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	06/13/2025

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Deficiency Text Not Available

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident received adequate supervision for 3 of 4 residents (CR #1, Resident#2, and Resident #3) reviewed for accidents and supervision. -CR #1 walked out of the facility unattended with a wander guard (device designed to prevent wandering in elderly) and was missing for approximately 1 hour and 9 minutes on 07/20/2024 and was located nearby an apartment complex. -The facility failed to ensure that Resident#2 had orders in place to monitor placement and functioning of a wanderguard from 07/23/2023-06/10/2025. -The facility failed to ensure that Resident#3 had orders in place to monitor placement and functioning of a wanderguard from 03/24/2025-06/10/2025. An Immediate Jeopardy (IJ) was identified on 06/11/2025. The IJ template was provided to the facility on [DATE] 5:43 PM. While the IJ was removed on 06/13/2025, the facility remained out of compliance scoped at pattern with no actual harm and potential for more than minimal harm due to the facility's need to complete in-service training and evaluate the effectiveness of their corrective systems. These failures could place all residents at risk of harm due to elopement. Findings Include: Resident CR#1 Record review of CR #1's face sheet revealed she was an [AGE] year-old female admitted to the facility on [DATE] with a primary diagnoses of anemia (condition where there are not enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues) Alzheimer's (a brain disorder that slowly destroys memory and thinking skills), and dementia (memory loss and difficulties with thinking, problem-solving, or language), and discharged from the facility, 06/09/2025. Record review of CR#1's quarterly MDS assessment dated [DATE] revealed a BIMS score of 4 to indicate she had severe cognitive impairment with a wander/elopement alarm for daily use. Record review of CR#1's undated care plan revealed: Focus: an elopement risk/wanderer AEB impaired safety awareness exit seeking. 07/20/2024 elopement resident was placed on Q 15 min checks until seen by psych(psychiatric) Date Initiated: 03/07/2024 Revision on: 07/26/2024. Goal: Safety will be maintained through the review date. Interventions: Check for wander guard proper functioning daily. Check for wanderguard placement every shift. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Focus: CR#1 is at risk for falls. Goal: CR#1 to be free from falls through the next review date, which is targeted for 07/24/2025. Interventions: CR#1 last fall was on, 03/22/2025 with no injury. The facility staff is to be sure CR#1's call light is within reach for the resident to use for assistance as needed. Record review of CR#1's Progress Notes dated 07/20/2024 at 9:59 PM signed by the LVN D read in part, .At about 8:30pm, resident was found wheeling herself back to her room. Resident's wanderguard was assessed and it was in good condition and functioning properly .At about 8:45pm, CNA came to writer, who was on 100 hall and notified writer that resident was neither in her bed in in her bathroom .Writer, CNA, CNA Coordinator and CMA (300/400 hall) immediately went into the room on all four halls before continuing the search around the premises and as far as the gas stations to the left and right of the facility. Writer returned and notified on-call staff, DON, Administrator and Resident's family. Resident was escorted into the building at about 9:59pm in her wheelchair by two emergency response staff, the Administrator and resident's daughter .Resident was fitted with a new wanderguard, which is functioning appropriately . Resident #2 Record review of Resident #2's face sheet revealed she was an [AGE] year-old female admitted to the facility on [DATE] with a primary diagnosis of Alzheimer's (a brain disorder that slowly destroys memory and thinking skills. Record review of Resident #2's admission MDS assessment dated [DATE] and quarterly MDS assessment dated [DATE] revealed she had a wander/elopement alarm for daily use and the resident does not require any assistive devices or staff assistance and has the ability to walk on their own, according to the MDS assessment. Record review of Resident #2's undated care plan revealed: Focus: an elopement risk/wanderer r/t (related to) wanders in facility exit seeking. Date Initiated: 03/22/2023 Revision on: 07/23/2024. Goal: Safety will be maintained through the review date. Interventions: Check for wander guard proper functioning daily. Check for wanderguard placement every shift. Focus: Resident #2 is at risk for fall with impaired mobility and fluctuation in cognition. Goal: Resident #2 will be free of falls the review date of, 07/16/2025. Interventions: Resident #2 has been free of falls since, 04/17/2023.wanderi Record review of Resident #2's Progress Notes dated 03/26/2025 at 9:28 a.m. signed by the Social Worker read in part, .Resident exit seeks at times, has a wander guard . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #2's Progress Notes dated 11/19/2024 at 12:49 p.m. signed by the Social Worker read in part, .Resident exit seeks at times, has a wander guard . Record review of Resident #2's electronic medical records physician orders reflected that orders to check the residents wanderguard functioning and placement daily each shift started 3/21/2023 and ended 07/27/2023. Record review of Resident #2's electronic medical records physician orders reflected that orders to check the residents wanderguard functioning and placement daily each shift started 06/10/2025. Resident #3 Record review of Resident #3's face sheet revealed he was a [AGE] year-old male admitted to the facility on [DATE] with a primary diagnosis of Cerebral Infraction (stroke) with secondary diagnosis of schizophrenia(a mental disorder that involves a range of problems with thinking, behavior and emotion) and cognitive communication deficit (results from impaired functioning of cognitive processes, including attention, memory, perception, insight, judgment, organization, orientation, and language). Record review of Resident #3's quarterly MDS assessment dated [DATE] revealed he was severely impaired for cognitive skills for daily decision making, and he had a wander/elopement alarm for daily use and and the resident does require assistive device with a manual wheelchair as they are unable to walk on their own, according to the MDS assessment. Record review of Resident #3's undated care plan revealed: Focus: an elopement risk/wanderer r/t exit seeking. Date Initiated: 03/24/2025 target date: 09/06/2025. Goal: Safety will be maintained through the review date. Interventions: Check for wander guard proper functioning daily. Check for wanderguard placement every shift. Record review of Resident #3's electronic medical records physician orders reflected orders to have a wanderguard on at all times started 03/24/2025. Record review of Resident #3's electronic medical records physician orders reflected that orders to check the residents wanderguard functioning and placement daily each shift started 06/10/2025. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 06/10/2025 at 12:10 p.m., the Administrator who stated he started at the facility in September of 2022 and the DON who stated she started at the facility in 2020. Both said that any resident that was high risk of elopement or exit seeking upon admission or anytime during the stay at the facility have interventions of a wanderguard to prevent elopement. Both said that residents with a wanderguard orders to monitor the function and placement of the guard every shift and it is documented on the MAR. Both said that CR #1 was able to elope from the facility while wearing a wanderguard. Both said that CR #1 was last seen at 8:30 p.m. inside the facility, then at 8:45 p.m. a visitor (name unknown) saw CR#1 outside of the facility and returned to the facility at 9:59 p.m. by a mobile response team. Both said that there was a concern identified that CR#1's wander guard did not alert staff that she eloped from the facility, and there was a facility investigation, report filed with State Survey Agency (SSA), a Quality Assurance and Performance Improvement (QAPI) was held in August of 2024, and Performance Improvement Plan (PIP) initiated July of 2024 to address concerns by ensuring all residents with an active wanderguard had daily monitoring for placement and functioning. The following policies were requested, Incident and accidents, Elopement/Wandering, and Wanderguard. In an interview on 06/10/2025 at 1:22 p.m., the DON a request was made for a policy wander guard placement and function testing. Interview on 06/10/2025 at 1:45 p.m. with MA A, who said that she started at the facility in December of 2024. She said while working on 07/20/2024 a visitor (name unknown) reported to her at 8:45pm that she saw an unknown resident that fit the description of CR#1 walking down the street. She said that she told CNA B to initiate the facility elopement code, and she proceeded to search for resident outside on facility grounds and in the community by car but was unsuccessful in locating CR#1. She said that she was notified that the resident was located by law enforcement sometime after 9pm and returned to the facility. She said that she did not hear the door alarm sound to indicate that CR#1's wander guard functioned to alert staff of the elopement. Interview on 06/10/2025 at 1:57 p.m., with CNA B, who said she started at the facility in October of 2022, and she is also the staffing coordinator. She said that on 07/20/2025 she worked the floor, and right before 9 p.m. a visitor (name unknown) saw unknown resident that fit the description of CR #1 walking down the street and reported to MA A. She said that facility elopement code was initiated when she reported it to LVN D the unit manager and LVN E the assigned nurse, and MA A started search for CR #1 outside of the facility immediately. She said that when CR #1 was not located inside of the facility the search was expanded by car to the community by MA A, CNA B, LVN D, MA F, CNA G, and herself. She said that CR #1 was located by a mobile response team sometime after 9 pm and returned to the facility before 10pm. She said that she did not hear a door alarm to sound to indicate that CR #1's wander guard functioned to alert staff of the elopement. Record review on 06/10/2025 of a facility provided list of current residents with a wanderguard that included Resident#2 and Resident #3. Observation on 06/10/2025 at 2:30 p.m., the DON tested the wanderguard of Resident #3 for placement and functioning using a facility device while Resident #3 was seated in his wheel chair in the main dining room, and by physically taking Resident #3 to the door located at the main entrance of facility, and it was observed to be in place and functioning. Resident #3 was not interviewable. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observation on 06/10/2025 at 2:45 p.m., Unit Manager/RN to test the wanderguard of Resident #2 for placement and functioning using a facility device at the bedside, and it was observed to be in place and functioning. Resident #2 asked the Unit Manager/RN when the wanderguard would be removed because she had for a long time. Unit Manager/RN said the wanderguard was still needed for safety. In an interview on 06/10/2025 at 3:37 p.m., CNA G said that she started at the facility in 2018. She said that she was working the on 07/20/2024 when CR#1 eloped from the facility. She said that she last saw CR#1 in the lobby at 8:30pm. She said that facility elopement code was initiated, and she assisted in the search of the resident off the facility grounds. She said that the CR#1 was located by law enforcement, but she was unsure of the time she was found or when she returned to the facility. She said that she did not hear a door alarm to sound to indicate that CR#1's wander guard functioned to alert staff of the elopement. In an interview on 06/11/2025 at 8:05 a.m., Resident #2 at the besides, said that she had a bracelet on her ankle to tell staff if she leaves the building. She said that she did not need the bracelet, and she had it for a long time. She said that staff checks every day with the box to make sure it works, and she did not take it off. In an effort to complete a phone interview on 06/11/2025 at 9:24 a.m., with former employee, LVN E, a message was left. In an effort to complete a phone interview on 06/11/2025 at 9:25 a.m. with former employee, MA F, the number was disconnected. In a phone interview on 06/11/2025 at 9:26 a.m. with the Medical Director, who said he participated in a QAPI to address concerns of an elopement in August of 2024, but he could not recall the residents name involved. He said that the resident was able to elope from the facility while wearing a wanderguard. He said that a plan was developed to train staff on the elopement process, monitor resident at high risk for elopement with a wanderguard with monitoring for placement and testing the function of the wanderguard each shift. He said that staff should follow their elopement process and monitor residents to prevent elopements, if not there is risk that residents can elope, and there is always the potential for harm with each elopement. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 06/11/2025 at 10:20 a.m. with LVN D, who said that she last worked at the facility in October of 2024 as a Unit Manager. She said that she worked on 07/20/2025 when CR#1 eloped. She said that a medication aide (MA A) was told by a visitator (name unknown) at 8:45pm that a resident that fit the description of CR#1 was seen walking down the street. She said that she was notified by the staffing coordinator (CNA B), that a medication aide (MA A) had started to search outside immediately, and the facility elopement code was initiated with a search inside the facility and outside the facility for 30 minutes. She said that when CR#1 was not located the search was expanded by car to the community by two medication aides (MA A and MA F), staffing coordinator (CNA B), the assigned CNA (CNA G), and herself. She said that CR#1 was located by a mobile response team sometime after 9pm and returned to the facility at 9:50pm. She said that she did not hear a door alarm to sound to indicate that CR#1's wander guard functioned to alert staff of the elopement. She said that CR#1's wander guard was tested prior to the elopement an upon returning to the facility and it was functioning but still replaced. She said that residents that are high risk for elopement must have orders in place to test for functioning and ensure placement every shift. She said that there is a policy and procedure in place to prevent elopement, if not followed the risk is elopement, and there can be harm with every elopement. Record review on 06/11/2025 at 12 pm of document titled QAPI and dated 08/15/2025 read in part, . Problem: Elopement risks Goal: Ensure all residents with wonder guards are monitored closely and all preventative measures are being followed. Root Cause: Staff aren't monitoring them close enough. Action Items: Ensure staff are doing daily checks of functionality of the wander guards. Person Responsible: Administrator/designee Follow up date: 7/18/2024. Date Resolved or reevaluated: ongoing Reviewed in QAPI: Monthly . Record review on 06/11/2025 at 12:05 pm of document titled PIP and dated 07/22/2024 read in part, .Focus Area: Resident Elopement Prevention Revie date: Random and PRN Background: A recent elopement incident involving a resident has highlighted the need for enhanced protocols and safe guards to prevent unauthorized departures. This PIP aims to address the gaps and reinforced safety measures, particularly with residents who wear wander guards. Goals: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Prevent further residents elopement incidents. Ensure proper functioning and regular testing of wander guard devices. Reinforce staff awareness regarding high risk residents. Enhanced elopement risk assessment and response protocols. Action plan: Ensure all wander guard devices are tested for proper function and alarm response. Log results Conduct standardized elopement risk assessments upon admission, quarterly, and with any change in condition. Residents identified as elopement risks will have checks every 2 hours. Provide inservice on elopement protocols Record review on 06/11/2025 at 12:10 p.m. of document titled Wanderguard Functionality from 07/20/2024-09/30/2024 to indicated that wanderguards was checked for functioning and placement daily, but the document did not provide information as to which residents was assessed. In an interview on 06/11/2025 at 1:00 p.m. the DON, who said there was only two residents during the PIP that was at risk for elopement with a wanderguard, CR#1 and Resident #2. She said that CR#1 and Resident #2 would have been the only residents apart of the daily audit to test placement and functioning of wanderguards, and the nurses would have documented that the guards were placed and functioning on the MAR. She said that she documented the residents involved with the PIP in a written statement, she provided a copy, and the record was reviewed. She agreed to email the document with the MAR for each resident 07/20/2024-09/30/2024 as evidence that that task was completed as part of the PIP. She agreed to email the following policies Incident and accidents, Elopement/Wandering, and Wanderguard. In an interview and observation on 06/11/2025 at 2:15 p.m., with LVN H, who said that she started in January 2025 at the facility, and she works the 400 hall from 6:00am-2:00pm. She said that residents are assessed for elopement at admission, readmission, and quarterly for elopement. She said that residents at high risk for elopement or with exit seeking behavior have orders for a wander guard. She said that residents with a wanderguard have orders for a nurse to check placement and function each shift, and the task is documented on MAR. She said that if a task is not documented it did not happen, and if there are no orders there is no way to document on the MAR. She said that if there is no monitoring for placement and functioning of a wanderguard a resident could elope if the wanderguard is taken off or it does not work. She said that the risk to a resident would be elopement, and there was a chance for harm for any elopement. She said that there were two residents on 400 hall with a wanderguard to include Resident#2. She was observed to check Resident#2's electronic medical records and confirmed there were no orders in place until 06/10/2025 to check placement and functioning of the wanderguard. She said that she thought Resident#2 had orders, she checked daily, and thought she documented on the MAR. She said that Resident#2 had a wanderguard since she started working at the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview and observation on 06/11/2025 at 2:20pm with RN I, who said that she started in March 2025 at the facility, and she works the 400 hall from 2:00pm-10:00pm. She said that residents are assessed for elopement at admission, readmission, and quarterly for elopement. She said that residents at high risk for elopement or with exit seeking behavior have orders for a wander guard. She said that residents with a wanderguard have orders for a nurse to check placement and function each shift, and the task is documented on MAR. She said that if a task is not documented it did not happen, and if there