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	03/27/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that residents are were free of any significant medication errors for 2 of 18 residents (Resident #68 and Resident #81) reviewed for medications.The facility failed to ensure that Resident #68's blood pressure medications hydralazine and telmisartan were held within the parameter the physician ordered. 2. RN F failed to administer Lacosamide Oral Tablet 150 MG (Lacosamide) (to treat partial-onset seizures), give 1 tablet via PEG-Tube every 12 hours for nausea, initialed as given to Resident #81, when it was not given on 3/24/26.These failures could place residents with high or low blood pressure at risk of fainting or a stroke due to not getting their blood pressure medication as ordered by their physician. 1.Record review of Resident #68's admission face sheet dated 3/27/2026 revealed he was a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included hypertension (high blood pressure), hypothyroidism (, dementia (memory problem), depression (, urinary tract infection, Alzheimer's disease and cognitive communication. Record review of Resident #68 quarterly MDS dated [DATE] Section C:500 revealed a BIMS score of 06 indicating the resident was cognitively severely impaired Record review of Resident #68's physician's order dated 11/02/2025 revealed an order for hydralazine HCl oral tablet 25 ml give 1 tablet by mouth three times a day for hypertension. Hold if SBP<130 or pulse >85.Record review of Resident #68 order dated 11/03/2025 for Telmisartan oral tablet 40mg by mouth one time a day for hypertension, Hold for SBP < 130 or pulse < than 60. Record review of Resident #68's MARs for February and March of 2026 revealed the following. February 2026 on the following dates Hydralazine 25 mg to be given three times a day for hypertension. Hold if SBP<130 or pulse >85. The Hydralazine was not documented as held on 2/2/2026 when SBP was 128/68 at 3:00pm and 126/58 at 9:00pm, 2/3/2026 when SBP was 112/62 at 9:00am and 127/67 at 3:00pm, 125/69 at 9:00pm, 2/4/2026: SBP was 122/75 at 9:00am, 124/74 at 3:00pm and 118/70 at 9:00pm, 2/5/2026 SBP was 126/77 at 3:00pm and 126/71 at 9:00pm, 2/6/2026 SBP was 128/70 at 9:00pm, 2/7/2026 SBP was 128/73 at 3:00pm and 126/74 at 9:00pm, 2/8/2026 SBP was 128/76 at 3:00pm and 127/75 at 9:00pm, 2/10/2026 SBP was 125/77 at 9:00am, 116/76 at 3:00pm and 127/74 at 9:00pm, 2/11/2026 SBP was 126/73 at 9:00am, 127/74 at 9:00pm, 2/12/2026 SBP was 124/70 at 9:00am, 127/68 9:00pm, 2/13/2026 SBP was 120/60 at 3:00pm, 2/14/2026 SBP was 128/74 at 3:00pm, 2/17/26: SBP was 120/69 at 9:00am, 124/70 at 9:00pm, 3/18/2026 SBP was 121/73 at 3:00pm, 2/19/2026 SPB was 124/76 at 3:00pm, 2/20/2026 SBP was 124/67 at 3:00pm and 124/76 at 9:00pm, 2/21/2026 SBP was 124/76 at 9:00pm, 2/22/2026 SBP was 127/67 at 9:00pm, 2/23/2026 when SBP was 124/70 at 3:00pm, 2/25/2026 SBP was 123/74 at 9:00am and on 2/26/2026 SBP was 124/74 at 9:00pm. The pulse on 2/4/2026 was 97 at 3:00pm, 2/5/2026 it was 87 at 9:00am, and on 2/21/2026 the pulse was 98 at 9:00am and 87 at 3:00pm. February 2026 on the following dates Telmisartan 40 mg to be given three times a day at 9:00am, to be held if SBP < 130 or pulse < than 60 was not documented as held on 2/3/2026 when SBP was 112/62 9:00 am, 2/4/2026: SBP was 122/75 9:00am, 2/10/2026 SBP was 125/77 9:00 am, 2/11/2026 SBP was 126/73 9:00am, 2/11/26: SBP was 12o/69 at 9:00am, 2/12/2026 SBP was 124/70 9:00am, 2/17/2025 120/69 9:00am and 2/25/2026 SBP was 123/74 at 9:00am The pulse at 9:00am on 2/7/2026 was 55, on 2/11/2026 it (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was 58, 2/12/2026 it was 55, 2/17/2026 it was 51, 2/20/2026 it was 50, 2/25/2026 it was 58 and on 2/27/2026 it was 52. Record review of the nurses' notes revealed no reasons why the medication was not held. March 2026 on the following dates Hydralazine 25 mg to be given three times a day for hypertension. Hold if SBP<130 or pulse >85 was not documented as held on 3/3/2026 when SBP was 122/69 at 3:00pm, and SBP was 129/77 at 9:00pm, 3/4/2026 SBP was 128/77 at 3:00pm, 3/7/2026 when SBP was 119/62 at 9:00am, and 127/76 at 9:00pm, 3/8/2026: SBP was 127/76 at 3:00pm and 124/77 at 9:00pm, 3/13/2026 SBP was 128/99 at 3:00pm, 3/16/2026 SBP was 126/68 at 9:00am, 3/26/2026 SBP was 118/68 and on 3/25/2026 the pulse was 90. March 2026 on the following dates Telmisartan 40 mg to be given once a day. Hold if SBP < 130 or pulse < than 60 was not documented as held on 