STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675556	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cypress Woods Care Center	135 1/2 Hospital Dr Angleton, TX 77515

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 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** 37059 Based on observation, interview, and record review, the facility failed to implement a comprehensive person-centered care plan for each resident to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 6 residents (Resident #1) reviewed for care plans in that: The facility failed to implement a comprehensive care plan intervention for Resident #1 which addressed her fall risk which included a fall mat at Resident #1's bedside. The facility failed to implement a comprehensive care plan intervention for Resident #1 which addressed her fall risk which included her bed should have been placed in the lowest position This failures placed the resident at risk for injury. Finding included: Record review of the admission sheet for Resident #1 revealed an [AGE] year-old female admitted on [DATE] and readmitted [DATE]. Her diagnoses included: diagnosis of muscle weakness, abnormal gait/mobility, cerebrovascular accident (loss of blood flow to a part of the brain) and dementia (group of symptoms that affects memory, thinking and interferes with daily life). Record review of Resident #1's Significant Change MDS assessment, dated 2/28/2024, revealed a BIMS score of 13 out of 15 which indicated her cognition was intact. Resident #1 used a wheelchair for mobility. Resident #1 required total dependence from two-person physical assist from staff for bed mobility and transfer. Record review of Resident #1's care plan, initiated 3/8/2024 revealed the following: Focus: (Resident #1) is at risk for falls/injuries related to CVA weakness. Goal: (Resident #1) will have no falls/injuries daily through next 90 day review. Interventions: .Fall mat in place (date initiated 5/6/2024) Keep bed in low position (date initiated 11/21/22 and revised 8/29/23). Record review of Resident #1's Fall assessment dated [DATE] revealed Resident #1 had a score of 17 which indicated a High Risk for falls. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 5/8/2024 at 10:07 a.m., revealed Resident #1 awake in bed with her bed not in the low position, and there was no fall mat at bedside or in the room. Observation on 5/8/2024 at 10:39 a.m., revealed Resident #1 awake in bed with her bed not in the low position, and there was no fall mat at bedside or in the room. Observation on 5/8/2024 at 10:59 a.m., revealed Resident #1 awake in bed with her bed not in the low position and there was no fall mat at bedside or in the room. Interview on 5/8/2024 at 11:00 a.m. with CNA A, who was assigned to Resident #1, revealed the nurses would tell her if there were any interventions that the resident needed. She was aware that the resident had falls in the past but was not aware of the fall mat intervention for Resident #1. She was not able to say why the bed was not in the lowest position. She said care planned interventions should be in the Kardex (system that organizes resident information). CNA A said she had been trained on reviewing the documentation system at the beginning of the shift, but she relied on the nurses to update her on intervention changes. Observation on 5/8/2024 at 11:15 a.m. of Resident #1 in her bed without a mat on the side of her bed and not in the low position was observed by CNA B and the ADMIN. Interview on 5/8/2024 at 11:16 a.m. with CNA B revealed Resident #1's bed was not in the lowest position and there was not a mat at the bedside. She said the bed was in a mid-position. She said it put the resident at risk for injury since she was a fall risk. She said it was the CNA's and Nurses responsibility to ensure interventions were in place. Observation on 5/8/2024 at 1:46 p.m., revealed Resident #1 awake in bed with her bed not in the low position and there was no fall mat at bedside or in the room. Interview on 5/8/2024 at 2:10 pm with LVN A revealed she had been off for two days and this was her first day back, and she did not realize that the fall mat intervention was started. She said she should have looked at the Kardex. She said it was all staff's responsibility to ensure fall interventions are in place. Interview on 5/8/2024 at 1:41pm with the DON, revealed Resident #1's had multiple previous falls they discussed interventions during the morning meetings after the falls and decided to implement the fall mat on 5/6/2024. She said she was not sure what happened and why the fall interventions were not in place for Resident #1. The DON said CNA's had been trained to refer to the Kardex for interventions needed and should read them daily. She said the nurses should have ensured the fall mat and the low bed intervention was in place for Resident #1. She said Central Supply should have initially placed the mat in the room on 5/6/2024. She said Central Supply should have been updated when the intervention was updated. Interview on 5/8/24 at 1:57 pm with Central Supply, revealed she was responsible for supplies needed for interventions like fall mats. She said she was not told Resident #1's needed a fall mat. She said she was told approximately 20 minutes prior to that interview (1:37pm). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 5/8/24 4:40 p.m. with, the Admin. revealed Resident #1 was supposed to have a fall mat and her bed should have been in a low position. He said the staff should have followed the care plans. He said the Nurses and CNA's were responsible for ensuring fall interventions are in place. He said it is the DON's responsibility and should have ensured the intervention was in place for Resident #1. He said the new interventions should have be communicated to the charge nurses. The charge nurses should have informed CNA's about Resident #1's interventions were in place. Record review of facility's policy, Care Plans Comprehensive Person-Centered (revised December 2016) revealed the following in part: 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 . 10. Identifying problems areas and their causes and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process. Record review of facility's policy, Fall Prevention Program not dated, revealed the following in part: .The Interdisciplinary Team will review fall risk assessments completed by the nursing department, as well as completing the Fall Resident Assessment Protocol and if appropriate, a fall prevention protocol will be initiated . Purpose: To ensure consistency in the implementation of preventive measures to assist with the reduction of falls . Procedure: 4. All resident receiving a score of ten (10) or more will be considered at risk for falls .6. The Director of Nursing/designee will be responsible for ensuring that residents who have been identified at risk or who have experienced recent falls have all recommended interventions in place .