STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676482	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cypress Pointe Health & Wellness	8561 Easton Commons Dr. Houston, TX 77095

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37059 Based on observations, interviews, and record reviews, the facility failed to provide necessary treatment and services to promote healing and prevent worsening pressure sores for 1 of 6 resident (Resident #1) reviewed for pressure ulcers. -The facility failed prevent development a pressure ulcer which was not identified or treated for Resident #1. This failure placed residents at risk of delayed identification/treatment of injuries, worsening of injuries, pain and infection. Findings Include: Record review of Resident #1's Face Sheet dated 6/13/2024 revealed, an [AGE] year-old male who admitted to the facility originally on 3/17/2021 and most recently on 2/29/2024 with the following diagnoses which included: contracture unspecified joint, hemiplegia and hemiparesis (paralysis and partial weakness) following cerebral infarction (stroke) affecting left non dominate side, unspecified dementia, unspecified mood (affective) disorder, muscle wasting and atrophy. Record review of Resident #1's Quarterly MDS dated [DATE] revealed, severely impaired cognition as indicated by a BIMS score of 00 out of 15, total dependence with most ADLs, total dependence with most functional abilities including shower/bathe self, upper body dressing. Substantial/maximal assistance (helper does more than half the effort) assistance with personal hygiene (includes washing and drying hands). Active Diagnosis included: Hemiplegia or Hemiparesis. Skin Conditions included: Resident was at risk for pressure ulcers/injuries. Other ulcers, Wounds and Skin Problems: Resident had Skin tears. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676482	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/14/2024
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F 0686 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #1's Care Plan (date initiated 5/2/2022) revealed, Focus: [Resident #1] has an ADL self-care performance deficient r/t Dementia. Goal - [Resident #1] will maintain current level of function through the review date. Interventions - .Provide skin care every shift and PRN to keep clean and prevent skin breakdown (date initiated 10/11/2023). Geri-sleeve bilateral forearms (date initiated 1/30/2024). Contractures: [Resident #1] has contractures of the left hand. Provide skin care to keep clean and prevent skin breakdown (date initiated 5/17/2022). Focus: [Resident #1 is risk for impaired skin integrity r/t immobility . resident had tendency to scratch self . Goal: [Resident #1 skin will remain intact through next review date (target date 6/5/2024). Interventions: Evaluate skin for areas of .redness. Keep skin clean and well lubricated. Nurse to check the skin after bathing for any skin issues . Perform objective pressure ulcer risk tool such as Braden/Norton Scale (date initiated 8/6/2021). Record review of Resident #1's order summary report dated 6/12/2024 revealed geri-sleeves bilateral forearms every shift for wound care (order and starts date 4/23/24). Record review of Resident #1 weekly skin assessment dated [DATE] revealed, no documentation of a wound, redness or skin tear between the index finger and thumb on his left hand. Record review of Resident #1's TAR dated 6/1/24 - 6/10/2024 revealed it was charted by RN A and LVN B the geri-sleeve were in place every shift for wound care (start date 4/23/2024). Record review of Resident #1's shower sheets dated 6/7/2024 and 6/10/2024 revealed no skin issues were documented by CNA A. Record review of Resident #1's Nursing Notes dated 6/11/2024 at 12:02 a.m. revealed, resident [Resident #1] left the facility to the hospital at 10:05 p.m. (6/10/2024). [Resident #1] had no new skin issues at the time of the transfer. Record review of EMS Run Report for Resident #1 dated 6/10/2024 revealed the following (nursing facility to hospital emergency room): Arrived on scene: 6/10/2024 at 9:51 p.m. Patient Contact: 6/10/2024 at 9:52 p.m. Transport Began: 6/10/2024 at 10:21 p.m. Arrival at Destination: 6/10/2024 at 10:38 p.m. .Patient [Resident #1] was found at 21:52:44 (9:52 p.m.) in emergent (yellow) condition. The patient is a [AGE] year-old adult male. The patient transportation for nausea and vomiting, coughing not available at origin. A stretcher was required due to the patients' monitoring requirement - oxygen administration (oxygen dependent, severe weakness in all extremities, and poor truck control). Patient was moved to the stretcher by two-man drawsheet .and secured inside .Transport began at 22:21:11 (10:21 p.m.) .and lasted 17 minutes .Forearm - left paralysis, Arm - whole arm and hand- left deformity .arrived at [hospital] at 22:38:49 (10:38 p. m). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #1's hospital emergency room admitted d 6/10/2024. Principle problem: Pneumonia or right lung due to infectious organism, unspecified part of lung. Record review of a photograph dated 6/10/24 at 12:04 p.m. revealed Resident #1's left hand with geri-sleeve. There was dark brownish dried substance along the edge of the geri-sleeve between the index finger and thumb. The inside of thumb appeared to have brown dried substance. The second photograph revealed attending ER Physician A holding Resident #1's hand and displayed the wound bed between the index finger and thumb with the geri-sleeve off. The wound bed was red and pink in color an appeared moist. The edge of the wound bed closest to the thumb was brown in color. The edge of the wound bed closest to the index finger was red. There was a blister in the center of the wound bed. The around the peri wound (area around the wound bed) appears light red, pink and light brown in color. Record review of Resident #1's hospital emergency room wound photograph dated 6/11/2024 at 1:01 a.m. reflected the wound bed was red and pink in color an appeared moist. The edge of the wound bed closest to the thumb was brown in color. The edge of the wound bed closest to the index finger was red. There was a blister in the center of the wound bed. The around the peri wound (area around the wound bed) appears light red, pink and light brown in color. Record review of Resident #1's hospital emergency wound assessment dated [DATE] at 6:00 a.m. revealed the following: First Assessment Date/First Assessment Time: 06/11/24 06:00 Present on Original Admission: Yes Primary Wound Type: Other (comment) Orientation: Left; Posterior Location: Finger D1, thumb Description (Comments): in between thumb and 2nd digit web area Wound Care Physical Therapy Diagnosis: Impaired Integumentary Integrity Associated with Partial-Thickness Skin Involvement and Scar Formation Pt referred to PT wound care to the L hand. Mobility/Transfer: total assistance Needs additional assist to position and open hand during wound care . 6/12/2024 at 1:26 p.m. - Nonstaged wound description - Partial thickness. Wound base appearance - early/partial granulation; red; pink; slough (dead tissue in wound) Wound bed granulation (new connective tissue) % - 80% Wound bed slough (dead tissue in wound) % - 10% (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Exposed structures - Muscle; Muscle Necrosis (death of body tissue) Peri-wound assessment - pink; white; macerated (soften or become softened by soaking in a liquid) Margins - attached edges Wound length - 4 cm Wound width - .6 cm Wound depth - .3 cm Wound measured as a cluster? - Yes Wound Surface area - 2.4 cm^2 Wound Volume - .72 cm ^2 Drainage: small Drainage odor: none Drainage Description: Serosanguineous (refers to fluids that contain or relate to both blood and the liquid part of blood (serum) Wound cleanse: irrigation; cleansed; peri wound care; normal saline. Primary Dressing - small piece of foam secured with tape. Patient seen for PT wound care eval and treatment to the Left hand wound per above. Left hand with flex contractures from old stroke and wound is macerated. Patient will be seen for PT wound care 3 times a week. , Nursing to change/reinforce dressings as needed or when soiled. Record review of video of Resident #1 date and time stamped (6/10/2024 at 9:06 a.m.) revealed CNA A prepared to give Resident #1 a bed bath. She removed socks from a drawer and had a container with a pump in the other hand. CNA did not take a new geri-sleeve out of the drawer to change out the one that Resident #1 had on. Interview on 6/12/2024 at 12:55 p.m. with CNA A said Resident #1 wore protective geri-sleeve on his arms because he would scratch himself. She said he always wore the sleeves except when he had a bed bath. She said she gave Resident #1 a bed bath on 6/10/2024 at approximately 9:00 a.m. She said she removed Resident #1's left geri-sleeve and cleaned his arms. She said she checked for bruises or skin tears. She said he had discoloration on the top of his hand that had been there previously. She said she was supposed to report if Resident #1 had any new skin tears or bruises. She said, I did not recall seeing anything on his left hand after the bed bath. She said, the arm sleeves are washed and reused. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview on 6/12/2024 at 1:12 with the WC A said Resident #1 did not have any skin issues or wound when he started wearing the geri-sleeves. She said he was ordered to have weekly skin assessments. She said she last completed Resident #1's skin assessment on 6/6/2024 and he had no issues. She said she saw Resident #1 in bed on 6/10/2024 during the day but did not see anything out of the ordinary. She said she stood at the room door and looked in and saw that the resident had on the geri-sleeves but did not walk over to him. Observation and attempted interview on 6/12/2024 at 2:07 p.m. of Resident #1 at the hospital revealed Resident was in the hospital bed. Resident #1 was asked if staff had taken off his protective geri-sleeve when he received a bed bath. Resident #1 did not respond. Resident was asked if he was in pain, and he did not respond. Resident #1 had a gauze