

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676467	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/30/2026
NAME OF PROVIDER OR SUPPLIER  Cypress Creek Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of 1 of 5 residents (CR #1) reviewed for pharmacy services. The facility failed to check CR #1's Vancomycin trough level according to MD orders after every 4th dose every 7 day for 2 weeks. The facility failed to ensure CR #1 did not receive IV Vancomycin after the 4th dose on 12/05/2026 at 7:00 am, without a trough level being obtained on 12/05/2026 at 7 p.m., 12/06/2025 at 7:00 am and 7:00pm, and 12/07/2026 at 7:00 am and 7:00 pm. This failure could cause Vancomycin toxicity, acute kidney injury, and hospitalization. Findings included: Record review of CR #1's admission record dated 4/30/26 revealed an [AGE] year-old female who admitted on [DATE]. She was discharged to an acute care hospital on 4/8/26. Her diagnosis included dementia, urinary tract infection, chronic kidney disease, acute kidney failure, and hypertension (high blood pressure). Record review of CR #1's discharge - return anticipated MDS assessment dated [DATE] revealed her cognitive skills for daily decision making was moderately impaired. She was dependent on staff for ADL care and required supervision or touching assistance for eating. Record review of CR #1's Order Summary Report revealed orders for: Vancomycin Intravenous solution use 1 gram every 12 hours for UTI for 14 days, order date 12/3/25. Vanco trough at 6 a.m. after 4th dose every 7 days for Vancomycin monitoring for 2 weeks, order date 12/3/25. Record review of CR #1's Medication Administration Record for December 2025 revealed the 1st dose of Vancomycin 1 gm was administered on 12/3/25 at 7:00 p.m., the 2nd dose on 12/4/25 at 7:00 a.m., 3rd dose on 12/4/25 at 7:00 p.m., and the 4th dose on 12/5/26 at 7:00 a.m. Vancomycin continued to be administered on 12/5/26 at 7:00 p.m., 12/6/25 at 7:00 a.m., 12/6/25 at 7:00 p.m., 12/7/25 at 7:00 a.m., and 12/7/25 at 7:00 p.m. The MAR did not indicate that a Vancomycin trough was collected after the 4th dose. Record review of CR #1's nursing note dated 12/3/25 at 6:55 p.m. by LVN T read in part, .Initial dose of ABT given as ordered. Resident tolerated well. No s/s of inflammation at IV site. No acute distress noted at this time. Plan of care continue. Record review of CR #1's nursing note dated 12/4/25 at 12:08 p.m. by LVN W read in part, .Resident continues on IV Vancomycin through Left Upper Arm Midline for UTI with NARN. Dressing intact. Midline flushing well. Record review of CR #1's nursing note dated 12/4/25 at 11:41 p.m. by LVN A read in part, .Vancomycin IV Q 12 HRS DX: UTI in progress with no adverse effects noted. Record review of CR #1's nursing note dated 12/5/25 at 4:58 p.m. by RN K read in part, .Continues on IV Vancomycin ABT for UTI, medicated per orders. Record review of CR #1's nursing note dated 12/6/25 at 7:23 p.m. (created date: 12/7/25 at 8:59 p.m.) by LVN T read in part, . LATE ENTRY. Resident continue Vancomycin in left arm for UTI. No infiltration noted. Resident tolerated the medication well. No signs of pain or discomfort noted. Temp 97.5, order for Vanco trough being clarified. Record review of CR #1's nursing note dated 12/7/25 at 3:31 a.m. by LVN O read in part, .Resident received a dose of Vancomycin on this shift for UTI. No infiltration noted. Resident tolerated the medication well. Record review of CR #1's nursing note dated 12/7/25 at 10:32 a.m. by RN S read in part, .Reviewed labs for last Vanc level. None obtained. Has received &gt; 4 doses of (continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>antibiotic. Called lab for stat trough before next dose. At 9:15 (a.m.) Doctor notified. stated to give dose now and monitor level when received. Lab contacted again will come this afternoon around 4 to draw trough. Subsequent orders entered. Record review of CR #1's nursing note dated 12/7/25 at 5:01 p.m. by LVN B read in part, .Resident continued on IV Vancomycin for UTI, no adverse reactions noted. Resident alert and responsive. Spoke with on-call this am concerning trough level. Lab notified to do trough level stat today. Lab called stated lab was done around 1537 today. Lab stated results