of Resident #1's incident report dated 9/6/25 prepared by LVN C read in part, .was reported by another resident, as the another resident was attempting to pull the wc away from the door so another resident could reenter the building from courtyard, as this resident was blocking the doorway and yelling in Spanish at the resident attempting to enter building. This resident, as reported, turned and began kicking at this resident, did not make contact. The other resident involved did state she grabbed the leg of this resident to stop her from making contact. Record review of Resident #1's incident report dated 3/16/26 prepared by LVN C read in part, .Physical Aggression Initiated. was reported that resident approached another resident in activities room, struck other resident to the leg.Record review of Resident #1's nursing note dated 3/16/26 written by LVN C read in part, .was reported to this nurse by activities director, that resident on resident incident was reported by other resident in activities room. This nurse noted this resident had rolled herself into the dining room. other resident was in wc in activities, reported this resident rolled in,struck left leg several times. This resident placed on one on one. administrator, DON notified of incident. MD aware and rec'd order to sent to [local hospital] for assessment. family notified.Record review of Resident #1's hospital record dated 3/16/26 read in part, .ED course: I spoke on the phone with [RN] from [nursing home]. She stated that the patient (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was sent to the emergency room for aggression. She states that there is 1 particular resident at the nursing home who the patient will be physically aggressive with whenever they encounter each other. She is otherwise not aggressive with anyone else or in any other situation. She stated that there is no need for psychiatric evaluation for aggressive if patient has not been aggressive in the emergency room. She states that if the patient has been medically cleared and is not aggressive in the emergency room, they are happy to receive her. Medical Decision Making. presents for evaluation of aggression, not aggressive on my exam. patient is not aggressive here in this appears to be an interpersonal issue between her and the other nursing home resident. No indication for ED psychiatry consult.In an observation on 4/1/26 at 8:22 a.m., 8:51 a.m., 2:18 p.m. and 3:14 p.m. revealed Resident #1 was asleep in bed with a blanket pulled over her head. Record review of Resident #2's face sheet dated 4/1/26 revealed a [AGE] year-old female who admitted on [DATE]. Her diagnoses included cerebral infarction (stroke), hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, contracture, need for assistance with personal care, stiffness, and anxiety.Record review of Resident #2's quarterly MDS assessment dated [DATE] revealed a BIMS score of 15 out of 15 which indicated intact cognition. She was dependent on staff for ADL care.Record review of Resident #2's care plan read in part, (Resident #2) has been observed squinting her eyes when another person/resident approaches or gets close to her. (Resident #2's) behavior is interpreted by others as a negative body language, such as anger or disgust, revised on 3/17/26.Record review of Resident #2's nursing note dated 3/16/26 written by LVN C read in part, .this writer was stopped in the hallway by activities director, was reported that altercation occurred between two residents in activity room, reported and witnessed by two other residents. administrator notified by activities. when this writer entered activities, this resident was in room, other resident had rolled herself to the dining area. this resident was in no distress, denied pain at the time. this resident rolled herself in electric wheelchair to her room. other resident placed on one on one. This nurse and SW spoke with resident in her room, resident in wc, watching ipad. did agree to skin assessment, indicated left leg as area that resident struck with (hand) about 5 times. resident with bilateral legs elevated in leg rests with prevlon [sic] boots bilaterally. skin assessment done with no areas of redness or bruising noted, no pain voiced or noted on palpations of areas. resident denies emotional distress. [family member] notified of incident. requested police report. In an interview on 4/1/26 at 8:58 a.m. Resident #3 said she witnessed the incident between Resident #1 and Resident #2. She said Resident #1 hit Resident #2 on the foot in the activities room a couple of weeks ago. She held Resident #1's hand until a staff member came into the activities room. The Activities Director arrived in the room and Resident #3 reported the incident to her. She had not seen Resident #1 hit any other residents and was unsure if Resident #1 hit Resident #2 before. In an interview on 4/1/26 at 9:23 a.m. Resident #2 said Resident #1 attacked her on sight/when she saw her. She said this occurred 3-4 times. The most recent incident was last week in the activities room when Resident #1 pounded on her left foot. She said no staff were present when it occurred. She felt small, belittled and ignored because