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	03/06/2026

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to incorporate the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care for 1 (Resident #5) of 1 resident reviewed for PASARR.-The facility failed to submit a complete and accurate request for nursing facility specialized services for Resident #5 in the LTC Online Portal within 20 business days.This failure could place residents at risk of not receiving necessary services to help them achieve their highest possible mental and physical well-being. Record review of Resident #5's face sheet dated 03/06/2026, revealed she was a [AGE] year-old female originally admitted on [DATE] and last re-admitted on [DATE]. Her medical diagnoses included Down Syndrome (a genetic condition that causes mild-to-moderate intellectual disability, developmental delays, and distinct physical features), Type 2 Diabetes Mellitus (high blood sugar), cognitive communication deficit, Disorganized Schizophrenia (a severe, chronic subtype of schizophrenia characterized by highly disorganized thinking, speech, and behavior, rather than prominent hallucinations or delusions), Bipolar Disorder (mental illness characterized by extreme mood swings between mania and depression) and unspecified lack of expected normal physiological development in childhood.Record review of Resident #5's care plan last captured 03/06/2026, she had a focus area initiated on 06/17/2025 of being identified as having PASRR positive status related to ID/DD , with interventions including facility holding annual and quarterly meetings. She had focus areas related to Down Syndrome initiated 01/23/2025 related to having communication problems related to Down Syndrome and rarely or never being understood or understanding, with interventions including anticipating and meeting needs and referring her to speech therapy for evaluation and treatment as ordered.Record review of Resident #5's Quarterly MDS dated [DATE], she was coded as rarely or never understood and did not complete the BIMS (a brief interview to gauge memory and thinking skills). She was totally dependent on staff for all ADLs including toileting, showering, dressing, eating and personal and oral hygiene. Record review of Resident #5's hospital records dated 01/16/2025, she was initially admitted to the hospital on [DATE] with a history of developmental delay and seizures and was transferred to the facility on [DATE].Record review of Resident #5's PASARR Level I dated 01/16/2025, she scored a 0, indicating a negative Level I screener , meaning she was not suspected as having a serious mental illness, intellectual disability or developmental disability at the time.Record review of Resident #5's baseline care plan dated 01/15/2025, Resident #5 was coded as understanding staff and not able to easily communicate with staff. Resident #5 was coded for physical, occupational and speech therapy to improve functional status.Record review of Resident #5's medical records, there were no Level II PASARR uploaded to her documents. Record review of Resident #5's record for IDT Meeting and NFSS Request by the state, Resident #5 had an IDT meeting on 3/24/2025 for a support mattress, physical therapy, speech therapy, wheelchair service, occupational therapy, and a positioning wedge. The state received Resident #5's NFSS request on 04/25/2025 for physical, occupational and speech assessment and service. The record also indicated Resident #5 was approved for a positioning wedge on 3/25/25 and the NFSS request (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

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 03/06/2026

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was not submitted. Record review of Resident #5's NFSS (a form submitted by facilities to request and receive specialized therapy and/or equipment for residents such as those who are PASARR positive) for Therapy titled NFSS Therapist, Referring Physician and NF Administration CMWC (Customized Mechanical Wheelchair)/DME Signature Page, Resident #5's therapist signed on 6/26/2025, her physician signed on 7/8/2025 and the Administrator signed the document on 7/21/25. Resident #5 had an NFSS form for her mattress that was signed by a therapist on 8/29/25, her physician on 8/29/25 and the Administrator on 8/29/25 . Observation and interview with Resident #5 on 3/6/2026 at 4:06pm, she was in her wheelchair in the hallway. She appeared well-groomed, in a pleasant mood. Resident #6 said hello and that she was fine and did not respond to other questions. Resident #5 had a purple wedge on her dresser, leg braces and a low air mattress close to the ground. Interview with the Director of Rehabilitation on 3/6/2026 at 4:06pm, she said she was informed that Resident #5 was on PASARR services by the MDS Department but did not remember who exactly. Resident #5 began services on 08/29/2025, which included physical, occupational and speech therapy. Resident #5 was also approved for a low air mattress and wheelchair at the time. Attempted interview by phone with MDS A on 3/6/2026 at 4:12pm, voicemail was left with no returned communication as of exit. Interview by phone with MDS B on 3/6/2026 at 4:16pm, MDS B said she had been at the facility since December 2025. MDS B said that once the facility received approval for PASARR