3/7/2026 at 9:00am when SBP was 119/62, 3/16/2026: SBP was 126/68. The pulse on 3/1/2026 at 9:00am was 54, at 9:00am on 3/1/2026, 3/3/2026 it was 56, 3/6/2026, 3/7/2026, 3/8/2026, 3/11/26, 3/12/2026, 3/16/2026, 3/17/2026, 3/20/2026, 03/22/2026 and 3/25/2026 the pulse was 50 and, on 3/10/2026 it was 51, 3/13/2026 it was 57, 3/23/2026 it was 56 and 3/24/2026 it was 58. Record review of Resident #68 clinical record for February and March 2026 revealed no documentation that the doctor was notified of the result of the blood pressure and pulse reading when they were consistently in the parameter they should be held. Further review of the nurse's notes for February and March revealed no documented reason why the medications were not held as ordered by the physician. In an interview on 3/27/2026 at 1:05 pm with LVN W, she said if there was an order for blood pressure medication to be held with a certain parameter and it was not held the blood pressure could get higher or lower and it could cause the resident to get sicker. She said in the case of Resident #68 if the blood pressure was low and Telmisartan or hydralazine was given the blood pressure could drop lower, and the resident could faint and if the pulse gets higher it could cause fainting, dizziness or stroke. She said in the case of Resident #68 not holding the medication had no adverse effect on him because his blood reading was always < than 130 and < than 60. She said holding the medication for Resident #68 based on his blood pressure reading he would get bradycardia. She said she notified the doctor and no instructions were given to make any change. She said she did not document the conversation in nurse's notes, she said in nursing if it's not documented it was not done. At that point she said she should have documented the nurse's notes, and she takes full responsibility for not documenting. In an interview on 3/27/2026 at 1:18pm the DON, regarding medications that were not held for Resident #68, revealed that he was going to call the provider to ask if he could review the parameters for the blood pressure or change the medication. He said if blood pressure medications were not followed, the blood pressure could go higher or lower. He said if the nurse did not observe any change in the resident's condition, it'll be up to the provider to review the medications and make the change. He said the facility also reviewed medications. He said medication review for LTC was only done if there's a change in conditions for residents such as falls. In that case they would go through the interventions and see if medication was causing orthostatic change in blood pressure. He said the nurse should look at the parameters before they give blood pressure medication. If blood pressure was out of parameters and the nurse still gave medication, it could cause the blood pressure to be higher or lower. He said they have quarterly medication administration in- services. He said the nurses should reach out to the physician if the blood pressure was always out of the parameter that it was ordered to be held so they could review the medications and make the needed changes. He said moving forward, if there's a pattern or there was no effect on the residents even within the parameters the physician asked for the medications to be held, they should notify the physician and let them decide what intervention needed to be done and document in the resident's record. 2.Record review of Resident #81's face sheet, dated 3/25/26, revealed a [AGE] year-old female was admitted on [DATE] and re-admitted on [DATE]. Resident #81 had a diagnoses of gastrostomy (a small opening into the abdomen and inserted a tube directly into the stomach allowing for food and liquids to be delivered directly into the stomach), gastro-esophageal reflux(Gastric reflux) disease without esophagitis, aphasia (not able to talk) following unspecified (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cerebrovascular disease (stroke), hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (medical condition involving paralysis of one side of limbs (one arm and one leg), convulsions (when muscles contract and relax quickly and cause uncontrolled shaking of the body), essential (primary) hypertension, (high blood pressure), and cognitive communication deficit, other lack of coordination. Record review of Resident #81's quarterly MDS, dated [DATE], reflected the BIMS score was 0 out of 15, which indicated the resident had severe cognitive impairment. Further record review