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	01/08/2025

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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37241 Based on interview, and record review the facility failed to obtain laboratory services to meet the needs of 1 of 5 residents (Resident #31) reviewed for laboratory services. The facility failed to ensure Resident #31 received lab test that were ordered for lipid panel and thyroid panel to know if the medications of atorvastatin and levothyroxine were at correct levels for administration to resident. This failure could place residents at risk for adverse effects of pain, discomfort, increase side effects, not receiving the therapeutic effects of the medication, and a decline in health. Findings included: Record review of Resident #31's face sheet revealed a [AGE] year-old female admitted on [DATE]. Diagnosis were Cerebral Infarction (occurs when blood flow to the brain was blocked), Hypothyroidism (condition which the thyroid gland does not produce enough thyroid hormone), and Hypertensive Heart Disease (complications from high blood pressure). Record review of Resident #31's Quarterly MDS dated [DATE] revealed a BIMS score of 14 indicating cognition was intact. Record review of Resident #31's Medication Record for September 2024 revealed: Atorvastatin Calcium Oral Tablet 40 MG (Atorvastatin Calcium) Give 1 tablet by mouth at bedtime for Hypercholesterolemia And Levothyroxine Sodium Tablet 125 MCG Give 1 tablet by mouth in the morning for (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	low thyroid hormone were being given to resident as ordered. Record review of Resident #31's pharmacist communication to her physician dated 9/4/24 revealed a suggestion to have a lipid panels new and yearly and thyroid panel now one time. This was signed as agreed by physician on 9/23/24. Record review of physician orders reviewed on 1/7/25 for active orders revealed no orders for the labs requested on 9/23/24. Interview on 1/7/24 at 3:45 PM with DON and she stated that the order had not been ordered and not followed through from the pharmacist suggestion. Attempted interview with physician on 1/8/24 at 12:20 PM. Left a message with answering service because the physician was at lunch. The physician never returned the call. Interview on 1/8/25 at 1:05 PM with DON and she stated that the process begins with the pharmacist review and suggestion. This was then emailed or given to the MDS nurse. The MDS nurse sends to medical records. The person there ensures to get the form signed by the physician on if the physician agrees or disagrees. Once signed, she sends it back to the MDS nurse to order. After ordered, Medical Records scans into PCC and files away the form. She was not sure what happened and where the breakdown was. This order was never placed. The signed form was an order and should be followed up on and completed. These were not urgent labs but should have been done since it was an order. The physician would be looking for levels of the medication. There were no recent labs, and it was important to know what the medication levels were to ensure correct medication was being given. Interview on 1/8/24 at 1:10 PM with MDS nurse and she stated that she was to follow up on what is required after the papers are signed. The physician signed form from the pharmacist was an order. She did not know what happened with this order. She said it was possible for it to be uploaded into the system before she received it. This should have been completed. It was important to do what the physician ordered. Interview on 1/8/24 at 1:20 PM with Medical Records and she stated she did not know anything that was done on the medical side. She said she received the pharmacist form and she either put them out for the physician to sign or sent them to the physician to sign. After I receive the form back, I give them to the MDS nurse. She was then responsible for doing what was needed medically. They then were returned, and she would upload and file away. Record review of facility policy titled, Lab and Diagnostic test Results - Clinical Protocol revised November 2018 read in part, .The physician will identify and order diagnostic and lab testing .The staff will process test requisitions and arrange for tests