

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675556	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/07/2024
NAME OF PROVIDER OR SUPPLIER  Cypress Woods Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 25263</p> <p>Based on observation, interview and record review the facility failed to ensure the residents environment remained as free of accident hazards as possible and each resident received adequate supervision and assistance devices to prevent accidents for 8 of 59 residents (Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, Resident #8 and Resident #9) reviewed for accidents and supervision.</p> <p>1. The facility failed to ensure 8 residents were able to evacuate in the event of an emergency due to plywood bolted down to the exterior door that barricaded the exit on Hall A.</p> <p>2. The facility failed to ensure 8 residents on Hall A had two exits available in an event of an emergency due to the dead-end corridor.</p> <p>An immediate jeopardy (IJ) was identified on 6/4/2024 at 5:37 p.m. The IJ template was provided to the facility on [DATE] at 5:37p.m. While the IJ was removed on 6/5/2024 at 12:01p.m., the facility remained out of compliance at a scope of pattern with the potential for more than minimal harm that is not immediate jeopardy, due to the facility's need to evaluate the effectiveness of the corrective systems.</p> <p>This failure placed residents at risk of physical and psychological harm, and possible death, due to the exit door creating a dead-end corridor in an emergency.</p> <p>Findings Included :</p> <p>Resident #1</p> <p>Record review of Resident #1's face sheet dated 6/5/2024 revealed a [AGE] year-old male that was admitted to the facility on [DATE] with diagnoses of Emphysema (type of lung disease), unspecified, unspecified abnormalities of gait and mobility (change in walking pattern), other lack of coordination, and cognitive impairment (a condition in which there is a decline in memory and thinking).</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #1's MDS dated [DATE] revealed Section C0500 had a brief interview of mental status score of 00, which indicated severe cognitive impairment. Section GG- Functional Abilities and Goals -Roll left and right, sit to lying, lying to sitting side of bed, sit to stand, transfer (toilet/shower) and walk 10, 50 and 150 feet were all scored a6 which represented he was independent.</p> <p>Record review of Resident #1's care plan revised on 4/28/2023 revealed Resident #1 had a slightly limited physical mobility r/t use of cane when ambulating, goal- Resident #1 will demonstrate the appropriate use of adaptive device to increase mobility.</p> <p>Resident #2</p> <p>Record review of Resident #2's face sheet dated 6/5/2024 revealed a [AGE] year-old male that was admitted to the facility on [DATE] with diagnoses of dementia (a loss of thinking, remembering and reasoning), hypertensive heart disease (a change in left ventricle, atrial and arteries as a result of chronic blood pressure), unspecified abnormalities of gait and mobility (change in walking pattern), unspecified lack of coordination and cognitive communication deficit.</p> <p>Record review of Resident #2's MDS dated [DATE] revealed Section C-0500 brief interview of mental status was unscored (00), which indicated severe cognitive impairment. Section C-1310 Onset of mental status change (B) Inattention and (C) Disorganized thinking were coded as a 1 for behavior continuously present and did not fluctuate. Section GG Functional abilities GG-0115 notated Upper extremity (shoulder, elbow, wrist and hand) coded as a 2 which indicated impairment on both sides. Section GG-0170 reflected lying to sitting on side of bed was coded as a 03 which indicated partial assistance needed by staff. Sit to stand, chair to bed, toilet transfer and tub/shower transfers were coded as (02) which represented substantial assistance needed by staff. Walk 10 feet was coded an88 which indicated not attempted due to safety concerns.</p> <p>Record Review of Resident #2's care plan dated 5/26/2021 and revised on 9/29/2023 revealed Resident #2 had impaired cognitive function r/t forgetfulness, diagnoses of dementia, BIMs indicated severe impairment. Resident #2 had a communication problem r/t/ hearing loss, he was HOH.</p> <p>Resident #3</p> <p>Record review of Resident #3's face sheet 6/7/2024 revealed an [AGE] year-old female that was admitted to the facility on [DATE] and with diagnoses of cerebral infarction(stroke caused by disrupted blood flow to the brain), other lack of coordination, unspecified abnormality of gait (change in walking pattern), hypertensive heart disease (a change in left ventricle, atrial and arteries as a result of chronic blood pressure), unspecified dementia, and cognitive communication deficit.</p> <p>Record review of Resident #3's quarterly MDS dated [DATE] revealed C0500- brief interview of mental status was unscored (00) which indicated severe impairment. Section GG Functional Abilities indicated Upper Extremities and lower extremities (1) indicated impairment on one side. Mobility Devices reflected (C) Wheelchair was used. Roll left and right, sit to lying, lying to sitting on side of bed was coded a 03 which indicated partial/moderate staff assistance was needed. Sit to stand, chair/bed to chair transfer, tub/shower and toilet transfers were coded a 02 which indicated substantial assistance required by staff.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of resident daily census dated 6/4/2024, listed 8 residents in rooms 101-106. Rooms 102B, 103B and 105A were empty.