STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676195	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Falcon Point Post Acute	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain an infection and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infections for 1 (CR#1) of 10 residents reviewed for infection control. The facility failed to clean and disinfect blood from the wall and carpet in Room B, after CR#1 had a fall on 12/31/25 the resulted in a head injury. These failures could place residents at risk of sickness, infection, and a diminished quality of life. Findings included:Record review of CR#1's facesheet revealed a [AGE] year-old woman was initially admitted on [DATE], and the most current admission date was on 12/20/25. Her admitting diagnoses were COPD (ongoing lung condition caused by damage to the lungs), dementia (loss of cognitive functioning that interferes with daily life and activities) with mild behavior disturbance, macular degeneration (eye disease that affects central vision), difficulty in walking, respiratory failure, and cognitive communication deficit (refers to difficulties in communication that arise from impairments in cognitive processes, affecting an individual's ability to express and understand messages effectively). Record review of CR#1's care plan last updated 12/28/25 revealed that she had impaired visual function and severe visual impairment related to macular degeneration. CR#1 also had a history of falls. In December 2025, it was documented that CR#1 had an unwitnessed fall without injury on 12/21/25, witnessed falls without injury on 12/28/25 and 12/29/25, and an unwitnessed fall with injury on 12/31/25. Record review of CR#1's MDS dated [DATE], under Section C- Cognitive patterns revealed a BIMS score of 15 (normal cognition). Record review of an updated BIMS assessment for CR#1, completed 12/27/25, revealed a score of 6 (severe cognitive impairment). Record review of CR#1's progress notes dated 12/30/25 at 1:05 p.m., social services documented that he contacted CR#1's RP and informed her that CR#1 was moved from Room A to Room B and the RP agreed with the move. Record review of CR#1's progress notes dated 12/31/25 at 12:53 p.m., LVN A documented a CIC (change in condition) due to a fall. Her BP was 120/70, P- 61, and temp- 97.8 degrees. CR#1 experienced increased confusion and memory loss. Record review of CR#1's progress notes dated 12/31/25 at 2:03 p.m., LVN A documented that she found CR#1 on the floor in Room B after an unwitnessed fall. Noted with bruising and active bleeding to forehead. Pressure was applied, vital signs obtained, NP, and family notified. CR#1 was transferred to the hospital for further evaluation and left the unit in stable condition. Record review of CR#1's progress notes dated 1/2/26 at 4:10 p.m., the DON documented that he communicated with the RP and CR#1 was accepted to a different nursing home and she would be admitted after her hospital discharge. In an interview on 1/6/26 at 10:17 a.m., the RP stated after CR#1 was discharged to the hospital post fall, she went back to the facility on 1/3/26 to grab the rest of CR#1's belongings. Inside the room, she found a bloody pillow that was sitting inside of CR#1's wheelchair, clothing items inside of the drawers of the resident who lived there previously, and fecal matter on the bottom of the other bed. The RP stated that Room B was not cleaned prior to (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CR#1's room change and stated it looked like the room had been used as storage. The RP stated that she would submit photos with time stamps into evidence. In an observation on 1/6/26 at 12:20 p.m., Room B was vacant with 2 beds inside the room and the dresser was tucked in a corner near the front door. A few feet next to the closet, there was a dark reddish/purple circle the size of a fist on the carpet near the front of the room. The origin of the spot was unknown. Record review of the photographic evidence submitted by the RP on behalf of CR#1 on 1/7/26 at 10:26 p.m. revealed the following:Thursday 1/1/26 at 3:19 p.m., indicated there was a white pillowcase on a pillow sitting across the handlebars of the wheelchair. There was bright red blood on the right side of the pillowcase and there was blood on the pillow. An oxygen machine can be seen in the background. Caption documented that the pillow was inside of Room B and she knew it was CR#1's because it was inside of the wheelchair she used. In an interview on 1/8/26 at 11:17 a.m., LVN A stated that she was PRN and she came into work once a week. She stated that she was informed on 12/30/25 that CR#1 was moving into Room B on the skilled hallway, and Resident #2 who resided in that room, would be moving to a room on the long-term care side of the facility. She stated that