

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676477	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2026
NAME OF PROVIDER OR SUPPLIER Cypress Springs Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 501 Yates Street Mount Vernon, TX 75457	
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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that respiratory care was provided consistent with professional standards of practice for 1 of 3 residents (Resident #1) reviewed for respiratory care. The facility failed to ensure Resident #1's nebulizer (a device used to deliver medicine to the lungs) mask was stored properly. This failure could place residents requiring respiratory care at risk for shortness of breath, respiratory distress, or complications. Findings included: Record review of Resident #1's face sheet, dated 04/15/2026, revealed a [AGE] year-old male admitted [DATE] with diagnoses that included intracerebral hemorrhage (brain bleed), hypertension (high blood pressure), hyperlipidemia (high levels of fat in the blood) and dysphagia (difficulty swallowing). Record review of Resident #1's MDS, dated [DATE], revealed he was usually understood, usually understood what was said to him and had a BIMS score of 13 which indicated intact cognition. Record review of Resident #1's physician's orders revealed an order for Ipratropium-Albuterol Inhalation solution 0.5-2.5 (3) MG/3ML 1 vial inhale orally three times a day for acute respiratory failure with hypoxia dated 03/11/2026. Further review of the physician's orders printed 04/15/2026 did not reveal an order to change or date the nebulizer mask and tubing. Record review of Resident #1's MAR dated 04/01/2026-04/30/2026 revealed he received the Ipratropium-Albuterol Inhalation solution medication three times per day from 04/01/2026-04/14/2026 per physician's order. During an observation on 4/15/26 at 10:04 a.m., revealed Resident #1's nebulizer mask and tubing were observed lying on the recliner chair in the resident's room. The mask was not stored in a protective bag. A storage bag was present; however, it was not labeled or dated. During an interview on 4/15/26 at 12:04 a.m., RN B revealed she was unsure who was responsible for ensuring nebulizer masks were properly stored in a bag and labeled with a date. RN B stated the nebulizer treatment was administered; however, she was PRN and was unsure when the nebulizer equipment should be changed. During an interview on 4/15/26 at 1:42 p.m., the DON stated that nebulizer mask and tubing should be stored in a clean bag and both the equipment and bag should be dated. The DON stated the tubing, and mask was typically changed on Sundays and there should be an order in place for routine changes. The DON stated that improper storage increased the risk of infection. During an interview on 4/15/26 at 2:08 p.m., the Administrator stated nursing staff was responsible for ensuring nebulizer equipment and oxygen tubing were properly stored in a bag with a date for infection control purposes. The Administrator stated each resident should have an order addressing respiratory supply changes. Record review of the facility Oxygen Administration policy, dated 6/2025, revealed all oxygen tubing, humidifiers, masks, and cannulas used to deliver oxygen will be changed weekly and when visibly soiled. Oxygen items will be stored in a plastic bag at the resident's bedside to protect the equipment from dust and dirt when not in use.</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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for 1 of 1 kitchen observed for food service in that: The facility failed to keep personal food or beverage items out of the walk-in cooler. This failure could place residents who received meals from the kitchen at risk of food borne illnesses. The findings were: Observation of the walk-in cooler on 04/15/2026 at 9:37 a.m. revealed an open 16 ounce can containing an energy drink that was more than 2/3 full. During an interview on 04/15/2026 at 9:45 a.m., the FSS stated that she had in-serviced her staff that personal drinks were not allowed in the kitchen areas near residents' food items due to infection control. The FSS removed the open drink can. During an interview on 04/15/2026 at 9:50 a.m., [NAME] A stated that the drink belonged to her and she was aware she was not supposed to have the open drink in the walk-in cooler. [NAME] A stated she would review with her supervisor to determine where she should keep personal food items. [NAME] A stated that the practice could result in contamination. During an interview on 04/15/2026 at 2:08 p.m., the Administrator stated that no personal food or drink items should be near food preparation or storage areas due to risk of contamination. The Administrator stated the FSS was responsible for ensuring the practice did not occur. Review of facility policy titled, Nutrition Services Personnel Guidelines, dated 01/01/2026, revealed XV. All personal belongings may not be kept in the food preparation or food storage areas.</p>		