services, the facility had 14 days to apply for services . MDS B said that the MDS Department worked on obtaining services and scheduling meetings with the local mental health authorities.Interview with the Administrator on 3/6/2026 at 5:38pm, he said he was not aware that Resident #5's NFSS documents were not submitted in a timely manner. He said that MDS A would know more about this situation.Record review of the facility's policy titled, Post admission Notification of Significant Change in Individual with Mental Disorder/Intellectual Disability, un dated, it read in part, This facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has a mental illness or intellectual disability for resident review. The policy did not address the submission deadlines.Requested Resident #5's Level II assessment from the Administrator by email on 3/6/2026 at 4:38pm, no documents were submitted as of exit.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that the resident environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistance devices to prevent accidents for 1 of 4 residents (Resident #13) reviewed for accident hazards.The facility failed to ensure Resident #13's electrical bed remote did not have exposed wiring, with the inner blue, green and red wires separated from the white outer sheath.This failure could place residents at risk of injury from using damaged electrical equipment. Record review of Resident #13's face sheet dated 3/6/2026, revealed she was an [AGE] year-old female originally admitted on [DATE] and last re-admitted on [DATE] . Her medical diagnoses included type 2 diabetes mellitus (high blood sugar), morbid obesity due to excess calories, unsteadiness on feet, cellulitis (inflammation of the skin), presence of a cardiac pacemaker (electrical device that helps regulate the heart's rhythm by sending electrical impulses to the heart muscle to ensure a normal heart rate), and spinal stenosis lumbar region (narrowing of spinal canal, putting pressure on the spine and nerves).Record review of Resident #13's Quarterly MDS dated [DATE], revealed she scored an 8 out of 15 on the BIMS (short interview gauging thinking and memory), indicating moderate cognitive impairment. Resident #13 was totally dependent on staff for ADLs including showering, toileting, putting on and taking off footwear, and oral and personal hygiene.Record review of Resident #13's care plan last captured 03/06/2026 revealed she was care-planned for congestive heart failure with interventions to monitor for signs and symptoms of heart failure including shortness of breath upon exertion, weakness and increased heart rate. Resident #13 also had a pacemaker with interventions including monitoring vital signs and symptoms of altered cardiac output or pacemaker malfunction including dizziness, pulse rate lower than programmed rate and difficulty breathing.Observation and interview with Resident #13 on 3/6/2026 at 10:08am, Resident #13's bed remote was connected to a grey cord which connected to an outlet on the left side of the bed. Resident #13 was sitting in her wheelchair at the right side of her bed and took the remote in her hand and showed the exposed wiring. There was black electrical tape wrapped around half of the cord. There were exposed inner wires of red, green and blue underneath the grey sheath at the remote end and at the outlet end. There was a cut around the middle of the grey sheath with the same exposed red, green and blue wiring underneath. She said the inner wires connecting her electrical bed to the operating remote cord had been exposed from its outer sheath since she received this bed until the night of 03/05/2026 when the remote was taped up with black electrical tape. Resident #13 was unaware of when she received the bed. She said that the Maintenance Director said the remote for her electrical bed was on backorder. Observation and interview with the Maintenance Director on 3/6/2026 at 11:50am, he answered that the bed was low voltage when asked if exposed wires were okay. The Maintenance Director said the sheath was still on the individual wires of the remote cord. When asked if the manufacturer would consider that okay, he said he did not think they would. When asked if the bed was a safety hazard due to the exposed inner wires, the Maintenance Director said the bed had low voltage. He received the report about Resident #13's exposed wire on 03/03/2026 and he said he wrapped it up with electrical tape the same day.Observation and interview with LVN M on 3/6/2026 at 11:55am, LVN M looked at the wires under the bed and exposed sheath near the remote and along the wire. She said that Resident #13's bed remote's wires should not have been exposed like that .Interview with LVN G on 3/6/2026 at 12:06pm, LVN G said they told the Maintenance Director two weeks ago about the bed remote's exposed wiring. LVN G said that after Resident #13's family complained about it, LVN G told the Maintenance Director again on 03/05/2026 and someone came to wrap the exposed wiring with scotch tape that night . Record review of the facility's policy on maintenance services, undated, it read in part, The day-to-day maintenance operation is under the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	supervision of the Maintenance Director . The policy did not specify how resident equipment should be maintained.