she was constantly asking staff (unknown) for Resident #1 to be removed. She said she was not fearful of Resident #1 and felt safe in the building.In an interview on 4/1/26 at 9:35 a.m. the Facility Ombudsman said Resident #1 and Resident #2 did not have a good relationship. A few weeks ago, there was an altercation (between the two). Resident #2 reported to her that she was fine and had friends but did not feel safe when Resident #1 was around. Staff said sometimes Resident #2 made eye gestures around Resident #1. She said a care plan meeting was needed to determine why Resident #1 had so much anger when she saw Resident #2. The facility had not followed up on the care plan meeting request. Resident #2 is limited, cannot move around well, and is stuck in her wheelchair. She said Resident #1 could come from behind her, and last year Resident #1 pulled Resident #2's hair. She said she was unsure if the facility was providing protection for Resident #2 and did not know if the facility was taking the situation seriously.In an interview on 4/1/26 at 11:07 a.m. the Activities Director said Resident #3 reported to her that Resident #1 tried to kick Resident #2 approximately 2 weeks ago. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Activities Director said on that day, she was not present in the room with the residents but was pushing residents into the dining room for lunch and could see through the glass window into the activities room. She questioned the allegation and hoped the residents were not making false statements or trying to gang up on Resident #1. She reported the allegation to the nurse. On approximately Thursday 3/26/26 the Activities Director said she witnessed Resident #1 roll up in her wheelchair and try to kick Resident #2 in the dining room during activities. She told Resident #1 she could not do that, separated them, and reported it to LVN C. She said she ensured the two residents were not together. In an interview on 4/1/26 at 12:34 p.m. the DON said Resident #1 and Resident #2 had an incident about a year ago and were doing fine (until this incident). After the incident on 3/16/26 Resident #2 was assessed and it was reported by the Social Worker that she was not fearful of Resident #1, had no injuries to her leg, and refused x-rays. To ensure the safety of the residents Resident #1 was placed on 1:1 monitoring until she went to the hospital. Resident #1 was also moved to a different hallway, evaluated by psych services, a GDR was completed, medication time was adjusted and behavior monitoring was implemented. The psych doctor at the hospital cleared Resident #1 and said she was pleasantly confused with no distress and Resident #1's psychiatrist said she did not require any additional monitoring at the facility. She said Resident #1 had a BIMS score of 3 (severe impairment) and Resident #2 was with it (cognition intact). Sometimes Resident #2 would go and sit right next to Resident #1. Resident #2 would also squint her eyes at people, and some took offense to it. Resident #2 was educated on trying to stay away from Resident #1. She said Resident #2's family wanted Resident #1 kicked out of the facility. The staff were in-serviced on abuse/neglect, resident to resident altercations, and separating Resident #1 and Resident #2 if seen together. Residents were not allowed to be in the day room, dining room, or activities room alone. She felt the facility was doing everything needed to keep Resident #2 safe.In an interview on 4/1/26 at 1:20 p.m. Resident #2 said she felt unprotected and at random Resident #1 could get angry and lash out at her. She said she was a trigger for Resident #1 and made her mad but had no idea why. She said the most recent incident was unprovoked and Resident #1 struck her 3 times. Staff assessed her and she denied an x-ray and pain medication. She said the incident brought her to tears and her pride and feelings were hurt. She said, Why does this lady (Resident #1) keep hitting me and no one is doing anything for my benefit She said the resident had not physically injured her, but she was fearful of Resident #1 because she did not understand what triggered her. She and Resident #1 were previously roommates and Resident #1 would throw her items on the floor and the two had previous altercations. She said both residents roamed freely and neither were on 1:1 supervision and could not be restricted to certain areas. She said it affected her social living, and it sucked because she had to try and avoid confrontation that she did not know about. She said she still attended social activities but if she saw Resident #1 there, she might avoid it because it was better. She said no further incidents occurred since the last incident and staff tried to keep the two separate.In an interview on 4/1/26 at 3:05 p.m. the Psychiatrist said when he assessed Resident #2 after the incident, she informed him that she felt safe in the building, was not in distress, and did not report being fearful. He said Resident #1 and Resident #2 were on his caseload and normally saw them for mental health and psychiatry services. He said Resident #1 was easily redirected and had dementia. He recommended that the