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have a policy regarding use and storage of foods brought to residents by family and other visitors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to enact a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage of resident's food and beverage items for 3 of 3 Residents (Resident #2, Resident #3 and Resident #4) reviewed for personal food in that: The facility failed to implement the food policy related to personal refrigerators and monitor the temperatures for in-room personal refrigerators and freezers daily for Resident #2, Resident #3, and Resident #4. This deficient practice could place residents who had personal in-room refrigerators at risk of food borne illnesses. The findings were: Record review of Resident #2's Face Sheet, dated 04/15/2026 revealed Resident #2 admitted [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease (a progressive lung disease that restricts airflow), Deep Vein Thrombosis (a condition where a blood clot forms in a deep vein causing pain, swelling, tenderness and redness), Schizophrenia (a chronic brain disorder that caused individuals to interpret reality abnormally) and depression. (a mood disorder causing persistent sadness, low energy, and loss of interest in life). Record review of Resident #2's Quarterly MDS dated [DATE] revealed no hearing or communication deficits and a BIMS score of 13 which indicated intact cognition. Observation and interview on 04/15/2026 at 10:09 a.m., revealed Resident #2 had a personal in-room refrigerator with 1 gallon of milk with an expiration date of 04/20/2026. Further observation revealed a temperature log taped on the side of the refrigerator with temperature checks completed only on 04/10/2026, 04/13/2026, 04/14/2026 and 04/15/2026. All temperature readings on the log indicated 32°. Further observation revealed the thermometer registered 32° in the refrigerator and 22° in the freezer. All temperatures were within acceptable parameters but were not obtained daily. Resident #2 stated he did not know who checked the thermometer in his refrigerator and that he never had any spoiled food that he recalled. Record review of Resident #3's Face Sheet, dated 04/15/26, revealed Resident #3 admitted [DATE] with diagnoses that included cervical disc degeneration, cerebral infarction (a type of stroke that occurs when blood flow to the brain is blocked, causing tissue death due to oxygen starvation), aphasia (difficulty speaking), hypertension (high blood pressure), and chronic kidney disease (an irreversible loss of kidney function). Record review of Resident #3's Quarterly MDS dated [DATE] revealed resident #3 was usually understood by others, usually understood what was said to her, and had a BIMS score of 03 which indicated severe cognitive impairment. Observation and interview on 04/15/2026 at 10:23 a.m. revealed Resident #3 had a personal in-room refrigerator with 3 pints of ice cream in the freezer with expiration dates of 05/03/2026, 05/06/2026 and 05/09/2026. Further observation revealed a temperature log taped on the side of the refrigerator with temperature checks completed only on 04/10/2026, 04/13/2026, and 04/15/2026. All temperature readings indicated 30° for the refrigerator and 20° for the freezer which were in acceptable parameters but were not obtained daily. Record review of face sheet date 4/15/2026 revealed Resident #4 was an [AGE] year-old female admitted [DATE] with the diagnoses that include Diabetes Type II (a metabolic condition that causes difficulty controlling blood sugar), unspecified chronic bronchitis (a condition that makes it difficult to breath), and spinal cord disease (a condition that causes disruption of communication between the brain and the body). Record review of the Quarterly MDS dated [DATE], revealed Resident #4 had clear speech, was understood by others, understood what was said to her and had a BIMS score of 15 which indicated intact cognitive function. Observation and interview on 04/15/2026 at 10:30 a.m. revealed Resident #4 had a personal in-room refrigerator log had a missing temperature check for 04/11/2026 and 04/12/2026 which revealed temperatures were not obtained daily. Resident #4 stated that the staff do not always keep up with the temperature check, but they do look at the refrigerator daily. During an interview on 04/15/2026 at 1:44 p.m., the DON stated that the nursing staff was not responsible for monitoring the temperatures in the residents personal refrigerators and stated that administrative staff were (continued on next page)</p>		

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>assigned to each room as a room ambassador to check the refrigerators for spoiled food items. The DON stated that failure to monitor the temperatures in the personal refrigerators could result in spoiled food items and subsequently food borne illness. During an interview on 04/15/2026 at 1:154 p.m., the Housekeeping Supervisor stated she had been at the facility approximately 5 weeks and that she was not aware that monitoring a resident's personal refrigerator temperatures and completing the temperature log was the responsibility of the housekeeping staff. The Housekeeping Supervisor stated she was informed on 04/16/2026 by the Administrator that she would be responsible for the task and that she was completing an audit today of all residents' personal refrigerator temperature check logs. The Housekeeping Supervisor stated that failure to monitor the temperatures in the personal refrigerators and freezers could result in spoiled food that could make people sick. During an interview on 04/15/2026 at 2:08 p.m., the Administrator stated that she expected the housekeeping staff to check all temperatures in residents' personal refrigerators and annotate findings on the temperature log daily. The Administrator stated the facility utilized an Ambassador Round sheet which directs the assigned staff to check the refrigerators for spoiled food items and cleanliness, but that it did not indicate to check the temperature of the refrigerator and freezer. The Administrator stated she informed the Housekeeping Supervisor on 04/15/2026 (unknown time) that she would be responsible for ensuring the temperatures were taken and logged daily. The Administrator stated that residents were at risk of consumption of spoiled food due staff not checking to ensure refrigerator temperatures were not at a temperature of 41° or below. Record review of the facility policy titled, Residents Personal Refrigerator, dated 01/01/2025, revealed V. a temperature monitoring log will be maintained, and a designated staff member will document refrigerator temperatures daily and the facility will keep a thermometer in the refrigerator and maintain it at 41 degrees or below.</p>