prior to CR#1's move in, the room should have been deep cleaned. LVN A explained a deep clean consisted of using disinfectant and alcohol wipes to wipe everything down, changing linens, and removing all items out of the room from previous residents. Prior to moving in, the nurse on duty would verify that was done before another resident moved in. LVN A stated that she was the nurse who found CR#1 on 12/31/25 post fall. She stated when she found her, her head was bleeding and she sat in the middle of the floor. Her oxygen tank was next to her and she hypothesized (educated guess) that CR#1 could have hit her head on the floor or the wall. In an observation on 1/8/26 at 11:27 a.m., LVN A joined the surveyor back inside of Room B to explain how she found CR#1 post fall. In the area where LVN A stated that she fell, there was a very dark colored spot near the wall of the room. HK B was in the hallway and the surveyor asked if she could put on gloves and grab a light-colored cloth and spray the dark spot so that they could see the color of the spot. HK B rubbed the spot with the cloth and stated that it felt hard like it was glue. She then sprayed the spot with the substance inside of the spray bottle and rubbed it with her cloth. On the cloth, there was a reddish-brown tint. HK B looked at the cloth and stated it could be blood. She sprayed the spot and wiped it a second time and stated yea, I think it is blood. Upon further observation, the edge of the wall near the spot, there was a smudge of a dark red substance that appeared to be 3x2 inches in diameter. In an interview on 1/8/26 at 11:33 a.m., the Maintenance Director stated that he was informed of new admissions or room transfers through a room readiness group text. He stated that he was currently over housekeeping and the maintenance department and once he was informed on which room, he would have a member of housekeeping deep clean the room by disinfecting the mattress and disinfecting any hard services, lights, or door handles. When the room was complete, he would verify that the room was ready to go. Maintenance would fix any cosmetic issues and they were usually completed once a resident moved out so that the room would be ready for the next admission. He was asked to step into Room B and he was shown the spot and informed of the findings from HK B. He explained that Room B was on the schedule to have the carpet cleaned and HK B was the usual housekeeper on that hall, however HK B had been on vacation for a while. In HK B's absence, Room B was assigned to HK C. Maintenance director reviewed the spot on the carpet and the spot on the wall and stated that it was an issue with infection control and the room should have been reviewed for cleanliness. He called Floor tech and informed him that carpet inside of Room B needed to be cleaned and asked HK B to deep clean the room after. In an interview with HK B on 1/8/25 at 11:51 a.m., she stated that she went on vacation from 12/21/25- 1/5/26. She explained that a deep clean consisted of (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cleaning the television, remote, disinfecting the mattress, and everything overall. She stated that before she left, there was another resident in Room B and CR#1 had not been moved. She stated that no one came behind her to check the rooms after she completed cleaning them. In an interview on 1/8/26 at 12:00 p.m. with Floor Tech, he stated that he was responsible for cleaning floors around the facility. He was supposed to clean the floor inside of Room B (he could not recall when) but he was pulled into other halls and was told he could finish out the hall where Room B was located at a different time. In an interview on 1/8/26 at 12:30 p.m. with ADON C, she stated that she managed the long-term care halls and ADON D managed the short-term care halls where Room B was located. She was shown the image of the dark spot on the carpet and the red smudge on the wall in Room B. She stated that CR#1 probably hit her head on the wall. She explained that leaving bodily fluids like blood exposed was an issue with infection control and housekeeping should have cleaned it up with blood cleaner. From the photo where there were blood stains on the pillow, ADON C stated that the blood looked fresh and said that it was a big problem. She stated that housekeeping was supposed to clean the room after every resident leaves. ADON C was asked to confirm what the substance was on the pillow and the floor from looking at the photos. She stated that it was blood and there was no way around it. In an interview on 1/8/26 at 1:03 p.m. with ADON D, she stated that she was familiar with CR#1 but she could not remember when she was moved from long term care to short term care. She recalled that CR#1 was removed from her previous room because she was not