

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676239	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2025
NAME OF PROVIDER OR SUPPLIER Villa Toscana at Cypress Woods		STREET ADDRESS, CITY, STATE, ZIP CODE 15015 Cypress Woods Medical Dr Houston, TX 77014	

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)
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>(continued on next page)</p>

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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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that each resident has a right to secure and confidential personal and clinical records. A. One of 12 residents (Resident #1) on 300 Hall had his personal health information left on the unlocked computer screen on LVN A's nursing cart. This failure could result in Resident #1's personal information being exposed to unauthorized individuals. This problem had the potential to affect all 24 residents in care of LVN A on 11/13/2025. The findings included: Record review of Resident #1's face sheet, dated 11/14/2025, revealed a 55-years-old male admitted on [DATE]. Resident's #1's diagnoses included intestinal obstruction unspecified (a medical condition where food or stool cannot pass through the small or large intestine, but the specific cause is not yet known or categorized), malignant neoplasm of colon (a cancerous tumor in the large intestine that can invade nearby tissues or spread to other parts of the body), ileostomy status (opening in the abdomen to divert waste from the small intestine), essential hypertension (high blood pressure that has no identifiable cause), mild intellectual disabilities (characterized by a slower-than-normal development in conceptual, social, and practical skills, typically with an IQ (Intelligence Quotient) range of 50-69). Record review of Resident #1's MDS, dated [DATE], revealed a BIMS score of 11 which indicated moderate cognitive impairment suggesting that the individual needs additional support and monitoring. Observation on 11/13/2025 at 10:15 a.m. revealed the nursing cart of LVN A was positioned near room [ROOM NUMBER] unattended. It was locked but the computer screen was open with Resident #1's clinical information in Point Click Care (computer program) displayed on the screen. This confidential information was opened for anyone such as visitors or other residents to see. LVN A came back to the nursing cart at 10:19 a.m. During an interview on 11/13/2025 at 10:21 a.m. with LVN A, she stated that she just stepped away for a few minutes to get some additional supplies. She stated that she received HIPAA training (Health Insurance Portability and Accountability Act which protects sensitive patient health information from disclosure without consent) at time of hire and annually. She said that she is responsible for closing the computer screen and locking the nursing cart when she steps away. She stated that leaving a computer without minimizing the computer screen can lead to exposing residents' private medical information to non-authorized personnel or public. During an interview on 11/13/2025 at 5:56 p.m. DON revealed the policy was that the computer on the medication cart should be minimized when the nurse or medication aide are not using the computer. She said the nurse or the medication aide using the computer are responsible for minimizing the screen. She said if the screen was not minimized someone could have unauthorized access. She said the ADON and the DON monitor to ensure the screens are closed. She said they monitor through observation rounds. She said she did not know why the screen was left open on the nursing cart. During interview on 11/14/2025 at 12:55 p.m. with ADM revealed all staff were trained on HIPAA at the time of hire by signing acknowledgements, and at least annually after that. He stated that everybody is responsible for maintaining privacy of residents' information and if a computer screen is open and information is exposed that can cause a privacy breach of residents' personal and medical information. Record review of facility's staff educational course script, undated, revealed that HIPAA 101 - protecting private health information is any data that can identify a patient such as names, addresses, birth dates, medical record numbers, and other personal details. Digital best practice interacts with email and devices using strict security measures that protect private health information at every step: (2). Lock or log off devices when stepping away. Record review of staff in-services, dated 11/13/2025, revealed 12 nursing staff were in serviced on nurse/med aide cart protocol Carts are to be locked, and screens are to be closed when not in front of cart. No earlier dated staff in-services were available for review. Record review of HR - Personnel Handbook, dated 9/20/2019, revealed information on Confidentiality/HIPAA Regulation: The Privacy Policy reflects practices that have been adopted by the facility to protect patients' privacy and security in relation to their Protected Health Information as defined under HIPAA regulation. It is the duty and responsibility of each staff person associated with this facility to be fully familiar with Privacy Policy and to comply with the requirements detailed within it. The Privacy Policy is available to all facility employees for review at any time and may be obtained by requesting a copy from the Privacy Officer.</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>(continued on next page)</p>

