

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

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/04/2024
NAME OF PROVIDER OR SUPPLIER Falcon Point Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 23553 West Fernhurst Drive Katy, TX 77494	
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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36918 Based on observation, interview and record review, the facility failed to ensure the residents' right to privacy during personal care for 2 of 5 residents (Resident #1 and Resident #2) reviewed for privacy in that: -The facility failed to ensure CNA J provided privacy during incontinent care for Resident #1. -The facility failed to ensure CNA D provided privacy during incontinent care for Resident #2. This failure could place residents at risk of having their bodies exposed to the public, resulting in low self-esteem and a diminished quality of life. Findings included: Resident #1 Record review of Resident #1's face sheet dated 11/04/24 revealed she was a [AGE] year-old female was admitted to the facility on [DATE]. Resident #1 had diagnoses which included: diabetes mellitus (body do not produce enough insulin or cannot use it properly), atherosclerotic heart disease (inflammatory disease of the arteries), and heart disease (conditions that affect the heart). Record review of Resident #1's admission MDS assessment dated [DATE] revealed a BIMS score of 11 of 15 indicated moderate impaired cognition. Further review revealed the resident needed extensive assistance with ADL and was incontinent of bowel and bladder. Record review of Resident #1's baseline care plan dated 10/07/24 revealed resident had ADL self-care deficits and frequently incontinent of bowel and bladder. During an observation on 10/09/24 at 1:48 p.m., during incontinent care for Resident #1, CNA J did not close the blind or pull the privacy curtain around the bed. Resident # 1 was in a private room, but if anybody opened the door or walked by the window, they could see Resident #1 exposed body. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 676195	Facility ID: 676195 If continuation sheet Page 1 of 7

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/09/24 at 5:50 p.m., CNA J said she did not close the curtain because Resident #1 was in the room by herself, and she forgot to close the blind, and anybody passing by the window could see Resident #1. CNA J said if somebody opened the door while she provided care, then the person could see Resident #1, and Resident #1 did not have privacy, which was a dignity issue. CNA J said she had a skill - check off on dignity, and the nurse monitored aides when the nurse made random rounds. During an interview on 11/04/24 at 7:38 a.m., the DON said when CNA J was providing care for Resident # 1, to maintain privacy, the door, the curtain, and the blind should be closed to prevent anybody from seeing Resident #1 during care because it was a dignity issue. The DON said the nurse monitored the aides, and the nursing managers monitored the nurses during random rounds. During an interview on 11/04/24 at 12:36 p.m., the Administrator said CNA J should have pulled the window blind and the privacy curtain during care to prevent the resident from being exposed if anybody walked into the room or by the window. Resident #2 Record review of Resident #2's face sheet dated 10/10/24 revealed she was a [AGE] year-old female was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #2 had diagnoses which included: dementia (loss of cognitive functioning), hypertension (blood pushing against the walls of the arteries is consistently high), and cerebral infraction (lack of adequate blood supply to the brain which can cause parts of the brain to die off). Record review of Resident #2's quarterly MDS assessment dated [DATE] revealed a BIMS score of 03 of 15 indicated severely impaired cognition. Further review revealed the resident needed extensive assistance to dependent on staff with ADL and was incontinent of bowel and bladder. Record review of Resident #2's undated care plan revealed resident had ADL self-care performance deficit related to impaired mobility. Interventions: toilet use. The resident required extensive assistance by one staff. During an observation on 10/09/24 at 2:35 p.m., when incontinent care was provided for Resident #2 by CNA D. CNA D did not pull the curtain around the bed to provide complete privacy during incontinent care, the foot of the bed was open. Resident #2's bed was by the door, and she had a roommate. During an interview on 10/09/24 at 4:28 p.m., CNA D said she had already started incontinent care for Resident #2 when she realized she had not pulled the curtain around the bed. CNA D stated because she did not pull the curtain around the bed, anybody who walked into the room could see Resident #2 naked, and it was a dignity issue. CNA D said she had a skill - check off on dignity, and the nurse monitored aides when the nurse made random rounds. (continued on next page)		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/09/24 at 6:39 p.m., RN A said CNA D should have closed the curtain, blind, and door; this action were taken to provide privacy for Resident #2. RN A said if the blind was not closed, then anybody could see Resident#2, and it was not right. RN A said CNA D should have pulled the privacy curtain around the bed to prevent anybody who walked into the room from seeing Resident #2, even if the resident was in a private room and it was a dignity issue. RN A said she had a skill - check off on privacy, and the nurse monitored the aides while the DON monitored the nurse during Random rounding. Record review of the facility policy on dignity dated 2001 (Revised February 2021) read in part . each resident shall be cared for in a manner that promote and enhance his or her sense of well - being . policy interpretation and implementation . # 11. Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures .		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 36918 Based on observation, interview, and record review the facility failed to ensure a resident who was unable to carry out activities of daily living (ADLs) received the necessary services to maintain nutrition, grooming and personal and oral hygiene for 3 of 5 residents (Resident #1, Resident #2, and Resident # 3) reviewed for ADLs. The facility failed to ensure Resident #1, Resident #2 and Resident #3 were provided with timely incontinent care by facility staff. This failure could place residents at risk for discomfort, skin breakdown, and urinary tract infections. Findings included: Resident #1 Record review of Resident #1's face sheet dated 11/04/24 revealed she was a [AGE] year-old female was admitted to the facility on [DATE]. Resident #1 had diagnoses which included: diabetes mellitus (body do not produce enough insulin or cannot use it properly), atherosclerotic heart disease (inflammatory disease of the arteries), and heart disease (conditions that affects the heart), Record review of Resident #1's admission MDS assessment dated [DATE] revealed a BIMS score of 11 of 15 indicated moderate impaired cognition. Further review revealed the resident needed extensive assistance with ADL and was incontinent of bowel and bladder. Record review of Resident #1's baseline care plan dated 10/07/24 revealed resident had ADL self-care deficits and frequently incontinent of bowel and bladder. During an interview on 10/09/24 at 1:27 p.m., Resident #1 said she was wet and needed to be changed. Resident #1 said the staff did not come to check on her often because she was changed by CNA J either before breakfast or after breakfast. Resident #1 said the nurse treated her surgical site after CNA J provided incontinent care. During an observation on 10/09/24 at 1:49 p.m., the incontinent care provided by CNA J for Resident #1 revealed that the incontinent brief was saturated with urine from front to back. The incontinent brief stuffing was broken apart, and the wet line indicator was smeared and faded. During an interview on 10/09/24 at 5:54 p.m., CNA J said she was Resident #1's aide and came to work at 7:00 a.m. CNA J said she checked Resident #1 when the wound care nurse changed Resident #1's dressing, and Resident #1 was not wet. CNA J said it had been more than four hours since she checked on Resident #1 because she was busy with other residents. CNA J said Resident #1 incontinent brief was soaked with urine, the wet indicator line on the incontinent brief was dark blue, and some parts of the line was faded. CNA J said Resident #1 could have a skin breakdown if she were left with the wet incontinent brief. CNA J said the nurse monitored the aides during rounding. CNA J said she had in service on incontinent care. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/04/24 at 7:20 a.m., the DON said the aides should make rounds every two hours and when a resident called for help. The DON said if Resident #1 was left in a wet, incontinent brief for an extended period, Resident #1 could have skin breakdown and possibly infection. The DON said CNA J should have a skills - check off during orientation and in service on incontinent care occasionally. The DON said the nurse monitored the aides during rounds, and the unit manager and the DON monitored the nurses when they made random rounds. During an interview on 11/04/24 at 12:29 p.m., the Administrator said the aides should make rounds for incontinent care every two hours. The Administrator said Resident #1 could have skin breakdown, general discomfort, and rash if she was left sitting or lying in a wet incontinent berif. Resident #2 Record review of Resident #2's face sheet dated 10/10/24 revealed she was a [AGE] year-old female was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #2 had diagnoses which included: dementia (loss of cognitive functioning), hypertension (blood pushing against the walls of the arteries is consistently high), and cerebral infraction (lack of adequate blood supply to the brain which can cause parts of the brain to die off), Record review of Resident #2's quarterly MDS assessment dated [DATE] revealed a BIMS score of 03 of 15 indicated severely impaired cognition. Further review revealed the resident needed extensive assistance to dependent on staff with ADL and was incontinent of bowel and bladder. Record review of Resident #2's undated care plan revealed resident had ADL self-care performance deficit related to impaired mobility. Interventions: toilet use. The resident required extensive assistance from one staff. During an interview on 10/09/24 at 2:12 p.m., Resident #2's FM said she had been with Resident #2 since after breakfast, and the night shift usually gets her up, and the staff does not put her back in bed until after lunch. Resident #2's FM said none of the aides had come to check on Resident #2 to see if she was wet and needed to be changed. During an interview on 10/09/14 at 2:21 p.m., RN A said she was Resident#2's nurse, and the night shift got her up. RN A said she had been busy and had not checked on Resident #2 after making the initial rounding, and the aide did not say she refused care. RN A said the aide for Resident #2 was CNA S, and he came to work around 11:00 a.m. RN A said CNA J cared for Resident #2 before CNA S came to work. During an interview on 10/09/24 at 2:30 p.m., CNA J said Resident #2 was not assigned to her. CNA J said she did not get Resident #2 up this morning because she was on a night shift get-up. CNA J said she had not changed or checked on Resident #2 today. CNA J said if Resident #2 was left on a wet, incontinent brief, Resident#2 could get rashes, skin breakdown, and infection. During an observation on 10/09/24 at 2:35 p.m., incontinent care was provided for Resident #2 by CNA D. When CNA D removed Resident #2's pants, it revealed that Resident #2 incontinent brief was saturated with urine and the wet indicator line was dark blue, mashed and was faded out in the front of the brief and the resident pant was wet from front to the buttocks. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/09/24 at 4:28 p.m., CNA D said Resident #2 pants were wet from urine from between her legs to her buttocks. CNA D said she did not have Resident #2, but she was asked to go and change Resident #2. CNA D said the incontinent brief was saturated urine, and it looked like Resident #2 had not been changed in hours. CNA D said Resident #2 could have a pressure ulcer and infection if Resident #2 was left in a wet urine incontinent brief. CNA D said the nurses were responsible for monitoring the aides and making sure they provided appropriate care for the residents. CNA D said she had skills - check off on rounding and incontinent care, and aides should make rounds for incontinent every two hours. During an interview on 10/09/24 at 5:35 p.m., CNA S said he had not changed Resident #2 since he came in to work today at 11:00 a.m., and Resident #2 was already in her wheelchair when he came to work, and he had not seen or changed her incontinent brief. CNA S said he was supposed to make rounds every two hours for incontinent care. He said Resident #2's buttocks could turn red and eventually become a bed sore if she was left to sit on a wet urine brief for an extended period. CNA S said he had skill check off on incontinent care and rounding. CNA S said the nurse monitors the aides when the nurse made random round. During an Interview on 10/09/24 at 6:31 p.m., RN A said the aides should make rounds every two hours and as needed. RN A said CNA J was Resident #2 before CNA S came, took work, and took over from CNA J. RN A said both (CNA J and CNA S) did not check on Resident #2 if she needed changing. RN A said Resident #2 would start to develop redness, and from that, it could become a pressure ulcer. RN A said the nurses monitored the aides during rounds, and she did not ask CNA J and CNA S if Resident #2 was changed because she was busy with medication passes. She said she had in service on incontinent care and rounding. Resident #3 Record review of Resident #3's face sheet dated 10/10/24 revealed she was an [AGE] year-old female was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #3 had diagnoses which included: dementia (loss of cognitive functioning), cerebrovascular disease (conditions which affect the blood vessels in the brain and spinal cord), and heart failure (conditions that occurs when the heart cannot pump enough oxygen rich blood to the body). Record review of Resident #3's quarterly MDS assessment dated [DATE] revealed a BIMS score of 12 of 15 indicated moderate impaired cognition. Further review revealed the resident needed moderate assistance with ADL and was incontinent of bowel and bladder. Record review of Resident #3's care plan revision dated 08/21/24 revealed Resident #3 has frequent episodes of bowel and bladder incontinence due to impaired physical and functional mobility. Interventions: observe during rounding on all shifts for incontinent episodes, and assist. Provided incontinent care every shift and as needed using appropriate technique. During an observation and interview on 10/09/24 at 3:00 p.m., it revealed Resident #3 was sitting in her wheelchair in front of her room door, and her pants between her legs were wet and had an ammonia odor(urine). Resident #3 said she was changed in the morning before breakfast and sitting here waiting for the aide to come and change her. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 10/09/24 at 3:03 p.m., CNA U asked Resident #3 if she needed help and Resident #3 pointed to her pants. CNA U said Resident #3 pants were wet with urine. During an interview on 10/09/24 at 6:24 p.m., CNA U said Resident #3 had a wet incontinent brief, which caused Resident #3's pants to be soaked with urine. CNA U said Resident #3 was not changed for about four hours or more, which could cause the urine to leak onto Resident #3 pants. CNA U said Resident #3 would have a skin breakdown if she continued to sit on a wet, incontinent brief. CNA U said the nurses monitored the aides when they made rounds. CNA U said she had skills check-off and in-service on incontinent care and rounding. CNA U said she was not the aide for Resident #3. CNA U said aides made rounds every 2 hours and as needed for incontinent care. During an interview on 10/09/24 at 6:50 p.m., LVN O said aides should make rounds every two hours for incontinent care. LVN O said if Resident #3 was wet on the buttock and between the legs, Resident #3 had not been changed for more than two hours. LVN O said if Resident #3 sat on a wet brief, it could cause skin breakdown. LVN O said the charge nurse monitors the aides during rounding. LVN O said the aide did not tell him Resident #3 refused to be changed. LVN O said he did not check on the resident because it was a busy day. LVN O did not respond when he was asked what was different from today and other days. LVN O said he had in-service on rounding and incontinent care. Record review of the facility skill check off on perineal/ incontinent care dated 10/22/24 signed By Sunday CNA S revealed he had training on incontinent care. Record review of the facility skill check off on perineal/ incontinent care dated 10/14/24 signed By Sunday CNA U revealed she had training on incontinent care. Record review of the facility skill check off on perineal/ incontinent care dated 10/14/24 signed By Sunday CNA D revealed she had training on incontinent care. Record review of the facility policy on ADL dated 2001 (Revised March 2018) read in part . residents will receive services to maintain . grooming .		