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	03/17/2026

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

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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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure each resident was permitted to remain in the facility and not transfer or discharge the resident from the facility for 1 of 5 residents (Resident #1) reviewed for discharge requirements.The facility failed to ensure Resident #1 was given a discharge date 30 days after being given a 30-day discharge notice on 03/06/26.The facility failed to readmit Resident #1 after he was discharged from the hospital prior to the 30th day after his 30-day discharge notice. This failure could place discharged residents and residents residing in the facility at risk of being discharged and not allowed to return to the facility causing a disruption in their care and/or services.Findings included:Record review of Resident #1's admission record reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included type 2 diabetes (chronic condition that happens when blood sugar levels are persistently high which can lead to heart disease, kidney disease, and stroke) with diabetic neuropathy (damage to nerves outside of the brain and spinal cord that leads to pain, weakness, numbness or tingling in one or more parts of the body) and foot ulcer (wound on the foot arising from neuropathy, peripheral arterial disease, and impaired wound healing caused by diabetes), end stage renal disease (when the kidneys lose the ability to remove waste and balance fluids), dependence on renal dialysis (process of filtering blood through a machine to remove excess water and toxins in the blood when the kidneys no longer function), essential (primary) hypertension (high blood pressure), heart failure (when the heart does not pump blood as well as it should causing fluid to build up in the lungs), major depressive disorder, recurrent (persistently low or depressed mood and a loss of interest in activities that creates significant difficulty in daily life, work, and social functioning), and atherosclerotic heart disease (buildup of fats and other substances in and on the artery walls of the heart causing decreased blood flow and/or clots) with atherosclerosis of coronary artery bypass graft(s).Record review of Resident #1's quarterly MDS dated [DATE] reflected a BIMS score of 13 which indicated he had no cognitive impairment. This MDS reflected he used a walker and an electric wheelchair for mobility, and he was independent with all of his self-care. The MDS reflected he had diabetic foot ulcer(s) upon admission. Record review of Resident #1's discharge-return anticipated MDS dated [DATE] reflected active discharge planning was already occurring for the resident to return to the community and a referral to the local contact agency was not wanted by the resident.Record review of Resident #1's progress notes reflected the following notes:A Social Service Note dated 01/28/26 at 11:42 am by the SW, Resident approached me to request assistance for possible future discharge. He wants to live alone and will need a wide range of services since he is wheelchair bound. I told him I would look into it and have some form of response when I returned to this facility on 02/08/26.General Note dated 01/28/26 at 4:20 pm by the DON, Meeting held with resident and administrator. Ombudsman present via telephone. Resident was issued a 30-day discharge notice. Resident refused to receive copy of notice. DON read notice out loud to resident. Resident did not ask any questions. Ombudsman stated she would try to come to the facility on Monday. Social worker [name] was made aware of resident's discharge notice. General Note dated 01/29/26 at 3:40 pm by the DON, Resident requested a meeting (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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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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	about another resident's medical care and would get mad when he was told he was not allowed to have that information. The ADON stated he refused dialysis often and was non-compliant with insulin, medications, and fluid restrictions. She stated he was able to sign himself out and went to the store and brought back sodas, energy drinks, etc. She stated they had to put coded door locks on staff doors (breakroom, nutrition room, kitchen) because he would go in and take stuff especially from the lounge/ break room; he would take staff's food that was brought in for meal breaks. The ADON stated Resident #1 frequently told staff that he was recording them for his safety while they did their daily tasks. She stated there was an instance when he video recorded a resident who was yelling about being in her wheelchair. The ADON stated it was unknown if he purposely or inadvertently video or voice recorded other residents, but he often sat in the recliner in the corner near the nurse's station and just had his phone up and appeared to be recording, however he refused to show staff what he was doing. The ADON stated several staff have told her they felt uncomfortable and threatened by Resident #1 due to his sexual comments and aggressive behavior. In an interview on 03/17/26 at 8:10 pm, the DON stated Resident #1 had been at the facility for almost a year and since the beginning he was non-compliant with his insulin, medications, dialysis, fluid restrictions, diet recommendations, and wound care. The DON stated he had a roommate when he arrived and requested a room by himself, and the admin was able to grant that request at the time. She stated Resident #1 bought a lot of things and put them in the room. She stated when the census began to grow in the last couple of months, the admin told him that he had to move to another room because they needed to make that hall a skilled hall She said Resident #1 agreed to the move, but that night he played his music very loudly disrupting other residents sleep. She stated the resident had headphones but did not want to use them when asked to turn his music down so other residents could sleep. The DON stated the morning after he was moved was when he started recording staff and threatening to call state on them. She stated most of the female staff had come to her and reported he was making sexual comments and gestures toward them and making them uncomfortable. She stated he had a phone holder on his wheelchair and would go around and record staff and say he was, recording for his safety. The DON stated Resident #1 was issued a 30-day notice on 01/28/26 because he was already behind on his room and board payments to the facility, but he appealed and won, due to a technicality, however he did not pay the facility the money he owed. She stated he was issued another 30-day notice on 03/06/26 effective 03/12/26 because he was still behind on his payments. The DON stated the SW explained to Resident #1 his apartment would be ready on 03/12/26 but he was still obligated to pay the facility. The DON stated she and the ADON spoke to Resident #1 about refusing his wound care, smoking, and being non-compliant with his medications, insulin, and diet recommendations and gave him in depth information/education about what could happen. She stated Resident #1 started getting worried and told them he did not want to have any amputations. On Saturday, 03/07/26, Resident #1 agreed to go to the hospital per the physician's recommendation. The DON stated the administrator was very transparent about Resident #1's behaviors to the facility that accepted him when he got discharged from the hospital. The DON stated she was very involved with the discharge process because the SW came to the facility once a month. She stated the facility owners were concerned about staff wanting to quit due to Resident #1's behavior. In an interview on 03/17/26 at 8:40 pm, the Admin stated the facility originally issued Resident #1 a 30-day discharge notice on 01/28/26. He stated Resident #1 refused a copy of the notice, then appealed it and won. The Admin stated he was not aware until 03/03/26 Resident #1 had not paid the facility for February and March 2026. The Admin stated the DON was with him when he gave Resident #1 both of the 30-day notices. The Admin stated on 03/06/26 he asked Resident #1 why he had not paid and Resident #1 told him he wanted to move to an apartment. The Admin stated he told Resident #1 that he had to pay what he owed the facility by 03/06/26 and if he did not pay the money owed, he had to issue a discharge notice. The Admin stated the SW was at the facility that day and made Resident #1's Medicaid appointment for him. The Admin stated when the discharg