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observations and record review, the facility failed to ensure that the residents were free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the residents' medical symptoms for 3 of 28 residents observed for restraints/bed rails. The facility failed to ensure that bedrails were not used on the side of Residents #2, Resident #3 and Resident #4's bed without the resident having been evaluated for the medical need. This failure could result in residents having physical restraints used that limited their movement without being evaluated for the medical need. Findings included: Record review of Resident #4's face sheet revealed an [AGE] year-old woman admitted to the facility on [DATE]. Record review of Resident #4's orders dated 11/13/2025 revealed, Resident #4 did not have orders for the bedrails. An observation was conducted on 11/13/2025 at 1:08PM of Resident #4 which revealed both side bed rails were up on her bed. Record review of Resident #3's face sheet revealed a [AGE] year-old woman admitted to the facility on [DATE]. Record review of Resident #3's orders dated 11/13/2025 revealed, Resident #3 did not have orders for the bedrails. An observation was conducted on 11/13/2025 at 2:20PM of Resident #3 laying in the bed with two bed rails raised. Resident #3's bed was in high position at the time of the observation. Resident #3 stated the bed rails have always been on the bed. Record review of Resident #2's face sheet revealed a [AGE] year-old male admitted to the facility on [DATE]. Record review of Resident #2's orders dated 11/13/2025 revealed, Resident #2 did not have orders for the bedrails. An observation was conducted on 11/13/2025 at 5:45PM of Resident #2 laying in the bed with two bed rails raised. An interview was conducted on 11/13/2025 at 5:45PM with Resident #3 who stated she does not know why there are bed rails on her bed. Resident #3 stated it was not her choice to have the rails placed on her bed. An interview was conducted on 11/13/2025 at 6:00p.m. with Resident #3's RP who stated that the bed rails were not from personal request but because when Resident #3 first arrived at the facility she kept falling. RP stated that the facility put the bed rails up to prevent Resident #3 from falling out of bed. RP stated that the bed rails are usually locked up most of the time unless staff are changing Resident #3's brief. An observation was conducted on 11/13/2025 at 5:46p.m., which revealed Resident #2 was trying to get out of his bed. Resident #2 was hollering and saying he needed help getting out of bed. Resident #2 had his feet on the ground and was not able to use the bedrails to reposition himself. An interview with Resident #2 at 5:47p.m., revealed Resident #2 was not interviewable. An interview was conducted on 11/13/2025 at 5:16pm with LVN A which revealed she had been trained on restraints. She said she only knows how to have the bed rails down when the patient is in bed. She said example of restraints is having someone tied down and restricting someone from getting out of the bed. She said she does not know the policy for the bed rails here. She said staff do not need to have doctor orders for bed rails. She said the bed rails help stop falls, and some use as assistance for turning. She said the bed rails are used to help the resident from falling. She said she does not know of any resident being hurt on the bed rails. She said she had not noticed a decline in the residents with bed rails. Said she does not consider the bed rails a restraint. She said they use the bed rails if they are on the beds when the resident is in the bed. An interview was conducted on 11/13/2025 at 5:40pm with the DON which revealed the facility is a free restraint facility and they try not to use restraints. She said some examples of restraints are lap bands, hand mitts or a table put on their chair, and full 4 side rails are restraints. She said the policy was bed rails are used to assist the resident to turn side to side, the resident could use the rails to hold onto when getting out of bed. The DON said the benefit is to provide independence for the resident, and risks are entrapment, and sliding between the bed rails. The DON said they do not have to have a doctor's order for the bed rails. The DON said there had been some bruises and skin tears due to the bed rails. She said she did not remember what residents did or when the residents sustained the bruises and skin tears. She said she was not sure how long ago that was. The DON said she did not know of any residents who had a decline due to the bedrails being used The DON said the assessment had the reason the bed rails were being used on each resident. During an interview on 11/13/2025 at 5:55p.m. with LVN C revealed he had not been trained on restraints. He said that the policy on restraints was that the facility had to have a doctor's order to use the bed rails. He said the family requests the doctor order and they do an assessment to see if the resident qualify to use the bedrails. He said he was unsure if he had been trained on the bed rails at the facility. He said he thinks he just had on the job training. He said the bed rails are up for some of the residents because the bed rails decrease the risk of injury. He</p>		

