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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, psychosocial well-being of each resident, encouraging both independences and interaction in the community for 1 of 3 (Resident #29) residents and 1 of 3 (Unit A) units reviewed for activities .1. The facility failed to ensure residents in Unit A had activities provided that followed the facility schedule on 03/24/2026 at 10:30 AM and 03/27/2026 at 10:30 AM and 2:00 PM. 2. The facility failed to ensure Resident #29 participated in activities that followed her care plan during 03/24/2026 and 03/27/2026 . These failures could place residents at risk of a decline in their mental and psychosocial well-being . Record review of Resident #29's face sheet, dated 03/24/2026, reflected a [AGE] year-old female who was originally admitted to the facility on [DATE] and last re-admitted [DATE]. Her diagnoses included senile degeneration of brain (this encompasses a range of neurological disorders characterized by a progressive decline in cognitive function, impacting memory, reasoning, and the ability to perform everyday activities), dementia (declining brain function related to thinking and judgement that is severe enough to impact daily life) and major depressive disorder (prolonged periods of sadness and hopelessness). She was on the secured unit.Record review of Resident #29's care plan meeting, dated 01/16/2026 , she enjoyed walking and would need non-dairy accommodation for activities. Record review of Resident #29's quarterly MDS, dated [DATE], reflected Resident #29 had a BIMS score of 04, which indicated severe cognitive impairment related to memory and thinking. She required moderate assistance with ADLs which included toileting, showering, dressing and footwear.Record review of Resident #29's care plan, last captured 03/27/2026, reflected she had actual falls (last revised 01/19/2026) with interventions which included day staff providing redirection to engaging activities like ball tossing to minimize daytime napping and support adequate nighttime sleep. Resident #29 was also care-planned for being dependent on staff for meeting emotional, intellectual, physical and social needs and would sit outside and come to music and pastry socials (dated 03/25/2026), with interventions which included inviting her to scheduled activities.In confidential interviews conducted on an undisclosed date and undisclosed time revealed 3 out of 15 residents in Unit A, which was the secured unit, complained about not having enough activities provided to suit their preferences such as playing cards, pencils, paper and notebooks for their personal use and going on walks around the facility.In an observation and interview of Unit A on 03/24/2026 at 2:00 PM, revealed residents were sitting in front of the television conversing or watching TV . Other residents were sitting by the nurse's station. Resident #29 was sitting in front of the television. She said she was okay and did not have any concerns. There were no activities such as ball toss, coloring, or music observed . There was a calendar for March 2026 hanging in the main lobby to the secured unit. Activities for 03/24/2026 were pastries and jokes at 10:30am, sit outside/music at 11:00a.m., BINGO at 2:00p.m., word search at 3:30pm, and evening news at 6:00p.m. Activities for 03/27/2026 were balloon toss/music at 10:30a.m., craft at 11:00p.m., read a poem at (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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1:00p.m., BINGO for 2:00p.m., and evening news at 6:00p.m.In an observation of activities provided on 03/24/2026 and 03/26/2026 at 11:30 AM, revealed residents were observed outside sitting and talking with the Activities Director .In an observation of and interview in Unit A on 03/27/2026 at 10:30 AM, residents were observed sitting in front of the television conversing or watching TV. Two residents appeared to be asleep with their heads on their folded arms while sitting at the dining tables. Resident #29 was sitting in front of the television. Residents stated they were doing fine and had no concerns. In another observation on Unit A on 03/27/2026 at 2:00 PM, revealed Resident #29 was sitting in the common area watching TV along with 10 residents. CNA M said activities in Unit A included providing water, snacks, music and dance. Most residents refused to do activities outside of the unit and preferred to watch TV. CNA M put on music after dinner on 03/23/2026. CNA M showed the supply closet with coloring books, coloring pencils and puzzles. In a later observation on 03/27/2026 at 2:27 PM, there were 10 residents in the common area coloring and listening to music on the TV. Five residents were sitting in the common area or dining room not participating, and two residents were in the common area sitting with residents but not coloring. RN G was observed assisting residents to the common area for activities. RN G said the Activities Director came to get residents for BINGO. RN G said activities in Unit A included church and therapy, where someone from the therapy department would come and get about 10 residents to exercise. RN G said staff came to play balloons with residents the morning of 03/27/2026 but could not specify any timeframe . In an interview with the Director of Rehab on 03/27/2026 at 2:39 PM, she said her staff conducted individual and group therapy about one to two times per week in Unit A. Groups consisted of 2 to 4 residents if they were scheduled for therapy or if they were willing to participate. Some residents were able to come down to the main gym, but most residents were not able to come off the unit. In an interview with the Activities Director on 03/27/2026 at 3:37 PM, she said she had a consistent group of 8 residents for BINGO and around 5 residents would play cards outside . There were two residents who were able to