are no orders there is no way to document on the MAR. She said that if there is no monitoring for placement and functioning of a wanderguard a resident could elope if the wanderguard is taken off or it does not work. She said that the risk to a resident would be elopement, and there was a chance for harm for any elopement. She said that there were two residents on 400 hall with a wanderguard to include Resident#2. She was observed to check Resident#2's electronic medical records and confirmed there were no orders in place until 06/10/2025 to check placement and functioning of the wanderguard. She said that she thought Resident#2 had orders, she checked daily, and thought she documented on the MAR. She said that Resident#2 had a wanderguard since she started working at the facility. In an interview and observation on 06/11/2025 at 2:25 p.m. LVN J, said that she started at the facility in March 2025, and she works the 200 and 100 hall from 6:00am -2:00pm. She said that residents are assessed for elopement at admission, readmission, and quarterly for elopement. She said that residents at high risk for elopement or with exit seeking behavior have orders for a wander guard. She said that residents with a wanderguard have orders for a nurse to check placement and function each shift, and the task is documented on MAR. She said that if a task is not documented it did not happen, and if there are no orders there is no way to document on the MAR. She said that if there is no monitoring for placement and functioning of a wanderguard a resident could elope if the wanderguard is taken off or it does not work. She said that the risk to a resident would be elopement, and there was a chance for harm for any elopement. She said that there was one resident on 200 hall with a wanderguard, Resident #3. She was observed to check Resident#3's electronic medical records and confirmed there were no orders in place until 06/10/2025 to check placement and functioning of the wanderguard. She said that she thought Resident#3 had orders, she checked daily, and thought she documented on the MAR. She said that Resident#3 had a wanderguard since March or April of 2025. In an interview and observation on 06/11/2025 at 2:30pm with RN K, who said that she started at the facility 11 years ago, and she works the 200 and 100 hall from 2:00pm. She said that residents are assessed for elopement at admission, readmission, and quarterly for elopement. She said that residents at high risk for elopement or with exit seeking behavior have orders for a wander guard. She said that residents with a wanderguard have orders for a nurse to check placement and function each shift, and the task is documented on MAR. She said that if a task is not documented it did not happen, and if there are no orders there is no way to document on the MAR. She said that if there is no monitoring for placement and functioning of a wanderguard a resident could elope if the wanderguard is taken off or it does not work. She said that the risk to a resident would be elopement, and there was a chance for harm for any elopement. She said that there was one resident on 200 hall with a wanderguard, Resident #3. She was observed to check Resident#3's electronic medical records and confirmed there were no orders in place until 06/10/2025 to check placement and functioning of the wanderguard. She said that she thought Resident#3 had orders, she checked daily, and thought she documented on the MAR. She said that Resident#3 had a wanderguard since March of 2025. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 06/11/2025 at 3:20 pm with the DON, who said residents are assessed for elopement at admission, readmission, and quarterly for elopement. She said that residents at high risk for elopement or with exit seeking behavior have orders for a wander guard. She said that residents with a wanderguard have orders for a nurse to check placement and function each shift, and the task is documented on MAR. She said that if a task is not documented it did not happen, and if there are no orders there is no way to document on the MAR. She said that if there is no monitoring for placement and functioning of a wanderguard a resident could elope if the wanderguard is taken off or it does not work. She said that the risk to a resident would be elopement, and there was a chance for harm for any elopement. She said that Resident#2 did not have a wanderguard during the time of the QAPI and PIP. She said that Resident#2's order was discontinued because she was no longer exit seeking, and the order was received on 06/10/2025 when Resident#2 started showing behaviors of exit seeking. She did not provided answer when asked why Resident#3's orders started on 6/10/2025, when he has had a wanderguard since March of 2025. In an interview on 06/11/2025 at 3:30 p.m., the Administrator, who said residents are assessed for elopement at admission, readmission, and quarterly for elopement. He said that residents at high risk for elopement or with exit seeking behavior have orders for a wander guard. He said that residents with a wanderguard have orders for a nurse to check placement and function each shift, and the task is documented on MAR. He said that if a task is not documented it did not happen, and if there are no orders there is no way to document on the MAR. He said that if there is no monitoring for placement and functioning of a wanderguard a resident could elope if the wanderguard is taken off or it does not work. He said that the risk to a resident would be elopement, and there was a chance for harm for any elopement. He said that Resident #2 and Resident #3 had a wanderguard, both should have orders to check placement and function each shift, and both have had the guards in place for some time. He said that he did not know for how long Resident #2 had the guard, it was in place when CR#1 eloped last year, and Resident #2 should have been a part of the PIP to ensure monitoring for placement and functioning. He said that it would not be a true statement that Resident #2 only got the guard on 06/10/2025. He said that he did not know why the DON would say that Resident #2 only got the guard on 6/10/2025 and that was concerning for him to know. Requested the following policies were requested, Incident and accidents, Elopement/Wandering, and Wanderguard. The policies for Incident and Accidents, Elopement/Wandering, and Wanderguard on 06/10/2025 at 12:10 p. m., and on 06/11/2025 at 1:00pm and 3:30pm, and were not received prior to exit. A policy for testing wanderguards for placement and functioning on 06/11/2025 at 1:22 p.m. and was not received prior to exit. Record review of policy titled, Wandering Unsafe Resident, with a revised date of December 2008 read in part, The facility will strive to prevent unsafe wandering while maintaining the least restrictive environment for residents who are at risk for elopement . Safety Interventions 4. Interventions to try to maintain safety will be included in the residents are plan. This was determined to be an Immediate Jeopardy (IJ) on 06/11/2025. The Administrator was notified on 06/11/2025. The IJ template was provided to the facility on [DATE] at 5:43pm. In an interview on 06/12/2025 at 9:49 a.m. the CO-Medical Director, who said that he was notified about the IJ being called, and he had been included on the POR. He said that all treatments and care should have orders, should be documented, and standard. (continued on next page)

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	675986	A. Building B. Wing	06/13/2025

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The following Plan of Removal (POR) submitted by the facility was accepted on 06/12/2025 at 1:14 p.m. The plan of removal reflected the following: Facility Name: Date: June 12th, 2025 Plan of Removal F 689 Accidents/Hazards Facility submits the following Plan of Removal for the alleged failure to ensure the resident environment remained free of accidents, and hazards each resident received adequate supervision to prevent accidents for CR #1, Resident #2, and Resident #3. What corrective actions have been implemented for the identified residents? A. Resident CR#1 discharged from facility on 6/09/2025. B. On 6/11/2025, Resident #2 medical record was reviewed by the Clinical Services Director to ensure Wanderguard orders were in place, with instructions to verify proper placement every shift and ensure proper functioning daily. Care plans reviewed for residents with Wanderguards and updated if indicated. Wanderguard devices are in place and have been verified to be functioning correctly by the DON on 6/11/2025. C. On 6/11/2025, Resident #3 medical record was reviewed by the Clinical Services Director to ensure Wanderguard orders were in place, with instructions to verify proper placement every shift and ensure proper functioning daily. Care plans reviewed for residents with Wanderguards and updated if indicated. Wanderguard devices are in place and have been verified to be functioning correctly by the DON on 6/11/2025. D. On 6/11/2025 at 06:31 pm the Administrator notified the Medical Director of alleged deficient practice. E. On 6/11/2025 the DON/Nurse Managers completed a 100% elopement risk assessment of all residents residing in the facility for risk of elopement, and no new residents were identified to be at risk. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	F. On 6/11/2025 DON/Nurse Managers audited the residents' orders that require a Wanderguard, no concerns were identified. G. On 6/11/2025 the DON/Nurse Managers and Administrator were in-serviced on the Elopement Policy by the Regional [NAME] President of Operations and the Clinical Services Director. H. On 6/11/2025 the license nurses were trained on testing the Wanderguard device. I. On 6/11/2025 the DON received a written warning on the Elopement Policy by the Administrator. J. The Clinical Services Director reviewed facility Elopement Policy on 6/11/2025 no revisions were deemed necessary. How were other residents at risk to be affected by this deficient practice identified? A. Residents that are at risk for elopement have the potential to be affected by the alleged deficient practice. What does the facility need to change immediately to keep residents safe and ensure it does not happen again? A. An in-service was initiated on 6/11/2025 by the Corporate Clinical Service Director, DON, and Nurse Managers with the licensed nursing staff on the Elopement Policy and obtaining orders for residents that requires a Wanderguard. Licensed nurses will not be allowed to return to work until they receive this in-service. Completion date 6/11/2025. B. An in-service was initiated on 6/11/2025 by the Nurse Managers and the Administrator with the facility frontline staff on the residents that requires a Wanderguard and obtaining orders. Completion date 6/11/2025. C. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Newly hired nurses will be in-serviced by the DON/designee on the Elopement Policy and obtaining orders for residents that require a Wanderguard. Licensed nurses will not be allowed to work until they receive this in-service. Completion date 6/11/2025. D. Newly hired frontline staff will be in-serviced by the DON/designee on the residents that requires a Wanderguard. They will not be allowed to work until they receive this in-service. Completion date 6/11/2025. E. New Admissions and Readmissions Elopement Assessment and Risk Management will be reviewed daily in the morning meeting to identify residents at risk for elopement and ensure adequate supervision in place, monitoring of Wanderguard placement and proper functionality. The Charge Nurse will monitor the placement and functionality of the Wanderguard devices daily and document on the resident's MAR. The DON/designee will monitor the placement and functionality of the devices 3x week X 6 weeks and review will be documented on an audit report form. Quality Assurance An impromptu Quality Assurance and Performance Improvement review of the plan of removal was completed on 6/11/2025 with the Medical Director. The Medical Director has reviewed and agrees with this plan. The Plan of Removal was confirmed for the IJ by mon[TRUNCATED]

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who were incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 2 of 3 residents (Resident #9 and Resident #90) reviewed for incontinent care. -The facility failed to ensure CNA A cleaned Resident #9 properly during incontinent care on 6/10/25. -The facility failed to ensure CNA G cleaned Resident # 90's indwelling Foley catheter properly and followed proper hand hygiene during incontinent care on 6/11/25. -Resident #90 did not have a STATLOCK to secure the Foley catheter. These failures could place residents at risk for pain, infection, injury, and hospitalization. Finding included: Record review of a face sheet print date of 6/12/25 reflected, Resident #9 was a [AGE] year old female admitted [DATE]. Resident #9's diagnoses included abnormalities of gait and mobility, lack of coordination, weakness, acute kidney failure, osteoarthritis (a common joint condition that occurs when the cartilage that cushions the ends of bones gradually wears down), other lack of coordination, pain in right knee, pain in right ankle and joints of right foot, muscle wasting and atrophy, multiple sites unsteadiness on feet, pain in left knee, repeated falls, hypo-osmolality and hyponatremia, benign neoplasm of meninges (tumor arising from the membranes covering the brain and spinal cord), hypothyroidism (a condition where the thyroid gland doesn't produce enough thyroid hormones to regulate metabolism and energy use), muscle weakness (generalized), other abnormalities of gait and mobility, cognitive communication deficit, muscle wasting and atrophy, covid-19, dysphagia, oral phase, other chronic allergic conjunctivitis, major depressive disorder, recurrent, moderate, Alzheimer's disease with late onset, dementia(progressive neurodegenerative disorder that primarily affects memory, thinking and behavior) psychotic disturbance (a person is having trouble distinguishing between what is real and what is not) and acute cystitis(inflammation of the bladder without hematuria (blood in the urine). Record review of Resident #9's quarterly MDS dated [DATE] reflected a BIMS of 7 which indicated the residents cognition was severely impaired. Record review of section H (Bowel and Bladder) in the MDS reflected incontinent of bowel and bladder. Record review of Resident #9's care plan dated 4/30/25 indicated she had an ADL Self Care Performance Deficit and required assistance with all ADLs. Observation of incontinent care on 06/10/25 at 11:36 AM, done by CNA A , revealed Resident #9 was lying in the bed on her back, CNA A unfastened the brief , using the wet wipes, she did not separate the labia to clean, resident had large bowel movement, CNA A used the same wet wipe to clean the groin, and did not clean around resident buttocks and changed gloves. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Attempted interview with CNA A on 6/10/25, unable she left for the day. On 6/11/25 at 5:30 PM and on 6/13/25 at 1:33 PM via telephone and there was no response. 2.Record review of Resident #90's face sheet printed 06/12/25, indicated Resident #90 was admitted on [DATE]. Resident #90's diagnoses included the following: essential (primary) hypertension (high blood pressure), gastro-esophageal reflux disease (gastric reflux) without esophagitis, acute kidney failure (sudden kidney failure), acute posthemorrhagic anemia, melena(blood in the stool), other asthma (chronic lung condition causes the airways inflamed and narrow, making it difficult to breathe), chronic obstructive pulmonary disease (a common lung disease causing restriction of airflow and breathing problems), other symptoms and signs involving cognitive functions and awareness, muscle weakness (generalized, cognitive communication deficit, gastrointestinal hemorrhage, elevated white blood cell count, benign prostatic hyperplasia (enlarge prostrate)without lower urinary tract symptoms, obstructive and reflux uropathy, unspecified, hypertensive heart disease without heart failure, other symptoms and signs involving appearance and behavior acute (illness that develops quickly) and chronic (lasting for a long time) respiratory failure with hypoxia (lack of oxygen to sustain bodily functions), neuromuscular (affecting the nerves controlling the muscles) dysfunction of the bladder, sepsis (infection in the blood). Record review of Resident #90's admission MDS assessment dated [DATE], Section C (Cognitive Patterns) reflected a BIMS score of 5 which indicated severe impairment in thinking. Section H (Bladder and Bowel) reflected resident had an indwelling catheter. Resident #90's functional status revealed he was independent with supervision of staff with bed mobility, transfer, and toilet use. Further review revealed Resident #90 had an indwelling Foley catheter. Record review of Resident #90's physician order dated from May 2025 read in part . change Foley catheter with 18 inch catheter and 10cc bulb on the 1st of each month dated 3/23 . keep catheter from kinks and drainage bag lower than bladder at all times dated 4/29/25. Observation on 6/11/25 at 2:32 p.m. of indwelling catheter and incontinent care for Resident #90 performed by CNA J, Resident #90 was sitting on the wheelchair with catheter bag hung on the side of the wheelchair. CNA J washed her hands, donned a gown and transferred the resident to bed and removed the residents pants. Resident #90's indwelling catheter was not secured to the thigh to prevent pulling. CNA J used wet wipes cleaned visible part of the catheter tubing about ½ inch of catheter, she did not clean the catheter in a circular motion from the insertion site. Interview on 06/11/25 at 2:52 PM, CNA J said she was very nervous, during the care, she said the nurses was responsible for ensuring that a statlock /secure strap was attached to the Foley. She said she had an in-service a month ago on indwelling Foley. Interview on 06/11/25 at 3:00 PM, LVN H said it was the responsibility of the nurse to assess residents that had a Foley catheter to ensure that a Statlock was in place every shift to prevent the Foley catheter from being pulled out. LVN H said it placed the resident at risk for pain, bleeding, and infections. LVN H said she was Resident #90's nurse. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/11/25 at 6:05 PM, the DON said residents with an indwelling Foley catheter should have a statlock/secure strap in place to prevent pulling the Foley tubing out. The DON said it was the nurses that were supposed to ensure that this device was in place. The DON said the nurses should be assessing the resident at least once a shift. The DON said if the residents Foley tubing is dislodged with the bulb still inflated, the incident could cause the resident discomfort as well as more discomfort in inserting a new Foley catheter and catheter should be cleaned in a circular motion and 4 inches away from insertion site. The DON said it ultimately fell on her to ensure that the nurses were carrying out this task and the CNAs were trained to open labia and clean to prevent infection. Record review of the facility policy for Catheter Care Urinary dated 3/31/2016 revealed: For the female: Use a washcloth with warm water and soap to cleanse around the meatus. Cleanse the glans using circular strokes from the meatus outward. Change the position of the washcloth with each cleansing stroke. With a clean washcloth, rinse with warm water using the above technique. Return foreskin to normal position. 