STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675986	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of Cypress Station	420 Lantern Bend Dr Houston, TX 77090

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure each resident was free from abuse for 1 of 9 residents (Resident #1) reviewed for abuse. Resident #2 was physically abusive to Resident #1 on 9/26/25 when he punched him with a closed fist in the face.These failures placed residents, who resided in the facility, at risk of abuse, pain and emotional distress. The findings included:Resident #2Record review of Resident #2's admission Record generated on 3/19/26 revealed he was readmitted to the facility on [DATE] with diagnoses of encephalopathy (a syndrome of brain dysfunction caused by toxins, infections, metabolic imbalances, or trauma, leading to altered mental status, confusion, and cognitive deficits), aphasia (inability or impaired ability to understand or produce speech, as a result of brain disease or damage), hemiplegia (a severe neurological condition causing paralysis on one side of the body) and hemiparesis (partial weakness or reduced mobility on one side of the body caused by nervous system damage) following cerebral infarction (a type of ischemic stroke caused by blocked blood flow to the brain), bipolar disorder a chronic mental health condition characterized by intense mood shifts between extreme highs, including mania/hypomania and lows, including depression), and anxiety disorder (mental health conditions characterized by excessive, persistent, and uncontrollable worry or fear that interferes with daily life, work, or relationships). He was [AGE] years of age. Record review of Resident #2's quarterly MDS assessment dated [DATE] revealed he was usually understood and could usually understand others. He had a BIMS of 9, indicating he had moderate cognitive impairment. He required supervision for transferring from chair/bed-to-chair and walking 10 feet. He used a wheelchair and could propel himself 50 feet independently. He had behavioral symptoms not directed at others 1 to 3 days of 7 days. Record review of Resident #2's care plan dated 8/26/24 stated Resident #2 had a potential to demonstrate physical behaviors related to becoming agitated and combative with others as evidenced by alleged physical aggression on 12/16/24, 8/8/25 and 9/26/25 toward other residents. Interventions included psych consult for evaluation and treatment, analysis of key times, places, circumstances, triggers and what de-escalates behavior, provide physical and verbal cues to alleviate anxiety, give the resident as many choices as possible about care and activities. Record review of Resident #2's care plan dated 8/28/24 revealed he had a behavior problem related to rummaging through other resident's rooms. Interventions included, administer medications as ordered. anticipate and meet the resident's needs. intervene as necessary to protect the rights and safety of others. Record review of Resident #2's Progress Note dated 9/26/25 at 3:53pm read, Resident was witnessed to have suddenly got out of his wheelchair and walked up to another resident. Resident suddenly with his fist, hit the other resident on the face. Resident states, ?He is always messing with me, I got upset and hit him to put a stopto (sic) it.'. An officer arrived, interviewed resident and transferred resident to (local county).Record review of Resident #2's Progress Note dated 11/10/25 at 11:31am revealed Resident #2 was readmitted to the facility from the county jail. Resident #1 Record review of Resident #1's admission Record generated on 3/19/26 revealed he was admitted to the facility on [DATE] with diagnoses of quadriplegia (paralysis of all four limbs), epilepsy (a chronic (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675986	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of Cypress Station	420 Lantern Bend Dr Houston, TX 77090

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 0600 Level of Harm - Actual harm Residents Affected - Few	neurological disorder characterized by recurrent, unprovoked seizures caused by abnormal electrical activity in the brain), bipolar disorder and major depressive disorder (a serious mental health condition characterized by persistent sadness, low mood, and loss of interest in activities for at least two weeks). He was [AGE] years of age. Record review of Resident #1's care plan revised dated 2/14/22 revealed he had a potential to demonstrate verbally abusive behaviors related to yelling, cursing, and being disrespectful to staff and yelling/cursing at his roommate. Interventions included, Analyze (sic) of key times, places, circumstances, triggers and what de-escalates behavior and document. assess and anticipate resident's needs. give the resident as many choices as possible about care and activities. Record review of Resident #1's annual MDS assessment dated [DATE] revealed