participate in activities outside of Unit A. The Activities Director said she hosted snack or ice cream socials or balloon toss for the other 22 residents in Unit A directly after she hosted socials for the outside unit but did not know what activities were going on the same time she had BINGO. She said there was no activities calendar for Unit A that was geared towards suitable activities for those who wanted to stay in the unit . When asked why there was no balloon toss as scheduled for 03/27/2026 at 10:30 AM, the Activities Director said she went in there at 7:00 AM and had residents play balloon toss until 8:30 AM but agreed she did not follow the day's timeline. The Activities Director said she would go into Unit A and reinforce activities with the staff there more often .In an interview with the DON on 03/27/2026 at 4:14 PM, he said it was difficult to take residents off Unit A because they needed a nurse and a nurse aide for supervision and care. He said the Activities Director provided activities and input advice for activities when she was not in Unit A for unit staff to provide. He said his nursing staff would be able to provide diversional activities. He was not aware of an alternate activity scheduled tailored for residents in Unit A. When asked if the activities in Unit A met residents' needs, he said he would talk to the Activities Director and look into it. Record review of the facility's policy on activities, copyrighted 2026, it read in part, It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences. 2. Activities will be designed with the intent to:a. Enhance the resident's sense of well-being, belonging, and usefulness.b. Create opportunities for each resident to have a meaningful life.c. Promote or enhance physical activity.d. Promote or enhance cognition.e. Promote or enhance emotional health.f. Promote self-esteem, dignity, pleasure, comfort, education, creativity, success and independence.g. Reflect resident's interests and age.h. Reflect cultural and religious interests of the residents.i. Reflect choices of the residents.4. Activities may be conducted in different ways:a. One-to-One Programs.b. Person Appropriate - activities relevant to the specific needs, interests, culture, background, etc. for the resident they are developed for.c. Program of Activities - to include a combination of large and small groups, (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	one-to-one, and self-directed as the resident desires to attend.9. Special considerations will be made for developing meaningful activities for residents with dementia and/or special needs. These include, but are not limited to, considerations for:a. Residents who exhibit unusual amounts of energy or walking without purpose.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that the medication error rate was not five percent or greater. The facility had a medication error rate of 20% based on 9 errors out of 45 opportunities of medication observation, which involved 2 of 5 residents (Resident #81, Resident #78 and Resident #34) and 1 of 7 staff (RN F) observed during medication administration reviewed for medication errors. 1. RN F failed to administer Lacosamide Oral Tablet 150 MG (Lacosamide) (to treat partial-onset seizures), to Resident #81 on 3/24/26.2. RN F failed to administer MiraLAX Oral Powder 17 GM(grams)/SCOOP(Used to treat occasional constipation) to Resident #81 on 3/24/26.3. RN F failed to administer Prednisone Oral Tablet (used to treat a number of different conditions, such as inflammation and marrow patient [swelling], severe allergies, adrenal problems arthritis, asthma blood or bone marrow problems. [Prednisone]), to Resident #81 on 3/24/26.4. RN F failed to administer Ascorbic Acid Tablet 500 MG to Resident #34 on 3/24/26.5. RN F failed to administer Ferrous Sulfate Tablet 325 (65 Ferrous) to Resident #34, on 3/24/26.6. RN F failed to administer Tramadol HCl Oral Tablet 50 MG (Tramadol HCl) to Resident #78 on 3/24/26.7. RN F failed to administer Brimonidine Tartrate (used to lower pressure inside the eye that is caused by open- angle glaucoma or ocular[eye] hypertension) Solution to Resident #78 on 3/24/26.8. RN F failed to administer Dorzolamide HCl-Timolol (use to treat elevated intraocular pressure in patients with ocular hypertension or open -angle glaucoma) and Mal Ophthalmic Solution 2-0.5 % (Dorzolamide HCl-Timolol Maleate) to Resident #78 on 3/24/26.9. RN F failed to administer Artificial Tears (used to lubricate dry eyes and help keep moisture on the surface of the eyes) and Ophthalmic Solution 1 % (Carboxymethylcellulose Sodium (Ophth [for the eyes]) to Resident #78 on 3/24/26.These failures could place residents at risk for increased negative side effects, and a decline in health. Findings include:1. Record review of Resident #81's face sheet, dated 3/25/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE] and re-admitted on [DATE]. Resident #81 had diagnoses which included 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 cerebrovascular disease (stroke), hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (medical condition involving paralysis of one side limbs (one arm and one legs), 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. The resident was totally dependent on staff for bed repositioning and personal hygiene. 