

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

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 07/02/2026
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)		
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to refer a resident with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II residents reviewed for 1 of 8 residents (Resident #10) reviewed for resident assessment. The facility failed to ensure Resident #10's PASRR Level I screening reflected his mental illness diagnosis. This failure could place residents at risk of not receiving specialized services for their mental illness. Findings included: Record review of Resident #10's admission Record dated 7/2/26 revealed a [AGE] year-old male who admitted to the facility on [DATE]. His diagnoses included major depressive disorder, recurrent severe without psychotic features (11/5/25), major depressive disorder, single episode mild (6/16/25), post-traumatic stress disorder (3/15/25), and anxiety. Record review of Resident #10's quarterly MDS assessment, dated 4/18/26 revealed a BIMS score of 14 out of 15 which indicated intact cognition. Record review of Resident #10's care plan dated 1/23/26 indicated he used antidepressant medication related to depression. He also had ineffective coping related to history of trauma, depression, and PTSD related to witnessing the death of his family member. Record review of Resident #10's PASRR Level I screening dated 3/14/25 indicated there was no evidence or an indicator that the resident had a mental illness. Resident #10 did not have a primary diagnosis of dementia. In an interview on 6/30/26 at 12:12 p.m. Resident #10 said he was on physical therapy but did not want to speak with any other therapists. In an interview on 7/2/26 at 11:09 a.m. the MDS Specialist said she was standing in for the facility's MDS nurse while she was on leave. She said Resident #10 had a PL 1 submitted on 3/14/25 which indicated negative eligibility. She said Resident #10 did have diagnoses of major depressive disorder and PTSD which would trigger a positive PL 1 for mental illness. She said a form 1012 (the Mental Illness/Dementia Resident Review, which assists nursing facilities (NFs) in evaluating whether a resident with a negative PASRR Level I (PL1) Screening requires additional assessment for mental illness (MI) or has a primary dementia diagnosis) should have been completed, but was not, so she completed one yesterday (7/1/26). She said she just completed a form 1012 and needed to resubmit a PL 1. She said if a PL 1 originally reflected negative but was supportive of a positive MI diagnosis, facility staff should reach out to the entity (unknown) to update to reflect positive. She said Resident #10 did not have a diagnosis of dementia. She said Resident #10's negative PL 1 should have been caught/addressed when the PTSD diagnosis was added on 3/15/25 and when the major depressive disorder diagnosis was added on 6/16/25. She said Admissions staff input the results of the PL 1 and the MDS nurse screened to ensure no diagnoses triggered a positive PL 1. She said the nursing IDT and Social Worker were responsible to ensure new diagnoses were reviewed. She said the purpose of the PASRR screening was to see if the resident qualified for PASRR, behavioral, and psychosocial services. She said Resident #10 had not (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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had any PASRR evaluations. She said there was no risk to Resident #10 because he currently saw psych services in the facility. She said the MDS nurse was ultimately responsible to ensure the accuracy of PASRR screenings. In an interview on 7/2/26 at 2:36 p.m. the Administrator said she was informed that a diagnosis for Resident #10 was put in last year and was unaware that they needed to submit another PASRR screening. She said if a diagnosis is added, the Social Worker and MDS nurse needed to ensure it was caught. She said the Social Worker was not in the building. She said there was no risk to Resident #10 because the facility was providing the same psych services. Record review of the facility's Resident Assessment - Coordination with PASARR Program policy revised 10/2023 read in part, . This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. Policy Explanation and Compliance Guidelines: 1. All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening. a. PASARR Level I - initial pre-screening that is completed prior to admission i. Negative Level I Screen - permits admission to proceed and ends the PASARR process unless a possible serious mental disorder or intellectual disability arises later. ii. Positive Level I Screen - necessitates a PASARR Level II evaluation prior to admission. 6. The Social Services Director shall be responsible for keeping track of each resident's PASARR screening status, and referring to the appropriate authority. Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review. Examples include: a. A resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a mental disorder (where dementia is not the primary diagnosis). b. A resident whose intellectual disability or related condition was not previously identified and evaluated through PASARR.