he had a BIMS of 15, indicating he had no cognitive impairment. He had verbal behaviors directed toward others that occurred 4-6 days of 7 days. He had upper and lower extremity functional limitations on both sides of his body. He was dependent on staff for personal hygiene and transfers and used a motorized wheelchair independently. Record review of a Provider Investigation Report dated 9/30/25 revealed on 9/26/25 at 12:00pm, the Activity Director stated Resident #2 punched Resident #1. The document noted the Administrator interviewed the alleged perpetrator (Resident #2) and he said he hit Resident #1 because he was always messing with him. The Administrator interviewed Resident #1 who stated he was on his phone and did not tell him anything. Record review of Resident #1's Progress Note dated 9/26/25 at 3:53pm read, Another Resident was witnessed to have suddenly got out of his wheelchair and walked up to this resident. The other resident suddenly with his fist, hit this resident on the left side of the face . head to toe assessment completed (sic) no discolorations, skin tears, redness, swelling or open areas noted. Resident states that his left side of the face is hurting and pain to the touch .Record review of Resident #1's Patient Visit Information from a local hospital dated 9/26/25 revealed he was seen for an alleged assault and had patient discharge instructions for a facial bruise. In an interview on 3/18/26 at 2:00pm, the Activity Director said on the day of the incident between Resident #1 and Resident #2, they were sitting outside on the patio. Resident #1 was seated on one side of the patio and Resident #2 was seated on the other side of the patio. She said she heard Resident #1 activate a task on his phone, then Resident #2 stood up from his wheelchair, walked over to Resident #1, then started swinging at him. She said it was a pretty exaggerated punch. In an interview on 3/18/26 at 12:20pm Resident #1 said on the day of the physical altercation a few months ago, he was sitting outside and said a phrase that prompted a task on his phone into his headset. He said Resident #2 thought he was talking to him. He said Resident #2 stood up from his wheelchair, walked a distance across the patio, then started swinging at him causing him excruciating pain. He said he felt helpless because he could not defend himself. He said he had limited mobility in his arms and hands. In an interview on 3/19/26 at 1:30pm, the Administrator stated after Resident #2 readmitted to the facility, they made sure Resident #1 and Resident #2 were not in the same area at the same time. He said Resident #1 did not have any issues with Resident #2 returning to the facility, and there were no incidents since September 2025. In an observation on 3/19/26 at 3:40pm, Resident #2 was seated in a wheelchair in his room eating a snack. Surveyor attempted to interview Resident #2 and was unsuccessful. Record review of In-Service Training Reports revealed the following: - An In-service training report dated 11/11/25 for nursing staff conducted by the Administrator read, (Resident #2) will be encouraged to participate in more activities and we will increase monitoring when he's around (Resident #1) and (Resident #3). - An in-service training reported dated 12/15/25 for administration and DON conducted by RN R read, Resident to Resident Altercation and Interventions. move to another hall.behavior specific care plans. trigger identification (loud noises, a lot of people around). Record review of the facility's policy regarding Abuse Prevention Program dated August 2006 read, Our residents have the right to be free from abuse, neglect. comprehensive policies and procedures have been developed to aid our facility in preventing abuse, neglect, or mistreatment of our residents. Our abuse prevention program provides policies and procedures that govern, as a minimum. Identification of occurrences and patterns of potential mistreatment/abuse. the implementation of changes to prevent future occurrences of abuse.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675986	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of Cypress Station	420 Lantern Bend Dr Houston, TX 77090