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 the 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 water 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 medication, 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 4/28/23MiraLAX Oral Powder 17 GM/SCOOP (Used to treat occasional constipation) (Polyethylene Glycol 3350), Give 1 scoop via G-Tube one time a day for Constipation mix with 4-8 OZ OF water or juice (hold for LBM, report and document)-order date (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/6/24Prednisone Oral Tablet (used to treat a number of different conditions, such as inflammation marrow patient (swelling), severe allergies, adrenal problems arthritis, asthma blood or bone marrow problems. (Prednisone) Give 40 mg via PEG-Tube one time a day for diffuse urticaria (an inflammatory skin condition characterized by the sudden appearance of numerous itchy, raised, red or skin-colored welts (wheals) spread across large areas of the body) for 5 Days- order date 3/19/26. During an observation of medication administration on 3/24/26 at 8:26 a.m. for Resident #81, revealed RN F was observed checking Resident #81's blood pressure (BP144/87, Pulse-71), RN F opened the medication cart, then punched three other medications, crushed it individually and then diluted with 10cc of water. RN F then went back to the resident's room, checked G-Tube for residual, and administered the medications through Resident #81's G-Tube. RN F placed the blood cuff in the medication cart without cleaning the blood pressure cuff. 2. Record review of Resident #34's face sheet, dated 03/24/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #34 had diagnoses which included: iron deficiency anemias (not having enough healthy red blood cells to carry oxygen to the body's tissues), anxiety disorder (a mental health condition characterized by persistent, excessive, and uncontrollable worry or fear that interferes with daily life, unlike normal, temporary stress), hypertension (blood vessels is too high), and heart failure (heart does not pump enough blood for the body's needs), hyperlipidemia (abnormally high fat and lipids) and type 2 diabetes mellitus without complication, (a chronic condition where the body cannot effectively use (insulin resistance) or produce enough of it, leading to high blood sugar levels hyperglycemia).Record review of Resident #34's quarterly MDS, dated [DATE], reflected the BIMS score was 10 out of 15, which indicated the resident had moderate cognitive impairment. The resident was totally dependent on staff for bed repositioning and personal hygiene. Resident #34 was incontinent of bladder and bowel. Record review of Resident #34's care plan, dated 1/24/26, reflected Resident #34 had an ADL self-care performance deficit and the goal was the resident would improve the current level of function.Record review of Resident #34's Physician order, reflected in part:Ascorbic Acid Tablet 500 MG Give 1 tablet by mouth one time a day to enhance iron absorption in iron deficiency anemia related to iron deficiency anemia, -Start Date 02/23/20Ferrous Sulfate Tablet 325 (65 Fe) MG Give 1 tablet by mouth one time a day for Treatment of iron deficiency anemia related to iron deficiency anemia, -Start Date02/23/2026Tramadol HCl Oral Tablet 50 MG (Tramadol HCl) Give 1 tablet by mouth every 12 hours for severe pain -Start Date07/21/2025During observation with RN F on 3/24/26 at 9:00 AM, she checked Resident #34's blood pressure (114/83 P71) before administering medication to Resident #34. RN F administered medication to Resident #34's medications by mouth. RN said, that was all medications for now. RN F did not administer Ascorbic Acid Tablet 500 MG Give 1 tablet by mouth one time a day, Ferrous Sulfate Tablet 325 (65 Fe) MG Give 1 tablet by mouth one time a day and Tramadol HCl Oral Tablet 50 MG (Tramadol HCl) Give 1 tablet by mouth every 12 hours. All medication were initialed as given at 9:00 AM.Interview with Resident #34 on 3/25/26 at 12:30 PM revealed Resident #34 stated regarding her pain medication, she said she did not know what medication she was taking and she was not in pain.3. Record review of Resident #78's ----- reflected an [AGE] year-old male who was admitted to the facility on 4/2/24 and re-admitted [DATE]. Resident #78 had diagnoses which included muscle weakness, difficulty in walking, not elsewhere classified, unspecified glaucoma (is a group of eye disease that damage the optic nerve- the cable connecting the eye to the brain-usually caused by too much fluid pressure building up inside the eye), benign prostatic hyperplasia (non-cancerous condition in older men where the prostate gland enlarges, pressing on the urethra and bladder) with lower urinary tract infection, anemia (lower than normal amount of healthy red blood cells or hemoglobin in your blood) in other chronic diseases classified elsewhere, personal history of urinary (tract) infections, unsteadiness on feet, other lack of coordination and Alzheimer's disease (a progressive incurable brain disorder the slowly destroys memory, thinking skills and eventually the ability to perform simple tasks).Record review of Resident #78's annual MDS, dated [DATE], reflected the BIMS score was 7 out of 15, which indicated the (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident had moderate cognitive impairment. The resident was totally dependent on staff for bed repositioning and personal hygiene. The MDS indicated Resident #78 was incontinent of bladder and bowel. Record review of Resident #78's care plan, dated 2/15/26, reflected Resident #78 had an ADL self-care performance deficit and the goal was the resident would improve the current level of function.Record review of Resident #78's physician order, reflected in part:1. Brimonidine Tartrate Solution 0.1 % Instill 1 drop in right eye three times a day for IOP(intra ocular pressure) right eye -Start Date 01/21/2026 2. dorzolamide HCl-Timolol Mal Ophthalmic Solution 2-0.5 % (Dorzolamide HCl-Timolol Maleate) Instill 1 drop in both eyes two times a day related to glaucoma, wait at least 5 minutes between different eye drop.3. Artificial Tears Ophthalmic Solution 1 % (Carboxymethylcellulose Sodium (Ophth) Instill 1 drop in both eyes four times a day for dry eyes.During observation with MA S on 3/24/26 at 10:06 AM, revealed she administered 2 medications by mouth to Resident #78. MA S said the nurses did eye drops. RN F did not administer Brimonidine Tartrate Solution 0.1 % Instill 1 drop