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NAME OF PROVIDER OR SUPPLIER Falcon Point Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 23553 West Fernhurst Drive Katy, TX 77494	

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who were incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 6 residents (Resident #22) reviewed for incontinent care. -The facility failed to ensure CNA FF changed gloves and cleaned Resident #22's scrotum and buttocks before putting on a clean brief during incontinent care on 3/6/26. This failure could place residents at risk for pain, infection, injury, and hospitalization. Record review of Resident #22's face sheet dated 03/06/2026 revealed he was an [AGE] year-old male who was admitted to the facility on [DATE]. His medical diagnoses included reduced mobility , mild protein-calorie malnutrition, other sequelae of cerebral infarction (consequences of stroke), secondary hypertension (blood pressure), hyperlipidemia (high fat in the blood) unspecified hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (paralysis or partial paralysis following stroke affecting left non-dominant side), other lack of coordination, cognitive communication deficit, dependence on supplemental oxygen, need for assistance with personal care, muscle weakness (generalized), other abnormalities of gait and mobility.Record review of Resident #22's admission MDS assessment, dated 12/25/25, reflected a BIMS score of 15 out of 15, which indicated intact cognition. He required assistance from staff with ADL care. Record review of Resident #22 's care plan, dated 10/04/25, reflected, . The resident had an ADL self-care deficit .Interventions.Personal Hygiene and Toilet use- Resident is totally dependent . Resident #22 was also care-planned for incontinent care, with interventions including changing brief in a timely manner preventing skin break down. Observation of incontinent Care on 3/6/26 at 10:40AM, performed by CNA FF, she washed hands then donned clean gloves. Resident #22 was lying on his back with wife at his bedside. CNA FF picked up a clean and wet wipes, unfasten the soiled brief, using wet wipes cleaned the groin but did not clean the penis or the scrotum. Resident #22 was repositioned on his left side. Resident #22 was soiled of urine and feces., CNA FF cleaned in between the buttocks several times using the wet wipes. She did not clean around the buttocks without changing gloves, opened a jar of zinc oxide ointment and applied it to resident around buttocks and the groin, she then placed a clean brief on and then took off the soiled gloves and washed hands.Interview on 3/6/26 at 11:50AM with CNA FF, regarding incontinent care, she said she did a good job, she was asked why she used the same gloves throughout incontinent care, she said Oh, I forgot, I was confused because (Resident #22?s) wife handed ointment of zinc oxide to me, that threw me off and I did not change the gloves. CNA FF said she had in-services on incontinent care, and she knew not changing gloves, cleaning the buttocks, scrotum could cause more skin break, odors and urinary tract infection.Interview with the Administrator on 3/6/26 at 5:00 PM, regarding expectation for incontinent care and handing, he said his expectation was for incontinent care to be done in a manner to prevent urinary tract infection. Review of the facility's policy titled Subject: Perineal Care Revision date February 2018: Purpose The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition.MALEFor a male resident: a. Wet washcloth and apply soap or skin cleansing agent. b. Wash perineal area starting with urethra and working outward. e. Wash and rinse urethral area using a circular motion. f. Continue to wash the perineal area including the penis, scrotum and inner thighs. g. Thoroughly rinse perineal area in same order, using fresh water and clean washcloth. h. If the resident has an indwelling catheter, hold the tubing to one side and support the tubing against the leg to avoid traction or unnecessary movement of the catheter. i. Gently dry perineum following same sequence. j. Reposition foreskin of uncircumcised male. k. Ask the resident to turn on his side with his upper leg slightly bent, if able. l. Rinse washcloths and apply soap or skin cleansing agent. m. Wash and rinse the rectal area thoroughly, including the area under the scrotum, the anus, and the buttocks. n. Dry area thoroughly.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for food procurement.-The facility failed to ensure residents' lunch was served at a safe temperature on 3/6/2026.These failures could place residents who ate food from the kitchen at risk of foodborne illness and disease.Observation of food temperature and interview on 3/6/2026 at 12:39pm, the DM delivered a regular lunch test tray which included fish tenders, hushpuppies, potato wedges and coleslaw. She left immediately to get a thermometer, alcohol wipes and a glass of ice water and came back at 12:45pm. The DM placed the thermometer in the ice water, and the temperature reading was 32.9F. The DM left and came back at 12:50pm with a new thermometer and then took it out and placed the thermometer in the ice water with a reading of 32.5F. The DM then measured each food item, placing the thermometer end in ice water and waiting until the reading went down to 32.5F and wiping before measuring the next food item. The fish tenders read 113.5F, the potatoes were 100.5F, the hushpuppies were 98.5F, and the coleslaw was 56.1F. The DM said the fish tenders should have been 135F especially off the steam table, the potatoes should be the same at 135F, the hushpuppies should be 130F and the coleslaw should have been 40F. The DM said the thermometer should have read 32F from the ice water, and that kitchen staff check food temperatures on