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 0607 Level of Harm - Actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to implement written policies and procedures that prohibit and prevent abuse for 2 of 9 residents (Residents #1 and #2) reviewed for abuse. The facility failed to implement written policies regarding prevention of abuse when Resident #2 was physically abusive to Resident #1 on 9/26/25 when he punched him with a closed fist in the face. The facility failed to implement written policies regarding abuse prevention and protection when Resident #2 was moved to a new room on 3/11/26 placing Resident #1 and Resident #2 in close proximity to each other after Resident #2 assaulted Resident #1 on 9/26/25.This failure placed residents at risk of abuse, mental anguish and fearfulness. The findings included: Record review of the facility's policy regarding Abuse Prevention Program dated August 2006 read, Our residents have the right to be free from abuse, neglect. comprehensive policies and procedures have been developed to aid our facility in preventing abuse, neglect, or mistreatment of our residents. Our abuse prevention program provides policies and procedures that govern, as a minimum. Identification of occurrences and patterns of potential mistreatment/abuse. the implementation of changes to prevent future occurrences of abuse. Resident #2Record review of Resident #2's admission Record generated on 3/19/26 revealed he was readmitted to the facility on [DATE] with diagnoses of encephalopathy (a syndrome of brain dysfunction caused by toxins, infections, metabolic imbalances, or trauma, leading to altered mental status, confusion, and cognitive deficits), aphasia (inability or impaired ability to understand or produce speech, as a result of brain disease or damage), hemiplegia (a severe neurological condition causing paralysis on one side of the body) and hemiparesis (partial weakness or reduced mobility on one side of the body caused by nervous system damage) following cerebral infarction (a type of ischemic stroke caused by blocked blood flow to the brain), bipolar disorder a chronic mental health condition characterized by intense mood shifts between extreme highs, including mania/hypomania and lows, including depression), and anxiety disorder (mental health conditions characterized by excessive, persistent, and uncontrollable worry or fear that interferes with daily life, work, or relationships). He was [AGE] years of age. Record review of Resident #2's quarterly MDS assessment dated [DATE] revealed he was usually understood and could usually understand others. He had a BIMS of 9, indicating he had moderate cognitive impairment. He required supervision for transferring from chair/bed-to-chair and walking 10 feet. He used a wheelchair and could propel himself 50 feet independently. He had behavioral symptoms not directed at others 1 to 3 days of 7 days. Record review of Resident #2's care plan dated 8/26/24 stated Resident #2 had a potential to demonstrate physical behaviors related to becoming agitated and combative with others as evidenced by alleged physical aggression on 12/16/24, 8/8/25 and 9/26/25 toward other residents. Interventions included psych consult for evaluation and treatment, analysis of key times, places, circumstances, triggers and what de-escalates behavior, provide physical and verbal cues to alleviate anxiety, give the resident as many choices as possible about care and activities. Record review of Resident #2's care plan dated 8/28/24 revealed he had a behavior problem related to rummaging through other resident's rooms. Interventions included, administer medications as ordered. anticipate and meet the resident's needs. intervene as necessary to protect the rights and safety of others. Record review of Resident #2's Progress Note dated 9/26/25 at 3:53pm read, Resident was witnessed to have suddenly got out of his wheelchair and walked up to another resident. Resident suddenly with his fist, hit the other resident on the face. Resident states, ?He is always messing with me, I got upset and hit him to put a stopto (sic) it.'. An officer arrived, interviewed resident and transferred resident to (local county).Record review of Resident #2's Progress Note dated 11/10/25 at 11:31am revealed Resident #2 was readmitted to the facility from the county jail. Record review of Resident #2's Progress Note dated 3/11/26 at 8:44pm revealed Resident #2 was moved to a new room. Resident #1 Record review of Resident #1's admission Record generated on 3/19/26 revealed (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675986	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of Cypress Station	420 Lantern Bend Dr Houston, TX 77090

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 0607 Level of Harm - Actual harm Residents Affected - Few	he was admitted to the facility on [DATE] with diagnoses of quadriplegia (paralysis of all four limbs), epilepsy (a chronic neurological disorder characterized by recurrent, unprovoked seizures caused by abnormal electrical activity in the brain), bipolar disorder and major depressive disorder (a serious mental health condition characterized by persistent sadness, low mood, and loss of interest in activities for at least two weeks). He was [AGE] years of age. Record review of Resident #1's care plan revised dated 2/14/22 revealed he had a potential to demonstrate verbally abusive behaviors related to yelling, cursing, and being disrespectful to staff and yelling/cursing at his roommate. Interventions included, Analyze (sic) of key times, places, circumstances, triggers and what de-escalates behavior and document. assess