in right the eye three times a day. Dorzolamide HCl-Timolol Mal Ophthalmic Solution 2-0.5 % (Dorzolamide HCl-Timolol Maleate) Instill 1 drop in both eyes two times a day. Artificial Tears Ophthalmic Solution 1 % (Carboxymethylcellulose Sodium [Ophth]) Instill 1 drop in both eyes four times a day . All medication was initialed as given at 9:00 AM to Resident #78.Interview with Resident#78 on 3/25/26 at 5:00 PM, he said he did not get his eyes medication and that was why his eyes were itchy.Interview with RN F on 3/26/26 at 4:30 PM, she said she went back to Resident #78 eyedrops when she went back. She can't remember the eyedrops she had to give Resident #78, he had artificial drops and the other one that started with B. She knew when medications were not given in a timely manner it would be effective and she did have in-services before started working with the facility.Interview with RN F on 3/26/26 at 4:30 PM revealed she worked 7a-7p. When asked why Residents #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 medication, she had iron, vitamins, she didn't remember the time she did it but it was right after, not many hours. What she remembered was she passed meds at another side and went back after and she was not there. She went back to Resident #34, and they didn't have Tramadol. She had to get it from Pixis (a machine where residents could get a one-time dose of a medication with a code from the pharmacy). RN F stated the number of pills were given to Resident #34 during medication pass on 3/24/26. She did not give Tramadol at that time at 9:00 am. She thought she was finished and done with medication. 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 were for 9:00 a.m. and 5:00 p.m., medication for 3 times daily were given at 9:00 a.m., 1:00 p.m. and 5:00p.m. and medication for every 12 hours were for 9:00 a.m. and 9:00 p.m. if the state surveyor did not observe the medications given 3/24/2026 in the morning, he could not defend 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 state 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, according to the physician orders and follow the facility time schedule for medication. Record review of the facility's Administering Medications policy, dated 3/2019, revealed in part, Policy Statement Medications Compliance Guidelines:Resident medications are administered in an accurate, safe, timely, and sanitary manner. 6. Administer medications as ordered by the physician. Routine medications shall be administered according to the established medication administration schedule for the community.The Director of Nursing Services will supervise and direct all nursing personnel who administer medications and/or have related functions. Medications must be administered in accordance with the orders, including any required time frame.

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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 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 (continued on next page)

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	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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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.

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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.1. The facility failed to ensure leftover food consisting of sliced American cheese and shredded cheese past their use by dates were discarded. 2. The facility failed to ensure scrambled eggs, pureed sausage, pureed beef, brown gravy left outside on pans which were to be used later with temperatures in the danger zone were discarded. 3. The facility failed to ensure frozen pork chops were thawed properly.4. The facility failed to ensure equipment/serving utensils were washed and sanitized. These failures could place residents who ate food from the kitchen at risk of foodborne illness and disease. Observation of the facility's kitchen on 03-24-26 at 8:45 AM revealed the following. 1. Thawing frozen pork chops with a temperature of 66.2 degrees Fahrenheit in the kitchen sink immersed in water 75 degrees Fahrenheit. 2. A pan of brown gravy with a temperature of 116 degrees Fahrenheit on a food cart stationed on the kitchen hallway by the walk-in fridge. 3. A pan of pureed beef with a temperature of 61 degrees Fahrenheit on a food cart stationed on the kitchen hallway by the walk-in fridge.4. A pan of pureed sausage with a temperature of 58 degrees Fahrenheit on a food cart stationed on the kitchen hallway by the walk-in fridge.5. A pan of Scrambled Eggs with a temperature of 86 degrees Fahrenheit on a food cart stationed on the kitchen hallway by the walk-in fridge.6. A package of sliced American cheese with no used by date,7. Shredded cheese with no used by date. 8. Can opener blade was dirty with food debris. An interview with the Dietary Food Service Manager on 3-26-26 at 8:45 AM, revealed that the sliced American cheese and shredded cheese stored in the refrigerator should be discarded prior to the use by date. She stated the leftover foods observed in pans within the danger zone (a range between 40 degrees Fahrenheit to 140 degrees Fahrenheit where bacteria could grow rapidly) should have been discarded. She further stated that it was her responsibility that the department meets requirements. She said she will in-service dietary staff on proper handling, storing, dating leftover food for compliance.Record review of the facility's policies and procedures for Food Safety dated 3-30-23 read in part .potentially hazardous leftover foods are properly covered, labeled, dated, and refrigerated immediately. They are discarded on the used by date unless otherwise indicated. A policy on thawing frozen food properly was requested from the Food Service Manager and the Administrator on 03/26/2026 at 4:18pm, the Administrator stated that the facility did not have one.