facility place the two residents on different hallways. He said he had not noticed any changes in Resident #2's behavior.In an interview on 4/1/26 at 3:15 p.m. LVN C said she was informed of the incident between Resident #1 and Resident #2. She ensured the safety of the residents and assessed Resident #2 with no discoloration or bruising. The MD, DON, and Administrator were notified immediately. Interventions included ensuring the residents were not in the same vicinity. In an interview on 4/1/26 at 3:26 p.m. Resident #4 said Resident #1 hits Resident 2 and gets in a rage when she sees Resident #2. He said incidents occurred between the two residents 2 times in the activity room and 1 time outside. He said Resident #1 came into the activities room and started hitting Resident #2 on the foot for no reason. In an interview on 4/1/26 at 4:05 p.m. the Administrator said since he had been at the facility (October (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1, 2025) this was the first incident between Resident #1 and Resident #2 and believed the interventions were effective. He said the DA dropped the charges and determined that it was one resident who slapped the other, nothing serious so to say. He said there were also different stories shared about the incident that included kicking and/or slapping. He said there were witnesses to the incident, but they were friends of Resident #2 and may or may not be reliable. He said he immediately investigated the incident, called the police, separated the residents, sent Resident #1 out to see psych, monitored them throughout the week, spoke with the attending MD and had the residents evaluated by psych in the facility. Resident #1 and Resident #2 were on separate hallways and were monitored to ensure they were not close to each other. He said Resident #1 shared with him in Spanish that Resident #2 was the one who liked to purchase all the meat. He said Resident #1's BIMS score was a 3, she was a very pleasant lady, and he did not see where she was a threat to anyone in the facility. He said someone could push her buttons, but she was very calm. He said Resident #2 had a BIMS score of 15, was able to ambulate, make decisions, and was emotional. He said Resident #2's family was very demanding, and he was unable to tell Resident #1 that she had to go somewhere else (move out of the facility). He in-serviced the staff on abuse/neglect and resident to resident altercations. Record review of the facility's in-service attendance record dated 3/16/26 revealed Topic: resident to resident altercation. In the event that there is a resident-to-resident altercation, it is imperative to ensure the safety of both residents . Residents must be separated immediately. The Administrator must be notified immediately and IR must be completed. MD, RP, and DON must be notified of situation. Record review of the facility's Abuse, Neglect, and Exploitation policy revised on 5/2025 read in part, .it is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the interdisciplinary team reviewed and revised the resident's comprehensive care plan after each assessment for 1 (Resident #1) of 5 residents reviewed for care plan revisions.The facility failed to update and add interventions to Resident #1's care plan regarding physical behaviors toward other residents, including Resident #2.This failure could place residents at risk of injury.Findings included:Record review of Resident #1's face sheet dated 4/1/26 revealed a [AGE] year-old female who readmitted on [DATE]. Her diagnoses included hemiplegia and hemiparesis (hemiparesis is partial weakness on one side of the body, while hemiplegia is complete or near-complete paralysis on one side affecting right dominant side) following unspecified cerebrovascular disease (refers to a group of conditions that affect the blood vessels of the brain, often leading to stroke or other neurological impairments), dementia, mood disorder, bipolar disorder, psychotic disorder with hallucinations, and depression.Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed a BIMS score of 3 out of 15 which indicated severe cognitive impairment. No physical or verbal behaviors toward others were exhibited during the assessment period. She was dependent on staff for ADL care.Record review of Resident #1's care plan last reviewed 3/6/26 read in part, Behavior problem: [Resident #1] has a unwanted behaviors aeb aggressive behavior (throwing roommates clothes on floor) hitting others, revised 6/6/2025. Goal: [Resident #1] will have no evidence of behavior problems by review date. Interventions were to Administer medications as ordered; Monitor/document for side effects and effectiveness, dated 3/10/2025. Give 1:1 assistance (1:1 assistance typically refers to a support system where one individual provides direct assistance to another) to try and calm resident down, as needed, dated 3/10/2025. Hospice was notified of incident, dated 3/10/2025. [Resident #1] was placed in another room, dated 3/10/2025. No interventions for unwanted behaviors were added since 3/10/2025.Record review of Resident #1's incident report dated 9/6/25 prepared by LVN C read in part, .was reported by another