and anticipate resident's needs. give the resident as many choices as possible about care and activities. Record review of Resident #1's annual MDS assessment dated [DATE] revealed he had a BIMS of 15, indicating he had no cognitive impairment. He had verbal behaviors directed toward others that occurred 4-6 days of 7 days. He had upper and lower extremity functional limitations on both sides of his body. He was dependent on staff for personal hygiene and transfers and used a motorized wheelchair independently. Record review of a Provider Investigation Report dated 9/30/25 revealed on 9/26/25 at 12:00pm, the Activity Director stated Resident #2 punched Resident #1. The document noted the Administrator interviewed the alleged perpetrator and he said he hit Resident #1 because he was always messing with him. The Administrator interviewed Resident #1 who stated he was on his phone and did not tell him anything. Record review of Resident #1's Progress Note dated 9/26/25 at 3:53pm read, Another Resident was witnessed to have suddenly got out of his wheelchair and walked up to this resident. The other resident suddenly with his fist, hit this resident on the left side of the face . head to toe assessment completed (sic) no discolorations, skin tears, redness, swelling or open areas noted. Resident states that his left side of the face is hurting and pain to the touch .Record review of Resident #1's Patient Visit Information from a local hospital dated 9/26/25 revealed he was seen for an alleged assault and had patient discharge instructions for a facial bruise. In an interview on 3/18/26 at 2:00pm, the Activity Director said on the day of the incident between Resident #1 and Resident #2, they were sitting outside on the patio. Resident #1 was seated on one side of the patio and Resident #2 was seated on the other side of the patio. She said she heard Resident #1 activate a task on his phone, then Resident #2 stood up from his wheelchair, walked over to Resident #1, then started swinging at him. She said it was a pretty exaggerated punch. In an interview on 3/18/26 at 12:20pm Resident #1 said on the day of the physical altercation a few months ago, he was sitting outside and said a phrase that prompted a task on his phone into his headset. He said Resident #2 thought he was talking to him. He said Resident #2 stood up from his wheelchair, walked a distance across the patio, then started swinging at him causing him excruciating pain. He said he felt helpless because he could not defend himself. He said he had limited mobility in his arms and hands. He said a few weeks ago, Resident #2 was moved to his hall and he did not like it. He said now Resident #2 sat outside of his room and looked in. He said he would do everything he could to defend himself. In an interview on 3/19/26 at 10:25am, the DON stated they were monitoring Resident #1 and Resident #2 in the hallway and common areas. She said they made sure they were not in the same hallway. She said they spoke to Resident #1 before Resident #2 returned to the facility and Resident #1 said he did not have any issues with Resident #2. When informed that the residents were residing in the same hall, she said Resident #2 was at the end of the hallway and reiterated Resident #1 did not have issues with Resident #2. In an interview on 3/19/26 at 1:30pm, the Administrator stated after Resident #2 readmitted to the facility, they made sure Resident #1 and Resident #2 were not in the same area at the same time. He said Resident #1 did not have any issues with Resident #2 returning to the facility, and there were no incidents since September 2025 He said they moved Resident #2 recently to the back of the hallway where Resident #1 resided because they were making room for new admissions. He said Resident #1 did not have an issue with Resident #2 moving to his hall because they did not interact. In an observation on 3/19/26 at 3:40pm, the surveyor walked past Resident #1's room to (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675986	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of Cypress Station	420 Lantern Bend Dr Houston, TX 77090

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 0607 Level of Harm - Actual harm Residents Affected - Few	approach Resident #2's room. Resident #2's room was four doors down and across the hallway from Resident #1, and Resident #2's room was at the end of a hallway that dead-ended into an emergency exit door. Resident #2 was seated in a wheelchair in his room eating a snack. Surveyor attempted to interview Resident #2 and was unsuccessful. In an interview on 3/20/26 at 4:40pm, Resident #1 said the facility staff did not speak to him when Resident #2 was moved to his hallway. He said he did not speak to Resident #2 unless Resident #2 stopped by his room then Resident #1 would ask Resident #2 to go somewhere else. Record review of In-Service Training Reports revealed the following: - An In-service training report dated 11/11/25 for nursing staff conducted by the Administrator read, (Resident #2) will be encouraged to participate in more activities and we will increase monitoring when he's around (Resident #1) and (Resident #3). - An in-service training reported dated 12/15/25 for administration and DON conducted by RN R read, Resident to Resident Altercation and Interventions. move to another hall.behavior specific care plans. trigger identification (loud noises, a lot of people around).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675986	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of Cypress Station	420 Lantern Bend Dr Houston, TX 77090