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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 infections for 3 of 10 residents (Residents #34, Resident #66 and Resident #81) and 1 of 3 staff (RN F). The facility failed to ensure that personal wash basins, emesis basins and toothbrushes were labeled with resident's names to prevent infection.RN F failed to sanitize the blood pressure cuff between Resident #81 and Resident #34 on 3/24/26.RN F failed to wear PPE when administering Resident #81's G-Tube medications, who was on EBP, on 3/24/26.Resident #66 was observed with his catheter bag on the floor on 03/24/2026. These failures could place residents at risk for spread of infection, cross contamination, and decrease in quality of life. 1.Observation on 3/24/2026 at 9:00am revealed the following:-In room [ROOM NUMBER] there was basin directly on the bathroom floor, not in a plastic bag and it had no name. -In room [ROOM NUMBER] there was a basin directly on the bathroom floor not in a plastic bag with no name. -In room [ROOM NUMBER] there was a basin on the floor and an emesis basin in the bathroom, not in a plastic bag with no names. Two residents reside in the room.-In room [ROOM NUMBER] there was a basin directly on the floor, not in a plastic bag and it had no name on it. -In room [ROOM NUMBER] there was a basin on the floor not in a plastic bag with no name. Two residents reside in the room.-In room [ROOM NUMBER] there was a denture cup on the sink with no name. Two residents reside in the room.-In room [ROOM NUMBER] there was an emesis basin, wash basins with no name on them and they were not in plastic bags. Toothbrushes were on the sink and a razor with no names. Two residents reside in the room. In an interview with CNA J on 3/25/2026 at 10:00 am she said the basins and toothbrushes should be labeled with residents' names. She said if basins and toothbrushes were not labeled with residents' names it would cause cross contamination and possible infection. 2 and 3.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 cerebrovascular disease (stroke), hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (medical condition involving paralysis of one side limbs (one arm and one legs), 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. Observation of medication administration on 3/24/26 at 8:26AM by RN F revealed Resident #81's door had EPB posted. RN F did not wear a gown. RN F checked Resident #81's blood pressure and pulse oximeter and administered 3 medications via resident G-Tube. Interview on 3/24/26 at 9:12AM with RN F she said for not using EBP while administering medication to Resident #81, she was very sorry. Record review of Resident #34's face sheet, dated 03/24/26, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #34 had diagnoses which included: iron deficiency anemias (not having enough healthy red blood cells to carry oxygen to the body's tissues), anxiety disorder (a mental health condition characterized by persistent, excessive, and uncontrollable worry or fear that interferes with daily life, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	unlike normal, temporary stress), hypertension (blood vessels is too high), heart failure (heart does not pump enough blood for the body's needs), hyperlipidemia (abnormally high fat and lipids) and type 2 diabetes mellitus without complication,(a chronic condition where the body cannot effectively use (insulin resistance) or produce enough of it, leading to high blood sugar levels hyperglycemia). Record review of Resident #34's quarterly MDS, dated [DATE], reflected the BIMS score was 10 out of 15, which indicated the resident had moderate 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 #34 was incontinent of bladder and bowel. Record review of Resident #34's care plan, dated 1/24/26, reflected Resident #34 had an ADL self-care performance deficit and the goal was the resident would improve current level of function. During an observation on 03/24/2026 at 8:26 a.m. RN F performed blood pressure checks. RN F did not sanitize the blood pressure cuff in-between uses after checking Resident #81's and Resident #34's blood pressure. RN F did not wear a gown before checking Resident #81's blood pressure, pulse oximeter, and before administering 3 medications via G-Tube. During an interview on 03/24/2026 at 9:12 a.m. with RN F she said she forgot to sanitize the blood pressure cuff between residents, she knew better because it was for infection control and the DON had given them a lot of in-services on sanitizing BP cuff in-between residents. RN F said she forgot to wear PPE while assisting with transferring Resident #81. She said she did have in-service about PPE usage to prevent infection every month at least bi-weekly. Interview with ADM on 3/26/26 at 5:00 PM, regarding expectation for Resident #81 on EBP during care. ADM said his expectation was for all residents with EBP signs should be posted on their door, the staffs were supposed to don PPE before entering their room to perform any care, to prevent infection. 