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 1 laundry areas (Laundry Room) reviewed for infection control. The facility failed to ensure the Housekeeping Manager handled clean linen in a sanitary manner on 7/2/26. The failure could lead to cross contamination or infection. Findings included: In an observation and interview on 7/2/26 at 11:59 a.m. the Surveyor and Housekeeping Supervisor entered the clean linen side of the laundry room. Upon entering the clean side, the Housekeeping Supervisor did not wash his hands. He opened the lid of the broken trashcan so this Surveyor could throw away a paper towel. While the Housekeeping Supervisor showed the dryer lint trap to the Surveyor, the door to the dryer opened slightly and a clean towel fell on the ground. The Housekeeping Supervisor picked the towel up from the floor with his bare hands and tossed it back into the dryer that was filled with clean linens. The Housekeeping Supervisor said he did not wash his hands upon entering the laundry room and said he touched the trash can. He said he should handle clean linen with gloves. He said he picked the towel up and placed it back in the dryer but should not have due to cross contamination. He said the incident probably occurred because he was focused on showing the lint trap to the Surveyor. He said he conducted infection control training for his employees. In an interview on 7/2/26 at 12:21 p.m. the Corporate QA RN said when handling clean linen staff should wash their hands due to not wanting to get anything dirty. She said if clean linen hit the floor it would need to be rewashed, because it was now dirty. She said it was not good practice to throw the towel back into the dryer with clean linen. She said laundry staff were trained on infection by nursing and the online computer training. In an interview on 7/2/26 at 2:39 p.m. the Administrator said she expected dirty items to never come to the clean side without being laundered first. She said staff should follow company policies for linen and infection control and hand hygiene should be followed per CDC recommendation. Record review of the facility's Laundry policy revised on 1/2026 revealed in part, .The facility launders linens and clothing in accordance with current CDC guidelines to prevent transmission of pathogens. 2. The facility's laundry area will provide hand washing facilities and products as well as PPE. Record review of the Hand Hygiene in-service dated 6/11/26 presented by the Infection Preventionist revealed in part, .Proper hand hygiene is the most effective way to prevent the spread of infection and protect our resident, coworkers, and ourselves. Wash your hands with soap and warm running water for at least 20 seconds, making sure to clean all surfaces of your hands, including between fingers, thumbs, and wrists. Dry hands thoroughly with a clean paper towel and use the towel to turn off the faucet. Hand hygiene must be performed before and after resident contact, before clean procedures, after removing gloves, and after contact with body fluids or contaminated surfaces. Remember: Gloves do not replace handwashing. The Housekeeping Supervisor name was on the in-service. Record review of the facility's Infection Prevention and Control Program revised 3/2026 revealed in part, .This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. 4. Standard precautions.c. hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures. 12. Linens: a. Laundry and direct care staff shall handle, store, process, and transport linens to prevent spread of infection. B. clean linen shall be separated from soiled linen at all times.		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain an effective pest control program so that the facility was free of pests for 3 of 16 resident rooms (rm 401, RM [ROOM NUMBER], and RM [ROOM NUMBER]) reviewed for pest control.1.The facility failed to ensure occupied resident room [ROOM NUMBER] was free of small black ants. 2.The facility failed to ensure occupied resident room [ROOM NUMBER] was free of flies.3.The facility failed to ensure occupied resident room [ROOM NUMBER] was free of small black ants and winged insects. This failure could place residents at risk of having pests in their rooms and a decreased quality of life.Findings included: Observation and interview on 6/30/26 at 10:50 a.m. of occupied resident room [ROOM NUMBER] revealed there were 11 ant-like insects with wings crawling on the bathroom wall and ceiling near the bathroom light. CNA H observed the insects and said they looked like termites. She said she never saw them before. Two small black ants were also observed crawling in the bathroom sink. In an interview on 6/30/26 at 10:55 a.m. the Plant Operations Director said the facility did not have termites to his knowledge and would call pest control to come to the facility. In an interview on 6/30/26 at 11:00 a.m. Resident #1 and Resident #3 who resided in room [ROOM NUMBER] said they used the restroom today and had not seen any bugs.In an observation on 6/30/26 at 10:59 a.m. of occupied room [ROOM NUMBER] with the Maintenance Director revealed there were 5 small black ants crawling in the bathroom sink. In an observation on 6/30/26 at 1:25 p.m. in room [ROOM NUMBER] revealed there were flies flying around Resident #2, with one fly landing on the resident. Resident #2 waved the fly off and asked the Surveyor if she brought them in. In an interview on 7/2/26 at 2:30 p.m. the Administrator said she expected the facility to provide a homelike environment that was free of pests. She said the facility had a good effective system in place and pest control made routine visits. She said there might be a sighting of insects here or there, and the Maintenance Director was good about getting pest control to the facility during an off cycle. She said the facility did their best to conceal pest and did not believe there was an infestation.Record review of the facility's service request log dated April 2026 - June 2026 revealed the following pertinent pest sightings:4/4/26 - black ants4/13/26 - ants restroom sink (310)4/25/26 - sugar ants bedside drawer (room [ROOM NUMBER])4/30/26 - bugs (like ants with wings) room [ROOM NUMBER] by overhead light5/1/26 - ants beside drawer (room [ROOM NUMBER])5/5/26 - bugs5/15/(26) - bugs in bathroom sink5/20/26 - sugar ants in drawer (400 hall)6/25/(26) - black ants in the mini fridge6/30/26 - sugar ants, ants with wings in room [ROOM NUMBER] bathroom6/30/26 - sugar ants in room [ROOM NUMBER] restroom sinkRecord review of the facility's Pest Control Program revised 1/2026 read in part, . It is the policy of this facility to maintain an effective pest control program that eradicates and contains common household pests and rodents. Effective pest control program is defined as measures to eradicate and contain common household pests (e.g., bed bugs, lice, roaches, ants, mosquitos, flies, mice and rats).		