STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676467	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cypress Creek Rehabilitation and Healthcare Center	13600 Birdcall Lane Cypress, TX 77429

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure each resident was free from abuse for 1 of 13 residents (Resident #1) reviewed for abuse. CNA A was verbally abusive to Resident #1 on 04/23/2024 after he used a racial slur (derogatory terms or phrases used to insult, demean, or dehumanize individuals or groups based on their race or ethnicity). This failure placed residents at risk of experiencing anger, depression, and anxiety during staff encounters. Findings included: Record review of Resident #1's face sheet dated 05/08/2025 revealed he was a [AGE] year-old male who was admitted to the facility on [DATE]. He was diagnosed with psychotic disturbance (a state where an individual experiences a significant loss of contact with reality), mood disturbance (a serious mental illness that causes persistent and intense changes in a person's mood, energy, and behavior), anxiety (excessive worry about future events or fear of present or past events), congestive heart failure (a chronic condition in which the heart does not pump blood as well as it should), history of urinary tract infection (an infection that affects any part of urinary system), insomnia due to other mental disorder (a significant lack of sleep related to mental disorders), essential hypertension (a chronic condition of persistently high blood pressure with no identifiable cause), cerebral infarction (an ischemic stroke which occurs when blood flow to the brain is blocked), and history of transient ischemic attack (a brief stroke-like attack that despite resolving within minutes to hours, still requires immediate medical attention). Record review of Resident #1's annual MDS dated [DATE] revealed he had a BIMS score of 14 (cognitively intact); Resident #1 did not exhibit symptoms related to hallucinations, delusions, physical or verbal symptoms directed towards others, or rejection of care; Resident #1 was independently ambulatory; Resident #1 was independent with eating, toilet hygiene, dressing, personal hygiene and required supervision or touching assistance with shoers/baths; Resident #1 was occasionally incontinent of bladder and always continent of bowel; and Resident #1 was not prescribed antipsychotic, antianxiety, or antidepressant drugs. Record review of Resident #1's care plan revised 03/17/2025 revealed the following care areas: (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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* [Resident #1] has impaired cognitive function and impaired thought processes related to dementia, short/long-term memory issues, and impaired decision making. Goal included: The resident's needs will be met, and dignity will be maintained. Interventions included: Ask yes/no questions in order to determine the resident's needs. Cue, reorient, and supervise as needed. Engage the resident in simple, structured activities that avoid overly demanding tasks. Keep the resident's routine consistent and try to provide consistent care givers as much as possible on order to decrease confusion. Present just one thought, idea, question, or command at a time. * [Resident #1] has communication problems, at times does not understand English (Spanish speaking) and is slightly hard of hearing. Goal included: The resident will be able to make basic needs known on a daily basis. Interventions included: Allow adequate time to respond, repeat as necessary, do not rush, request clarification from the resident to ensure understanding, face when speaking, make eye contact, turn off TV/radio to reduce environmental noise. Ask yes/no questions if appropriate. Use simple, brief, consistent words/cues. * [Resident #1] is resistive to care related to: refuses showers at times, refuses medications at times. Goal included: [Resident #1] will be encouraged to cooperate with care. Interventions included: Allow [Resident #1] to make decisions about treatment regime to provide sense of control. Educate resident/family/caregivers of the possible outcomes of not complying with treatment or care. Give clear explanation of all care activities prior to and as they occur during each contact. If the resident resists with ADLs, reassure resident, leave, and return 5-10 minutes later and try again. Provide resident with opportunities for choice during care provision. * [Resident #1] has unwanted behaviors. Resident reported to have sexually and aggressive behaviors. Goal included: Behavior episodes will be reduced to less than daily. Interventions included: Give 1:1 assistance to try and calm the resident down, as needed. * [Resident #1] has a camera in room that may or may not have sound per family request. Goal included: Family and resident choice to have a camera in the room will be respected. Interventions included: Do not be intimidated by the camera. Continue to provide good care as you always do. Do not judge the family or resident for their action. Provide dignity and respect to all we care for. Voice all concerns to the appropriate staff member such as the DON or Administrator. Record review of Resident #1's nursing progress notes for April 2024 revealed: * (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/23/2024 