should be ready in an hour or so. Record review of CR #1's nursing note dated 12/7/25 at 11:20 p.m. by LVN S read in part, .Vancomycin trough critical reported to on call physician . Critical Vancomycin trough 33.7. Ordered to hold next two doses of Vancomycin. Record review of CR #1's laboratory results dated [DATE] revealed Vancomycin trough was collected on 12/7/25 at 3:37 p.m. The result was a critical high level of 33.7 ug/mL with a reference range of 10.0 - 20.0. The results were called into the facility on [DATE] at 11:13 p.m. In an interview on 4/30/26 at 1:59 p.m. CR #1's MD said the Vancomycin trough was normally drawn before every 4th dose, approximately 30 minutes to 1 hour before the medication was due. She said she would advise staff to obtain the initial trough prior to administering the next dose because the trough was needed to provide guidance. She said without knowing the initial trough the nursing staff could not continue to give the medication. She did not recall having a conversation with nursing staff about clarifying the trough order. She said the critical trough level of 33.7 needed to be addressed and Vancomycin could have an effect on the kidneys, but said it was only at that level for a short time. She said the Vancomycin was filtered through the kidneys and the level decreased and there was no long-term effect. She said CR #1 had mild chronic kidney dysfunction and her kidney concerns were more related to her diabetes and age. In an observation and interview on 4/30/26 at 2:39 p.m. LVN T said Vancomycin trough levels were usually done according to the MD order. She said CR #1's MD order for the Vancomycin trough was not clear and she reported it to RN S and probably reached out to the NP. She said she was unsure what was wrong with the order. She said a trough level was pending but could not remember. She said she questioned where the trough was and was unsure if she hung the IV. LVN T pulled up CR #1's Medication Administration Record for December 2025 which showed a check mark for administration of the Vancomycin with LVN T's initials on 12/6/25 for the 7:00 a.m. dose. In an interview on 4/30/26 at 3:48 p.m., previous employee RN S said she vaguely remembered the incident and was unsure how she found out the trough was not collected. In an interview on 4/30/26 at 3:55 p.m., previous employee LVN O said staff were supposed to know the Vancomycin trough level before administering another dose. She said the level should be known prior to because it had to be in a certain therapeutic range. She said there was not a time when she gave Vancomycin without knowing the trough. In an interview on 4/30/26 at 4:22 p.m., previous employee LVN O said she did not recall administering Vancomycin. This Surveyor asked what the check mark on the medication administration record meant. LVN O said anyone could have set her up by putting her initials on the MAR. In an interview on 4/30/26 at 4:31 p.m. the DON said nursing staff should know that a Vancomycin trough was needed after the 3rd day. She said a nurse (unknown) put CR #1's Vancomycin trough order to start on 12/7/25 (instead of starting it after the 4th dose). She said Vancomycin troughs were collected on 12/7/25, 12/9/25, 12/11/25 and 12/13/25 and did not see any troughs collected for CR #1 prior to 12/7/25. She said some Vancomycin doses were given to CR #1 before the trough was known. She said if the trough was not taken according to MD order, staff should communicate with the MD because if not, there was a risk for toxicity. She said there were no concerns brought up to her at the time regarding missing the trough and said she did not remember doing any in-services about it. She stated she expected nursing staff to follow the MD order. Record review of the facility's Medication Administration policy revised 1/2026 read in part, .Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Record review of the facility's Intravenous Therapy revised 1/2026 read in part, .The facility (continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>will adhere to accepted standards of practice regarding infusion practices. Procedures: .Review and verify practitioner's orders for infusion solution or medication, dose, frequency and route of administration.</p>