

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

Printed: 10/09/2026
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 07/07/2026
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident's environment remained free of accidents and hazards for 1 of 1 resident (Resident #2) reviewed for accident hazards. The facility failed to ensure a safe transfer for Resident #2 when CNA C and CNA D performed a transfer without utilizing a gait belt on 07/06/2026. This failure could place residents at risk of injury or harm. Findings included: Record review of Resident #2's face sheet dated 07/07/2026 indicated he was an [AGE] year-old male and admitted to the facility on [DATE]. Resident #2 had diagnoses which included Chronic Obstructive Pulmonary Disease (a group of lung diseases that blocks air flow and causes difficulty breathing), hypertension (high blood pressure), Difficulty in walking, unspecified dementia (forgetfulness), depression. Record review of Resident #2's comprehensive MDS assessment dated [DATE] indicated Resident #2 had a BIMS score of 3 which indicated he had severe cognitive impairment. The MDS indicated Resident #2 required partial/moderate assistance from staff with toilet transfers. Record review of Resident #2's care plan dated 05/17/2026 indicated he has an ADL self-care performance deficit related to cognitive impairment and weakness. Interventions indicated transfer: sit to stand: maximum assist, chair/bed to chair: maximum assist, Toilet transfer: Substantial/max assist, tub/shower transfer: maximum assist, Toilet Use: frequently incontinent of bowel and bladder, requires Substantial/max assist with toileting hygiene. During observation on 07/06/2026 at 11:36 AM, CNA C and CNA D attempted to transfer Resident #2 from the wheelchair to the toilet. CNA C attempted to place Resident #2's hands on the wall railing to assist him with standing while transferring, but Resident #2 could not grasp onto the railing with stability. CNA C grabbed under Resident #2's arms and pulled him to a standing position, CNA C then pivoted him toward the toilet. CNA D then pulled down Resident #2's brief and pants as CNA C lowered him to the toilet. After Resident #2 was done using the toilet, CNA C then grabbed under Resident #2's arms and lifted him to a standing position while CNA D pulled up Resident #2's brief and pants while holding on to the back of his shirt then continued to lower Resident #2 into the wheelchair. During an interview on 07/07/2026 at 1:32 PM, CNA D stated Resident #2 was a two-person assist and a gait belt transfer. CNA D stated she should have used a gait belt for the transfer to prevent a fall or injury while transferring Resident #2. During an interview on 07/07/2026 at 1:45 PM, CNA C stated Resident #2 was a two-person assist. She stated she knew she was supposed to apply the gait belt when transferring a resident, but she did not apply one that day, because she was nervous and not prepared. CNA C stated the purpose of a gait belt was to help the residents keep their balance without staff having to pull on body parts or clothing. CNA said a gait belt should be used with all transfers to ensure resident safety and prevent injuries or falls. During an interview on 07/07/2026 at 3:35 PM, the DON stated Resident #2 was a two-person assist. The DON (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated a gait belt should be utilized during transfers to prevent any injuries or falls. The DON said she expected all clinical staff to ensure appropriate and proper transfers were done by utilizing the gait belt. The DON said she was ultimately responsible to ensure the staff was using the gait belt during transfers. During an interview on 07/07/2026 at 4:45 PM, the Administrator stated she expected the gait belt to be used during transfers to prevent injuries and falls and help stabilize the residents. The Administrator said all staff were responsible for ensuring the residents are free of injuries and prevent falls. The Administrator said she expected the clinical staff to use the gait belt for transfers and use appropriate transferring techniques to ensure safety for residents and the staff. Record review of the facility's policy Transfer of Residents revised on 06/2020, indicated . Residents who require assistance in transferring will be transferred using a gait/transfer belt or with a lift .		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure respiratory care was provided with professional standards of practice for 1 of 2 residents (Resident #1) reviewed for respiratory care and services. The facility failed to properly store Resident #1's nebulizer (a drug delivery device used to administer medication in the form of a mist inhaled into the lungs) mask while not in use. This failure could place residents who require respiratory care at risk for respiratory infections and exacerbation of respiratory distress. Findings include: Record review of Resident #1's face sheet, dated 07/07/2026, indicated Resident #1 was a [AGE] year-old male, admitted to the facility on [DATE] with a diagnosis which included chronic obstructive pulmonary disease (a group of lung diseases that blocks air flow and causes difficulty breathing), anemia (a blood disorder where there is a lack of healthy hemoglobin carrying red blood cells), urinary retention. Record review of Resident #1's admission MDS assessment, dated 07/02/2026, indicated Resident #1 understood others and made himself understood. The assessment indicated Resident #1 was cognitively intact with a BIMS score of 14. The assessment indicated Resident #1 did not reject care necessary to achieve the resident's goals for health or well-being. The MDS indicated Resident #1 was dependent on bed mobility, transfers, dressing, toilet use, and showering. Record review of Resident #1's care plan, dated 06/29/2026, indicated Resident #1 had an impaired respiratory status related to chronic obstructed pulmonary disease. The care plan interventions included provide nebulizer therapy as ordered. Record review of Resident #1's order summary report, dated 07/07/2026, indicated Resident #1 received Ipratropium- Albuterol solution 0.5-2.5 (3) mg/3ml via nebulizer every 6 hours as needed for shortness of breath and/or wheezing. During an observation and interview on 07/06/2026 at 09:15 a.m., Resident #1 was lying in bed with his eyes closed. Resident #1's nebulizer mask was laying on the table at bedside uncovered. During an observation on 07/06/2026 at 10:15 a.m., Resident #1 was lying in bed. The nebulizer mask was laying on the table at bedside uncovered. During an observation on 07/06/2026 at 2:11 p.m., Resident #1 was asleep in bed. The nebulizer mask was laying on the table at bedside uncovered. During an interview and observation on 07/06/2026 at 3:16 p.m., LVN A stated she was Resident #1's 6a-6p charge nurse, LVN A stated Resident #1 had an order for PRN nebulizer treatments. LVN A observed Resident #1's nebulizer mask on the bedside table, not covered. LVN A stated Resident #1's nebulizer mask should be covered when not in use. LVN A stated she administered Resident 1's breathing treatments today, but failed to place the back in the plastic bag after usage. LVN A stated all nursing staff were responsible for ensuring infection control was provided for each resident. LVN A stated these failures could potentially put residents at risk for respiratory infection. During an interview on 07/06/2026 at 4:24 p.m., the DON said she expected Resident #1's nebulizer mask to be stored in a bag when not in use. The DON stated the charge nurses were responsible for nebulizers treatments and ensuring proper infection control precautions were utilized. The DON said the charge nurses were responsible for monitoring to ensure respiratory equipment was returned to the designed bag after each use. The DON stated she was responsible for monitoring the charge nurses. The DON said these failures could potentially cause an increase in the risk of infection due to cross contamination. During an interview on 07/07/2026 at 4:40 p.m., the Administrator said she expected nebulizers to be stored in bags when not in use to decrease any chances of cross contamination. The Administrator stated this was monitored by the clinical staff. The Administrator stated these failures put residents at risk for respiratory infection due to particles that could accumulate on the mask. Record review of the facility's Oxygen Administration policy, (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revised June 2020 indicated, . B. 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.		