4. Record review of Resident #66's face sheet last captured on 03/27/2026, revealed he was a [AGE] year-old male originally admitted on [DATE]. His medical diagnoses type 2 diabetes mellitus (high blood sugar), weakness, and neuromuscular dysfunction of bladder. Record review of Resident #66's care plan last captured 03/26/2026, he had a focus area of occasionally refusing care including ADLs and treatments dated 08/28/2025 with interventions including allowing the resident to make decisions about treatment regime and educating the resident of the possible outcomes of not complying with treatment of care. Resident #66 had a focus area of behavior problem of removing the privacy bag of his foley and taking the foley catheter bag off the hanger from the bed and placing it on the floor and emptied his own foley catheter bag dated 03/24/2026 with interventions including caregivers providing opportunity for positive interaction and educating the resident, family and caregivers on successful coping and interaction strategies. Record review of Resident #66's progress notes, there was no documentation on educating residents on the behavior of removing catheter bag off the bed and placing it on the floor before 03/24/2026. Observation of Resident #66 on 03/24/2026 around 10:20am, Resident #66 was sitting in bed and his catheter bag was on the floor. Resident #66 said that for his convenience he liked to move it around and did not like it to attach to the bed off the floor. Resident #66 said it was not the staff's fault and that it was his preferences, and he knew it should have been attached to the bed off the floor. Interview with RN O on 03/26/2026 at 2:33pm, he said Resident #66's catheter bag was not supposed to be on the floor. Resident #66 would keep removing it from the attachment. Resident #66 said he wanted to keep it that way for his own convenience. Staff attempted to redirect him but Resident #66 was independent with bladder care. RN O said a risk to residents could be the tubing connecting the catheter to the resident could become tangled and pop out or burst. It could result in an infection control issue. Interview with the DON and Administrator on 03/26/2026 at 4:02pm, the DON said Resident #66 knew what he was doing and preferred emptying his own catheter bag and was independent with urinary incontinent care. Resident #66 was known to remove his privacy covering and had done whatever he wanted with his foley. Resident #66 said he did not like it; he did not give any reason why he did not like to secure the tubing. This behavior was ongoing since admission. If Resident #66 was steady and in bed this behavior would not affect him, but since he was independent (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and moved around on his own Resident #66 could trip on his catheter tube. Interview with MDS K and MDS L on 03/27/2026 at 11:08am, MDS K said that he was not aware Resident #66 had a behavior of unhooking his catheter bag and letting it touch the floor. MDS K did not see it until recently. MDS K said not documenting this behavior could cause residents harm down the road if the behavior kept recurring, it could cause trauma which would require the facility to intervene, including informing the physician. Record review of the facility's policy on Infection Control, undated, read in part, . 5. Gowns and protective apparel 1. Gowns and protective apparel are worn to provide barrier protection and reduce the opportunity for transmission of microorganisms in the LTCF. Gowns are worn to prevent contamination of clothing and to protect the skin of personnel from blood and body fluid exposures.2. Gowns are also worn by personnel during the care of patients infected with epidemiologically important microorganisms to reduce the opportunity for transmission of pathogens from residents or items in their environment to other residents or environment. 6. Resident care equipment and articles.3. Non-invasive resident care equipment is cleaned daily or as need between use by the nursing assistant. 7. Although soiled linen may be contaminated with pathogenic microorganisms, the risk of disease transmission is negligible if it is handled, transported, and laundered in a manner that avoids transfer of microorganisms. Hygienic and common-sense storage and processing of clean and soiled linen is recommended. Record review of the facility Policy and Procedures title Infection Prevention and Control policy dated December 2023 read in part.Policy Statement:The facility adopted infection prevention and control policies and procedures are intended to help maintain a safe, sanitary and comfortable environment and to prevent and manage transmission of disease and infection.Policy Interpretation and Implementation:Infection prevention and control policies and procedures apply to all personnel, consultation, contractors, resident, visitors and volunteers. The objectives of the infection prevention and control policies and procedures are to:A. Monitor, detect, investigate and control infections in the facility.B. Maintain a safe, sanitary and comfortable environment for resident, personnel, visitors and the general public.C. Provide evidence-based guidelines for infection prevention and control based on current practices.