16. Use a clean washcloth with warm water and soap to cleanse and rinse the catheter from insertion site to approximately four inches outward.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 2 of 6 residents (Resident #72 and Resident #23) reviewed for drug administration in that: - Resident #72's medication Calcium Carbonate(used as an antacid to relieve heartburn, acid indigestion and upset stomach) was provided 2 hours and 45 minutes late on 06/10/2025. - Resident#72's medication Diphenoxylate/atropine 2.5 mg (to treat severe diarrhea) was provided 2 hours and 45 minutes late on 06/10/2025. - Resident #72's medication Dicyclomine 40 mg (drug used to treat irritable bowel syndrome) was provided 2 hours 45 minutes late on 06/10/2025. - Resident #23's Lisinopril (used alone or together with other medicines to treat high blood pressure) not given as ordered on 6/10/25. The nurse surveyor had to intervened. This deficient practice could affect residents who receive medication and place them at risk for not receiving a therapeutic effect. The findings were: Record review of Resident #72'S face sheet, dated 6/10/25, revealed Resident #72 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses lymphedema(a condition where swelling occurs, usually in the arms or leg, due to a problem with the lymphatic), cachexia (wasting syndrome), adult failure to thrive, irritable bowel syndrome with diarrhea, cellulitis(bacterial skin) unspecified, muscle weakness (generalized), major depressive disorder, single episode, moderate, adjustment disorder with mixed anxiety and depressed mood, irritable bowel syndrome, unspecified, other malaise, acute embolism and thrombosis (sudden blood clot) of unspecified deep veins of left lower extremity, rhabdomyolysis (muscles break down, releasing harmful substances into your bloodstream), dehydration, fracture of unspecified part of neck of right femur, subsequent encounter for closed fracture with delayed healing(s, cellulitis of left lower limb. Record review of Resident #72'S quarterly MDS, dated [DATE], revealed Resident #72 had a BIMS score of 14, signifying moderate cognitive impairment. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident#72's physician orders obtained, revealed the following: Order date was 7/18/23: Diphenoxylate-Atropine Tablet 2.5-0.025 MG *Controlled Drug*=Give 1 tablet by mouth before meals for IBS AND Give 1 tablet by mouth every 12 hours as needed for IBS. Order date was 5/6/24: Tums Oral Tablet Chewable 500 MG (Calcium Carbonate (Antacid) Give 1 tablet by mouth before meals and at bedtime for indigestion. Order date was 3/12/25: Dicyclomine HCl Tablet 20 MG Give 2 tablet by mouth before meals and at bedtime related to IRRITABLE BOWEL SYNDROME. Record review of the MAR on 6/10/25 reflected the following medications was initialed as given: Diphenoxylate-Atropine Tablet 2.5-0.025 MG *Controlled Drug* Give 1 tablet by mouth before meals for IBS (Scheduled time on MAR was 7:00 am, 11:00 am, 4:00 pm). Tums Oral Tablet Chewable 500 MG (Calcium Carbonate (Antacid)) Give 1 tablet by mouth before meals and at bedtime for indigestion (Scheduled time on MAR was 06:30 am, 11:30 am, 4:30 p.m. and 8:00 p.m.). Dicyclomine HCl Tablet 20 MG Dicyclomine HCl Tablet 20 MG Give 2 tablet by mouth before meals and at bedtime related to IRRITABLE BOWEL SYNDROME, (Scheduled time on MAR was 06:30 am, 11:30 am, 4:30 pm and 8:00 p.m.). Observation of medication pass on 6/10/25 at 10:55 AM, MA B, Resident #72 was lying in bed he said I normally get my med Dicyclomine and most medication before 7AM, they mess up med all the time Interview with MA B on 6/10/25 at 10:55 AM, she said the meal tray was served for breakfast between 7:00 AM to 7:15 AM. Interview with Resident #72 on 6/12/25 at 11:10 AM, he said regarding his medication he had complained to Nurse T about not getting his medication in a timely manner, he was supposed to take some of his medication before breakfast to help his stomach and it has been going on for 2 months and he wish they keep his medication schedule time. Interview with LVN T on 6/12/25 at 11:22 AM, regarding Resident #72's, concerns about medication timing, she said, Resident #72 spoke to him about 2 months ago about then MA who no longer works for the facility and MA did apologize to Resident #72 and he had not complained anymore. The MA then started passing medication on 100 hall because of Resident #72. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.Record review of Resident 23's face sheet, dated 6/10/25, revealed Resident #23 was a [AGE] year old female admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses osteoarthritis (degenerative joint disease in which the tissues in the joint break down over time)) anemia, (low number of red blood cell in the blood) unsteadiness on feet lack of coordination, cellulitis of unspecified part of limb, muscle wasting and atrophy, not elsewhere classified, unspecified site(m, constipation, unspecified, pain in unspecified joint, other lack of coordination, essential (primary) hypertension, covid-19, chronic obstructive pulmonary disease, unspecified, major depressive disorder, recurrent severe without psychotic features, difficulty in walking, not elsewhere classified, muscle weakness (generalized), type 2 diabetes mellitus (high glucose in the blood) with diabetic retinopathy (eye condition that can cause vision loss or blindness due to damage to the retina caused by diabetes) without macular edema, other abnormalities of gait and mobility, insomnia due to other mental disorder, major depressive disorder, recurrent, moderate, type 2 diabetes mellitus with hyperglycemia, type 2 diabetes mellitus with diabetic polyneuropathy(peripheral nerves throughout weakness are damaged or not working properly, body mass index adult, epigastric pain, other malaise, other chronic pain, urinary tract infection, site not specified, hydroureter, type 2 diabetes mellitus without complications, peripheral vascular disease,, anxiety disorder, Alzheimer's disease(a brain disorder that slowly destroys memory and eventually, the ability to carry out simple tasks) with late onset, primary insomnia, acute bronchitis, unspecified, chronic obstructive pulmonary disease with (acute) lower respiratory infection, polyneuropathy, unspecified, morbid (severe) obesity due to excess calories, chronic systolic (congestive) heart failure,, cataract (white opacity of the eye) extraction status, eye, dysphagia(difficulty swallowing), other sequelae of cerebral infarction (stroke), heart failure, history of falling, atherosclerotic heart disease (fatty materials like build up inside your arteries). Record review of Resident#23'S quarterly MDS, dated [DATE], revealed Resident #23 had a BIMS score of 15, signifying no cognitive impairment. Record review of Resident #23's physician orders revealed the following: Order date 3/28/25: Lisinopril Oral Tablet 10 MG (Lisinopril) Give 1 tablet by mouth one time a day (morning) Hypertension Hold for BP 105/60 Observation on 6/10/25 at 11:05 AM, during medication pass with MA B, Resident #23 was lying in bed, she checked Resident #23's blood pressure (BP127/65) she picked up a blister packet of Lisinopril tabs 5 mg and punched with other medication in medicine cup. The blister packet had Lisinopril tab 5 mg Give 2 tablets =10 mg. MA B at 11:08 AM was about to administer Resident #23's medications when surveyor stopped MA B and she added another Lisinopril tab 5 mg MA B stated it should be 10mg , 2 tablets and thank you very much (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/12/25 at 12:30 PM., MA B when asked what training did she have to ensure the right time was given the right medication, MA B stated, she said she started working for the facility about two weeks ago and she always start her medication pass on 200 hall and then 100 hall. MA B said she had training before she started working in the facility but was overshadowed when she started work with facility. MA B stated the rights of medication administration include the right resident, right dose, right documentation, right route, and right time. When asked why it was important to ensure the right resident was given the right medication at the right time MA B stated, Because if it's the wrong person, you could harm them if they don't need it. MA B said she would start her medication pass on 100 hall because Resident #72 had medication due before breakfast. During an interview on 6/12/25 at 1:55 PM, the DON stated, we have the [medication administration] competency that's done upon hire and we do it annually as a refresher and we also do it as needed. Corporate will come in and they'll do an observation, and they'll make recommendations. It's a lot of [as needed] from time to time. The DON stated the facility's consulting pharmacist will also visit to do cart audits and medication administration observations. The DON stated the facility also conducted random medication cart checks weekly and these audits included checking if medication was given at the right time. When asked what sort of negative effects could occur to the resident if a medication was given at the wrong time, the DON stated, Depending on the medication, itself, it can have an effect where it's running into another medication that it shouldn't be given near and if you're not going an appropriate amount of time you can give something too close together. You can get sedations; you can get all sorts of outcomes by not following when the medication is supposed to be given. Record review of the facility's Administering Medications policy dated December 2012 read in part, . Medications shall be administered in a safe and timely manner, and as prescribed .

