STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676226	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cypress Healthcare and Rehabilitation Center	1351 Sadler San Marcos, TX 78666

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to immediately consult with the resident's physician when there was a need to alter treatment significantly for 1 (Resident #1) of 4 residents reviewed for physician notification, in that: The facility failed to notify Resident #1's provider of medication refusals for insulin from 06/01/2025 through 06/19/2025 and Pioglitazone (for type 2 diabetes) on 06/01/2025, 06/07/2025, 06/08/2025, 06/14/2025, and 06/15/2025. This failure could result in decreased continuity of care, and a delay in needed treatment and services. Findings include: Review of Resident #1's face sheet reflected a [AGE] year-old male admitted on [DATE] with diagnoses of hypertensive heart disease (heart conditions that develop as a result of long-term high blood pressure), cerebral infarction (a condition where a part of the brain is damaged due to insufficient blood supply), type 2 diabetes mellitus (chronic condition where the body either doesn't produce enough insulin leading to elevated blood sugar), major depressive disorder, and muscle weakness. Review of Resident #1's care plan dated 03/04/2025 reflected Resident #1 had diabetes mellitus with goal to have no signs or symptoms of hyperglycemia (too much glucose in the blood) . Interventions reflected to administer diabetes medication as ordered by doctor and monitor/document effectiveness. Intervention also included to educate regarding medications and importance of compliance and have Resident #1 verbalize understanding. Review of Resident #1's quarterly MDS dated [DATE] reflected Resident #1 had a BIMS score of 12 which indicated moderate cognitive impairment. Review of Resident #1's physician orders reflected an order for insulin lispro injection solution before meals and at bed time with a start date of 02/26/2025 for type 2 diabetes. Further review reflected Resident #1 had an order for pioglitazone tablet one time a day for type 2 diabetes with a start date of 04/04/2025. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #1's MAR for June 1, 2025 to June 19, 2025 reflected Resident #1 refused his pioglitazone on 06/1/2025, 06/07/2025, 06/08/2025, 06/14/2025, and 06/15/2025. Further review reflected Resident #1 refused his insulin lispro injection three times a day from 06/01/2025 to 06/19/2025. Resident #1's blood sugar was taken three times a day from 06/01/2025 to 06/19/2025 with low of 110 mg/dL and high of 307 mg/dL. Review reflected if greater than 399 mg/dL notify provider. Review of Resident #1's nursing progress notes from 06/01/2025 to 06/19/2025 reflected the NP/MD was not notified of Resident #1's medication refusals for June 2025. Further review reflected Resident #1 was not provided education regarding medication refusals for June 2025. Review of Resident #1's social services quarterly note dated 06/03/2025 reflected Resident #1 wished to return home but appeared to lack safety awareness and full insight to situation and care needs. During an interview on 06/19/2025 at 10:14 AM, Resident #1 stated that staff checked his blood sugar all the time. Resident #1 stated that he refused his insulin and told the staff that he did not want it because he does not want to become dependent on it. Resident #1 stated that he has not felt ill due to his blood sugar levels and has not had to go to the hospital since he admitted to the facility. Resident #1 stated that the staff tell him what his blood sugar is and if it was too high he would take the insulin. During an interview on 06/19/2025 at 1:07 PM, LVN A stated that residents had the right to refuse medications. LVN A stated if a resident refused medication their provider should have been notified as well as their family. LVN A stated that the resident should have been educated as to what the medication was and why it was important to take. LVN A stated if a resident refused insulin it was important to let the resident know why they were supposed to receive insulin and that their body cannot lower blood sugar on its own and the insulin was to manage and prevent blood sugar from getting too high. LVN A stated possible consequences for not taking insulin was to not have controlled blood sugar, coma or stroke. LVN A stated that notification to the provider should be documented in the resident's chart as a progress note. During an interview on 06/19/2025 at 1:19 PM, LVN B stated that if a resident refused medication it would be written in the 24 hour report and the provider would be notified to see what needed to be done. LVN B stated that a refusal should have been documented in a progress note as well as the notification to the provider. LVN B stated that education could be provided depending on the resident's cognition. LVN B stated that education to the resident could include letting the resident know that they do not want the resident's blood sugar to drop or get too high. LVN B stated that potential harm for not taking insulin was lethargy (unusual tiredness, drowsiness, or lack of energy) increased thirst, or aggression. LVN B stated education should have also been documented in a progress note. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/19/2025 at 1:31 PM, LVN C stated that he normally worked with Resident #1 and on Resident #1's hall. LVN C stated that the protocol for medication refusals included to figure out why the resident refused the medication, ease any concern they may have with the medication and answer any questions the resident may have had. LVN C stated that if a resident refused medication the MD/NP would be notified. LVN C stated that the refusal should be documented in a progress note and on the MAR. LVN C stated that the provider should be notified each time a resident refused. LVN C stated that the potential risk for a resident refusing insulin was worsening of the diabetic condition. LVN C stated that he did not notify the provider today (06/19/2025) of Resident #1's medication refusal. LVN C stated that he sent the NP a text yesterday regarding the refusals. LVN C did not have the text message that he notified the provider. During an interview on 06/19/2025 at 1:41 PM, the NP stated that he was familiar with Resident #1. The NP stated that he had been notified earlier today (06/19/2025) that Resident #1 refused medication. The NP stated he cannot recall being notified of Resident #1's medication refusals prior to today. NP stated that he expected the facility to notify him when a resident refused insulin. NP stated that he has not provided any education to Resident #1 regarding insulin refusals and said for Resident #1 to continue as ordered. NP stated that Resident #1's A1C (blood test for sugar levels) has been controlled and Resident #1 has not had any issues. During an interview on 06/19/2025 at 1:49 PM, the DON stated that residents have the right to refuse medications and staff should approach the resident later and try again. The DON stated that the provider should have been notified of medication refusals and the notification should be documented in a progress note. The DON stated that refusing insulin would have the potential to increase blood sugar but it was dependent on the resident on the potential outcome. The DON stated she expected staff to provide education if a resident was cognitively able to understand and expected education to be documented in the progress notes after the refusal. The DON stated Resident #1 does refuse his insulin and believe he was not on it prior to his hospitalization that occurred prior to admission to the facility and stated the hospital usually added insulin to diabetes when they went to the hospital. The DON stated Resident #1 has not returned to the hospital since admission to the facility. During an interview on 06/19/2025 at 2:02 PM, the ADM stated that she expected staff to attempt again if a resident refused medication, but if they refuse then the family should be contacted to see if the family could assist. The ADM stated the provider should be contacted to let them know the resident was not taking the medication and that education should be provided to the resident about what medications were for. The ADM stated she expected notification to the provider to be documented. The ADM stated a lot of times they talk to the provider on the phone, but it needed to be documented in the progress notes. The ADM stated education should have also been documented in the progress notes. Review of undated facility policy titled Medications - Administering reflected if a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall document this in the record. Review of undated facility policy titled Medication - Documentation of Administration reflected documentation must include reasons why a medication was withheld not administered or refused. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of undated facility policy titled Change in a Resident's Condition of Status reflected charge nurse will notify the resident's provider when there has been a refusal of treatment or medications two or more consecutive times.