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	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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 3 (Resident #66) reviewed for care plans .-The facility failed to ensure Resident #66's behavior of placing his catheter bag on the floor was documented in the care plan. This failure could place residents at risk of staff not being aware of how to provide care tailored to individual residents' needs . Record review of Resident #66's face sheet, last captured on 03/27/2026, reflected a [AGE] year-old male who was originally admitted to the facility on [DATE]. His medical diagnoses included type 2 diabetes mellitus (high blood sugar), weakness, and neuromuscular dysfunction of bladder (nerve damage disrupts communication between the brain, spinal cord and bladder, leading to impaired bladder control).Record review of Resident #66's care plan, last captured 03/26/2026, reflected he had a focus area of occasionally refusing care which included ADLs and treatments, dated 08/28/2025, with interventions which included allowing the resident to make decisions about treatment regime and educating the resident of the possible outcomes of not complying with treatment of care. Resident #66 had a focus area of behavior problem of removing the privacy bag of his foley and taking the foley catheter bag off the hanger from the bed and placing it on the floor and emptied his own foley catheter bag, dated 03/24/2026, with interventions which included caregivers providing opportunity for positive interaction and educating the resident, family and caregivers on successful coping and interaction strategies. Record review of Resident #66's progress notes, reflected there was no documentation on educating the residents on the behavior of removing the catheter bag off the bed and placing it on the floor before 03/24/2026. The care plan was updated on 03/24/2026 to reflect Resident #66's behavior after surveyor intervention.Observation on 03/24/2026 around 10:20 AM, revealed Resident #66 was sitting in bed and his catheter bag was on the floor. Resident #66 said for his convenience he liked to move it around and did not like it to attach to the bed off the floor. Resident #66 said it was not the staff's fault and that it was his preferences, and he knew it should have been attached to the bed off the floor. Interview with RN O on 03/26/2026 at 2:33 PM, he said Resident #66's catheter bag was not supposed to be on the floor. Resident #66 would keep removing it from the attachment. Resident #66 said he wanted to keep it that way for his own convenience. Staff attempted to redirect him but Resident #66 was independent with bladder care. RN O said a risk to residents could be the tubing connecting the catheter to the resident could become tangled and pop out or burst. It could result in an infection control issue. RN O did not know whether or not this was documented in Resident #66's care plan. Interview with the DON and Administrator on 03/26/2026 at 4:02 PM, the DON said Resident #66 knew what he was doing and preferred emptying his own catheter bag and was independent with urinary incontinent care. Resident #66 was known to remove his privacy covering and had done whatever he wanted with his foley. Resident #66 said he did not like it, he did not give any reason why he did not like to secure the tubing. This behavior was ongoing since admission. It was not care-planned until recently . The DON said staff like the MDS team, or the IDT team should have been care-planning it. Without it being documented, other staff members would not be aware of it. If Resident #66 was steady and in bed this behavior would not affect him, but since he was independent and moved around on his own Resident #66 could trip on his catheter tube. Interview with MDS K and MDS L on 03/27/2026 at 11:08 AM, MDS K said he was not aware Resident #66 had a behavior of unhooking his catheter bag and letting it touch the floor. MDS K did not see it until recently. Resident behaviors would be discussed in morning meetings and documented in the medical records and care plan. MDS K said it was the MDS team's responsibility to add it in the care (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	plan, but he was not informed of this behavior. MDS K said not documenting this behavior could cause residents harm down the road if the behavior kept recurring, it could cause trauma which would require the facility to intervene, which included informing the physician.A policy on comprehensive care plans was requested on 04/27/2026 at 11:44 AM by email to the Administrator and DON and was not provided 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 the resident environment remained as free of accident hazards as was possible for 1 of 4 residents (Resident #1) reviewed for accident hazards. LVN W failed to properly dispose of lancets, used to prick Resident #1's finger to obtain blood for the glucose checks, and threw it in the regular trash can rather than the sharps container attached to the side her medication cart. This failure could place residents at risk of harming themselves or others with unsecured equipment.Findings include:Record review of Resident #1's face sheet, dated 03/24/2026, reflected a 53year-old female who was admitted to the facility on [DATE] and readmitted [DATE]. Her medical diagnoses included down syndrome (a genetic condition present at birth where a person has an extra chromosome, specifically chromosome 21), cognitive communication deficit, need for assistance with personal care, other abnormalities of gait and mobility, muscle weakness (generalized), type 2 diabetes mellitus (body cannot effectively use insulin (insulin resistance) or produce enough of it, leading to high blood sugar level) with unspecified complications (high blood pressure).Record review of Resident #1'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 #1's care plan, dated 11/27/2025, reflected Resident #1 had a focus area for impaired cognitive function, cognitive loss and impaired decision-making abilities with interventions which included monitoring, documenting and report as needed any changes in cognitive functions and changes in memory, general awareness and decision-making ability. Observation during blood glucose check on 3/24/26 at 11:09 AM revealed Resident #1 sitting in a high back wheelchair in her room. LVN W got a glucose check machine, one