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	06/13/2025

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

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to ensure that it was free of a medication error rate of below 5 percent (%) or greater. The facility had a medication error rate of 22%, based on 8 out of 37 opportunities, which involved 3 of 6 residents (Resident #72, Resident # 23 and Resident #506) and 2 of 3 staff (MA B and LVN M) reviewed for medication administration errors. MA B administered Calcium Carbonate(used as an antacid to relieve heartburn, acid indigestion and upset stomach), Diphenoxylate/atropine 2.5 mg, and Dicyclomine 40 mg (drug used to treat irritable bowel syndrome) more than 2 hours and 45 minutes after the scheduled time to Resident #72 on 6/10/25. MA B failed to administer Lisinopril (used to treat high blood pressure), Cetirizine HCL (used to treat allergy symptoms like runny nose sneezing, itchy eyes and hives), Lidocaine external (medication use to local anesthetic for pain), Buspirone (medication use to treat anxiety disorders) as ordered by the Physician to Resident #23 on 6/10/25. LVN M failed to administer Clopidogrel (Plavix is an antiplatelet drug you can take to prevent blood clots) to Resident #23 as ordered by the physician. These failures could place residents at risk for not receiving therapeutic effects of their medications and possible adverse reactions. The findings included: Record review of Resident #72's face sheet, dated 6/10/25, revealed Resident #72 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses lymphedema(a condition where swelling occurs, usually in the arms or leg, due to a problem with the lymphatic), cachexia (wasting syndrome), adult failure to thrive, irritable bowel syndrome with diarrhea, cellulitis(bacterial skin) unspecified, muscle weakness (generalized), major depressive disorder, single episode, moderate, adjustment disorder with mixed anxiety and depressed mood, irritable bowel syndrome, unspecified, other malaise, acute embolism and thrombosis (sudden blood clot) of unspecified deep veins of left lower extremity, rhabdomyolysis (muscles break down, releasing harmful substances into your bloodstream), dehydration, fracture of unspecified part of neck of right femur, subsequent encounter for closed fracture with delayed healing cellulitis of left lower limb. Record review of Resident #72s quarterly MDS, dated [DATE], revealed Resident #72 had a BIMS score of 14 which indicated no cognitive impairment. Resident #72 was dependent of staff for all ADLs. Record review of Resident#72's physician orders revealed the following: - Order date was 7/18/23: Diphenoxylate-Atropine Tablet 2.5-0.025 MG *Controlled Drug*=Give 1 tablet by mouth before meals for IBS AND Give 1 tablet by mouth every 12 hours as needed for IBS - (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Order date was 5/6/24: Tums Oral Tablet Chewable 500 MG (Calcium Carbonate (Antacid) Give 1 tablet by mouth before meals and at bedtime for indigestion. - Order date was 3/12/25: Dicyclomine HCl Tablet 20 MG Give 2 tablet by mouth before meals and at bedtime related to IRRITABLE BOWEL SYNDROME. Record review of the MAR and time schedule dated 6/10/25 reflected the following medications were initialed as given to Resident #72: Diphenoxylate-Atropine Tablet 2.5-0.025 MG *Controlled Drug* Give 1 tablet by mouth before meals for IBS (Scheduled time on MAR was 7:00 am, 11:00 am, 4:00 pm). MA B initialed on MAR for Diphenoxylate-Atropine Tablet 2.5-0.025 as given at 7:00 AM Tums Oral Tablet Chewable 500 MG (Calcium Carbonate (Antacid) Give 1 tablet by mouth before meals and at bedtime for indigestion (Scheduled time on MAR was 06:30 am, 11:30 am, 16:30 pm and 20:00). MA B initialed on MAR for Tums Oral Tablet Chewable 500 MG as given at 6:30 AM Dicyclomine HCl Tablet 20 MG, Give 2 tablets by mouth before meals and at bedtime related to IRRITABLE BOWEL SYNDROME, (Scheduled time on MAR was 06:30 am, 11:30 am, 16:30 pm and 20:00). MA B initialed on MAR for MA B initialed on MAR for Dicyclomine HCl Tablet 20 MG as given at 6:30 AM. Observation on 6/10/25 at 10:55AM, during medication pass with MA B, Resident #72 was lying in bed he said I normally get my med Dicyclomine and most medication before 7AM, they mess up med all the time MA B picked up blister packet and punched of Diphenoxylate-Atropine Tablet 2.5-0.025 MG and Dicyclomine HCl Tablet 20 MG, with other medications in the medication cup and administered to Resident #72 by mouth. MA B administered Tums Oral Tablet Chewable 500 MG to Resident #72. Interview with MA B on 6/10/25 at 10:55 AM, she said the meal tray was served for breakfast between 7:00 AM to 7:15 AM. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.Record review of Resident 23's face sheet, dated 6/10/25, revealed Resident #23 was a [AGE] year old female admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses osteoarthritis,(degenerative joint disease in which the tissues in the joint break down over time)) anemia, (low number of red blood cell in the blood) unsteadiness on feet lack of coordination, , cellulitis of unspecified part of limb, muscle wasting and atrophy, not elsewhere classified, unspecified site(m, constipation, unspecified, pain in unspecified joint, other lack of coordination, essential (primary) hypertension, covid-19, chronic obstructive pulmonary disease, unspecified, major depressive disorder, recurrent severe without psychotic features , difficulty in walking, not elsewhere classified, muscle weakness (generalized), type 2 diabetes mellitus (high glucose in the blood) with diabetic retinopathy (eye condition that can cause vision loss or blindness due to damage to the retina caused by diabetes) without macular edema, other abnormalities of gait and mobility, insomnia due to other mental disorder, major depressive disorder, recurrent, moderate, type 2 diabetes mellitus with hyperglycemia, type 2 diabetes mellitus with diabetic polyneuropathy(peripheral nerves throughout weakness are damaged or not working properly, body mass index adult, epigastric pain, other malaise, other chronic pain, urinary tract infection, site not specified, hydroureter, type 2 diabetes mellitus without complications, peripheral vascular disease,, anxiety disorder, Alzheimer's disease(a brain disorder that slowly destroys memory and eventually, the ability to carry out simple tasks) with late onset, primary insomnia, acute bronchitis, unspecified, chronic obstructive pulmonary disease with (acute) lower respiratory infection, polyneuropathy, unspecified, morbid (severe) obesity due to excess calories, chronic systolic (congestive) heart failure,, cataract (white opacity of the eye) extraction status, eye, dysphagia(difficulty swallowing), other sequelae of cerebral infarction (stroke), heart failure, history of falling, atherosclerotic heart disease (fatty materials like build up inside your arteries). Record review of Resident#23's quarterly MDS, dated [DATE], revealed Resident #23 had a BIMS score of 15, signifying no cognitive impairment. Resident #23 was dependent of staff for all ADLs. Record review of Resident#23's physician orders revealed the following: Order date 3/28/25: Lisinopril Oral Tablet 10 MG (Lisinopril) Give 1 tablet by mouth one time a day (morning) Hypertension Hold for BP 105/60 Order date 5/8/25: for Zyrtec Allergy Oral Capsule (Cetirizine HCl) Give 5 mg by mouth one time a day for Nasal congestion. Order date5/12/25: Buspirone HCl Oral Tablet 10 MG (Buspirone HCl) Give 1 tablet by mouth one time a day for anxiety. Order date 5/10/25: Lidocaine External Patch 5 % (Lidocaine) Apply to Right Knee topically one time a day for pain remove patch at 8 pm. Record review of the June 2025 MAR indicated on 6/10/25 the following medications was initialed as given: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Lisinopril Oral Tablet 10 MG (Lisinopril) Give 1 tablet by mouth one time a day (morning) Zyrtec Allergy Oral Capsule (Cetirizine HCl) Give 5 mg by mouth one time a day. (morning) Buspirone HCl Oral Tablet 10 MG (Buspirone HCl) Give 1 tablet by mouth one time a day. (Morning) Lidocaine External Patch 5 % (Lidocaine) Apply to Right Knee topically one time a day for pain remove patch at 8 pm. (morning) Observation of the medication pass on 6/10/25 at 11:05 AM, MA B entered Resident #23's room, the resident was lying in bed, she checked the blood pressure (was BP 127/65) she picked up a blister packet and punched out: - Buspirone Oral Tablet 7.5 mg. - Cetirizine (HCl) 10mg - Lisinopril tab 5 mg po and punched with other medication in medicine cup. The blister packet had Lisinopril tab 5 mg Give 2 tablets =10 mg. MA B at 11:08 AM was about to administered Resident #23's medications when surveyor stopped MA B and she added another Lisinopril tab 5 mg MA B stated it should be 10mg ,2 tablets and thank you very much. - MA B did not administer Lidocaine External Patch 5 % to Right Knee. Interview with MA B on 6/12/25 at 11:22 AM, she said not giving the medications as ordered was an oversight and she did not check the medication dosage and she would be very careful, she did not realize that Buspirone HCl Oral Tablet was 10 MG not 7.5mg on the blister, the ZyrTEC Allergy Oral Capsule (Cetirizine HCl) Give 5 mg by mouth one time a day for Nasal congestion, and Lisinopril Oral Tablet 5 MG (Lisinopril) was poured 1 tablet by mouth one time a day. Interview with MA B on 6/12/25 at 11:45 AM, regarding lidocaine 5% not given as ordered by the doctor. She said she did not give it to the resident because she always refused and was asked why she initialed the medication as given with no documentation MA B said she was sorry and was shown the blister packet of Buspirone HCl Oral Tablet 7.5 mg and Cetirizine 10 mg bottle in the medication cart for 100 hall, MA B said she was very sorry and would be more careful, she said not giving the medication as ordered could lead to resident not getting well, because it would not be effective. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #506's face sheet, dated 6/11/25, revealed Resident #506 was admitted to the facility on [DATE].Diagnoses included, disorders of brain, hyperlipidemia (high fat in the blood), essential (primary) hypertension(high blood pressure) (, malignant neoplasm of parietal lobe, chronic kidney disease, stage 3(kidneys are damaged and can't filter blood as well as they should), combined forms of age-related cataract(lens of your becomes cloudy) , bilateral, chronic obstructive pulmonary disease (the airways and air sacs in your lungs get damaged) , unspecified, occlusion and stenosis (narrowing)of right carotid artery, occlusion and stenosis of right middle cerebral artery, hemiplegia(weakness), unspecified affecting left nondominated side and gastrostomy tube(is a surgically place device used to give direct access to your stomach for nutrition, fluid and medications). Record review of Resident #506's physician orders obtained, revealed the following: Order date 6/10/25: Plavix Oral Tablet 75 MG (Clopidogrel Bisulfate) 1 tablet via G-Tube one time a day for hyperlipidemia. Observation on 6/11/25 at 9:25 AM, during medication pass with LVN M, Resident #506 was lying in bed. LVN M picked up a blister packet of Clopidogrel 75 mg 1 tablet crushed and diluted with 20cc of water in medication cup, she then checked Resident #506's GT for placement, flushed with 30cc of water before and administered Clopidogrel 75 mg. LVN M did not stir or rinse the medication cup. LVN M had a lot of residue of Clopidogrel in the medication cup and after medication administration, she discarded the medication cup. The nurse surveyor picked up the medication cup and showed her the residual and proceeded to show the DON who said that is a lot of medication in the medicine cup Interview with LVN M on 6/11/25 at 9:45 AM, said if medication was not given in totality resident would not get required effects of the medication. During an interview on 6/12/25 at 1:55 PM, the ADM, DON, regional nurse and regional ADM said the risk of not getting the medication as ordered by the doctor and in a timely manner could lead to not be effective and his expectation was zero medication error rate. The DON said not giving medication as ordered by the doctor could cause more health issues and potent of the medication in the blood and she would be in-servicing the staff. In an interview on 6/13/22 at 1:27 PM, the DON stated the staff were supposed to administered medications per the physician orders and the facility policy. She stated she was not aware that the medications was being administered late. After being informed on the time the medications was administered and the scheduled time, she stated the medications was administered late. Review of the facility policy revised 2012 and titled administering medications reflected, Medications shall be administered in a safe and timely manner, and as prescribed 3. Medications must be administered in accordance with the orders, including any required time frame. 4. Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents were free of any significant medication errors for 1 of 6 residents (Resident #506) reviewed for significant medication errors. LVN M failed to administer Clopidogrel (Plavix is an antiplatelet drug you can take to prevent blood clots) to Resident #23 as ordered by the physician. This failure could result in increased side effects and hospitalization. Findings include: Record review of Resident #506's face sheet, dated 6/11/25, revealed Resident #506 was admitted to the facility on [DATE]. Diagnoses included, disorders of brain, hyperlipidemia (high fat in the blood), essential (primary) hypertension(high blood pressure) (, malignant neoplasm of parietal lobe, chronic kidney disease, stage 3(kidneys are damaged and can't filter blood as well as they should), combined forms of age-related cataract(lens of your becomes cloudy) , bilateral, chronic obstructive pulmonary disease (the airways and air sacs in your lungs get damaged) , unspecified, occlusion and stenosis (narrowing)of right carotid artery, occlusion and stenosis of right middle cerebral artery, hemiplegia(weakness), unspecified affecting left nondominated side and gastrostomy tube(is a surgically place device used to give direct access to your stomach for nutrition, fluid and medications). Record review of Resident #506's physician orders revealed the following: Order date 6/10/25: Plavix Oral Tablet 75 MG (Clopidogrel Bisulfate) 1 tablet via G-Tube one time a day for hyperlipidemia. Observation on 6/11/25 at 9:25 AM, during medication pass with LVN M, Resident #506 was lying in bed. LVN M picked up a blister packet of Clopidogrel 75 mg 1 tablet crushed and diluted with 20cc of water in medication cup, she then checked Resident #506's GT for placement, flushed with 30cc of water before and administered Clopidogrel 75 mg. LVN M did not stir or rinse the medication cup. LVN M had lot of residue of Clopidogrel in the medication cup and after medication administration, she discarded medication cup. The nurse surveyor picked up medication cup and show her the residual and proceeded to show the DON who said that is a lot of medication in the medicine cup Interview with LVN M on 6/11/25 at 9:45 AM, she said if medication was not given in totality resident would not get required effects of the medication. During an interview on 6/12/25 at 1:55 PM, with the ADM, DON, regional nurse, and regional ADM on. The ADM said the risk of not getting the medication as ordered by the doctor and in a timely manner could lead to not be effective and his expectation was zero medication error rate. The DON said not giving medication as ordered by the doctor could cause more health issues and potent of the medication in the blood and she would be in-servicing the staff. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy revised 2012 and titled administering medications reflected, Medications shall be administered in a safe and timely manner, and as prescribed 3. Medications must be administered in accordance with the orders, including any required time frame. 4. Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to properly store, label, and/or secure medications and biologicals for 1 of 3 medication carts (400 hall medication cart) and 1 of 1 medication storage room reviewed for drug storage. 1. The facility failed to ensure medications that required a prescription were labeled with the appropriate information including open date in the medication room in the refrigerator. 2. 