

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

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Form Approved OMB
No. 0938-0391

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 05/19/2026
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)		
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview and record review, the facility failed to provide sufficient number of nursing staff on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans and the facility assessment for 1 of 1 facility reviewed for care and services. The facility failed to have sufficient nursing staff on an 24 hour basis that meet the appropriate competencies, skill set, and required qualifications to provide nursing and related services to attain or maintain the highest practicable physical, mental and psychosocial well-being for each resident on 4/1/26, 4/2/26, 4/3/26, 4/4/26, 4/7/26, 4/8/26, 4/10/26, 4/11/26, 4/18/26, 4/22/26, 4/24/26, 4/25/26, 4/28/26, 4/29/26, 5/2/26, 5/3/26, 5/5/26, 5/7/26, 5/11/26, 5/12/26, 5/13/26, 5/14/26, 5/16/26, 5/18/26 when there was only 1 nurse on duty and during their required lunch break there was no other nurse in the facility. This failure could place residents at risk for not having their physical, mental, and psychosocial well-being met. Findings included: Record review of the facilities monthly staffing schedules for April 2026 and May 2026, and time cards for RN A, LVN B, LVN C, and RN D indicated on: 4/1/26- RN A was the only 10:00pm to 6:00am nurse on duty and took a lunch break from 3:00am to 3:30am leaving no other nurse in the facility. 4/2/26- RN A was the only 10:00pm to 6:00am nurse on duty and took a lunch break from 3:00am to 3:30am leaving no other nurse in the facility. 4/3/26- RN A was the only 10:00pm to 6:00am nurse on duty and took a lunch break from 3:00am to 3:30am leaving no other nurse in the facility. 4/4/26- RN A was the only 10:00pm to 6:00am nurse on duty and took a lunch break from 3:00am to 3:30am leaving no other nurse in the facility. 4/4/26- LVN B was the only 2:00pm to 10:00pm nurse on duty and took a lunch break from 6:00pm to 6:30pm leaving no other nurse in the facility. 4/7/26- RN A was the only 10:00pm to 6:00am nurse on duty and took a lunch break from 3:00am to 3:30am leaving no other nurse in the facility. 4/8/26- RN A was the only 10:00pm to 6:00am nurse on duty and took a lunch break from 3:15am to 3:56am leaving no other nurse in the facility. 4/8/26-4/4/26- LVN B was the only 2:00pm to 10:00pm nurse on duty and took a lunch break from 6:00pm to 6:30pm leaving no other nurse in the facility. 4/10/26- RN A was the only 10:00pm to 6:00am nurse on duty and took a lunch break from 3:00am to 3:30am leaving no other nurse in the facility. 4/11/26-4/4/26- LVN C was the only 10:00pm to 6:00am nurse on duty and took a lunch break from 2:03am to 2:30am leaving no other nurse in the facility. 4/18/26- RN D was the only 2:00pm to 10:00pm nurse on duty and took a lunch break from 7:58pm to 8:29pm leaving no other nurse in the facility. 4/22/26- LVN C was the only 10:00pm to 6:00am nurse on duty and took a lunch break from 2:46am to 3:09am leaving no other nurse in the facility. 4/24/26- LVN C was the only 10:00pm to 6:00am nurse on duty and took a lunch break from 2:29am to 2:52am leaving no other nurse in the facility. 4/25/26- RN D was the only 2:00pm to 10:00pm nurse on duty and took a lunch break from 7:04pm to 7:33pm leaving no other nurse in the facility. 4/28/26- RN A was the only 10:00pm to 6:00am nurse on duty and took a lunch break from 3:21am to 4:01am leaving no other nurse in the facility. 4/29/26- RN A was the only 10:00pm to 6:00am nurse on duty and took a lunch break from 4:26am to 5:21am leaving no other nurse in the facility. 5/2/26- RN D was the only 2:00pm to 10:00pm nurse on duty and took a lunch break from 6:31pm to 7:04pm leaving no other nurse in the facility. 5/3/26- LVN C was the only 10:00pm to 6:00am nurse on duty and took a lunch break from 2:39am to (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3:12am leaving no other nurse in the facility. 5/5/26- RN A was the only 10:00pm to 6:00am nurse on duty and took a lunch break from 3:39am to 4:42am leaving no other nurse in the facility. 5/7/26- RN A was the only 10:00pm to 6:00am nurse on duty and took a lunch break from 3:57am to 4:34am leaving no other nurse in the facility. 