compatible with her previous roommate. When staff initiated a room change, housekeeping was advised to clean the room if it was not already done. Staff (nurses and aids) checked the room, the bed, call lights, and made sure everything was in place. The nurse on duty would double check the room and verify where the resident would be going, then the room transfer would be done. For the transfer with CR#1, ADON D stated that when she walked by to check the room, the CNA was still preparing it and prior to that, the Maintenance Director had checked the call light and restroom. When CR#1 fell on [DATE], she said that she was busy doing the paperwork for EMS and she did not enter the room. ADON D explained that any blood left behind from the fall should have been cleaned and disinfected and the pillow with blood on it should have been disposed. The harm in leaving blood exposed could potentially get someone sick. A call attempt to HK C was made on 1/8/26 at 2:22 p.m. but she did not answer. Voicemail was left requesting a call back. In an interview on 1/8/26 at 2:30 p.m., the DON stated CR#1 had a buildup of different behaviors that escalated and changed daily. These behaviors did not make her a good fit at the facility, and she was accepted to another facility for care. To accommodate her behaviors, he moved Resident #2 from Room B to the long-term care hall and CR#1 to Room B from the long-term care hall. The DON stated that when there was a resident discharge, all department heads were made aware and responsible for their roles. Housekeeping would go in and prepare the room while nursing would move a lot of things out of the room. When the DON was informed about the blood left behind on the floor and the wall from CR#1's fall on 12/31/25, he stated that housekeeping should have gone in the room, and it should have been thoroughly cleaned. He stated that leaving blood stained pillows exposed was not the standard and the harm in leaving hazardous bodily fluids exposed could be someone getting sick or infection. Record review of the facility's Policy and Practices titled: Infection Control, revised October 2018, documented that: This facilities infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment, and to help prevent and manage transmission of diseases and infections. The objectives of the infection control policy and practices were to:Prevent, detect, investigate, and control infections in the facility.Maintain a safe sanitary and comfortable environment for personnel, residents, visitors, and the general public.Establish (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	guidelines for implementing isolation precautions, including standard transmission-based precautions.Establish guidelines for the availability and accessibility of supplies and equipment necessary for standard and transmission-based precautions.Maintain records of incidents and corrective actions related to infections.Provide guidelines for the safe cleaning and processing of reusable resident care equipment.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, functional, and comfortable environment for residents, staff, and the public for 1 (CR #1) of 10 residents reviewed for sanitary conditions. CR#1 was transferred from room A to room B on 12/30/25. Room B had scuff marks along the walls and baseboards, scuff marks that exposed the dry wall along the walls, and clothing and a wheelchair that belonged to previous residents. These failures could place residents at risk of illness, contamination, and infection.Findings included:Record review of CR#1's facesheet revealed a [AGE] year-old woman was initially admitted on [DATE], and the most current admission date was on 12/20/25. Her admitting diagnoses was COPD (ongoing lung condition caused by damage to the lungs), dementia (loss of cognitive functioning that interferes with daily life and activities) with mild behavior disturbance, macular degeneration (eye disease that affects central vision), difficulty in walking, respiratory failure, and cognitive communication deficit (refers to difficulties in communication that arise from impairments in cognitive processes, affecting an individual's ability to express and understand messages effectively). Record review of CR#1's care plan last updated 12/28/25 revealed that she had impaired visual function and severe visual impairment related to macular degeneration. CR#1 also had a history of falls. In December 2025, it was documented that CR#1 had an unwitnessed fall without injury on 12/21/25, witnessed falls without injury on 12/28/25 and 12/29/25, and an unwitnessed fall with injury on 12/31/25. Record review of CR#1's MDS dated [DATE], under Section C- Cognitive patterns revealed a BIMS score of 15 (normal cognition). Under section E for behaviors and frequency of behaviors, 2 was documented