at 7:15 a.m. the Former DON wrote, SBAR - Situation . Resident having some inappropriate behaviors and using vulgar slurs toward staff on this shift. This started on 04/23/2024 . RN thinks the problem may be resident appears to have some agitation with staff that could be related to his dementia or possible UTI . Upon re-entering the hallway, this nurse witnessed resident's family member and staff conversing loudly. This nurse and the housekeeping supervisor escorted family member into resident's room to deescalate the situation . * On 04/24/2024 at 6:26 p.m., LVN B wrote, Resident returned to the facility with family . Family noted taking resident to the hospital on [DATE], stating, 'His back was hurting him, and he was flushed, they said he had a UTI.' Writer received paperwork from the hospital visit. Cephalexin (an antibiotic) 500MG 1 capsule PO q6 hours x 9 days for UTI . Record review of the facility's, Provider Investigation Report dated 04/26/2024 revealed the investigation was signed and dated by the Former Administrator on 04/26/2024. The document read in part, . Date Reported to HHSC: 04/23/2024 . Incident Date: 04/23/2024. Time: approximately 7:30 a.m. Witnesses: Reviewed camera footage. Family member showed [Former] DON footage. Description of the Allegation: Verbal aggression toward resident. Injury/Adverse effect: No. Description of Assessment: Head to toe assessment completed, no injuries noted, no emotional distress noted . Investigation Summary: Family member notified facility [Former] DON that [CNA A] was verbally aggressive with resident. Facility ensured CNA and resident remained separated. Police notified of incident by family member, found no offense that they could act upon and stated that it needed to be handled internally between facility/family. When facility management approached CNA for interview/statement, she refused and left the facility, self-terminating. CNAs reported to nurse that resident was being verbally aggressive on multiple occasions that day and that he was calling them racial slurs. Family member allowed [Former] DON to review camera footage, and [Former] DON determined that [CNA A] was confrontational and verbally aggressive. Family member and [Former] DON agreed that no physical harm occurred, and the resident was not showing signs of emotional distress, but the CNA response was inappropriate. Upon investigation and a review of Provider Letter 19-17, this incident does not rise to the criterion of abuse as there was no resulting physical or emotional harm or pain to this resident. Facility has elected that this allegation is unfounded. Facility determined CNA response was inappropriate and she is no longer in the facility as she self-terminated prior to facility full executing the investigation. Provider Action Taken Post-Investigation: In-serviced staff on resident's rights. In-serviced staff on abuse and neglect prohibition and reporting. Life Satisfaction surveys completed with residents on same hall as [Resident #1], no issues or concerns reported. Further review of the document revealed all staff were in-serviced on, Customer service/Dementia Residents/Behaviors - 04/23/2024, and Resident's Rights - 04/23/2024, Abuse/Neglect/Exploitation - 04/23/2024 and residents on the 200 hall were interviewed regarding abuse. Record review of, [Resident #1] Incident Statement, completed by the Former DON on 04/23/2024 revealed: * 8:15 a.m., arrived to facility, officers and family in front of the facility. Officers stated after review of video, no chargeable offense and left family member with information on reporting incident internally. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* Family member showed [Former] DON the video recorded approximately 6:45 a.m., aid in room standing by head of bed, shaking finger at resident, when aid exited room, she is heard stating 'Stay in the dark.' And she proceeds to turn out the lights in the resident's room. Aid returns to room and is heard telling resident, 'Better get up and go to the dining room cause I ain't bringing you breakfast (this was not observed or heard on the video provided).' Aid also heard telling resident she was going to take away his refrigerator . * CNA immediately removed from assignment and assisted to HR office to get written and verbal statement, aid refused to write a statement or give details of events. When explained she would be placed on suspension pending investigation, aid stated she was done and escorted out of facility . * Resident returned from pass with family member, no acute distress or signs of anxiety, emotional distress noted. Will continue observation/monitoring x 72 hours for any changes in condition . Record review of CNA A's personnel record revealed she was hired by the facility on 12/27/2023 and terminated on 04/23/2024. A criminal background check and Nurse Aide Registry search were completed on 12/21/2023. CNA A signed an Abuse/Neglect Policy and Procedure Competency Tool on 12/27/2023. CNA A was most recently in-serviced on Abuse, Neglect, and Exploitation and Safeguarding Resident Rights in Nursing Facilities on 03/04/2024. Observation and interview with Resident #1 on 05/08/2025 at 10:40 a.m. revealed he was alert, oriented, and laying in his bed. There was a camera on the wall facing Resident #1's bed. Resident #1 stated he lived in the facility about two years and the staff treated him well. He said one lady who worked at the facility was mean to him before when she tried to fight with him. He said the lady was a little crazy when he called her a nigger. He said nothing happened before the incident and the lady talked too strong to him. He said it did not feel good when she talked to him that way, but it did not make him sad or angry. He said he did not feel good about the incident, but he could not recall what the lady said, and he did not think what she said was abusive. He said before the incident, the lady had worked with him a lot and she was ok with him before that. He said the lady did not work at the facility anymore. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of a video taken inside of Resident #1's room dated 04/23/2024 and time stamped 6:56:38 a.m. revealed the camera faced Resident #1's bed. At the start of the video, CNA A and CNA C were standing a distance away from Resident #1 (he was sitting on the bed) while he waved his right hand in the air and repeated, Get out of here! Both staff walked closer towards Resident #1 and CNA A pointed her finger within approximately one foot of Resident #1's face and said, What you think you is? Resident #1 continued to repeat, Get out of here! CNA C stood towards the foot of Resident #1's bed. CNA A stood within approximately three feet on the side of Resident #1's bed and said, You know you almost my color? CNA C said to CNA A, Let's go. Resident #1 continued to say, Get out of here! CNA A (speaking to CNA C, who had already walked closer towards the door) said, We ought to take that ice box (refrigerator) right back out there on that hall. CNA A pointed towards an area below the camera's view (presumably where Resident #1's refrigerator was). CNA A walked closer towards Resident #1, within approximately two feet and said, Your mama a nigger! CNA A repeated the statement and Resident #1 called her a monkey. As both staff walked towards the door, CNA A said, You heard him say monkey, right? CNA A turned the lights off in Resident #1's room and said, Stay in the dark! Before CNA A closed the door all the way, Resident #1 said expletive words (curse words). In a telephone interview with Resident #1's family member on 05/08/2025 at 9:40 a.m., she stated on 04/23/2024, as she was on her way to work, she was alerted by a notification from the motion-operated camera in Resident #1's room that there was a commotion going on. She said the facility's staff woke Resident #1 up early that morning and he was already in a bad mood. She said Resident #1 asked the staff to leave him alone and leave the room several times, but they bullied and made fun of him. She said Resident #1 got angry and called the staff the n word. She said one of the staff (CNA A) got in Resident #1's face like she was about to hit him. She said she went to the facility and was not going to leave until the staff (CNA A) was fired. She said she told the staff (CNA A) that was the first and last time she would treat Resident #1 like that. She said she called the police but since the staff never hit Resident #1, the police said they could only make a report. She said she told Resident #1 he said something ugly to the staff, but they (facility staff) should be trained and used to being called names. In an interview with the Administrator and the DON on 05/08/2025 at 1:15 p.m., after reviewing the video, the DON stated CNA A's behavior was very inappropriate. The Administrator stated CNA A was manipulative and verbally abusive because of how she spoke to Resident #1 and walked up to him, pointing in his face. The DON stated she wondered what Resident #1 said and what happened in the few seconds before the start of the video. The Administrator stated CNA A and CNA C no longer worked at the facility, but she provided CNA C's name and phone number. The DON stated verbal abuse could result in the resident withdrawing socially and agitation during staff interactions. An attempt was made to contact CNA A by phone on 05/08/2025 at 1:36 p.m. A voicemail message was left, but the call was never returned. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone interview with CNA C on 05/08/2025 at 1:38 p.m., she stated she stopped working at the facility in December 2024. She stated around 04/23/2024, Resident #1 was temporarily moved to the hall she normally worked because he had some issues with his roommate on his regular hall. She said on 04/23/2024, before breakfast, she and CNA A went into Resident #1's room to wake him and let him know breakfast was coming. She said Resident #1 was instantly aggravated and said, Get out, I don't want any niggers in here. She said they tried to calm Resident #1 down. She said she did not pay attention to what CNA A and Resident #1 were saying to each other because she was making sure Resident #1 did not get up and hit them. She said things happened so fast and Resident #1 had a history of hitting staff. She said she recalled Resident #1 saying get out, no niggers, and she turned around and said that was fine to [Resident #1]. She said nobody cursed Resident #1 out. She said she told the Former DON that she did not recall CNA A saying anything to Resident #1 that was threatening or disrespectful. She said the Former DON told her CNA A did say some threatening and disrespectful things. She