

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676412	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2026
NAME OF PROVIDER OR SUPPLIER Fall Creek Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 observation, interview, and record review, the facility failed to develop a comprehensive person-centered care plan for each resident to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 6 residents (Resident #74) reviewed for comprehensive care plans. -The facility failed to provide Resident #74 with a comprehensive resident centered care plan to address her pressure ulcers. This failure could place residents at risk of not having their specific care needs met and from reaching their highest practicable well-being. Findings included: Record review of Resident #74's undated face sheet, revealed a [AGE] year old female, who admitted to the facility on [DATE] with diagnoses of displaced intertrochanteric fracture of right femur (right hip fracture), diverticulitis of large intestine (inflammation or infection of small pouches in lining of large intestine), stage 4 pressure ulcer of sacrum (exposed bone, tendon, or muscle of the tailbone area), stage 3 pressure ulcer of right buttock (subcutaneous fat visible but bone, tendon, muscle is not), non-pressure ulcer (open sore not caused by prolonged pressure) of right thigh, cognitive communication deficit (impaired ability to speak, listen, read, or write), bladder neck obstruction (urine unable to flow out of bladder), dementia (memory loss, impaired reasoning, and communication difficulties), and need for assistance. Record review of Resident #74's admission MDS assessment dated [DATE], revealed a BIMS Score of 14 which indicated normal cognition. The resident had an indwelling catheter (tube into bladder to drain urine) and was always incontinent of bowel. According to the MDS assessment, the resident had one or more unhealed pressure ulcers/injuries. The resident had one stage 3 pressure ulcer and one stage 4 pressure ulcer that were present upon admission, and she had one surgical wound. Record review of Resident #74's Care Plan dated 4/13/26 revealed a Focus: Resident #74 was at risk for further skin breakdown R/T decreased mobility, incontinence. The interventions included weekly skin assessments, and notifying the MD for ulcers that were deteriorating, a pressure relieving mattress, and assisting with turning & repositioning during rounds and as needed. The actual pressure ulcers were not on the Care Plan. Record review of Resident #74's Progress Notes dated 6/24/26 at 12:45pm from NP Q revealed the resident had a non-pressure ulcer of the right thigh, a stage 3 pressure ulcer of the right buttock, and a stage 4 pressure ulcer of the sacrum. Record review of Resident #74's Skin Observation dated 7/10/26 at 2:28pm from the Wound Care Nurse revealed the resident had a left heel DTI (injury caused by pressure that has not caused a wound yet) that measured 1.5cm x 1.5cm, a right heel DTI that measured 4cm x 2cm, a stage 3 pressure ulcer to the left buttock that measured 6cm x 2cm, and a stage 3 pressure ulcer to the right buttock that measured 2cm x 1cm. In an observation on 7/14/26 at 9:50am, Resident #74 was lying on her back in bed. She had an air mattress and heel boots on. The resident was non-verbal. Record review of Resident #74's Wound Care Note dated 7/16/26 at 6:46am (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 - Minimal harm or potential for actual harm Residents Affected - Few	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 developed within 7 days after the completion of the comprehensive MDS assessment. All Care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the plan of care. Other factors identified by the interdisciplinary team, or in accordance with the resident's preferences, will also be addressed in the plan of care. The facility's rationale for deciding whether to proceed with care planning will be evidenced in the clinical record. The comprehensive care plan will describe, at a minimum, the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. 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.		