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	01/30/2026

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the resident has the right to secure and confidential personal and medical records for 1 of 5 residents (Resident #17) reviewed for privacy.The facility failed to protect resident information from unauthorized access when resident medical records were left open, unsecured and visible to others.This failure could result in exposure to sensitive information that could cause embarrassment or emotional distress to a resident.Findings included:Record review of Resident #17's undated face sheet revealed she was a [AGE] year-old female with an initial admission date of 10/06/2022 and most recent admission on [DATE]. Resident #17 has diagnoses of cerebral palsy, major depressive disorder, mood disorder due to known physiological condition, and intellectual disabilities.Record review of Resident #17's Quarterly MDS assessment dated [DATE] revealed a BIMS of 15. Resident #17's BIMS demonstrated normal memory and recall abilities for an intact cognitive status.Record review of Resident #17's Care Plan dated 09/23/2025 revealed residents have a risk for cognitive impairment due to diagnosis of mild intellectual disorders. The interventions in place are to monitor, document, report any changes in cognitive function, specifically changes in decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding other, level of consciousness, and mental status.In an observation on 01/30/2026 at 7:18am on 100 hall, Resident #17's electronic medical record was left open and unattended on the medication cart. Resident #17's electronic medical record displayed room location, date of birth , allergies, code status, and medications.In an interview on 01/30/2026 at 7:20am on 100 hall, RT P came out Resident #17's room with an inhaler in hand. RT P stated she left the medical records unattended because she was trying to quickly administer medication to Resident #17 and did not realize the records were left open. RT P stated the risk of leaving medical records open is that anyone could look at the documents.In an interview on 01/30/2026 at 8:14am with DON stated medical records should not be open while walking away from the cart and they should be locked. The risk of medical records being left open is wandering eyes can view the residents' information and it was a HIPAA violation.In an interview on 01/30/2026 at 9:51am, the ADMN stated the confidentiality of resident's medical records have built in time out and the staff can minimize the screen to lock, before walking away. The ADMN stated the In -services on resident confidentiality of medical records are done quarterly or yearly. The risk of a resident's information being exposed can be shared with another party or potentially observed by an unattended party.Record Review of Resident Rights policy revised 01/2025 reflects.Privacy and confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.The resident has a right to secure and confidential personal and medical records.The resident has the right to refuse the release of (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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	personal and medical records except as provided at S483.70(i)(2) or other applicable federal or state laws.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment for 1 of 5 residents (Resident #37).The facility failed to revise the residents' care plan after a documented change in condition for redness to right eye which had worsened.This failure could result in avoidable complications, decline, or injury.Findings included:Record review of Resident #37's undated face sheet revealed a [AGE] year-old male with an initial admission of 04/07/2023 and most recent admission on [DATE]. Resident #37 has diagnoses of dry eye syndrome, cerebral infraction, dementia, congestive heart failure, dizziness and giddiness, and chronic chough.Record review of Resident #37's MDS assessment dated [DATE] revealed a BIMS of 13. Resident #17's vision revealed the resident see fine detail, such as regular print in newspapers/books.Record review of Resident #37's undated Medication Administration Record revealed Azithromycin Ophthalmic Solution 1%, Instill 1 drop in right eye two times a day for Eye irritation for 5 days with an order date of 01/27/2026.Record review of Resident #37's Care Plan did not indicate a change in conditions regarding the residents' eye.Record review of Resident #37's Change in Condition progress note dated 01/27/2026 by MD S. The change in condition stated Resident #37 had redness to the right eye with a small amount of drainage. An updated order was put into place for Azithromycin 1% eye drops in one drop right eye, twice a day for 5 days.In an interview on 01/29/2026 at 12:13pm the DON stated when a resident has a change in condition and she was present, she will access the resident and update the care plan, with the change. The DON stated care plans are updated by meeting with IDT and updated by the DON, ADON, MDS Nurse, and/or Unit Manager when a new risk has been identified and new interventions are updated daily. For Resident #37, the care plan was not updated timely, and she does take accountable. The risk of care plans not being revised based