STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676214	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Falcon Lake Nursing Home, LLC	200 Carla St Zapata, TX 78076

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the contents of the discharge notice included the reason for transfer or discharge, the effective date of transfer or discharge, the location to which the resident was transferred or discharged , a statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request the name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman for 1 (Resident #1) of 3 residents reviewed for discharge notices. The facility failed to include the location to which the resident was to be discharged and the name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman. This failure could place residents at risk of not receiving appropriate information regarding their discharge and violating their right to appeal. Findings included: Record review of Resident #1's face sheet, dated 01/30/26, reflected the resident was a [AGE] year-old male, admitted [DATE], with diagnoses that included type 2 diabetes (high levels of sugar in blood), major depressive disorder, heart disease, end stage renal disease (kidney failure), and dependence on renal dialysis (treatment to manage kidney function). Record review of Resident #1's MDS assessment, dated 01/01/26, reflected Resident #1 had a BIMS score of 13, indicating intact cognition. Record review of Resident #1's 30-day discharge notice, undated, reflected the reason for discharge was, Cannot provide the appropriate care for your specific needs, effective date of discharge: [DATE], a statement of the resident's appeal rights, Should you wish to appeal this decision, you have the right to do so. Please contact the ADM at (phone) or (email) to initiate the appeal process. We will provide you with the necessary information and support throughout the appeals procedure. The notice had no specific location to which the resident was to be discharged and no information regarding the Ombudsman. In an interview on 01/30/26 at 12:00 PM, with the OMB, she said the facility emailed her the 30-day discharge notice for Resident #1 on 01/28/26. The OMB said she was scheduled to visit Resident #1 today (01/30/26) to explain the appeals process because Resident #1 wanted to appeal. The OMB said part of the rule for the notice was for the OMB's information to be on the 30-day notice, in case the resident wanted to appeal. The OMB said the notice that was given to Resident #1 did not have the OMB's information. In an interview and observation on 01/30/26 at 12:25 PM, with Resident #1, he said he was given a 30-day discharge notice by the ADM and the DON. Resident #1 said the staff explained why he was given the notice, but he did not agree. Resident #1 said he had spoken to the OMB and was going to appeal. Resident was not injured or in distress. In an interview on 01/30/26 at 3:55 PM, with the ADM, he said the 30-day discharge notice was given to Resident #1 on 01/28/26. The ADM said he did not know if the discharge notice should have indicated where the resident would be discharged . The ADM said the facility would have planned the discharge within the 30 days. The ADM (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said the notice should have had the OMB's information. The ADM said he was not sure if the notice provided to Resident #1 had the OMB's information. The ADM said he just followed the notice letter template. The ADM said he was not sure where the template was from, but the DON provided the template to him. In an interview on 01/30/26 at 5:25 PM, with the DON, she said the ADM asked her for the 30-day discharge notice template. The DON said she was not sure what the notice information was supposed to consist of. The DON said she did a web search for examples, obtained a template, and provided the template to the ADM. Record review of the facility's Transfer and Discharge Notice policy dated December 2016 reflected - Policy: Our facility shall provide a resident and/or the resident's representative with a 30-day written notice of an impending transfer or discharge.3. The resident and/or representative will be notified in writing of the following information: c. The location to which the resident is being transferred or discharged ;f. The name, address, and telephone number of the Office of the State Long-term Care Ombudsman.

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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 interviews and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident needs, that included measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs, for 1 (Resident #1) of 3 residents reviewed for care plans. The facility failed to ensure Resident #1's care plan reflected inappropriate behaviors such as inappropriate comments, taking facility/staff items, playing music loudly, and recording with his phone. This failure could place residents at risk of not receiving appropriate interventions and care to meet their needs.Findings included:Record review of Resident #1's face sheet, dated 01/30/26, reflected the resident was a [AGE] year-old male, admitted [DATE], with diagnoses that included type 2 diabetes (high levels of sugar in blood), major depressive disorder, heart disease, end stage renal disease (kidney failure), and dependence on renal dialysis (treatment to manage kidney function). Record review of Resident #1's MDS assessment, dated 01/01/26, reflected Resident #1 had a BIMS score of 13, indicating intact cognition. Record review of Resident #1's care plan, dated 01/30/26, reflected Resident #1 had no inappropriate behaviors such as making rude/inappropriate comments, taking facility/staff items, playing music loudly, and recording with his phone. Record review of Resident #1's progress notes dated 08/29/25-01/30/26 revealed progress notes related to Resident #1's behaviors:On 10/16/25 at 11:24 AM - Resident was being inappropriate and using vulgar language with staff. Resident stated that he could see the staff's private area through her pants. Staff expressed that they felt very uncomfortable with the resident and language being used.On 12/20/25 at 2:18 PM - Staff reported that resident was seen taking furniture out of other rooms and placing them in his room. Staff educated resident on the dangers of moving furniture that could cause potential injuries.Resident #1's progress notes did not reflect other progress notes related to Resident #1's behaviors or interventions implemented to address behaviors. In an interview on 01/30/26 at 11:15 AM, with the ADON, she said Resident #1 made inappropriate comments to the staff such as talking about their bodies. The ADON said Resident #1 took belongings from the staff's lounge such as the staff's meals and took facility belongings to his room like the nurse station's chair. The ADON said they redirected Resident #1 to stop these behaviors. The ADON said Resident #1 started recording staff with his phone which she was not sure if he was allowed to do. The ADON said Resident #1 played his music loudly which did not allow others to sleep. The ADON said they verbally redirected Resident #1 to stop recording and to use his headphones when listening to music at night so residents could sleep. The ADON said she was not sure if these behaviors were care planned. The ADON said the DON updated care plans. In an interview and observation on 01/30/26 at 12:25 PM, with Resident #1, he said he was given a 30-day discharge notice by the ADM because of his behaviors. Resident #1 said he did not agree with the notice as he did not behave or do the things the facility said he was doing. Resident was not injured or in distress. In an interview with on 01/30/26 at 3:15 PM, with the DON, she said Resident #1 had inappropriate behaviors such as making rude/sarcastic comments towards the staff. The DON said other residents complained that they could not sleep because of Resident #1 playing his music loudly. The DON said most recently, Resident #1 started recording the staff and tried to catch them doing something wrong. The DON said she reviewed the residents' chart and updated the care plans as needed. The DON said Resident #1's behaviors were not care planned but should have been. The DON said the staff verbally redirected Resident #1 to stop the behaviors, but there were no other interventions implemented for the behaviors. The DON said there was no negative outcome for Resident #1. The DON said it was important for the care plan (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to be individualized and developed accurately so staff knew how to care for the residents. Record review of the facility's Care Plans, Comprehensive Person-Centered policy dated December 2016 reflected - Policy: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition changes.