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. (continued on next page)

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure that residents receive proper treatment and care to maintain mobility, and good foot health. The facility failed to ensure toenails are trimmed regularly and free from abnormal nail conditions and ingrown toenails for 2 of 6 residents (Resident #5 and Resident #6) reviewed for foot care. This failure could place residents at risk of infection, pain, injury and altered gait. Finding included: Record review of Resident # 5's face sheet dated 11/14/2025 revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Resident # 5 had diagnoses that included encephalopathy (any disorder that affects the brain's function or structure leading to altered mental function), osteoporosis (disease that weakens the bones and make them more likely to break), muscle weakness, abnormalities of gait or mobility, ataxic gait (impaired balance or coordination due to damage to the brain, nerves or muscles), dementia (memory, thinking, difficulty), pain in left lower leg, difficulty in walking, lack of coordination, cognitive communication deficit (problems with communication), adult neglect or abandonment (Observed pattern of unmet needs), and anxiety (feeling of uneasiness or worry). Record review of Resident #5's quarterly MDS dated [DATE] revealed Resident #5 had a BIMS score of 5 indicating severe cognitive impairment. The MDS also revealed Resident #5 was partial/moderate assist with personal care, dressing and putting on/off footwear. Record review of Resident # 5's care plan dated 7/25/2025 revealed resident had an ADL self-care performance deficit. Interventions were BATHING: Check nail length and trim and clean on bath day and as necessary. Record review of Resident # 6's face sheet dated 11/13/2025 revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #6 had diagnoses which included neurocognitive disorder with Lewy bodies (type of progressive dementia that leads to a decline in thinking, reasoning, and independent function), cognitive communication deficit (problems with communication), muscle weakness, difficulty in walking, lack of coordination, vascular dementia (lack of blood that carries oxygen and nutrients to a part of the brain), parkinsonism (syndrome characterized by tremors and postural instability), chronic pain, visual loss-both eyes. Record review of Resident #6's quarterly MDS dated [DATE] revealed Resident #6 had a BIMS score of 4 indicating severe cognitive impairment. The MDS also revealed Resident #6 required supervision/touching assistance with personal care, dressing and putting on/off footwear. Record review of Resident # 6's care plan dated 2/13/2025 revealed that the resident had an ADL self-care deficit related to dementia (memory, thinking, difficulty). Interventions were BATHING: assist time one staff. Observation of Resident #5 on 11/13/2025 at 12:09 p.m., revealed she was standing at her door, waiting for her lunch to be served. She was wearing blue non-slip socks, with no shoes. Observation of Resident #6 on 11/13/2025 at 12:13 p.m., revealed . Resident #6's toenails were about 1inch long, yellowish on both feet. Resident #6's toenails were curved downward and some of them were digging into her skin. Her toenail on big toe was thick and brittle. Observation of Resident #5 on 11/14/2025 at 8:58 a.m., revealed she was walking in the hallway of the secure care unit. Resident #5 was wearing no-slip blue socks, but she did not have shoes on. Resident#5 went to her room and removed her socks, while sitting in her bed. Resident #5's toenails were yellow colored, thick and about an inch long ; both her big toenails were curved toward the other toenails while the rest of the toenails were curved toward the big toe. Her feet were very dry with flaky skin. During an interview with Resident #5 on 11/14/2025 at 8:59a.m., she said If they just would give me a nail clipper or scissors, I would cut these toenails myself. She said that her toenails hurt sometimes, and she could not wear any shoes .Observation of Resident #6 on 11/14/2025 at 9:15 a.m., revealed Resident #6 had about an inch long , yellowish toenails on both feet. Resident #6's toenails were curved downward and some of them were digging into her skin. Her toenail on big toe was thick and brittle. Attempted interview with Resident #6 on 11/14/2025 at 9:17a.m., revealed she was not interviewable. During an Interview with CNA C on 11/13/2025 at 3:38p.m., she stated that the staff in the secure care unit was not touching residents' toenails. She said the podiatrist would come to the unit and provide toenail care. She said the staff reported to the nurse if any resident needed foot care. She said not trimming resident's nails can cause discomfort, pain, and infection. She did not know why Resident #5 and Resident #6's toenails had not been cut or referred to the podiatrist. During an Interview with the DON on 11/13/2025 at 5:28p.m., she stated the podiatrist saw the residents every 62 to 90 days. She said staff were to report if a resident had long toenails to a nurse. She said not cutting long toenails could cause the resident to have an ingrown toenail and could be painful to treat. She said she did not know why Resident #5 and Resident #6 did not</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 4 residents (Residents #8) reviewed for pharmacy services. The facility failed to ensure RN A checked the pharmacy delivery before signing off that medication delivered was correct. The medication RN A signed for could not be located. These failures could result in residents not receiving their medications as ordered and have adverse effects due to the medications not being administered. Findings Included: An interview was conducted on 11/13/2025 at 4:21PM with LVN B who reported being employed at the facility for 3 weeks. LVN B stated that all LVNs complete audits of the MC which should be done daily. LVN B stated that loose medications on the bottom of the MC could be from when LVNs popped the medication and the medications fell. LVN B stated that loose medications that have been found at the bottom of MCs could potentially be considered a medication error. LVN B stated that loose medications at the bottom of the MC could negatively affect residents by potential drug interactions and could cause a resident to go without their medication. LVN B stated this could have meant that the residents did not receive their medications as prescribed. LVN B described the 2 loose pills as potentially an antipsychotic and melatonin. An interview was conducted on 11/13/2025 at 4:31PM with LVN C who reported being employed at the facility for 9 years. LVN C stated that MCs should be audited by the LVNs regularly. LVN C stated that loose medications at the bottom of the MC could negatively affect residents by the potential for shortages of the medication and/or the residents not receiving their full dose of medications as prescribed. LVN C stated that the LVNs and RNs should verify medications received at the facility from the pharmacy, which includes they should look at the prescription card and compare it with the order slip that they had received. LVN C stated that medications received should not be misplaced. An interview was conducted on 11/13/2025 at 5:25PM with LVN D who reported being employed at the facility for 3 weeks. LVN D stated she had never verified medications that had been sent to the facility through the pharmacy. LVN D stated that if the medication delivered was a controlled medication, they are to get the controlled medication and write down the date and time received and put it in the lock box. LVN D stated if it was a reordered medication they would place the medication back into the resident's file. LVN D stated if the MTs or LVNs were to log onto the computer, it would say that the medication order had arrived. LVN D also stated that misplacing medications could negatively affect a resident by the medication would not be available to the resident if they needed it. An interview was conducted on 11/13/2025 at 5:40PM with the DON who revealed the nurse told her that she got the package of medication but did not confirm what was in the bag. She said she did not remember who opened the package. The DON said the hospice nurse came the next day asking for the medication and the facility could not find it. The DON said whoever opened the medication should have verified the medication was there. The DON said it should have been done when the medication came in that way if a medication was not in the bag they would know. It was hard to prove the facility did not get the medication when the nurse signed for it and did not look at it. The DON revealed she had been trained on medication storage. She said the training covered narcotic storage, and storing medication in the carts. She said she does not remember the last time she had that training. She said she would have to review the policy for loose medications in the medication cart, but they should not be in the cart. She said the nurse or the medication aide are responsible for ensuring there are no loose pills in the cart. If there are loose pills in the cart it could affect the resident by the resident possibly not getting their medication. She said the ADON monitors and so does the pharmacist. She said they monitor by doing cart checks. She said she did not know why there were loose pills on the medication carts. An interview was attempted on 11/14/2025 at 11:45AM with RN A. An interview was attempted on 11/14/2025 at 11:48AM with the pharmacist of the hospice company that provided the medications to RN A. An interview was conducted on 11/14/2025 at 1:00PM with the ADM who reported he had worked at the facility for 11 months. The ADM stated the DON, ADON and nursing staff are responsible for MC audits. The ADM stated that if there were medications at the bottom of the MC, then there could be possibility that the resident did not receive the medication. The ADM stated that the policy for receiving medication is that the staff should not allow medications into the facility unless they have seen it, counted it, and signed off for it. The ADM stated if staff members signed for medication, and the medication could no longer be found, it could mean the residents did not receive it. The ADM stated that during the investigation it was determined that the RN that signed off</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>(continued on next page)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, interview, and record review the facility failed to ensure in accordance with state and federal laws, all drugs and biologicals were stored in locked compartments, under proper temperature control and labeled in accordance with currently accepted professional principles for 1 (medication cart #1) of 2 medication carts reviewed for medication storage. The facility failed to ensure that MC #1 did not have unidentifiable medications in the bottom of the MC drawer. This failure could result in residents not receiving their medications as ordered and have adverse effects due to the medications not being administered. Findings included: An observation and audit conducted on 11/13/2025 at 4:21PM revealed Med Cart #1 which was stationed on the 500-hall, contained loose medications at the bottom of drawer #2. The observation revealed that 2 unidentifiable pills were under the blister packs. An interview was conducted on 11/13/2025 at 4:21PM with LVN B who reported being employed at the facility for 3 weeks. LVN B stated that all LVNs complete audits of the MC which should be done daily. LVN B stated that loose medications on the bottom of the MC could be from when LVNs popped the medication and the medications fell. LVN B stated that loose medications that have been found at the bottom of MCs could potentially be considered a medication error. LVN B stated that loose medications at the bottom of the MC could negatively affect residents by potential drug interactions and could cause a resident to go without their medication. LVN B stated this could have meant that the residents did not receive their medications as prescribed. LVN B described the 2 loose pills as potentially an antipsychotic and melatonin. An interview was conducted on 11/13/2025 at 4:31PM with LVN C who reported being employed at the facility for 9 years. LVN C stated that MCs should be audited by the LVNs regularly. LVN C stated that loose medications at the bottom of the MC could negatively affect residents by the potential for shortages of the medication and/or the residents not receiving their full dose of medications as prescribed. LVN C stated that the LVNs and RNs should verify medications received at the facility from the pharmacy, which includes they should look at the prescription card and compare it with the order slip that they had received. LVN C stated that medications received should not be misplaced. An interview was conducted on 11/13/2025 at 5:25PM with LVN D who reported being employed at the facility for 3 weeks. LVN D stated she had never verified medications that had been sent to the facility through the pharmacy. LVN D stated that if the medication delivered was a controlled medication, they are to get the controlled medication and write down the date and time received and put it in the lock box. LVN D stated if it was a reordered medication they would place the medication back into the resident's file. LVN D stated if the MTs or LVNs were to log onto the computer, it would say that the medication order had arrived. LVN D also stated that misplacing medications could negatively affect a resident by the medication would not be available to the resident if they needed it. An interview was conducted on 11/13/2025 at 5:40PM with the DON revealed she had been trained on medication storage. She said the training covered narcotic storage, and storing medication in the carts. She said she does not remember the last time she had that training. She said she would have to review the policy for loose medications in the medication cart, but they should not be in the cart. She said the nurse or the medication aide are responsible for ensuring there are no loose pills in the cart. If there are loose pills in the cart it could affect the resident by the resident possibly not getting their medication. She said the ADON monitors and so does the pharmacist. She said they monitor by doing cart checks. She said she did not know why there were loose pills on the medication carts. An interview was conducted on 11/14/2025 at 1:00PM with the ADM who reported he had worked at the facility for 11 months. The ADM stated the DON, ADON and nursing staff are responsible for MC audits. The ADM stated that if there were medications at the bottom of the MC, then there could be possibility that the resident did not receive the medication. Record review of policy titled PCU027-Medication Storage in the Facility dated 2025 revealed the following:1. Medication and biologicals are stored safely, securely, and properly following the manufacturer's recommendations or those of the supplier. The medication supply is accessible only to license nursing personnel, pharmacy personnel or members lawfully authorized to administer medications. a. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled or without secure closures are immediately removed from stock, disposed of according to the procedures for medication destruction, and reordered from the pharmacy, if a current order exists. Medication storage areas are kept clean, well lit, and free of clutter.</p>		