STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676239	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Toscana at Cypress Woods	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)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for 1 of 12 residents (Resident #1) reviewed for accommodations of needs. The facility failed to ensure Resident #1 had a call button that he could use with his contracted hands. This failure could place residents at risk of not having their needs met.Findings include: Record review of Resident #1's, undated, face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included end stage renal (kidney) disease, altered mental status, bipolar disorder (mood disorder), metabolic encephalopathy (brain dysfunction caused by an underlying medical problem), thrombocytopenia (low blood platelet count), congestive heart failure (failure of the heart to circulate blood effectively), restlessness and agitation, dysphagia (trouble swallowing), muscle weakness, abnormal posture, and cognitive communication deficit (communication problems resulting from cognitive impairment). Record review of Resident #1's admission MDS, dated [DATE], reflected a BIMS score of 06, which indicated severe cognitive impairment. It also reflected he had no limitations on his range of motion on his upper extremities. Record review of Resident #1's care plan, dated 02/04/2026, reflected the following: Focus: The resident has an ADL Self Care Performance DeficitGoal: The resident will maintain or improve current level of function in (Bed Mobility, Transfers, Eating, Dressing, Toilet Use and Personal Hygiene; ADL Score) through the review date.Intervention: Encourage the resident to use bell to call for assistance.Focus: The resident is risk for fallsGoal: The resident will be free of falls through the review date.Intervention: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Observation on 03/17/2026 at 09:12 AM revealed a loud male voice yelling Nurse! Nurse! from Resident #1's room. After the second time the yelling occurred, ADON A walked to the room. The person yelling was Resident #1. He had a call button within reach, but he had not used it. Both his left and right hands were contracted (permanent shortening or tightening of the tendons, muscles, and skin that restricts movement). During an interview and observation on 03/17/2026 at 10:27 AM, Resident #1 stated he knew how to press his call button, but he had a hard time doing it with his hands. He demonstrated he could pick up the call button with his right hand and use a left finger to press the button, but it took extreme effort and concentration. Observation on 03/17/2026 at 12:56 PM revealed Resident #1 yelled Nurse! Nurse!, and a medication aide went into his room to assist. Observation on 03/18/2026 at 06:50 AM revealed Resident #1 yelled Nurse! Nurse!, and CNAs E and F went into his room to assist him. Observation on 03/18/2026 at 06:55 AM revealed CNA F asked LVN H to obtain a flat call button for Resident #1 so he could more easily use it and stop yelling in the hall. Observation on 03/19/2026 at 10:21 AM revealed Resident #1 still had the standard call button and no flat button. He stated he would have liked a flat call button and would have used it if he had one he could more easily press. During an interview on 03/19/2026 at 02:30 PM, CNA E stated she worked at the facility for three months, and she always worked on the hall where Resident #1 lived. She stated Resident #1 could not use a call button, and she and her fellow aide had notified the nurse on the hall the day prior (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(03/18/2026) that he was not able to use his call button and needed a flat button to accommodate his contracted hands. She stated she thought he would use a flat button more often and would not have to scream into the hallway. Attempted interview on 03/19/2026 at 02:42 PM with CNA F by telephone was unsuccessful. A voicemail was left but not returned as of 03/25/2026. During an interview on 03/19/2026 at 03:26 PM, the DON stated Resident #1 had been in the facility before for short-term care but had only just returned recently. She stated any aide or nurse could enter things into the electronic work order system, and they were trained to do so. She stated she could not remember how recently the nursing staff were trained to enter requests into the work order system, but it had been a long time. She stated a potential negative outcome was their needs were not met and they could reach for something and fall. During an interview on 03/19/2026 at 04:03 PM, the ADM stated his expectations were that a call button that accommodated Resident #1's needs would be provided for him right away. He stated they had an extra one on another hall and traded it for Resident #1's call button. He stated he did not know, if the request had been entered into the electronic work order system, he just wanted to get the right device for the resident right away. Record review of the facility's, undated, policy titled Resident Rights reflected the following:The resident has a right to a dignified existence, self-determination, and communication with and access to persons and service services inside and outside the facility, including those specified in this policy.A facility must 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, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.Respect and dignity - the resident has a right to be treated with respect and dignity, including:3. The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so what endanger the health or safety of the resident or other residents.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 32 residents (Resident #2) reviewed for activities of daily living. The facility failed to ensure Resident #2 was checked for and provided with incontinence care from 09:10 AM to 03:30 PM on 03/17/2026. This failure could place residents at risk of discomfort, embarrassment, and skin breakdown.Findings include: Record review of Resident #2's, undated, face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included cerebral infarction (area of death in the brain), cognitive communication deficit (communication problems resulting from cognitive impairment), lack of coordination, overactive bladder, and dementia (a general term for a decline in mental ability-such as memory, language, and problem-solving-severe enough to interfere with daily life). Record review of Resident #2's quarterly MDS, dated [DATE], reflected a BIMS score of 07, which indicated a severe cognitive impairment. It also reflected she was completely dependent on staff assistance with toileting hygiene. Record review of Resident #2's care plan, dated 03/18/2026, reflected the following: Focus: The resident has bowel incontinence.Goal: The resident will not have any complications r/t bowel incontinence.Intervention: Check resident every two hours and assist with toileting as needed,Focus: The resident has an ADL Self Care Performance Deficit.Goal: The resident will maintain or improve current level of function in Bed Mobility, Transfers, Eating, Dressing, Toilet Use and Personal Hygiene; ADL Score) through the review date.Intervention: Toilet use: requires staff x2 for assistance.Focus: The resident has bladder incontinenceGoal: The resident will remain free from skin breakdown due to incontinence and brief use through the review date.Intervention: Activities: notify nursing if incontinent during activities. Incontinent care often and apply moisture barrier after each episode. Record review of Resident #2's toileting hygiene/incontinent care tasks, dated 03/17/2026, reflected she was provided incontinent care at 12:17 AM and 08:56 PM. There was no care recorded for the day shift 6 AM to 2 PM. Observation on 03/17/2026 at 09:15 AM revealed Resident #2 was seated at a table in the living room (common area near the nurse's station) eating her breakfast. During observation and interview on 03/17/2026 at 10:21 AM revealed Resident #2 was in the doorway of her room. She stated her brief had not been changed since she got out of bed. She stated she did not know what time that was. When asked if she felt wet or uncomfortable, she smiled and did not answer. Observation on 03/17/2026 at 11:21 AM revealed Resident #2 in the living room participating in a music activity. Observation on 03/17/2026 at 01:18 PM revealed Resident #2 in the living room receiving her lunch. She was still in the same clothing she had been wearing at 09:15 AM. Observation on 03/18/2026 of an automated electronic surveillance video, dated 03/17/2026, revealed Resident #2's camera did not activate between the hours of 09:10 AM and 03:30 PM. It activated when she was brought to her room and provided incontinent care at 03:30 PM. During an interview on 03/18/2026 at 03:37 PM, the FM for Resident #2 stated they monitored the automated electronic surveillance for Resident #2 and did not see Resident #2 return to her room for incontinent care until 03:30 PM, when the FM called the nurse's station to request the staff provide incontinent care. The FM stated they did not remember who they spoke to at that time. The FM stated they had to call the nurse's station again that day (03/18/2026) at lunchtime to request incontinent care be provided to Resident #2. During an interview on 03/19/2026 at 01:16 PM, RN D stated the aides on the hall should have checked residents every two to three hours and changed them as needed. She stated had she been at the facility on 03/17/2026 when Resident #2 was not checked/changed for six hours, that would not meet her expectation. She stated she was not working that day. She stated the possible negative impact of not being changed for six hours was a skin issue, UTI, or rash. During an interview on 03/19/2026 at 02:10 PM, CNA E stated they checked and changed residents every two (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hours. She stated some residents got up at breakfast and spent the whole day in the living room. She stated she checked on her residents throughout the day in the living room, and if they needed to be changed then she brought them back to be changed. CNA E stated CNA F was assigned to Resident #2 on 03/17/2026, and she (CNA E) had not provided her care. CNA E stated it was possible they might forget to check on a resident in the living room and change them if they got busy, but it was unlikely. She stated if residents were not changed frequently, they could get pressure sores. During an interview on 03/19/2026 at 03:30 PM, the DON stated she expected residents to be checked and changed every two to three hours. She stated Resident #2 waiting from 09:00 AM to 03:00 PM was inconsistent with her expectations and the staff should have rounded more frequently. She stated she monitored for compliance by being in the facility and making rounds. She stated staff were able to check the wetness gauge on the brief itself to find out if residents needed to be changed without completely undressing them and interrupting their activities in the living room. She stated the potential negative impact of being left sitting in a wet or soiled brief was skin breakdown and infections such as UTIs. She stated she provided training to staff about providing incontinent care every two-three hours within the last two months but did not know exactly when. During an interview on 03/19/2026 at 04:03 PM, the ADM stated facility staff were mandated to check on residents and provide incontinent care if needed. He stated six hours was too long for them to wait to check and change any incontinent resident. He stated the potential negative impact of not being provided incontinent care for six hours, depended on what the resident was sitting in during that time. Record review of the facility's policy, dated 05/11/2022 and titled Perineal Care, reflected the following:An incontinent resident of urine and/or bowel should be identified, assessed, and provided appropriate treatment and services to restore as much normal bladder/bowel function as possible.It is essential that residents using various devices, absorbent products, external collection, devices, etc., be checked and changed as needed on a schedule based upon the residence, avoiding pattern, professional, standards of practice, and the manufacturers recommendations.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents were offered sufficient fluid intake to maintain proper hydration and health for 8 of 32 residents (Residents #1, #6, #7, #8, #9, #11, #14 and #15) reviewed for hydration. The facility failed to ensure Residents #1, #6, #7, #8, #9, #11, #14 and #15 were offered the minimum quantity of fluids daily to maintain hydration on 03/17/2026 and 03/18/2026. This failure could place residents at risk of dehydration.Findings include: 1. Record review of Resident #1's, undated, face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included end stage renal (kidney) disease, altered mental status, bipolar disorder (mood disorder), metabolic encephalopathy (brain dysfunction caused by an underlying medical problem), thrombocytopenia (low blood platelet count), congestive heart failure (failure of the heart to circulate blood effectively), restlessness, and agitation, dysphagia (trouble swallowing), muscle weakness, abnormal posture, and cognitive communication deficit (communication problems resulting from cognitive impairment). Record review of the admission MDS for Resident #1, dated 02/07/2026, reflected a BIMS score of 06, which indicated severe cognitive impairment. Resident #1 required set up or clean up assistance with eating and drinking and was completely dependent on staff for transfers from his bed to his chair. Record review of Resident #1's care plan, dated 02/04/2026, reflected the following: Focus: The resident has potential fluid deficit r/t dialysis.Goal: The resident will be free of symptoms of dehydration and maintain moist mucous membranes, good skin turgorInterventions: Encourage fluids during med pass and with each care intervention. Encourage the resident to drink fluids of choice. Ensure the resident has fluids in reach. Inform the nurse if the resident is refusing to drink fluids. Record review of Resident #1's meal tickets reflected he received 24 ounces of fluids across his breakfast, lunch, and dinner trays. Observation and interview on 03/17/2026 at 10:27 AM revealed Resident #1 sitting up in his bed with an empty bedside table in front of him. There was a 32-ounce, lidded, handled cup filled with water with a straw in it on his windowsill, out of reach. He stated he could not have gotten up to reach the cup of water. He stated the water was not fresh and he did not know when it had been refilled. His skin and lips did not exhibit signs of dehydration. Observation and interview on 03/17/2026 at 01:10 PM revealed Resident #1 sitting in front of his lunch tray in his bed. He drank the one 8-ounce glass of red punch that was on his meal tray and was eating the ice within. He stated he would drink more if he had more to drink. There were no other drinks on his meal tray. Observation on 03/18/2026 at 06:40 AM revealed Resident #1 had no water accessible to him at his bedside. The 32-ounce pitcher was still sitting on his windowsill in the same place and had the same level of water that it contained the previous day. 2. Record review of Resident #6's, undated, face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included hypocalcemia (low blood calcium), hyperosmolality and hypernatremia (elevated sodium caused primarily by water deficit), lack of coordination, repeated falls, muscle weakness, contracture (permanent shortening and tightening of muscle fibers that reduces flexibility and function), muscle wasting and atrophy (loss of muscular strength due to disuse), chronic kidney disease, Parkinson's disease (progressive neurological disorder that affects movement), and ataxic gait (unsteady, poorly coordinated walking pattern caused by neurological dysfunction). Record review of Resident #6's quarterly MDS, dated [DATE], reflected a BIMS score of 05, which indicated severe cognitive impairment. It also reflected he required partial to moderate assistance with eating and drinking and was completely dependent on staff for transfers from his bed to his chair. Record review of Resident #6's care plan, dated 02/13/2026, reflected the following: Focus: The resident has potential fluid deficit r/t poor memory.Goal: The resident will be free of symptoms of dehydration and maintain moist mucous membranes, good skin turgorInterventions: Encourage the resident to drink fluids of choice. Ensure the resident has fluids in reach. Inform the nurse if the resident is refusing to drink fluids. Record (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	review of Resident #6's meal tickets reflected he received 28 ounces of fluids across his breakfast, lunch, and dinner trays. Observation on 03/17/2026 at 09:28 AM revealed Resident #6 lying asleep in his bed, which had a scoop mattress, was in low position, and had fall mats on either side. There was no cup of water within reach on his side of the room. Observation on 03/17/2026 at 03:12 PM revealed Resident #6 was sitting up in his wheelchair. There was no cup of water available in his room. He did not respond to efforts to interview him. His skin and lips did not exhibit signs of dehydration. Observation on 03/18/2026 at 07:18 AM revealed Resident #6 lying asleep in his bed in the low position with fall mats on either side. There was still no cup of water within reach on his side of the room. 3. Record review of Resident #7's, undated, face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included ataxia (a neurological condition leading to poor muscle control and lack of coordination), cognitive communication deficit (communication problems resulting from cognitive impairment), dysarthria and anarthria (damage to the brain causing lack of control to the muscles that allow speech), mild protein-calorie malnutrition (an individual does not receive enough protein to maintain adequate nutrition), dementia, depression, and muscle weakness. Record review of Resident #7's quarterly MDS, dated [DATE], reflected a BIMS score of 07, which indicated severe cognitive impairment. Resident #7 required supervision or touching assistance with eating and drinking and was completely dependent on staff for transfers from his bed to his chair. Record review of Resident #7's care plan, dated 02/19/2026, reflected the following: Focus: The resident has potential fluid deficit related to low intake.Goal: The resident will be free of symptoms of dehydration and maintain moist mucous membranes, good skin turgorInterventions: Encourage the resident to drink fluids of choice. Ensure the resident has fluids in reach. Inform the nurse if the resident is refusing to drink fluids. Record review of Resident #7's meal tickets reflected he received 28 ounces of fluids across his breakfast, lunch, and dinner trays. Observation on 03/17/2026 at 09:34 AM revealed Resident #7 sat in his bed in his room having breakfast. There was one 4-ounce cup of orange juice and one 4-ounce cup of milk on his breakfast tray. He was eating on his own. There was no drinking water in his room. He waved hello but did not respond to efforts to interview him. His skin and lips did not exhibit signs of dehydration. Observation on 03/18/2026 at 06:50 AM revealed Resident #7 was asleep in his room with no drinking water on his side of the room. 4. Record review of Resident #8's, undated, face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included hemiplegia and hemiparesis (paralysis on one side of the body) following cerebrovascular disease (disease related to lack of blood flow to the brain), cognitive communication deficit (communication problems resulting from cognitive impairment), muscle weakness, muscle wasting and atrophy (loss of muscular strength due to disuse), moderate protein-calorie malnutrition (an individual does not receive enough protein to maintain adequate nutrition), and lack of coordination. Record review of Resident #8's quarterly MDS, dated [DATE], reflected a BIMS score of 07, which indicated severe cognitive impairment. It Resident #8 required supervision or touching assistance with eating and drinking and was completely dependent on staff for transfers from her bed to her chair. Record review of Resident #8's care plan, dated 03/16/2026, reflected the following: Focus: The resident has potential fluid deficit r/t memory loss.Goal: The resident will be free of symptoms of dehydration and maintain moist mucous membranes, good skin turgorInterventions: Encourage the resident to drink fluids of choice. Ensure the resident has fluids in reach. Inform the nurse if the resident is refusing to drink fluids. Record review of Resident #8's meal tickets reflected he received 28 ounces of fluids across his breakfast, lunch, and dinner trays. Observation and interview on 03/17/2026 at 09:15 AM revealed Resident #8 sat in her bed. She stated she was waiting for breakfast. Her bedside table was in reach, but there was no drinking water or fluids on it. Her breakfast was served ten minutes later with a 4-ounce cup of orange juice and two 4-ounce cups of milk on the tray. Her skin and lips did not exhibit signs of dehydration. Observation on 03/18/2026 at 07:03 PM revealed Resident #8 sat in her bed. She had an empty medicine cup on her bedside table and, when asked if she had anything to drink, asked the (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	state surveyor to fill the cup with water. There were no other fluids available to her within reach. There was a 16-oounce disposable water bottle on the shelf behind her bed, but she could not reach the bottle. 5. Record review of Resident #9's, undated, face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included unspecified head injury, muscle weakness, ataxic gait (unsteady, poorly coordinated walking pattern caused by neurological dysfunction), lack of coordination, cognitive communication deficit (communication problems resulting from cognitive impairment), aphasia following cerebrovascular disease (language disorder after a stroke), muscle wasting and atrophy (loss of muscular strength due to disuse), weakness, depression, anxiety disorder, and type two diabetes mellitus (chronic condition that occurs when the body cannot properly use blood sugar). Record review of Resident #9's quarterly MDS, dated [DATE], reflected a BIMS score of 05, which indicated severe cognitive impairment. Resident #9 was independent with eating and drinking and was completely dependent on staff for transfers from his bed to his chair. Record review of Resident #9's care plan, dated 02/19/2026, reflected the following: Focus: The resident has potential fluid deficit do (sic) to dementa (sic).Goal: The resident will be free of symptoms of dehydration and maintain moist mucous membranes, good skin turgorInterventions: Encourage the resident to drink fluids of choice. Ensure the resident has fluids in reach. Inform the nurse if the resident is refusing to drink fluids. Record review of Resident #9's meal tickets reflected he received 28 ounces of fluids across his breakfast, lunch, and dinner trays. Observation on 03/17/2026 at 09:18 AM revealed Resident #9 laid in his bed, asleep, and no drinking water or other fluids was on his side of the room. His skin and lips did not exhibit signs of dehydration. Observation on 03/18/2026 at 07:00 AM revealed Resident #9 was asleep in his bed with no water on his bedside table, dresser, or anywhere else on his side of the room. 6. Record review of Resident #11's, undated, face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included depression, senile degeneration of brain, anxiety disorder, muscle weakness, lack of coordination, ataxic gait (unsteady, poorly coordinated walking pattern caused by neurological dysfunction), cognitive communication deficit (communication problems resulting from cognitive impairment), and moderate protein-calorie malnutrition (an individual does not receive enough protein to maintain adequate nutrition). Record review of Resident #11's quarterly MDS, dated [DATE], reflected a BIMS score of 05, which indicated severe cognitive impairment. Resident #11's required set up and clean up assistance with eating and drinking and partial to moderate assistance from staff for transfers from his bed to his chair. Record review of Resident #11's care plan, dated 12/18/2025, reflected the following: Focus: The resident has an ADL self-performance deficit.Goal: The resident will maintain or improve current level of ADL functionInterventions: Eating requires staff X 1 Record review of Resident #11's meal tickets reflected he received 24 ounces of fluids across his breakfast, lunch, and dinner trays. Observation on 03/17/2026 at 09:11 AM revealed Resident #11 was seated in his wheelchair in his room. He had no drinking water or fluids accessible to him in his room. When asked if he had any water or was thirsty, he shrugged and did not engage verbally. His skin and lips did not exhibit signs of dehydration. Observation on 03/18/2026 at 07:19 AM revealed Resident #11 was asleep in his bed and had no water or fluids accessible on his side of the room. 7. Record review of Resident #14's, undated, face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included atherosclerotic heart disease, muscle weakness, muscle wasting and atrophy (loss of muscular strength due to disuse), difficulty in walking, ataxic gait (unsteady, poorly coordinated walking pattern caused by neurological dysfunction), repeated falls, depression, anxiety disorder, frontotemporal neurocognitive disorder (progressive brain disorder that affects the frontal and temporal lobe of the brain), cognitive communication deficit (communication problems resulting from cognitive impairment), and lack of coordination. Record review of Resident #14's quarterly MDS, dated [DATE], reflected a BIMS score of 07, which indicated severe cognitive impairment. Resident #14 was independent with eating and drinking and required supervision or touching assistance of staff for transfers from her bed to her chair. Record review of Resident #14's (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	care plan, dated 02/03/2026, reflected the following: Focus: The resident has potential fluid deficit r/t memory loss.Goal: The resident will be free of symptoms of dehydration and maintain moist mucous membranes, good skin turgorInterventions: Encourage the resident to drink fluids of choice. Ensure the resident has fluids in reach. Inform the nurse if the resident is refusing to drink fluids. Record review of Resident #14's meal tickets reflected he received 32 ounces of fluids across his breakfast, lunch, and dinner trays. Observation and interview on 03/18/2026 at 06:44 AM revealed Resident #14 laid in her bed with no drinking water or fluids available to her within reach. When asked if she was thirsty, she stated, Yeah some water would be nice. She then stated she might have some next to her bed and struggled to look around at her bedside table, which was not in reach and did not have any drinks on it. Her skin and lips did not exhibit signs of dehydration. 8. Record review of Resident #15's, undated, face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included senile degeneration of brain, abnormalities of gait and mobility, lack of coordination, moderate protein-calorie malnutrition (an individual does not receive enough protein to maintain adequate nutrition), depression, anxiety disorder, muscle weakness, and cognitive communication deficit (communication problems resulting from cognitive impairment). Record review of Resident #15's quarterly MDS, dated [DATE], reflected a BIMS score of 02, which indicated severe cognitive impairment. Resident #15 required partial to moderate assistance with eating and drinking and was completely dependent on staff for transfers from her bed to her chair. Record review of Resident #15's care plan, dated 12/18/2025, reflected the following: Focus: The resident has potential fluid deficit r/t dementia.Goal: The resident will be free of symptoms of dehydration and maintain moist mucous membranes, good skin turgorInterventions: Encourage the resident to drink fluids of choice. Ensure the resident has fluids in reach. Record review of Resident #15's meal tickets reflected she received 28 ounces of fluids across his breakfast, lunch, and dinner trays. Observation on 03/17/2026 at 09:06 AM revealed Resident #15 was in bed with no drinking water or fluids in reach. She did not respond to efforts to interview her. Her skin and lips did not exhibit signs of dehydration. Observation on 03/18/2026 at 07:04 AM revealed Resident #15 lying in bed asleep with no drinking water or fluids visible in her room. Observation on 03/18/2026 at 07:30 AM revealed an ice chest on the 200-hall which contained an inch of water and a few ice cubes floating in it. There was a water dispenser filled with ice water and lemon and disposable foam cups beside it. Observation on 03/18/2026 at 10:27 AM revealed the ice chest was closed into a nutrition room on the 200-hall. It still only had an inch of water in it, and the ice that was within at 07:30 AM had melted or been removed. During an interview on 03/18/2026 at 07:35 AM, CNA E stated she was not sure who was supposed to fill the ice chest. She stated she guessed someone would fill the ice chest after breakfast that day and that would be when they passed around fresh water to all the residents in their rooms. She stated the ice machine on their side of the building (serving the 100, 200, and 300 halls) was broken so they had to go to the other side of the building to get ice. She stated residents could always get water if they were up and could get water themselves, because there was a dispenser of ice water at the nurse's station filled by the dietary department every shift. She stated residents who could not get up on their own could ask for water. She stated residents who forgot to ask for water were reminded to drink. She stated she did not refill any of the water cups on her hall the previous day and did not know why there had not been fresh water passed on the 200 and 300 hall the previous day. During an interview on 03/19/2026 at 10:45 AM, the LD stated she reviewed lab results and observed meals being served at the facility once per quarter and had not noticed any issues that would make her think the residents were not receiving enough fluids. She stated the standard quantity of fluids that should have been offered to each resident per day was 1900 cc, which equaled 64 ounces. She stated the minimum quantity of fluids she would expect to be offered, even to someone with fluid restrictions or receiving hemodialysis (a life-saving treatment for kidney failure that removes waste from the blood), was a liter and a half, which equaled 50 ounces. She stated the amount of fluids ordered on the facility menu were not her decision, but the facility used a food (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676239	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Toscana at Cypress Woods	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)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ordering company that had their own dietitians who produced the menus. She stated if some residents were only receiving 4 ounces of fluids at breakfast and 8 ounces at lunch and dinner, the nursing department would have to offer fluids consistently to ensure residents did not become dehydrated. She stated milk and coffee also contained fluids that would prevent dehydration and should be included in daily totals. During an interview on 03/19/2026 at 01:16 PM, RN D stated she worked PRN but was usually on the 200 hall when she worked. She stated she did monitor for compliance with hydration requirements by offering water every single time she entered the resident's rooms. She stated she frequently offered water for those who were not able to drink water on their own, and she ensured there was ice and fresh water for all residents. She stated the fresh water was to be passed every shift at the beginning of the shift. She stated she could not explain why some residents were not seen with fresh water on 03/17/2026 and 03/18/2026, as she had not been working. She stated if she saw the conditions on the hall like that, she would have made sure water was given to every resident. She stated all the residents had fresh water on her hall that morning. She stated with the meal service and the medication administration, there would be no way the residents would go without any water for an entire day. She stated it was important to stay hydrated for wound healing and to prevent infections. During an interview on 03/19/2026 at 02:30 PM, CNA E stated the procedure for passing water was when the ice chest was filled with ice, the aides went around filling pitchers with water every two hours just like they did when they checked the residents for incontinent care or other needs. She stated on the first day of the investigation, which was 03/17/2026, there was no ice in the ice chest. She stated she did not know who was supposed to fill the ice chest, but she and her fellow aides kept waiting for someone to fill the ice chest so they could start passing fresh water. CNA E stated they usually placed the tables close to the resident beds. She stated there were two days that went by where nobody filled the ice chest or made the fresh cups available to residents, but someone had finally gotten them ice that morning and they passed water as usual. CNA E stated the cups were small on the meal trays, and she did not know why the meal trays did not also have cups of water on them as well as juice and milk. She stated there were several residents who would probably like to have additional fluids with their meals. She stated she thought it would also help if there was a set schedule for who should fill the ice chest and when. She stated the possible negative outcome of a resident not receiving fluids was they could become dehydrated, weak, and sick. During an interview on 03/19/2026 at 02:40 PM, ADON B stated the expectation was the aides or nursing staff passed fresh water every shift. She stated she had done in-services on it and would probably need to add a specific time that it was done each shift if it was not being done every day. She stated she monitored for compliance with hydration rounds by making her own rounds. She stated she was on the hall more than she was in her office watching to make sure residents received the care they needed. She stated there was ice, clean scoops, and fresh cups available on the halls every day, but for the past two days the nursing staff had not ensured the residents were receiving their fresh ice water. She stated she found the ice chest that morning (03/19/2026) in the nutrition room, dirty and in need of fresh ice. She stated she did not have a specific staff member responsible for cleaning the ice chests and scoops each shift, as she had no reason to think it was not being done prior to this week. She stated the residents may not have received fresh ice water on 03/17/2026 and 03/18/2026, based on the state of the ice chest. She stated they talked to their nursing staff about the importance of hydration. She stated the residents who ate in the dining room received a cup of juice, tea, or punch as well as were offered a cup of water. She stated many of those residents accepted a cup of ice water at meals. She stated she did not know why a cup of ice water was not placed on the meal trays that came to the halls. She stated she tried to get the dietary department to do that, but it had not happened so far. She stated if a resident did not receive enough fluids, it could lead to dehydration, UTI, and dry skin. An attempted interview was made on 03/19/2026 at 02:42 PM with CNA F by telephone was unsuccessful. A voicemail was left but not returned as of 03/25/2026. During an interview on 03/19/2026 at 03:12 PM, the DON stated she had (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	been out for two weeks and had just returned on 03/18/2026. She stated the procedure was supposed to be that there was an ice chest for each nurse's station and the nursing staff was to pass fresh ice water each shift. She stated she interpreted at the beginning of each shift. She stated no specific staff was assigned to refill the ice chest in particular, but the night shift was assigned the job of washing the ice scoops and ice chest. She stated she noticed meal trays did not have cups of water on them. She stated residents were receiving fluids through medication administration and the juice, milk, and coffee they received at and between meal times. She stated there were no residents in the facility on fluid restrictions. She stated ice water needed to be offered to residents every shift, whether they drank it or not. She stated this issue had not been identified by the facility QAPI program as a quality deficiency, but the observations made during the survey were not consistent with her expectations. She stated she monitored for compliance with hydration protocols through doing rounds and monitoring labs and infections. She stated the potential negative impacts of not providing adequate hydration were dehydration and UTI. During an interview on 03/19/2026 at 03:58 PM, the MD stated her recommendation would be the least amount of fluid any resident was offered each day was 1500 cc, equivalent to 50 ounces. She stated she had no reason to be concerned that residents at the facility were not receiving enough fluids. During an interview on 03/19/2026 at 04:03 PM, the ADM stated there should have been hydration carts going out on the halls for the residents to have the opportunity to receive ice and water. He stated he monitored through visual and morning rounds and being observant of surroundings. He stated the potential negative impact of the residents not receiving water at the bedside was dehydration. Record review of in-services from 2025 and 2026 reflected one in-service related to hydration, titled Night Shift Responsibilities and including instruction to pass ice and water each shift. Record review of the facility's, undated, policy titled Hydration reflected the following: GoalsThe resident will maintain adequate hydrationThe resident will not experience skin breakdown related to hydration status.Vital signs will remain within a normal paraFluid intake is monitorThe resident will not demonstrate signs or symptoms of dehydration.2.Staff should offer hydration, unless contraindicated, at the following intervals. 1. Direct care interaction with the resident in the residence room [ROOM NUMBER]. Prior to, during, and following meals 3. During a medication pass 4. During activities3. The facility may utilize fine dining programs to encourage fluids prior to, during and following meals. The facility may use education and encouragement to increase fluid intake with intermittent direct care duties. Freshwater will be maintained at bedside when not con indicated. The facility may implement a hydration card system designed to offer appropriate fluids every shift to residents except where contraindicated. Alternative treatment approaches may include use of popsicles, gelatin, and other similar non-fluid foods as recommended by the dietitian.