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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 personal linen cart reviewed for infection control practices. The facility failed to ensure clean laundry was transported to prevent the spread of infection. These failures could place residents and staff at risk for cross contamination and the spread of infection. Findings included: During an observation on 07/06/2026 at 09:15 a.m., an uncovered laundry cart that had clean clothes exposed was unattended on the front of Zone D Hall. During an observation on 07/06/2026 at 10:25 a.m., an uncovered laundry cart that had clean clothes exposed was unattended on the front of Zone D Hall. During an interview on 07/06/2026 at 10:51 a.m., Laundry staff/Housekeeper B said she was aware the laundry cart should have been covered while distributing clothes to the residents. Laundry staff/Housekeeper B said she had gotten distracted, and failed to cover the laundry cart. Laundry staff/Housekeeper B said it was important to keep the clean clothes covered to prevent cross contamination. During an interview on 07/06/2026 at 10:55 a.m., the Housekeeping Supervisor said the laundry cart should be always covered to prevent cross contamination of floating particles, and other residents that may randomly touch the clean clothing. During an interview on 07/06/2026 at 4:24 p.m., the DON said all staff were responsible for infection control prevention and precautions. The DON said it was important for the laundry cart to remain covered to prevent floating particles from cross contamination as well as excessive or random brushing up against the clean clothing which could result in a chance of infection. During an interview on 07/07/2026 at 4:40 p.m., the Administrator stated she expected the staff to keep the clean laundry covered while transported and while delivered to the residents to prevent cross contamination. The Administrator said she expected all staff to ensure infection preventives were utilized daily to protect the residents' health and wellbeing. Record review of the facility's policy Infection Control Plan: Overview updated on March 2024 indicated, The facility will establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Linens - Personnel will handle, store, process and transport linens so as to prevent the spread of infection.		