the steam table before they go out. The first cart leaves the kitchen within 10 minutes, when the kitchen staff deliver trays on metal racks to hallways and then aides will deliver food to residents. The DM said the facility did not have hot plates, but they had metal tray racks to deliver food. If food was not the right temperature, then residents could get sick. Interview with Dietary Aide A on 03/06/2026 at 3:28pm, she said that residents did not complain about food. Dietary Aide A said it could take 10 to 15 minutes to get trays from the kitchen to the hallway.Interview with the Administrator on 3/6/2026 at 4:30pm, he said he had not heard of complaints of cold food. He said warming plates were not used at the facility. If residents were served food in the temperature danger zone, it could cause residents to fall ill.Record review of the policy on food temperatures, undated, it read, Purpose: Ensure food is served at a safe temperature to prevent food-borne illness. Procedure: 1. Hot foods should be maintained at a minimum of 135 degrees F. 2. Cold foods should be maintained at a maximum of 41 degrees F.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infection for 1 of 6 residents (Resident #5) and 2 of 2 staffs (CNA KK, CNA HH) reviewed for infection control. -The facility failed to ensure CNA FF donned PPE before transferring Resident #5 via mechanical lift from her bed to her wheelchair on 3/6/26. -The facility failed to ensure CNA HH donned PPE before transferring Resident #5 via mechanical lift from her bed to her wheelchair on 3/6/26. This failure could place residents at risk for spread of infection and cross contamination to residents causing resident illness and/or distress. Record review of Resident #5's face sheet dated 03/6/2026 revealed she was a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted [DATE]. Her medical diagnoses included down syndrome, unspecified, cognitive communication deficit, need for assistance with personal care, other abnormalities of gait and mobility, muscle weakness (generalized), type 2 diabetes mellitus with unspecified complications Record review of Resident #5's quarterly MDS assessment, dated 11/30/25, reflected a BIMS score of 3 out of 15, which indicated severe cognition impairment. She required assistance from staff with ADL care. Record review of Resident #5's care plan, dated 11/27/25, reflected, . The resident had an ADL self-care deficit .Interventions .Personal hygiene and Toilet use- Resident is totally dependent with two person transfers from bed to wheelchair and from wheelchair to bed. During observation on 3/6/26 at 11:55 AM, Resident #5 had an Enhanced Barrier Precaution sign posted on her door. Resident #5 was lying in bed, CNA FF did not don (put on) PPE before entering Resident #5's room with the mechanical lift, CNA HH entered room to assist with Resident #5's transfer, she donned clean gloves without donning other PPE (gloves and gown), t [NAME] transferred resident to her wheelchair. In an interview with CNA FF on 3/06/26 at 2:16 p.m., she said she forgot to wear PPE while transferring Resident #5. She said she wore PPE earlier while performing incontinent care to Resident #5. She said she did have in-services about using PPE to prevent infection to her and the resident.In an interview with CNA HH on 3/06/26 at 2:31 p.m., she said she forgot to wear PPE while assisting with transferring Resident #5, She said she did have in-services about using PPE to prevent infection every month at least bi-weekly.Interview with the Administrator on 3/6/26 at 5:00 PM, regarding expectations for Resident #5 on EBP during care. The Administrator said his expectation was for all residents with EBP signs posted on their door, the staff were supposed to don PPE before entering their room to perform any care, to prevent infection.Review of the facility's policy titled Enhanced barrier precautions not dated: .Policy.Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug-resistant organisms (MDROs) to residents. Policy Interpretation and Implementation 1. Enhanced barrier precautions (EBPs) refer to infection prevention and control interventions designed to reduce the transmission of multi-drug-resistant organisms (MDROs) during high contact resident care activities. 2. Enhanced barrier precautions apply when: a. A resident is infected or colonized with a CDC-targeted MDRO, but does not have a wound or indwelling medical device, and does not have secretions or excretions that cannot be covered or contained; b. A resident is NOT known to be infected or colonized with any MDRO, has a wound or indwelling medical devices, and does not have secretions or excretions that are unable to be covered or contained; and c. Contact precautions do not otherwise apply. 3. Contact precautions apply when: a. A resident is infected or colonized with any MDRO and has secretions or excretions that cannot be covered or contained; and b. A resident is NOT known to be infected or colonized with any MDRO, has a wound or indwelling medical device, and has secretions or excretions that cannot be covered or contained; or c. A resident is infected or colonized with any MDRO and there is a current investigation of a suspected or confirmed MDRO outbreak. EBPs employ targeted gown and glove use in addition to standard (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	precautions during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). b. Personal protective equipment (PPE) is changed before caring for another resident. c. Face protection may be used if there is also a risk of splash or spray. 8. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: a. dressing; b. bathing/showering; c. providing hygiene or grooming; d. changing briefs or assisting with toileting; e. transferring; f. providing bed mobility;