resident, as the another resident was attempting to pull the wc away from the door so another resident could reenter the building from courtyard, as this resident was blocking the doorway and yelling in Spanish at the resident attempting to enter building. This resident, as reported, turned and began kicking at this resident, did not make contact. The other resident involved did state she grabbed the leg of this resident to stop her from making contact. Record review of Resident #1's incident report dated 3/16/26 prepared by LVN C read in part, .Physical Aggression Initiated. was reported that resident approached another resident in activities room, struck other resident to the leg.Record review of Resident #1's nursing note dated 3/16/26 written by LVN C read in part, .was reported to this nurse by activities director, that resident on resident incident was reported by other resident in activities room. This nurse noted this resident had rolled herself into the dining room. other resident was in wc in activities, reported this resident rolled in,struck left leg several times. this resident placed on one on one. administrator, DON notified of incident. MD aware and rec'd order to sent to [local hospital] for assessment. family notified.Record review of Resident #1's hospital record dated 3/16/26 read in part, .ED course: I spoke on the phone with [RN] from [nursing home]. She stated that the patient was sent to the emergency room for aggression. She states that there is 1 particular resident at the nursing home who the patient will be physically aggressive with whenever they encounter each other. She is otherwise not aggressive with anyone else or in any other situation. She stated that there is no need for psychiatric evaluation for aggressive if patient has not been aggressive in the emergency room. She states that if the patient has been medically cleared and is not aggressive in the emergency room, they are happy to receive her. Medical Decision Making. presents for evaluation of aggression, not aggressive on my exam. patient is not aggressive here in this appears to be an interpersonal issue between her and the other (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nursing home resident. No indication for ED psychiatry consult.In an observation on 4/1/26 at 8:22 a.m., 8:51 a.m., 2:18 p.m. and 3:14 p.m. revealed Resident #1 was asleep in bed with a blanket pulled over her head. Record review of Resident #2's face sheet dated 4/1/26 revealed a [AGE] year-old female who admitted on [DATE]. Her diagnoses included cerebral infarction (stroke), hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, contracture, need for assistance with personal care, stiffness, and anxiety.Record review of Resident #2's quarterly MDS assessment dated [DATE] revealed a BIMS score of 15 out of 15 which indicated intact cognition. She was dependent on staff for ADL care.Record review of Resident #2's nursing note dated 3/16/26 written by LVN C read in part, .this writer was stopped in the hallway by activities director, was reported that altercation occurred between two residents in activity room, reported and witnessed by two other residents. administrator notified by activities. when this writer entered activities, this resident was in room, other resident had rolled herself to the dining area. this resident was in no distress, denied pain at the time. this resident rolled herself in electric wheelchair to her room. other resident placed on one on one. This nurse and SW spoke with resident in her room, resident in wc, watching ipad. did agree to skin assessment, indicated left leg as area that resident struck with (hand) about 5 times. resident with bilateral legs elevated in leg rests with prevlon [sic] boots bilaterally. skin assessment done with no areas of redness or bruising noted, no pain voiced or noted on palpations of areas. resident denies emotional distress. [family member] notified of incident. requested police report. In an interview on 4/1/26 at 8:58 a.m. Resident #3 said she witnessed the incident between Resident #1 and Resident #2. She said Resident #1 hit Resident #2 on the foot in the activities room a couple of weeks ago. She held Resident #1's hand until a staff member came into the activities room. The Activities Director arrived in the room and Resident #3 reported the incident to her. She had not seen Resident #1 hit any other residents and was unsure if Resident #1 hit Resident #2 before. In an interview on 4/1/26 at 9:23 a.m. Resident #2 said Resident #1 attacked her on sight/when she saw her. She said this occurred 3-4 times. The most recent incident was last week in the activities room when Resident #1 pounded on her left foot. She said no staff were present when it occurred. She felt small, belittled and ignored because she was constantly asking staff (unknown) for Resident #1 to be removed. She said she was not fearful of Resident #1 and felt safe in the building.In an interview on 4/1/26 at 9:35 a.m. the Facility Ombudsman said Resident #1 and Resident #2 did not have a good relationship. A few weeks ago, there was an altercation (between the two). Resident #2 reported to her that she was fine and had friends