400-hall medication cart had medication open not dated. These failures could place residents at risk of not receiving the appropriate medications and not reaching the intended therapeutic dose and possible exacerbation of health conditions. Findings include: Observation on 06/11/25 at 12:50 PM with LVN M, in the Medication room refrigerator revealed the following: 1. Haloperidol 2mg/ml Quantity 30mls open not dated 2.Gabapentin solution 250/5ml Quantity 84 mls open with no date Interview with LVN M on 6/11/25 at 12:50 PM, she said any elixir open should have an open date on it for its potency. Observation of the medication cart on 400 hall on 6/11/25 at 12:55 PM reflected: Gabapentin (used to help manage seizures and nerve pain) Solution 250/5ml and quantity 473 ml. Had give 10mls per GTube TID, the bottle had labeled Refrigerate 3 times on it after opening, there was no open date. Interview on 6/12/25 at 10:00 AM, LVN H said she did not administer the medication and she did not see the label and if the medication is not stored as ordered by the pharmacist it could lose the effectiveness. During an interview on 06/12/2025 at 1:55 PM, the DON and ADM, stated all liquid medication opened should have an open label on it and follow pharmacist recommendations. The DON stated the nurses was responsible for ensuring the proper labeling and storage of the medications. Record review of the facility policy on Medication Storage revised April of 2007 reflected in part: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.The nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner .The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection and prevention control program that included, at a minimum, a system for preventing and controlling infections for 2 of 2 residents (Resident #9 and Resident #90) and 2 of 2 staff (CNA A and CNA J) reviewed for incontinent care and to help prevent the development and transmission of communicable diseases and infections for 1 (Resident #71) of 28 residents reviewed for infection control. The facility failed to ensure CNA A washed or sanitized her hands after doffing (taking off) dirty gloves after providing incontinent care on 6/10/25 for Resident #9. The facility failed to ensure CNA J washed or sanitized her hands after doffing (taking off) dirty gloves after providing incontinent care on 6/11/25 for Resident #90. This deficient practice placed residents at risk for cross contamination and the spread of infection. Finding included: Record review of Resident #9's face sheet print date of 6/12/25 reflected a [AGE] year old female with a date of admission of 2/20/20. Resident #9's diagnoses included abnormalities of gait and mobility, lack of coordination, weakness, acute kidney failure, osteoarthritis (a common joint condition that occurs when the cartilage that cushions the ends of bones gradually wears down), other lack of coordination, pain in right knee, pain in right ankle and joints of right foot, muscle wasting and atrophy, multiple sites unsteadiness on feet, pain in left knee, repeated falls, hypo-osmolality and hyponatremia, benign neoplasm of meninges (tumor arising from the membranes covering the brain and spinal cord), hypothyroidism (a condition where the thyroid gland doesn't produce enough thyroid hormones to regulate metabolism and energy use), muscle weakness (generalized), other abnormalities of gait and mobility, cognitive communication deficit, muscle wasting and atrophy, covid-19, dysphagia, oral phase, other chronic allergic conjunctivitis, major depressive disorder, recurrent, moderate, Alzheimer's disease with late onset, dementia(progressive neurodegenerative disorder that primarily affects memory, thinking and behavior) psychotic disturbance (a person is having trouble distinguishing between what is real and what is not) and acute cystitis(inflammation of the bladder without hematuria (blood in the urine). Record review of Resident #9's quarterly MDS dated [DATE] reflected a BIMS of 7 which indicated resident cognition was severely impaired. Record review of section H (Bowel and Bladder) in the MDS reflected incontinent of bowel and bladder. Record review of Resident #9's care plan dated 4/30/25 indicated an ADL Self Care Performance Deficit, and required assistance with all ADLs. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of incontinent care on 06/10/25 at 11:36 AM, done by CNA A , Resident #9 was lying in the bed on her back, CNA A unfastened the residents brief , using the wet wipes, she did not open/separate labia to clean, resident had large bowel movement, CNA A used the same wet wipe to clean the groin, she changed gloves, did not wash hands or use hand sanitizer. Resident draw sheet was soiled, CNA A doffed soiled gloves without washing hands, opened door went to parked housekeeping cart on the hallway and grabbed trash bag, and then went to the clean linen room and picked up clean draw sheet, and came back to Resident #9 room, resident had another bowel movement, , CNA A cleaned BM several times without washing hands doffed gloves and donned another pair of clean gloves to pick up clean brief and place it resident and fasten. Unable to interview CNA A on 6/10/25 because she left for home, called twice on 6/11/25 at 5:30 PM and on 6/13/25 at 1:33 PM there were no response, the DON said CNA A worked PRN. The DON did not provide CNA A's personnel file as requested. Record review of Resident #90's face sheet dated 06/12/25 revealed an [AGE] year old male who was admitted on [DATE]. diagnoses included the following: essential (primary) hypertension (high blood pressure), gastro-esophageal reflux disease (gastric reflux) without esophagitis, acute kidney failure (sudden kidney failure), acute posthemorrhagic anemia, melena(blood in the stool), other asthma (chronic lung condition causes the airways inflamed and narrow, making it difficult to breathe), chronic obstructive pulmonary disease (a common lung disease causing restriction of airflow and breathing problems), other symptoms and signs involving cognitive functions and awareness, muscle weakness (generalized, cognitive communication deficit, gastrointestinal hemorrhage, elevated white blood cell count, benign prostatic hyperplasia (enlarge prostrate)without lower urinary tract symptoms, obstructive and reflux uropathy, unspecified, hypertensive heart disease without heart failure, other symptoms and signs involving appearance and behavior acute (illness that develops quickly) and chronic (lasting for a long time) respiratory failure with hypoxia (lack of oxygen to sustain bodily functions), neuromuscular (affecting the nerves controlling the muscles) dysfunction of the bladder, sepsis (infection in the blood). Record review of Resident #90's admission MDS assessment dated [DATE], Section C (Cognitive Patterns) reflected a BIMS score 5 which indicated severe cognitive impairment. Section H (Bladder and Bowel) reflected resident had an indwelling catheter. Resident #90's functional status revealed he was independent with supervision of staff with bed mobility, transfer, and toilet use. Record review of Resident #90's physician order dated from May 2025 read in part . change Foley catheter with 18 inch catheter and 10cc bulb on the 1st of each month dated 3/23 . keep catheter from kinks and drainage bag lower than bladder at all times dated 4/29/25. Record review of the facility antibiotic stewardship dated 3/28/25 to 4/1/25 revealed resident was treated with Ciprofloxacin for urinary tract infection. (Ciprofloxacin is prescribed for the treatment of various bacterial infections) Observation on 6/11/25 at 2:32 p.m. of indwelling catheter and incontinent care for Resident #90 performed by (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	06/13/2025

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

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA G, Resident #90 was sitting on the w/chair with catheter bag hung on the side of the wheelchair. CNA washed her hands, donned gown and transferred the resident to bed, donned clean gloves, picked up wet wipe packet and placed on Rsident #90's bed, while cleaning Resident #90's F/C with the wet wipes, it fell on the floor, CNA J picked wet wipes off the floor and throw it in the trash can without changing gloves, then picked up a clean brief to put on Resident #90, while repositioning the resident the brief fell on the floor, CNA picked it up and placed on the resident and fastened. In an interview with CNA J on 6/11/25 at 2:50 PM, she said during F/C and incontinent care , she said she was nervous, she had in-service a month ago on 300 hall, she said she forgot to change her gloves and it could lead to cross contamination and infection. Interview on 06/11/25 at 6:05 PM, the DON said the nurse should have sanitized her hands in between each glove changes. She stated not doing so could result in spread of germs and the facility's policy for staff to wash or sanitize hands when going from a dirty to clean surface. She stated staff had been in-serviced on infection control and hand hygiene. She stated if hand hygiene or sanitizing was not performed when going from a dirty to clean surface, it could cause an infection. Record review of the facility's Skills Checklist-Treatment dated 02/19/2025 revealed CNA J demonstrated competency in handwashing. Review of facility policy, titled Hand Hygiene revised 12/2023 revealed Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: Before donning [putting on] sterile gloves after removing gloves .