bandage wrapped around his left hand between the index finger and the thumb. He held his left hand against his chest, with the thumb closest to his chest. Interview on 6/12/2024 at 3:34 p.m. via phone with CNA A said she did not see blood, skin tears or scabs on Resident #1's left contracted hand or any dried substance on the geri-sleeve. She said she was not trained or informed by a nurse on when to take the geri-sleeves off other than when she gave Resident #1 a bed bath. CNA A said she placed the same sleeves back on Resident #1 on the bed bath she gave him on 6/10/2024. She said she did not specifically look at the webbing between the index finger and the thumb. She was not able to explain how she removed the arm sleeve, washed the arm but and did not see the area between the index finger and the thumb. Interview on 6/13/2024 at 8:38 p.m. with NP A said he expected the staff to ensure the geri-sleeves were in place for Resident #1. He said the facility would have decided when the sleeves should have been taken off. NP A said the order was to ensure the sleeves were always in place, because Resident #1 scratched himself. He said when Resident #1 was showered was acceptable. He said the facility had not called him to clarify the order for the geri-sleeves. Interview on 6/13/2024 at 9:04 a.m. with CNA B said she could not remember when she last provided Resident #1 with a bed bath. She said in the past she had to remove the arm sleeves when Resident #1 was given a bed bath. She said he kept the sleeves on to prevent him from scratching himself. She said she was trained by RN A to keep the sleeves clean and dry. Interview on 6/13/2024 at 9:29 a.m. with RN A said it was her understanding that she was responsible to ensure the geri-sleeves were on. RN A said Resident #1 wore the protective geri-sleeves to prevent skin tears, because he would scratch himself. She said the Nurses and CNA's were responsible and needed to change the geri-sleeves of soiled or on shower days. RN A said she documented daily on Resident #1's TAR that the geri-sleeves were in place. She said, she made sure they were in place, and she eyeballed them. She said eyeballed meant she visibly looked to see if the sleeves were on. She said she did not physically touch the sleeves. RN A said on 6/10/2024, she worked 6:00 a.m. - 2:00 pm. She said she did not check Resident #1's skin or look under the sleeves. RN A said LVN B worked after her on 6/10/2024. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview on 6/13/2024 at 9:56 a.m. with WC A said Resident #1 was checked from head to toe on his last weekly skin assessment (6/6/2024). She said she checked the arms and removed the sleeves slow and gentle and looked for pressure points as she pointed to the elbows. She said the sleeves should be on at all times except when they were soiled or when he received a bed bath. She said she made sure the sleeves were pulled up and were not creased so not to cause a potential injury. WC A said the nurses monitored and made sure the sleeves were on. She said she saw his contracted left hand, but she said she did not particularly look at that part between the thumb and index finger, because it was very difficult to look at. She said he always held the contracted left hand, which was paralyzed, close to his chest. Interview on 6/13/2024 at 10:29 a.m. LVN A said she sent Resident #1 to the hospital on 6/10/2024 at the request of Resident #1's family member. She said before sending him out she performed mouth care and a brief change. She said she did not examine his arms or geri-sleeves. LVN A said she ensured the geri-sleeves were in place, but she did not inspect his skin for new injuries or skin tears. LVN A said she checked his blood pressure with the left wrist and he did not open the left contracted hand. She said she did not observe the area between the index finger and the thumb. She said she did not change Resident #1's sleeve during her 2:00 p.m. -10:00 p.m. shift. She said the CNA's normally changed the geri-sleeve if Resident #1 needed it. Interview on 6/13/2024 at 10:42 a.m. the DON said based on Resident #1's order for the geri-sleeve, she expected the nurses to make sure the sleeves were in place and to check if there was any negative affects from pressure. She said it should be checked like a hand splint for example. The DON said she ensured the sleeves were monitored for Resident #1 by reviewing the TAR was completed daily. The DON said she had not trained the nurses on geri-sleeves but said it was a nursing standard of practice and they should have known to check the skin. She said she expected then nurses to check the placement and to look under the sleeve. Interview on 6/13/2024 at 11:58 a.m. with CNA C said she assisted with Resident #1's brief change on 6/10/2024 before he was transferred to the hospital. She said she checked and made sure the geri-sleeve was on but did not check if the sleeve had blood, dried blood or if there was an injury. She said she did not look or inspect between his index finger and thumb and did not check his skin. She