5/11/26- RN A was the only 10:00pm to 6:00am nurse on duty and took a lunch break from 4:54am to 5:27am leaving no other nurse in the facility. 5/12/26- RN A was the only 10:00pm to 6:00am nurse on duty and took a lunch break from 4:04am to 4:27am leaving no other nurse in the facility. 5/13/26-4/4/26- LVN B was the only 2:00pm to 10:00pm nurse on duty and took a lunch break from 5:20pm to 5:51pm leaving no other nurse in the facility. 5/14/26-4/4/26- LVN B was the only 2:00pm to 10:00pm nurse on duty and took a lunch break from 6:31pm to 7:01pm leaving no other nurse in the facility. 5/16/26- RN D was the only 6:00am to 2:00pm nurse on duty and took a lunch break from 1:20pm to 1:49pm leaving no other nurse in the facility. 5/18/26-4/4/26- LVN B was the only 2:00pm to 10:00pm nurse on duty and took a lunch break from 8:15pm to 8:45pm leaving no other nurse in the facility. During an interview on 5/18/2026 at 12:10pm LVN E said she had only worked at the facility for 2 weeks. She said she was the only floor nurse on the 6am to 2pm shift. She said they were required to take a 30-minute lunch break. She said when she takes a lunch break the ADON or MDS nurse covered for her until she returned. She said she did not know what the other shifts did. She said the staffing on the floor was they have 2 CNA's and 1 med aide and the nurse. During an interview on 5/18/26 at 2:20 PM LVN B said he had worked at the facility for about 1 1/2 months. He said it was a requirement that the nurse clock out for a 30-minute lunch break every shift. He said he was told to try and take the lunch break between 2pm-5pm when there were administrative nurses there that could watch his halls until he returned. He said sometimes it was not possible to clock out for a lunch break during those times. He said if he did not clock out for a lunch break then he had to fill out a form explaining why he did not take a lunch break and then would be talked to by the Administrator the next day. He said he had worked some 10-6 shifts and was told he still had to clock out for a lunch break even though there was no other nurse to watch the halls for him. He said the directive that they must take a lunch break came from the Administrator. During an interview on 5/19/2026 at 8:51am RN A said during a monthly in-service meeting staff were told they must take a 30-minute lunch break. She said there was no other nurse on the 10pm to 6am shift so she said she usually clocked out and sat in the conference room or break room. During an interview on 5/19/2026 at 9:30am HR said during the morning meetings the Administrator had been pulling an overtime report and gave the administrative staff missed punch sheets for anyone that had not taken a lunch break and said to have them correct it. She said it was the expectation that all staff would take at least a 30-minute lunch break. She said that the nurses usually tell the CNA's when they take a lunch break to call them if needed. During an interview on 5/19/2026 at 12:42pm LVN F said she was the medication nurse and does strictly medications and the charge nurse took care of the residents. She said they had been told they must take their lunch breaks by the DON. She said they had to take their lunch breaks or it had to be approved by the Administrator. During an interview on 5/19/2026 at 1:50pm the Administrator said she had not thought about the nurse not being in the facility because she was not sure if they were leaving the building on their lunch breaks. She said staff should not leave the facility or clock out if they were the only nurse. She said her expectation going forward was nurses will not clock out unless there are 2 nurses in the facility. She said the CNA's should know to call 911 but if the nurse was not here then who would take control of the resident and said there could be a medical emergency. Record review of the facility policy titled Nursing Department-Staffing, Scheduling & Postings dated 10/24/2022 indicated: Purpose: To ensure an adequate number of nursing personnel are available to meet resident needs. 1. The Facility will employ sufficient nursing staff on an 24 hour basis that meet the appropriate competencies, skill set, and required qualifications to provide nursing and related services to attain or maintain the highest practicable physical, mental and psychosocial well-being for each resident. B. Nursing stations will be staffed with nursing personnel when residents are housed in the nursing unit.		