</p> <p>An interview with the Administrator on 6/4/2024 at 10:49 a.m., revealed the air conditioning systems in the facility had not been working well. He said there were 5 to 7 total units throughout the facility. He said the unit in the back of the building where Nursing station 2 was located was leaking freon, another unit in the back unit needed a compressor and Hall A unit needed a blower motor replaced. He stated the plywood that replaced the exit door was put in place because the portable air conditioning ducts had to go through that door to cool Hall A. He stated the portable air conditioning inserted through the plywood in the exit door was done on 6/2/2024 by a local contractor. He stated the plywood had been there for only two days. He said the Maintenance Director oversaw this project. He was asked why the residents on Hall A were not moved to another hall where the exit door was not barricaded, and he stated the interviewable residents were asked about moving to other rooms and they said they were fine remaining in their rooms. He did not recall which residents were asked specifically. He stated if there was an emergency, they would have evacuated the residents on Hall A through the front entrance door. He stated the evacuation routes were posted at the nursing stations and near each exit door.</p> <p>An interview with Resident # 8 on 6/4/2024 at 11:18 a.m., she stated that it had been warm in her room. She was unaware of the temperature. She stated she did not recall maintenance or the ADM coming in to check the temperature prior to today. She said the temperature was bearable because she had her fans. She said she had both fans on to ensure she was cool. She used a small personal fan that sat on her nightstand and a floor fan. She said she did not notice plywood covering the exit door on Hall A. She said she did not know what would have happened in an emergency because the door near her was closed off. She said she guessed staff would have to bring her through another door.</p> <p>An interview with the FM of Resident #6 on 6/4/2024 at 11:25 a.m., revealed he was not aware of the plywood on the exit door on hall A. He stated he visited Resident #6 once a week and said the plywood was not there when he visited on last Wednesday (5/29/24). He said the facility was usually cool and there were no issues. The FM stated Resident #6 was not verbal. He said she was cold-natured and not sure if she was affected by the air conditioning not working well. He stated he noticed the plywood over the door today (6/4/2024). He stated he asked himself, Are they allowed to have that there? He said Resident #6 would need help in an evacuation as she required total care by staff. He said he guessed they would have to evacuate her through another door in an emergency.</p> <p>An interview with RN B on 6/4/2024 at 11:56 a.m. revealed she had been employed with the facility for a few months. She stated she normally worked the morning shift. She stated the air conditioning had been out for about two weeks. She stated a family member had inquired about the air conditioning not working and about the exit door in Hall B. She said the thermostat on Hall A read 83 degrees Fahrenheit a few days before the yellow portable was placed. She said it really got warm in the front of the building. She said she saw the plywood covering the door but was more concerned the residents had cool air and figured the Administrator or maintenance must have given the okay for the contractor to install it. She did not ask any questions about it. She said in an emergency they would have evacuated the residents on Hall A out the front door which was the closest exit.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>An interview with CNA B on 6/4/24 at 12:21pm, she stated she had been employed since 2023. She stated she normally worked the 6a-6p shift. She stated she normally worked Hall A. She stated that the air conditioning had been an issue since the end of May 2024. She said she mentioned to the Maintenance Director that it was warm down that hall. He said the air conditioning was flipping the breaker at first then the unit went out. She stated she saw the plywood but was happy the residents had cooler air. She said they would have had to move the residents through another exit or the front door in the event of an emergency. She said she knew boarding that exit door on with wood was a bad idea.</p> <p>An interview with the DON on 6/4/2024 at 2:01p.m., she stated she did not work between 5/25/24-6/3/2024. She said she was on vacation and returned to work on today (6/4/24) and although she did see the plywood, she was going to ask questions about it in the morning meeting, but the Investigator entered the facility, so they did not have a morning meeting. She said her backup while she was off was the MDS Nurse. She stated she was not made aware of the plywood barricading the exit door prior to observing it on 6/4/24. She said she did not know that was considered a dead-end corridor. She said in an emergency they could have gotten the residents out of the windows. She said the nurse on duty could have made the decision to move the residents to another hall. She said she was not sure why the residents down Hall A were not moved to another hall with two exit doors.</p> <p>An interview with the Medical Records Coordinator on 6/4/2024 at 2:35 p.m., revealed she had been employed at the facility for nine years. She stated the plywood had been setup by a local contractor to run the portable air conditioning ducts through to help cool Hall A. She stated she did notice the plywood replaced the exit door. She stated she only thought about the residents getting cool air and did not think it was a hazard. She said the air conditioner on Hall A went out on or about 5/25/2024 and the portable was setup on 6/2/2024.