STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455815	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fallbrook Rehabiliation and Care Center	10851 Crescent Moon Dr Houston, TX 77064

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review, the facility failed to ensure medication carts were secured for 3 of 5 medication carts (MC #1, MC #2, and MC #3) reviewed for drug storage and labeling.The facility failed to ensure MC #1, MC #2 and MC #3 were locked, medications secured, and not accessible to other staff, residents, or visitors. This failure could place residents at risk of having unauthorized access to medications, decreased effectiveness of medication, or missing medications.Findings included:During an observation on 11/18/2025 at 4:39p.m., revealed MC #1 and MC #2, was on the wall across from the nurses' station, and unlocked. The nurse was going through medication on both medication carts when she walked off and went down the hall and into a resident's room. When the LVN A walked off she left three blister packs of medication on top of MC #1. She also left MC #1 and MC #2 unlocked while a resident was sitting next to MC #1. MC #1 and MC#2 both contained residents' prescription drugs, over the counter medications like Tylenol Ibuprofen, and vitamins, and narcotics in a locked box in the medication cart.During an observation on 11/19/2025 at 12:55p.m., revealed MC #3, was on the wall across from the nurses' station and unlocked. The nurse was sitting at the nurse's station talking to another staff member. The LVN B did not see the surveyor open the drawers and take pictures. MC #3 had residents' prescription drugs, mucus extended release5, stool softener, oral pain relief gel, allergy relief and syringes. During an interview with LVN A on 11/18/2025 at 4:42p.m., she had been trained on medication storage. She said the policy for the medication carts was the medication cart must always be locked when not around it. She said she was responsible for ensuring the medication carts were locked. She said if the medication carts were left unlocked and unattended a resident could get into the cart. She said the DON monitored to ensure the medication carts were locked. She said the DON monitored the medication carts by observations. She said she left the medication out and MC#1 and MC#2 unlocked because she had to go check on a resident. She said she should have locked both carts and put the medication up. During an interview with LVN B on 11/19/2025 at 12:56p.m., she had been trained on medication storage. She said the policy for the medication carts was the medication cart must always be locked when staff were not using the cart. She said the nurses were responsible for ensuring the medication carts were locked. She said if the medication carts were left unlocked and unattended anyone could get into the cart. She said the DON monitored to ensure the medication carts were locked. She said the ADM monitored the medication carts through observations. She said MC #3 was left open by another nurse, but it was her medication cart. She said she did not see the surveyor opening the drawers on the medication cart. During an interview with the DON on 11/20/2025 at 2:38p.m., he said he had been trained on medication storage. He said the policy for the medication cart was that it needed to be locked and the narcotics needed to be double locked. He also said the medication cart was to be locked anytime staff walked away from it. He said if the medication was left unlocked and unattended something could come up missing and a resident would not get their medications. He said the DON and ADM monitors to ensure staff are locking the medication carts. He said the DON and ADM monitored through observation. He also said any staff could monitor the medication carts and let the nurse know the cart was unlocked. He said he did not know why the medication carts were unlocked. He also said he did not know why the nurse left medication on top of MC #1. During an interview with the ADM on 11/20/2025 at 12:58p.m., he said he had been trained on medication storage. He said the policy for medication storage the medication cart had to be locked any time staff walked away from the cart. He said the medication cart should be locked anytime the nurse turned away from the medication cart. He said if the mediation cart was left unlocked or unattended someone could take something from the medication cart. He also said the resident would not have their medications and the facility would have to reorder the medication. He said the person who was on the medication cart was responsible for ensuring the cart was locked. He also said the DON monitored to ensure staff were locking the medication carts. He said the DON would monitor through observations. He said he did not know why the medication carts were unlocked. He also said he did not know why LVN A left medication on top of the medication cart when she walked away. Record review of Medication Storage Policy dated 9/1/2021, revealed It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security.