of the MDS revealed the resident was totally dependent on staff for bed repositioning and personal hygiene. Further record review of the MDS indicated Resident #81 was incontinent of bladder and bowel. Record review of Resident #81's care plan, dated 1/24/26, reflected Resident #81 had an ADL self-care performance deficit and the goal was the resident would improve current level of function. Record review of Resident #81's Physician's Orders, dated 2/17/26, reflected the following orders: Had NPO (nothing per oral/nothing by mouth) check gastric tube placement by auscultation (using stethoscope to listen to bowel sound) prior to meds, formula, and H2O flushes every shift. Check for residual every shift if > 60ccs, stop feeding and notify MD every shift. Feeding of Isosource 1.5 Cal 45 cc/hr. via pump, Flush GT with 30 ml water before and after administration of meds, flush with 10 cc between each medication every shift. Record review of Resident #81's Physician order, reflected in part:Lacosamide Oral Tablet 150 MG (Lacosamide) (to treat partial-onset seizures)*Controlled Drug*Give 1 tablet via PEG-Tube every 12 hours for nausea- order date 4/28/23. During an observation of medication administration on 3/24/26 at 8:26 a.m., for Resident #81, RN F was observed checking Resident 81's blood pressure (BP144/87, P71), RN F open the medication cart, then punched three other medications, crushed them individually and then diluted with 10cc of water, then went back to the resident's room, checked G-Tube for residual, and administered the medication through Resident #81's G-Tube. Interview with RN F on 3/26/26 at 4:30 pm she said works 7a-7p. She started working in August 2025 as needed. When asked why Resident #34, #78 and #81 medications were not given as ordered by the doctor. RN F said she went back and found out that she had to get 3 more medications, she had iron, vitamin, she didn't remember the time she gave it t but it was right after, not many hours. What she remembers was she passed meds at another side and went back after and the surveyor was not there. In an interview with the DON on 3/26/26 at 5:38 PM, the DON said his expectation for medication administration was for nurses to administer medication as ordered by the physician. The DON said the facility had morning medication pass times for 9:00 a.m., medications given twice daily was for 9:00 a.m. and 5:00pm, medication for 3 times daily were to given 9:00 am, 1:00pm and 5:00pm and medication for every 12 hours was for 9:00 am and 9:00 pm if the state surveyor did not observe medications given 3/24/2026 in the morning, he could not defend it but the medications were initialed as given at 9:00 a.m The DON said he always monitored the staff periodically and the pharmacist also monitored the staff. The last time the pharmacist monitored staff was in January 2026. The DON said if RN F gave the medication, she should have informed the nurse surveyor During an interview on 3/26/26 at 5:40 p.m., the Administrator said he expected nursing staff to give medications timely, correctly, and according to the physician orders. Record review of the facility's policies and procedure title Administering Medication dated April 2019 read in part. Policy StatementMedications are administered in a safe and timely manner and as prescribed.Policy Interpretation and Implementation1. Only persons licensed or permitted by the state to prepare, administer, and document administration of medications may do so.4. Medications are administered in accordance with the prescriber's order, including any required time frame. 5. Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include:a. Enhancing optimal therapeutic effect of the medicationb. Preventing potential medication or food interaction and c. Honoring resident choices and preferences consistent with his6. Medication errors are documented, reported and reviewed by QAPI committee to inform process changes.7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders)8. If a dosage is believed to be (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	inappropriate or excessive for a resident, or the medication has been identified as having potential adverse consequences for a resident or suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident attending physician or facility medical director to discuss the concern. 22. The individual administering the medication initials the resident MAR or appropriate line after giving each medication before administering the next medication.