said she was trained to report new injuries if observed during a bath or if there was a changed needed because the sleeves were soiled. Interview on 6/13/2024 at 2:00 p.m. with WC B said she performed wound care on Resident #1's left hand on 6/12/2024 at the hospital. WC B said the injury was caused by pressure and was present prior to Resident #1's admission to the ER. She said they do not stage in this area but there was partial thickness (damage to the first two layers of skin). Interview on 6/13/2024 at 2:12 p.m. with the Attending ER Physician said Resident #1 had a contracted left hand on 6/10/2024. She said she remembered skin break down between the index finger and thumb. She said it was red, pink and had a small amount of drainage. The Attending ER Physician said the wound was present when Resident #1 arrived at the ER. She said Resident #1 had blood that soaked through the geri-sleeve and dried between the index finger and thumb. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview on 6/14/2024 at 9:35 a.m. with RN B said he worked the night of 6/10/2024 in the hospital emergency room . He said Resident #1 came via ambulance. RN B said Resident #1 had on an elastic arm sleeve on his left arm and he placed an IV in the same arm. He said Resident #1 was nonverbal. RN B said the webbing between the index finger and the thumb was not intact. He said the top two layers of Resident 1's skin was gone and there was pink and red flesh exposed. He said he took photos of the left-hand injury within approximately the first hour of admission. He said the Attending ER Physician recommended photographs of the injury to have proof the resident arrived with the wound. He said he could not recall if Resident #1 exhibited pain. Interview on 6/14/2024 at 11:39 a.m. with the Administrator said based on the order she expected nurses to ensure the geri-sleeves were in place and assess the skin once a shift. She said she expected cna's to report any new skin issues to the nurses when Resident #1's skin was observed during bed baths and ensure the geri-sleeves were on. She said WC A was expected to do a head-to-toe assessment. She said if Resident #1 was reluctant to a complete head to toe assessment, that should have included his arms and hands, then the WC A should have let Resident #1 calm down, try again later and maybe try with another staff to assist to address the skin that was not seen. She said she and DON completed daily rounds to ensure staff were meeting the needs of the residents. Record review of facility policy System pathway #1 - Skin and Wound Management revealed the following in part: Each resident receives the care and services necessary to retain or regain optimal kin integrity to the extent possible. Each resident skin is assessed to determine his or her risk for the skin integrity being compromised or the presence of wounds and or pressure injuries. A plan of care should be developed and implemented based on the skin review/checks. If the skin is compromised, the interdisciplinary team notifies the physician for any orders and those appropriate measure and additional interventions are put in place to minimize further compromising of skin and to aid in the healing to extent possible. Responsible Disciplines: Licensed Nursing, CNA's, Therapists Record review of facility job description Charge Nurse dated 4/1/2019 revealed the following in part: To ensure that each patient's attains or maintains the highest possible level of functioning by providing quality nursing care and by working with the interdisciplinary team to ensure a holistic approach to patient care. 1. Follow established standards of nursing practices . Record review of facility job description Treatment Nurse dated 4/1/2019 revealed the following in part: The primary purpose of this position is to provide oversight of the primary skin care provided to residents . 1. Identify, manage, and treat specific skin conditions and primary and secondary lesions, such as skin abrasions, . pressure injuries/ulcers . 2. Perform skin assessments using techniques including observation, inspection . 10.reporting skin concerns . Record review of facility job description Certified Nursing Assistant dated 4/1/2019 revealed the following in part: To support each patients' physical needs by providing top quality care in accordance with community policies and procedures. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Record review of facility policy Assistive Devices and Equipment (date revised January 2020), revealed the following in part: Our community maintains and supervises the use of assistive devices and equipment for residents. 3. Recommendations for the use of devices and equipment are based on the comprehensive assessment and documented in the resident care plan . 6. The following factors are addressed to the extent possible to decrease the risk of avoidable accidents associated with devices and equipment. B. Personal fit - the equipment or device is used only according to its intended purpose and is measured to fit the resident's size and weight.