on a change in condition could be staff not using appropriate modalities.In an interview on 01/29/2026 at 1:09pm the ADMN stated they have a meeting every morning with IDT and discuss when it's deemed appropriate the care plan was updated. Care plans are to be revised as soon as possible. For a new change in condition, SBARS are completed, and the staff will communicate shift to shift when something is new with a resident. Once the care plan was updated, it is filtered in Kardex for all staff to review changes before providing care. For Resident #37, the order was received on 01/27/2026 and the expectation was the care plan to be updated after the SBAR was completed and not days on out. The risk of a care plan not being revised was lack of communication with staff and the residents, which could result in the residents having issues with an adverse effect.In an interview on 01/29/2026 at 3:25pm with LVN V, MDS Specialist stated she will assist with day-to-day MDS, Care Plans, and documentation. LVN V stated revisions to care plans are updated immediately as the change has been confirmed or within 24 hours. The risk of care plans not being revised was the residents not receiving proper care relating to their condition and change.In an interview on 01/29/2026 at 3:32pm with ADON stated changes in conditions are discussed during morning meetings. The IDT meetings assist with updating and educating staff on new changes or diagnosis for each resident of concern. The risk of the care plans not being revised is something missing, which could cause a decline in the residents.Record Review of Care Plan Revisions policy revised 01/2025 reflects.The purpose of this procedure is to provide a consistent process for reviewing and revising the care planfor those residents experiencing a status change.1. The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiencesa status change.2. Procedure for reviewing and revising the care plan when a resident experiences a status change:a. Upon identification of a change in status, (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the nurse will notify the MDS Coordinator, thephysician, and the resident representative, if applicable.b. The MDS Coordinator and the Interdisciplinary Team will discuss the resident condition andcollaborate on intervention options.c. The team meeting discussion will be documented in the nursing progress notes.d. The care plan will be updated with the new or modified interventions.f. Care plans will be modified as needed by the MDS Coordinator or other designated staffmember.g. The Unit Manager or other designated staff member will communicate care plan interventionsto all staff involved in the resident's care.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interviews, and record review the facility failed to ensure all drugs and biologicals were stored securely for 2 of 8 (Respiratory Therapist Cart on 100 hall and Nurse Cart on 300 hall) medication carts reviewed for storage of medications.The facility failed to ensure RT P on the 100 hall and LVN T on the 300 hall lock medication carts before walking away and providing care to residents.This failure could place all residents at risk oof unauthorized access to prescription and over-the-counter medications, including controlled substances.Findings included:An observation of RT cart on the 100 hall on 01/30/2026 at 7:18am was revealed to be unlocked.In an interview on 01/30/2026 at 7:20am RT P stated she was assisting a resident with their medications and forgot to lock the cart. The risk of the medication cart being unlocked was that anyone could come and take the medications.An observation of Nurse cart on the 300 hall on 01/30/2026 at 7:24am was revealed to be unlocked.In an interview on 01/30/2026 at 7:25am LVN T stated she heard a resident yelling for help and went to assist which is why the cart was not locked. The risk of the medication cart being left unlocked was that a resident could possibly get into the cart and take the medication.In an interview on 01/30/2026 at 8:14am the DON stated the expectation for the medication cart was to be locked before walking away. The risk for medication carts being unlocked was medication being taken out and used for alternative purposes.In an interview on 01/30/2026 at 9:51am the ADMN stated for safety and security they do purposeful rounding throughout the day to double check medication carts locked when staff walk away. Her role was to make sure all systems are completed within local, state, compliance and if it is a deficient practice discovered, they will need to form a plan to become compliant. The risk of medication carts being unlocked is medication error and potential harm to residents.Record Review of Medication Storage policy revised 05/2023 reflects.It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security.1. General Guidelines:a. All drugs and biologicals will be stored in locked compartments (i.e., medication carts,cabinets, drawers, refrigerators, medication rooms) under proper temperature controls.b. Only authorized personnel will have access to the keys to locked compartments.c. During a medication pass, medications must be under the direct observation of the personadministering medications or locked in the medication storage area/cart.