signifying that CR#1 had exhibited behavioral symptoms not directed towards of others in the past 4-6 days. Under section GG- Functional Abilities, CR#1 was independent with rolling from left and right, lying to sitting on the side of the bed, and sitting to lying. She required supervision or touch assistance with sitting to stand, transferring, and walking 10-150 feet. Record review of an updated BIMS assessment for CR#1, completed 12/27/25, revealed a score of 6 (severe cognitive impairment). Record review of CR#1's progress notes dated 12/30/25 at 1:05 p.m., social services documented that they informed CR#1'sRP that she was moved from Room A to Room B and the RP agreed with the move. In an interview on 1/6/26 at 10:17 a.m. with the RP, she stated that after CR#1 was discharged to the hospital post fall, she went back to the facility on 1/3/26 to grab the rest of CR#1's belongings. Inside the room, she found a bloody pillow that was sitting inside of CR#1's wheelchair, clothing items inside of the drawers of the resident who lived there previously, and fecal matter on the bottom of the other bed. RP stated that Room B was not cleaned prior to CR#1's room change and stated it looked like the room had been used as storage. RP stated that she would submit photos with time stamps into evidence. In an observation on 1/6/26 at 12:20 p.m., Room B had 2 beds inside the room and the dresser was tucked in a corner near the front door. In the far-left corner of the room near the window was a large electric wheelchair used for a geriatric patient that had the foot holders sitting on top of the chair with other wheelchair parts. The walls were a pale-yellow color and they were scuffed with black and grey marks all around the room and the base boards. The walls also had deep scuffs that exposed the white dry wall underneath the paint and next to Bed A, there were droplets of a liquid that had dried on the wall wet. An oxygen machine with the date 12-29-25, was seen on the nightstand of Bed B. Inside of the closet was a trash bag full of clothes. On the collar of one of the shirts inside the room, it had the previous resident's name and room number. Hung on the rack inside the closet was a jacket, 2 sweaters, 2 shirts, and there were two pairs of sweatpants. A few feet next to the closet, there was a dark (continued on next page)

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reddish/purple circle the size of a fist on the carpet near the front of the room. The origin of the spot was unknown. Record review of the photographic evidence submitted by RP on behalf of CR#1 at 1/7/26 at 10:26 p.m. revealed the following:1. Thursday 1/1/26 at 3:19 p.m., There was a white pillowcase on a pillow sitting across the handlebars of the wheelchair. There was bright red blood on the right side of the pillowcase and there was blood on the pillow. An oxygen machine can be seen in the background. Caption documented that the pillow was inside of Room B and she knew it was CR#1's because it was inside of the wheelchair she used. In an interview on 1/8/26 at 11:17 a.m., LVN A stated that she was PRN and she came into work once a week. She stated that she was informed on 12/30/25 by the DPON that CR#1 was moving into Room B on the skilled hallway, and Resident #2 who resided in that room, would be moving to a room on the long-term care side of the facility. She stated that prior to CR#1's move in, the room should have been deep cleaned by housekeeping. LVNA explained a deep clean consisted of using disinfectant and alcohol wipes to wipe everything down, changing linens, and removing all items out of the room from previous residents. Prior to moving in, the nurse on duty would verify that was done before another resident moved in. On the day of the move, herself and other staff (names not disclosed) were transferring CR#1's personal belongings to her room and moving Resident #2's items out. She did not know why the motorized wheelchair from a resident who was discharged on 11/6/25 was still inside Room B and restated that she only worked once a week PRN. In an interview on 1/8/26 at 11:33 a.m., the Maintenance Director stated that he was informed of new admissions or room transfers through a room readiness group text. He stated that he was currently over housekeeping and the maintenance department and once he was informed on which room, he would have a member of housekeeping deep clean the room by disinfecting the mattress and disinfecting any hard services, lights, or door handles. When the room was complete, he would verify that the room was ready to go. When he was asked about why there were so many scuffs on the walls of Room B when it was supposed to have been ready for move-in, he stated that the marks on the while were created by the resident wheelchairs. He was informed that Room B