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 - 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 reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's nursing, mental and psychosocial needs for 1 of 9 residents (Resident #2) reviewed for comprehensive care plans in that: Resident #2's care plan for physical behaviors was not implemented when he physically abused Resident #3 on 8/8/25 and physically abused Resident #1 on 9/26/25. Resident #2's care plan intervention was to analyze the circumstances and triggers after incidents of physical behaviors. Nursing staff were unaware of circumstances and triggers that could cause Resident #2 to physically abuse other residents. These failures placed residents at risk of not having their behavioral needs met, which could lead to abuse and emotional distress. The findings included:Record review of Resident #2's admission Record generated on 3/19/26 revealed he was readmitted to the facility on [DATE] with diagnoses of encephalopathy, aphasia, hemiplegia and hemiparesis following cerebral infarction, bipolar disorder and anxiety disorder. He was [AGE] years of age. Record review of Resident #2's care plan dated 8/26/24 revealed he had a potential to demonstrate physical behaviors related to becoming agitated and combative with others as evidenced by alleged physical aggression on 12/16/24, 8/8/25 and 9/26/25 toward other residents. Interventions included psych consult for evaluation and treatment, analysis of key times, places, circumstances, triggers and what de-escalates behavior, provide physical and verbal cues to alleviate anxiety, give the resident as many choices as possible about care and activities. Record review of Resident #2's quarterly MDS assessment dated [DATE] revealed he was usually understood and could usually understand others. He had a BIMS of 9, indicating he had moderate cognitive impairment. He required supervision for transferring from chair/bed-to-chair and walking 10 feet. He used a wheelchair and could propel himself 50 feet independently.Record review of Resident #2's Progress Note dated 8/8/25 read, Resident was reported to have suddenly slapped with his hand, another resident on the right side of the other resident's face. Resident was trying to get by the other resident on the hallway. Both residents separated immediately.Facility started an abuse investigation. Record review of a Provider Investigation Report dated 8/12/25 revealed on 8/8/25, the receptionist reported that Resident #2 slapped Resident #3 in the face after having words. The document noted the Administrator interviewed the alleged perpetrator and he said he hit Resident #3 because he did not like what he said. When interviewing (Resident #3), he said they both had words and (Resident #2) just hit him in the face. The report did not indicate that there was an analysis of circumstances or triggers of the incident. In a telephone interview on 3/18/26 at 3:15pm, when asked about the incident between Resident #2 and Resident #3, the Former Receptionist said Resident #3 was sitting in a spot along the wall where he normally sat. She said Resident #2 wanted to sit in the same spot. She said they had a brief altercation when they started arguing, then Resident #2 stood up, leaned in and hit Resident #3 with a closed fist. Record review of Resident #2's Progress Note dated 9/26/25 at 3:53pm read, Resident was witnessed to have suddenly got out of his wheelchair and walked up to another resident. Resident suddenly with his fist, hit the other resident on the face. Resident states, ?He is always messing with me, I got upset and hit him to put a stopto (sic) it.'. An officer arrived, interviewed resident and transferred resident to (local county).Record review of a Provider Investigation Report dated 9/30/25 revealed on 9/26/25 at 12:00pm, the Activity Director stated Resident #2 punched Resident #1. The document noted the Administrator interviewed the alleged perpetrator and he said he hit Resident #1 because he was always messing with him. The Administrator interviewed Resident #1 who said he was on his phone and did not tell him anything. The report did not indicate that there was an analysis of circumstances or triggers of the incident. Record review of Resident #2's Progress Note dated 11/10/25 at 11:31am revealed Resident #2 was (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675986	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of Cypress Station	420 Lantern Bend Dr Houston, TX 77090