</p> <p>In a subsequent interview with the Administrator on 6/4/2024 at 3:27 p.m. revealed him to state the air conditioning blower motor on Hall A unit was being repaired right now and the Maintenance Director would remove the plywood from the exit door. He was asked why residents on Hall A were not moved to another hall since that door had been replaced with plywood and he stated he was not aware that created a dead-end corridor. He said in an emergency like a fire, the residents might have been harmed or burned from not having an exit closest to them to get out. He said having that door barricaded could have caused a delay in exiting the building, smoke inhalation, and bodily harm could have happened to residents and staff.</p> <p>An interview with the Maintenance Director on 6/5/24 at 1:08 p.m. He has been employed at the facility for about 6 months. He stated this was his first maintenance job. He said he had no experience working with air conditioning. He stated the only complaints about the facility being warm came from staff, not residents. He stated he had kept a temperature log and took temperatures in areas with portables. No rooms or hallways were over 78 degrees Fahrenheit. He stated he did not know the plywood bolted down to the door frame created a dead-end corridor. He said he was not aware of that. He said in an emergency staff could have evacuated the residents out the front door, which was the nearest exit. He said he received an in-service on door egress and blocking the exit doors. He said the Regional Maintenance Director had trained him and he was in-serviced by the Administrator as well.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The facility failed to ensure that 8 residents could evacuate due to a barricade at the end of a corridor. The barricade consisted of plywood which was bolted down.</p> <p>Immediate Corrective Actions For Removal Of Immediate Jeopardy</p> <p>The plywood physically barricading the exit door at the end of the 101-106 hall near resident rooms 101-106 was immediately removed by the Maintenance Assistant. The exit door is no longer barricaded. 6/4/2024 at 3:45 pm.</p> <p>The facility reviewed the system for ensuring that all exits are not blocked. Ad Hoc QAPI meeting was completed with the IDT, Administrator, DON, and Medical Director on 6/4/24 at 9:00 pm.</p> <p>Facility Plan to ensure compliance quickly:</p> <ol style="list-style-type: none"> <li>1. The Administrator checked all exits to ensure these areas were not blocked.</li> <li>2. Education provided to the administrator by the Regional Maintenance Director regarding Exit and Means of Egress. 6/4/2024 at 6:30 p.m.</li> <li>3. Education provided to Maintenance Director by the Administrator on ensuring exits are not blocked and Exit and Means of Egress. 6/4/2024 at 6:40 p.m.</li> <li>4. Education initiated on 6/4/24 at 7:52pm, to all department staff by the Administrator and Maintenance Director; related to means of egress must remove free from any blockage and evacuation routes. Staff will not be able to work their scheduled shifts without prior in-service on egress.</li> </ol> <p>Whoever discovers a blocked exit shall clear the exit, if possible, and the report the finding to his or her immediate supervisor or to a supervisor or manger in the building, if the immediate supervisor is not present. If no supervisor is on the building is present staff has been educated to call the Administrator or Maintenance Director. The Administrator and/or Maintenance Director will make sure it is immediately corrected.</p> <ol style="list-style-type: none"> <li>5. Facility will be in compliance by 6/5/24 by noon.</li> </ol> <p>Monitoring of the plan of removal from 6/4/2024 to 6/7/2024 included:</p> <p>Observation on 6/4/2024 at 5:50pm revealed the plywood and portable air conditioning ducts had been removed from Hall A's exit door.</p> <p>Interviews on 6/5/24 at 12:38pm, with the DON, Administrator and Social Services Coordinator revealed the Administrator stated the Regional Maintenance Director in-serviced him, the DON, Maintenance Director and Social Services on door egress. He stated the egress was not to be blocked. He said he also in-serviced the Maintenance Director about not putting anything to block the exit doors. If someone saw anyone put boxes or anything in front of the doors everyone was responsible for moving it immediately or report to the Administrator or Maintenance Director for help moving. There was a consensus with that group that they understood the plywood barricaded the door on Hall A and made it a dead-end corridor. It created a hazardous situation for residents down that hall.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Cypress Woods Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  135 1/2 Hospital Dr Angleton, TX 77515	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record Review of the ad hoc QAPI meeting reflected that on 6/4/24 at 9:00 p.m., the IDT, DON/MDS /ADM-once compliance is established the Administrator and maintenance will monitor to make sure no exit door is blocked to ensure continuation of resident's care is safe.</p> <p>Record review of exit or means of egress huddle sign-in sheet dated 6/4/2024 revealed the Maintenance Director and the Administrator were trained by Regional Maintenance Director on exit and means of egress.</p> <p>Record Review of exit and egress log dated 6/5/2024 revealed the maintenance director had checked all exit doors to ensure nothing blocked the doors.</p> <p>Interviews were completed between 6/5/2024-6/7/2024 with 3 CNAs on 6am-6pm and 2 CNAs on 6pm-6am shifts, 2 RNs, 3 charge nurses, the Social Services Coordinator, Dietary Manager, Activity Director and 2 LVNs on night shift revealed they were aware of the exits not being blocked, reporting any blocked exits and evacuation route locations .</p> <p>The Administrator was informed the Immediate Jeopardy was removed on 6/7/24 at 2:30 p.m. The facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy and a scope of pattern due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.</p>		