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	11/25/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 2 of 9 residents (Resident #1 and Resident #2) reviewed for resident rights. The facility failed to ensure CNA D communicated respectfully to Resident #1 and #2 when removing their food trays and answering call lights. This failure could place residents at risk of feeling not being valued or cause psychosocial harm and emotional distress. Findings included:Findings included:Record review of Resident #1's face sheet dated 11/25/2025 revealed Resident #1 was admitted on [DATE] with diagnosis of chronic obstructive pulmonary disease (a progressive lung disease that causes breathing difficulties due to narrowed airways and damaged air sacs), type 2 Diabetes Mellitus (a chronic condition where the body doesn't use insulin properly, leading to high blood sugar levels), rheumatoid arthritis (a chronic autoimmune disease causing joint inflammation, pain, swelling, and stiffness, most often affecting joints on both sides of the body like the fingers, wrists, and knees), major depressive disorder (a mental health condition characterized by persistent feelings of sadness and a loss of interest or pleasure in daily activities, affecting an individual's ability to function), hypertensive heat disease (a heart problem caused by long-standing high blood pressure). Record review of Resident #1's admission MDS Assessment, dated 10/01/2025, reflected a BIMS score of 15 which is indicative of intact cognition. Record Review of Resident #1's care plan, dated 9/29/2025, revealed Resident #1 is on hospice with goal of receiving appropriate care and services and remain comfortable. The resident had depression and goal to remain free of signs and symptoms of distress, symptoms of depression, anxiety or sad mood. Interventions were identified in care plan: administer medications as ordered. Monitor/document for side effects and effectiveness. Record review of Resident #2's face sheet dated 11/25/2025, indicated her admission on [DATE] with diagnosis of chronic obstructive pulmonary disease (a progressive lung disease that causes breathing difficulties due to narrowed airways and damaged air sacs), gastro-esophageal reflux disease (a chronic digestive disorder where stomach acid or contents leak back into the esophagus, causing symptoms like heartburn and regurgitation), insomnia (a sleep disorder characterized by difficulty falling or staying asleep, leading to daytime fatigue and irritability), and major depressive disorder (a mental health condition characterized by persistent feelings of sadness and a loss of interest or pleasure in daily activities, affecting an individual's ability to function). Record Review of Resident #2's care plan, dated 11/24/2025, revealed Resident #2 is on hospice with goal of receiving appropriate care and services and remain comfortable. The resident had a diagnosis of depression and a goal to remain free of signs and symptoms of distress, symptoms of depression, anxiety or sad mood. The following interventions were identified in the care plan for Resident #2: Administer medications as ordered. Monitor/document for side effects and effectiveness.Record review of Resident #2's admission MDS Assessment, dated 11/17/2025, reflected a BIMS score of 15 indicated intact cognition. During an interview on 11/25/2025 at 11:36 a.m., Resident #1 revealed that CNA D is acting like she is the boss around here and not very patient with her. She stated that CNA D took her coffee cups and milk carton from her table without asking her first. She stated that she told RN A regarding CNA D's rude behavior several times and specifically on 11/25/2025.During an interview on 11/25/2025 at 12:05pm, Resident #2 stated that CNA D behaved like she did not want to help her. When Resident #2 asked CNA D for pain medication last night, she answered the call light stating, what do you want now?, I told you to be patient. She stated that she did not want CNA D to take care of her anymore because she was not patient and was rude to her. She stated she tried to talk to CNA D nicely and she could not understand why she treated her that way. She stated that the behavior of CNA made her feel sad. She stated she told RN A without recalling exact dates about CNA D and did not report her to anybody else. During interview on 11/25/25 at 2:35 p.m. with CNA D she said she worked with nursing staffing agency sending her to different facilities and on as needed bases she worked at this facility since 2020. She stated that she worked on hall 100 for a while on 2-10 p.m. shifts. She stated that she always asked residents if they were done eating before taking their trays and coffee cup if they were dirty to clean resident's tables. She took two cups of coffee from Resident #1's table because she had too many cups on her table. She stated that she did not remember when she had her ANE training. She stated that she knows different types of abuse, neglect and exploitation. She gave an example of verbal abuse when staff talked to residents with disrespect and using offensive words toward them. She said that any