but did not feel safe when Resident #1 was around. Staff said sometimes Resident #2 made eye gestures around Resident #1. She said a care plan meeting was needed to determine why Resident #1 had so much anger when she saw Resident #2. The facility had not followed up on the care plan meeting request. Resident #2 is limited, cannot move around well, and is stuck in her wheelchair. She said Resident #1 could come from behind her, and last year Resident #1 pulled Resident #2's hair. She said she was unsure if the facility was providing protection for Resident #2 and did not know if the facility was taking the situation seriously.In an interview on 4/1/26 at 11:07 a.m. the Activities Director said Resident #3 reported to her that Resident #1 tried to kick Resident #2 approximately 2 weeks ago. She reported the information to the nurse. She said on approximately Thursday 3/26/26. Resident #1 rolled up in her wheelchair and tried to kick Resident #2 in the dining room. She told Resident #1 she could not do that, separated them, and reported it to LVN C. She said she ensured the two residents were not together. In an interview on 4/1/26 at 12:34 p.m. the DON said she and the MDS nurse were responsible for updating the care plan. She said Resident #1 already had behaviors care planned, and she did not know what else to put on the care plan because the behaviors were on there indefinitely. She said she had not conducted a recent care plan with Resident #1. After the incident on 3/16/26 Resident #1 was placed on 1:1 monitoring until she went to the hospital. Resident #1 was also moved to a different hallway, evaluated by psych services, a GDR was completed, medication time was adjusted and behavior monitoring was implemented. She said she forgot to put the interventions on (continued on next page)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1's care plan. She said interventions should be on the care plan to ensure they are in place and to make the staff aware of the plan of care and any previous behaviors to see what interventions are currently in place to avoid an incident from happening again. She said everyone used the care plan and CNAs used the Kardex (a nursing documentation system used to organize and quickly reference essential patient information for daily care). She felt the facility was doing everything needed to keep Resident #2 safe.In an interview on 4/1/26 at 1:20 p.m. Resident #2 said she felt unprotected and at random Resident #1 could get angry and lash out at her. She said the most recent incident was unprovoked. Staff assessed her and she denied an x-ray and pain medication. She said the incident brought her to tears and her pride and feelings were hurt. She said Why does this lady (Resident #1) keep hitting me and no one is doing anything for my benefit She said the resident had not physically injured her, but she was fearful of Resident #1 because she did not understand what triggered her. In an interview on 4/1/26 at 1:50 p.m. CNA G said she normally worked the overnight shift, and the residents were normally asleep at that time. She said she was not aware of any concerns between Resident #1 and Resident #2 but she would separate any residents who became involved in a resident-to-resident altercation. She said she could refer to the Kardex, POC, and nurse for interventions. In an interview on 4/1/26 at 3:15 p.m. LVN C said she was informed of the incident between Resident #1 and Resident #2. She ensured the safety of the residents and assessed Resident #2 with no discoloration or bruising. The MD, DON, and Administrator were notified immediately. Interventions included ensuring the residents were not in the same vicinity. In an interview on 4/1/26 at 3:26 p.m. Resident #4 said Resident #1 hits Resident 2 and gets in a rage when she sees Resident #2. He said incidents occurred between the two residents 2 times in the activity room and 1 time outside. He said Resident #1came into the activities room and started hitting Resident #2 on the foot for no reason. In an interview on 4/1/26 at 4:05 p.m. the Administrator said he expected care plans to be executed and to see if the interventions worked. If interventions did not work staff would adjust to something that worked. He said behaviors and interventions should be made known to the staff through methods such as staff communication and the electronic medical record. He said staff should use the care plan and the purpose was to ensure staff knew how to take care of the patient. Record review of the facility's Comprehensive Care Plans policy revised 1/2026 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 residents' comprehensive assessment. Policy Explanation and Compliance Guidelines. 2. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment. other factors identified by the interdisciplinary team or in accordance with the resident's preferences, will also be addressed in the plan of care. 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. f. Resident specific interventions that reflect the resident's needs and preferences and align with the resident's cultural identity, as indicated. 5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment.