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No. 0938-0391

| 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 05/06/2026 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Villa Toscana at Cypress Woods | 15015 Cypress Woods Medical Dr<br>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) |
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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for 2 of 4 (LVN A, CNA B) staff members reviewed for food service safety.The facility failed to ensure LVN A and CNA B's hands were washed or sanitized before and between serving residents their meals during breakfast in the secured unit.This failure placed the residents at risk for cross contamination, foodborne illness, and transmission of infectious organisms.Findings included:During an observation on 05/06/2026 at 9:31am in the secured unit CNA B did not wash or sanitize their hands before serving a resident's breakfast, between serving consecutive residents, or while moving back and forth between the residents and the meal trays. At 9:41am LVN Adid not wash or sanitize her hands after assisting a resident and completing an assessment. LVN A then brought the resident to the dining room, removed her gloves, received the resident's breakfast plate, and immediately began assisting with feeding. There were 8 residents in the secured unit's dining room during breakfast.During an interview on 05/06/2026 at 9:58am with LVN A she stated that she washes her hands before handling trays and afterward. She stated that the reason she wears gloves is the food can be sticky and she would sanitize her hands if she were unable to wash them. LVN A stated that she was unsure where she was required to sanitize between trays. When LVN A was asked about the observation of putting on the gloves, assessing a resident, holding the resident's hand to assist with walking to the secured unit's dining room and then assisting the resident with feedings, she acknowledged that not sanitizing could place residents at risk for infection, viral diseases, and contamination.During an interview on 05/06/2026 at 10:20 am with CNA B she stated that they usually have small hand sanitizer bottles available, but none were present un in the area. She stated that the meal service time becomes very busy, and tasks are expected to be completed quickly to keep the residents from being served cold food. She stated when she was going back and forth between rooms and passing out trays, she didn't use hand sanitizer because she was rushing to make sure all residents received their breakfast. CNA B stated that staff are supposed to wash or sanitize their hands between passing trays, and that the risk of not doing so is the spread of germs.During an interview on 05/06/2026 at 6:22pm with the DON she stated the expectation for hand hygiene is to sanitize hands before receiving a tray and again after placing the tray down, and before touching another tray. She stated that hand sanitizer can is available at the nurse's station and that pocket sized sanitizers could also be used, though she was unsure whether the company provides them, but there is also hand sanitizer in each resident's room. The DON stated the risk of not sanitizing if is the spread of infection. She also stated that gloves are not a substitute for handwashing and are intended for single use only.Record review of the facility's policy for ?Fundamentals pf of Infection Control Precautions' undated read. A variety of infection control measures are used for decreasing the risk of transmission of microorganisms in the facility. These measures make up the fundamentals of infection control precautions. Before and after eating or handling food (hand washing with soap and water); Before and after assisting a resident with meals; After removing gloves or aprons; and Upon and after coming in contact with a resident's intact skin, (e.g., when taking a pulse or blood pressure, and lifting a resident) |

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 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 6 (Resident #7) residents reviewed for comprehensive assessments.The facility failed to revise Resident #7's care plan with intervention after completing an elopement assessment when the resident scored high risk for eloping.This failure could result in the care plans not reflecting the residents' status, needs, and interventions and the potential to lead to unmet needs, inconsistent care, and avoidable decline.Findings include:During an interview on 05/06/2026 at 10:20am with CNA B she stated that Resident #7 attempted to elope from the facility approximately two weeks ago and was located at the front of the building in her wheelchair, still on the facility property, by a member of the dietary staff. She stated that she did not know the name of the dietary staff member at this time. CNA B stated that Resident #7 has not been on the secured unit long and has not attempted to leave since being placed in the unit.Record review of Resident #7's undated face sheet revealed a [AGE] year-old female who admitted into the facility on [DATE] and readmitted on [DATE]. She had diagnoses of dementia (a condition that affects memory and thinking), cerebrovascular disease (problems with blood flow in the brain), lack of coordination (difficulty controlling body movements), seizures (episodes of abnormal electrical activity in the brain), anxiety (feelings of worry or nervousness), dysphagia (trouble swallowing), depression (a mood disorder that causes sadness or loss of interest), difficulty in walking (problems with mobility), and cognitive communication deficit (trouble understanding or expressing information due to thinking or memory problems).Record review of Resident #7's Quarterly MDS assessment dated [DATE] revealed she had BIMS score of 04 out of 15 which indicated significant difficulty with memory, decision-making, and understanding of their surroundings. Resident #7 had no impairment in upper or lower extremities and used a wheelchair for mobility. Resident #7's functional abilities were scored as 03 out of 06 for partial/moderate assistance, which indicated the helper does less than half the effort when it comes to sitting to stand, walk 10 feet, and chair/bed to-chair transfer.Record review of Resident #7's Elopement Risk assessment dated [DATE] revealed a score of 23, which indicated a high risk for elopement completed by the ADON. The assessment revealed Resident #7 was able to propel self, was not on the secured unit, moderately impaired- decisions poor; cues/supervision required, one or more attempts to leave facility in the last year, does not recognize stop lights, physical needs, precautions when crossing the streets, and knows location of current residence. Elopement Risk assessment dated for 04/14/2026 revealed a score of 27, which indicated a high risk for elopement completed by the DON. The assessment revealed Resident #7 was able to propel self, was on the secured unit, moderately impaired- decisions poor; cues/supervision required, one or more attempts to leave facility in the last week, does not recognize stop lights, physical needs, precautions when crossing the streets, and knows location of current residence. Additional information noted included Resident #7 exited the building this morning and was able to be redirected. Elopement Risk assessment dated for 04/20/2026 revealed a score of 27, which indicated a high risk for elopement completed by the DON. The assessment revealed Resident #7 was able to propel self, was on the secured unit, moderately impaired- decisions poor; cues/supervision required, one or more attempts to leave facility in the last week, does not recognize stop lights, physical needs, precautions when crossing the streets, and knows location of current residence.Record review of Resident #7's Physician Orders active and discontinued as of 5/06/2026 revealed Sertraline HCl Oral Tablet 50 MG (Sertraline HCl) Give 1 tablet by mouth one time a day related to DEPRESSION, OXcarbazepine Oral Tablet 300 MG (Oxcarbazepine) Give 1 tablet by mouth<br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | two times a day for seizure, Apixaban Oral Tablet 2.5 MG (Apixaban) Give 1 tablet by mouth two times a day for Atrial Fibrillation, and LORazepam Oral Tablet 0.5 MG Give 1 tablet by mouth every 4 hours as needed for Anxiety for 14 Days and was ordered and started on 04/13/2026.Record review of Resident #7's Care Plan initiated on 04/14/2026 revealed the focus read an actual elopement or elopement attempt. Resident was confused and wandered outside the facility unattended. The interventions read, assess/record/report to the doctor risk factors for potential elopement such as: Resident's elopement or attempted elopement, Wandering, Repeated requests to leave facility, statements such as I'm leaving I'm going home, attempts to leave facility, elopement attempts from previous facility, home, or hospital,. If the resident is exit seeking, stay with the resident and notify the charge nurse by calling out, sending another staff member, call system, etc. The care plan did not indicate any focus or interventions from the elopement risk Assessment on 10/31/2025 when Resident #7 scored 23, which indicated a high-risk elopement. On 04/29/2026 the focus read Resident #7 had recent transition to the secure unit and maybe at risk for increased confusion and social isolation. The interventions read, including Activity staff, will invite, encourage, and remind Resident #7 daily to attend structured group activities appropriate for residents with dementia (e.g., reminiscence, music therapy, sensory stimulation, simple games). Activity staff will provide escort and/or hand-over-hand assistance as needed to support safe attendance and ease transition within the secure unit. Activity staff will utilize consistent daily routine and familiar programming to promote comfort and reduce confusion. Activity staff will provide simple instructions, cueing, redirection, and reassurance during activities to enhance participation and reduce anxiety. Activity staff will provide alternate 1:1 sensory or calming interventions when Resident #7 declines group participation.During an interview on 05/06/2026 at 4:37pm with Dietary Staff she stated that when she arrived at approximately 5:30am on 04/14/2026 she saw Resident #7 in the center parking lot. She stated her headlights illuminated Resident #7, and when she asked where she was going, Resident #7 replied she was going to see her mom. The Dietary Staff stated she redirected Resident #7 and told her she would help her find a ride, and Resident #7 then allowed the Dietary Staff to push her back into the facility in the wheelchair, though she was initially resisting returning inside. The Dietary Staff stated Resident #7 did not state how long she had been outside, and she did not believe the resident had been out for long. She stated Resident #7 did not appear agitated. She stated when they re-entered the building, a nurse called Resident #7's name and she appeared to be relieved that someone recognized her. The Dietary Staff stated that she believed the door alarm was sounding when they came back inside and stated she did not see a wander guard on the resident's leg.During an interview on 05/06/2026 at 5:42pm with the ADON she stated she had been made aware of the incident during the morning meeting on 04/14/2026. She reported the resident had been placed on 1:1 supervision until she was transferred to the secured unit. She stated the resident was able to selfˆpropel her wheelchair well and often stated she wanted to go home. She stated Resident #7 would typically wake up around 5:00 a.m., saying she had to go, and staff would get her up. The ADON stated the facility did not use Wander Guards and she was unsure why. She explained that the elopementˆrisk scoring system stopped asking additional questions if the resident was able to selfˆpropel. She stated the scoring was based on the questions answered, and residents on the secured unit were prompted with additional items. She stated Resident #7 was confused and often said she needed to get ready for her children. She stated Resident #7 scored the resident a 4 for impairment, noting the resident sometimes required cues for tasks such as changing clothes. She stated elopementˆrisk assessments were completed quarterly or with a change in condition, and she believed the ADONs were responsible for updating them. She stated that an elopement risk score of 23 would be considered high risk because higher scores indicated greater risk. She stated there should have been interventions in place and that staff should have informed the DON when the first assessment was completed with a high score. She stated Resident #7 would frequently get up and said she needed to leave, and the risk occurred when Resident #7 exited the door.During an interview on 05/06/2026 at (continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 6:22pm with the DON she had been informed that the resident was found outside in the walkway under the patio after the door alarm sounded. She stated an elopement assessment had been completed, Resident #7 scored over 11, and the team decided to place Resident #7 on the secured unit. She stated the incident was classified as an elopement attempt, explaining that an attempt involved going out the door, while an elopement meant leaving facility property; Resident #7 had remained on property, so it was not reportable at that time. The DON stated that for the 10/31/25 assessment, Resident #7's elopement risk score of 23 should have triggered care plan interventions, as higher scores indicated greater risk. She explained that interventions should have addressed wandering, walking without purpose, and elopement behaviors, which involved exitˆseeking and leaving the building. She stated it would have been ADON's responsibility to update the care plan.The facility policy for ?Comprehensive Care Planning' undated read.Comprehensive Care PlanningThe facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.When developing the comprehensive care plan, facility staff will, at a minimum, use the Minimum Data Set (MDS) to assess the resident's clinical condition, cognitive and functional status, and use of services.If a Care Area Assessment (CAA) is triggered, the facility will further assess the resident to determine whether the resident is at risk of developing or currently has a weakness or need associated with that CAA, and how the risk, weakness or need affects the resident. The facility will address these areas and will document the assessment of these risks, weaknesses or needs in the medical record and determine whether to develop a care plan and interventions to address the area. If the decision to proceed with care planning is made, the interdisciplinary team (IDT), in conjunction with the resident and/or resident's representative, if applicable, will develop and implement the comprehensive care plan and describe how the facility will address the resident's goals, preferences, strengths, weaknesses, and needs. |