lancet sharp, glucose strips and alcohol pad from the medication cart packed in front of Resident#1's door, wore PPE(Personal Protective Equipment) and clean gloves, explained the procedure to the resident. LVN W wiped Resident #1's finger with the alcohol pad, she then pricked Resident #1's finger and was unable to obtain blood drops. LVN W then took off the gloves and disposed the lancet in the trash in the resident's room. LVN W went to the parked medication cart and picked up another lancet, pricked Resident #1's finger and obtained blood, the glucose was 200mg/dl (milligrams per deciliter), LVN W then disposed the lancet and strip in the trash can in the room. During an observation/interview on 3/24/2026 at 11:30 a.m., LVN W stated the importance of ensuring sharps were properly disposed was to ensure no residents and staff could hurt themselves and expose themselves to an infection or disease. LVN W said she should have placed the lancet in the sharp box.During an interview on 3/25/2026 at 5:00 p.m. with the DON, revealed the policy on sharps disposal was requested. The ADM and DON both stated they were not aware of the improper disposal of the sharps. They both stated all sharps were to be properly disposed of to maintain infection control and to ensure the safety of residents who could hurt themselves and contract an infection or disease. During an interview on 3/25/2026 at 5:02 p.m. with the Administrator the policy on sharps disposal was requested. The ADM and DON both stated they were not aware of the improper disposal of the sharps. They both stated all sharps were to be properly disposed of to maintain infection control and to ensure the safety of residents who could hurt themselves and contract an infection or disease.Record review of the facility's policy on Regulated (Biohazard) Medical Waste, copyrighted July 2025, read in part, Policy:It is the policy of this facility to ensure that regulated medical waste is managed, handled, stored, and transported as per Federal, State and local guidance and regulations. (Include any specific state or local guidance and regulations.).10.Contaminated sharps will be placed in appropriate sharps containers located at the point of use. Items to be considered into placement within sharps containers include discarded laboratory tubes with small amounts of blood, scalpel blades, needles and syringes, and unused sterile sharps. 11.Sharps containers must be the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	following:a. Closable;b. Puncture resistant;c. Leak proof on sides and bottom;d. Labeled with the appropriate biohazard labels as per OSHA(Occupational Safety And Health Administration) standards.12. Sharps containers must be maintained upright throughout use and replaced routinely. Do not overfill the container.13.Sharps containers will be closed immediately prior to removal or replacement to prevent spillage or protrusion of contents during handling, storage, or transport.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure all drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, and included the appropriate accessory and cautionary instructions, and the expiration date when applicable for 1 of 4 medication carts (Nurses Cart P) reviewed for medication storage. -Nurse Cart P medication cart had medications that were opened and undated. This failure could place residents at risk of receiving expired medication and improperly stored medications which could result in delayed healing. Findings During an observation on [DATE] at 2:35pm of Nurse Cart P revealed the following opened medications were not dated when they were opened: The following eye drops and nasal drops were open with no date:1. Loteprednol Etabonate Ophthalmic2. Bacitracin Zinc and Polymyxin B Ophthalmic3. Fluticasone Propionate Nasal Spray USP 50mcg Interview with LVN GG on [DATE] at 4:44 PM revealed she was not aware of the following eye drops Loteprednol Etabonate Ophthalmic and Bacitracin Zinc and Polymyxin B Ophthalmic that were opened and not dated. She stated Loteprednol Etabonate Ophthalmic and Bacitracin Zinc and Polymyxin B Ophthalmic medication was good for 30 days for effectiveness. LVN GG said she checked her medication cart whenever she administered her medications. During an interview on [DATE] at 4:38 p.m., the Director of Nurse (DON) said eye drops opened should have an open date. The DON said the medicines would not be effective for the treatment after 30 days. The nurses were responsible for dating eye drops and nasal drops whenever it was opened. Record review of the facility's policy, not dated, Storage of Medication Purpose: Ensure that medications are stored in a safe, secure and orderly manner. Procedure: 11. multi-dose vials that have been opened or accessed should be dated and discarded within 28 days of opening /initial access unless the manufacturer specifies a shorter or longer date.

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F 0814 Level of Harm - Potential for minimal harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview and record review the facility failed to dispose of garbage and refuse properly for 1 of 2 dumpsters (dumpster A) reviewed for sanitary conditions. The facility failed to ensure dumpster A's lids and doors were secured. The failure could place residents at risk of infection from improperly disposed garbage . Observation on 3-24-26 at 8:45 AM revealed the facility dumpster area had 2 commercial sized dumpsters. Dumpster A was 3/4 full of garbage and the doors were open and the surrounding area had an accumulation of debris. In an interview with the food service manager on 3/24/26 at 8:45 AM she stated that the dumpster doors must always be closed to keep vermin, pests, and insects out of the dumpster and from entering the facility. She further stated that housekeeping and nursing also discard their waste and garbage in the dumpster. It was the responsibility of staff from dietary, nursing and housekeeping for ensuring the food waste will properly be removed and disposed of from the community. Record review of facility's policies and procedures on disposal of garbage and refuse not dated revealed that .7. Refuse containers and dumpster kept outside the facility shall be designed and constructed to have tightly fitting lids, doors or covers. Containers and dumpsters shall be kept clean so that accumulation of debris and insect/rodent attractions are minimized.