had only been occupied for 1 day before CR#1 was sent to the hospital. He stated that maintenance would fix any cosmetic issues and they were usually completed once a resident moved out so that the room would be ready for the next admission. When communicated that the appearance of Room B did not promote a comfortable and homelike environment, the Maintenance Director said he understood and he called in housekeeping to begin a deep clean of Room B and asked the Floor tech to shampoo the carpet. In an interview with HK B on 1/8/25 at 11:51 a.m., she stated that she went on vacation from 12/21/25- 1/5/26. She explained that a deep clean consisted of cleaning the television, remote, disinfecting the mattress, and everything overall. She stated that before she left, there was another resident in Room B and CR#1 had not been moved. She stated that no one came behind her to check the rooms after she completed cleaning them and she was only responsible for cleaning, and she did not touch any resident belongings or transfer them outside of the rooms. In an interview on 1/8/26 at 12:00 p.m., the Floor Tech stated he was responsible for cleaning floors around the facility. He was supposed to clean the floor inside of Room B (he could not recall when) but he was pulled onto other halls and was told he could finish out the hall where Room B was located at a different time. In an interview on 1/8/26 at 12:30 p.m., ADON C stated that she managed the long-term care halls and ADON D managed the short-term care halls where Room B was located. She stated that housekeeping was supposed to clean the room after every resident leaves. She was informed that clothing items from the previous resident were left inside of the closet in Room B. She stated the items left behind were expensive and she was sure his wife would be looking for those articles of clothing. In an interview on 1/8/26 at 1:03 p.m., ADON D stated that she was familiar with CR#1 (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	but she could not remember when she was moved from long term care to short term care. She recalled that CR#1 was removed from her previous room because she was not compatible with her previous roommate. When staff initiated a room change, housekeeping was advised to clean the room if it was not already done. Staff (nurses and aids) checked the room, the bed, call lights, and made sure everything was in place. The nurse on duty would double check the room and verify where the resident would be going, then the room transfer would be done. For the transfer with CR#1, ADON D stated that when she walked by to check the room, the CNA was still preparing it and prior to that, the Maintenance Director had checked the call light and restroom. When asked why the geriatric wheelchair was still inside the room, left behind by a resident that was discharged in 11/2025, she responded she would have to find out that information. ADON D was asked why Resident #2's clothing was still inside of the closet in Room B, she stated these items should have been moved. When asked if the scuff marks and exposed dry wall should have been addressed, she stated she could not speak to that, and it would probably be better addressed by maintenance. A call attempt to HK C was made on 1/8/26 at 2:22 p.m. but she did not answer. Voicemail was left requesting a call back. In an interview on 1/8/26 at 2:30 p.m., the DON stated CR#1 had a buildup of different behaviors that escalated and changed daily. These behaviors did not make her a good fit at the facility and she was accepted to another facility for care. To accommodate her behaviors, he moved Resident #2 from Room B to the long-term care hall and CR#1 to Room B from the long-term care hall. He explained that the reason the geriatric electric wheelchair was still inside of Room B was because the battery was drained and it would take at least 3 people to move it out. He confirmed that the wheelchair belonged to a previous resident of Room B, and the facility was waiting on a friend of that resident to come and grab it. Resident #2's clothing items were left inside of the room because it was a temporary move, and they were anticipating CR#1 to be admitted to another facility. The DON stated that when there was a resident discharge, all department heads were made aware and responsible for their roles. Housekeeping would go in and prepare the room while nursing would move a lot of things out of the room. When asked if the scuffs on the walls and baseboards were the standard for rooms, he stated that it was not and they (DON and the Administrator) would have to get with maintenance to figure out what happened. Record review of the facility's policy titled: Physical Environment (not dated) stated that the purpose was to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public.