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 - Actual harm Residents Affected - Few	readmitted to the facility from the county jail. In an interview on 3/18/26 at 12:20pm Resident #1 said on the day of the physical altercation a few months ago, he was sitting outside and said a phrase that prompted a task on his phone into his headset. He said Resident #2 thought he was talking to him. He said Resident #2 stood up from his wheelchair, walked a distance across the patio, then started swinging at him causing him excruciating pain. He said he felt helpless because he could not defend himself. He said he had limited mobility in his arms and hands. He said a few weeks ago, Resident #2 was moved to his hall and he did not like it. He said now Resident #2 sat outside of his room and looked in. He said he would do everything he could to defend himself. In an interview on 3/18/26 at 2:00pm, the Activity Director said on the day of the incident between Resident #1 and Resident #2, they were sitting outside on the patio. Resident #1 was seated on one side of the patio and Resident #2 was seated on the other side of the patio. She said she heard Resident #1 activate a task on his phone, then Resident #2 stood up from his wheelchair, walked over to Resident #1, then started swinging at him. She said it was a pretty exaggerated punch. In an interview on 3/18/26 at 4:55pm, CNA A said Resident #2 moved to her hall assignment in the last few weeks. She said she was not aware of past aggressive incidents regarding Resident #2, and further stated that Resident #2 had no signs of physical or verbal aggression. In an interview on 3/19/26 at 10:25am, the DON said Resident #2 did not have any behaviors on a daily basis. She said she did not identify triggers after the past physical abuse incidents. In an interview on 3/19/26 at 11:46am, LVN E said Resident #2 stayed to himself and did not bother anyone. She said she was aware that he had a history of physical abuse. She said she was not aware of any triggers or circumstances that would cause Resident #2 to become physically abusive toward others. In an interview on 3/19/26 at 2:00pm CNA T said Resident #2 was a good guy and minded his own business. She said she was aware that he had a history of physical abuse. She said she was not aware of any triggers or circumstances that would cause Resident #2 to become physically abusive toward others. In an interview on 3/19/26 at 4:56pm, the Social Worker said the MDS Nurse was responsible for writing the residents' care plans. She said Resident #2 was quiet. She said Resident #2 had not done anything to indicate he would hurt someone. She said they provide supervision to prevent abuse from occurring. In an interview on 3/19/26 at 5:05pm, the MDS nurse said she wrote the resident's care plan when they were admitted . She said if she noticed something or heard something new was going on with a resident in their daily morning meetings, she would add it to the care plan. She said Resident #2 was combative at times and became agitated easily. She said they did in-services with the staff to ensure they were aware of his behaviors. In an interview on 3/20/26 at 5:00pm, the Administrator said after Resident #2's physical abuse incidents, he did not assess to determine the circumstances or triggers that would cause the behavior. When asked what he thought his trigger could be, he said when the other person is talking noise. He said he could not say that they educate the nursing staff specifically on triggers. He stated Resident #2 had no behaviors and had been fine since he returned from jail. Record review of In-Service Training Reports revealed the following: - An In-service training report dated 11/11/25 for nursing staff conducted by the Administrator read, (Resident #2) will be encouraged to participate in more activities and we will increase monitoring when he's around (Resident #1) and (Resident #3). - An in-service training reported dated 12/15/25 for administration and DON conducted by RN R read, Resident to Resident Altercation and Interventions. move to another hall.behavior specific care plans. trigger identification (loud noises, a lot of people around). Record review of the facility policy regarding Care Plans-Comprehensive dated December 2009 read, An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. each resident's comprehensive care plan is designed to: incorporate identified problem areas; incorporate risk factors associated with identified problems.The Care Planning/Interdisciplinary Team is responsible for the periodic review and updated of care plans. when the desired outcome is not met.at least quarterly.