said either before or after breakfast that day, Resident #1's family member arrived at the facility with a lot of other family members. She said Resident #1's family members said things happened that actually did not happen, and the family member said they should be used to being called niggers. She said after that incident, she did not work with Resident #1, but he was fine. An attempt was made to contact the Former DON by phone on 05/08/2025 at 2:00 p.m. A voicemail message was left, but the call was never returned. In a telephone interview with Resident #1's NP on 05/08/2025 at 2:28 p.m., he stated he recalled being contacted in 2024 about a confrontation Resident #1 had with staff. He said he could not recall the exact date, but Resident #1 was agitated, so he ordered labs and found Resident #1 had a UTI. He said he visited Resident #1 the next week and he did not verbalize any concerns. He said Resident #1 was forgetful and did not have any negative outcomes. He said no harm was done because of the incident. In a telephone interview with the Former Administrator on 05/09/2025 at 11:11 a.m., she stated her husband was in the hospital when the incident happened between Resident #1 and CNA occurred in 2024, so the Former DON handled the investigation. She stated she never saw the video of the incident, but Resident #1's family said the aide was too aggressive when he called her the n word. She said the family member told the staff they were an n word, and they should be used to that. She said all the information she received was second-hand because she was not there at that time. She said there were two staff in Resident #1's room, but she recalled one of them, CNA A, walked out and quit the day of the incident. In an interview with the Housekeeping Supervisor on 05/09/2025 at 12:27 p.m., he stated he did not see the incident between Resident #1 and the facility staff on 04/23/2024. He said he was outside that day and heard Resident #1's family member going crazy, yelling, and screaming. He said he tried to calm the family member down. He said the family member showed him the video of the staff inside Resident #1's room, but he could not recall what was said in the video. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Administrator and RN D on 05/09/2025 at 2:15 p.m., after reviewing the video of the incident between Resident #1 and CNA A, RN D stated what CNA A did was abusive. RN D said all the facility's staff had been trained to handle aggressive residents. The Administrator stated if the incident occurred while she was the administrator, she would have removed/suspended the staff pending the investigation, assessed the resident, conducted life satisfaction rounds with all residents on the hall, completed a thorough investigation, asked all witnesses to write statements, in-serviced all staff, and initiated disciplinary action against all staff involved. Record review of the facility's policy, titled, Resident Rights revised 01/2025 revealed, . 1. Exercise of rights . a. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights . 4. Respect and dignity. The resident has the right to be treated with respect and dignity . 5. Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to: a. The resident has the right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part . 8. Safe environment. The resident has the right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely . Record review of the facility's policy, titled, Abuse, Neglect, and Exploitation revised on 01/08/2023 revealed, Policy: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Definitions: . 'Abuse' means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish, which can include staff to resident abuse and certain resident to resident altercations .Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. 'Willful' means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. 'Verbal Abuse' means the use of oral, written, or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability . 'Mental Abuse' includes, but is not limited to humiliation, harassment, threats of punishment or deprivation. Mental abuse also includes abuse that is facilitated or caused by nursing home staff taking or using photographs or recording in any manner that would demean or humiliate a resident . (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy, titled, Conduct and Behavior revised 02/2023 revealed, Policy: All employees must adhere to accepted professional standards. This includes displaying business conduct and behavior and exhibiting a high degree of integrity at all times. 1. Conduct that interferes with the safe operation of the facility, brings discredit to the company, residents, or staff, or that is offensive to a resident, family member, visitor, or employee, will not be tolerated and can be grounds for disciplinary action. 2. Examples of conduct and behavior that are considered inappropriate and are prohibited by this company include, but are not limited to, the following: a. Violation of the Resident Abuse or Neglect and/or Residents' Rights policies . d. Failure to treat all residents, visitors, and fellow employees with kindness, respect, and dignity; . h. Using profanity, abusive, or suggestive language or gestures or any other unprofessional behavior; . n. Fighting, threats, intimidation, or argumentative behavior .