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	02/06/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record reviews and interviews, the facility failed to be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area to each resident's bedside;abd /toilet and bathing facilities for 1 of 5 residents (Resident #1) reviewed for call lights.The facility failed to ensure Resident #1's call light was within reach on 02/06/2026, while he was lying bed.This failure could place residents at risk of not receiving immediate assistance when needed. Findings included: Record review of Resident #1's Face Sheet revealed, a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included muscle wasting, abnormality of gait and mobility, difficulty in walking, and lack of coordination.Record review of Resident #1's most recent Quarterly MDS (a standardized, comprehensive assessment of an adult's functional, medical, psychosocial, and cognitive status, used in nursing homes) dated 11/10/2025 revealed, BIMS (a standardized, mandatory 0-15 point cognitive assessment tool used in long-term care settings to measure mental acuity in residents) of 4. He used a wheelchair for mobility. He required partial/moderate assistance from staff with personal hygiene and upper body dressing. He was always incontinent with bowel and bladder.Record review of Resident #1's Care Plan dated 02/05/2025, included Problem: The resident was at risk for falls related to Diabetes, Neuropathy (nerve damage), and had recurrent falls. Goal: The resident will be free of falls. Interventions included: Be sure the resident's call light was within reach and encourage the resident to use it for assistance as needed. The resident needed prompt response to all requests for assistance.During an observation and interview on 02/06/26 at 12:40 p.m., revealed, Resident #1 lying in bed, his call light was observed between the bed rail mattress, and out of Resident #1's reach. Resident #1 stated he wanted to call staff to request water, but he could not reach his call light. Resident #1 stated he usually could reach his call light but not this time. During an interview on 02/06/26 at 1:04 p.m., CNA A stated call lights should be within residents' reach. She stated Resident #1 needed the call light to request assistance when needed. CNA A stated she checked the call lights after she provided care to the residents. CNA A stated if call lights were not within residents' reach, they might fall. During an interview on 02/06/26 at 1:12 p.m., the DON stated she expected all staff to check Residents call lights when they went into residents' room. The DON stated if call lights were not within residents' reach, staff should have picked them up and placed them by the residents. The DON stated staff should have used clips to ensure call lights stayed attached to Residents beds and were within their reach. The DON stated she expected staff to check call lights before they left residents rooms. She stated if the call lights were not within residents' reach, they would not be able to ask for help and that might jeopardize their safety.During an interview on 02/06/26 at 1:23 p.m., LVN A stated call lights should be within reach of residents. She stated nurses and CNAs should have noticed Resident #1's call light was out of his reach and clipped it to his bed.Record review of the facility's Call Lights Policy (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated August 2021, revealed, Staff to place the call light within the reach of the resident when leaving the room.