

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 11/16/2023
NAME OF PROVIDER OR SUPPLIER Cypress Pointe Health & Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<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** 27846</p> <p>Based on observation, interview and record review the facility failed to ensure a resident who needed respiratory care was provided with such care, consistent with professional standards of practice, the comprehensive person-centered care plan and the residents' goals and preferences for 1 of 20 residents (Resident #85) reviewed for respiratory care.</p> <p>The facility failed to set the flow rate at 2 liters of oxygen per the order for Resident #85.</p> <p>This deficient practice could place residents at risk of incorrect or inadequate respiratory support and could result in a decline in health.</p> <p>Findings include:</p> <p>Record review of Resident #85's, undated, face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #85 had diagnoses which included hypertensive heart disease with heart failure (left changes in the heart as a result of chronic elevated blood pressure), paroxysmal atrial fibrillation (intermittent rapid, erratic heart rate that stops on its own), Chronic systolic (congestive) heart failure (heart failure specific to the hearts left ventricular), presence of pacemaker, dyspnea (difficulty or labored breathing), and hyperkalemia (elevated potassium levels in the blood).</p> <p>Record review of Resident #85's quarterly MDS assessment, dated 10/25/2023, reflected she was assessed as having a BIMS of 10 out of 15, which indicated Resident #85 had moderate cognitive impairment. Section B indicted Resident #85 was usually understood and usually understood others. Section I identified Resident #85 had medically complex conditions. Section O did not reveal: Oxygen in use while in the facility.</p> <p>Record review of Resident #85's Medication Review Report, dated on or after date 11/14/2023, reflected Oxygen 2 liters as needed for shortness of breath. Order dated 03/08/2023.</p> <p>Record review of Resident #85's care plan, dated 11/15/2023, reflected the following:</p> <p>Focus: The resident had shortness of breath related to anxiety;</p> <p>Goal: The resident would maintain normal breathing pattens. Through the review date;</p> <p>(continued on next page)</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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interventions: Apply oxygen as ordered.</p> <p>In an observation on 11/14/2023, at approximately, 8:45 AM revealed Resident # 85 was in bed with oxygen at 5 liters per nasal cannula (oxygen delivery device into the nose).</p> <p>In an observation on 11/14/2023 at 1:57 PM revealed Resident #85 was in bed sleeping with oxygen per nasal cannula at 5 liters.</p> <p>In an observation and interview on 11/14/2023 at 2:57 PM, RN A stated she was taking care of Resident #85. RN A stated she checked the oxygen flow rate and the oxygen orders once a shift. RN A stated the nurse caring for the resident was responsible for the correct oxygen flow rate. RN A reviewed Resident #85's physician's order and stated the order was for 2 liters if needed for shortness of breath. RN A stated if the resident was short of breath and needed the flow rate higher the physician would be notified. RN A stated there would be a new order for the new rate. RN A stated if the resident needed a change that would be documented in the chart. RN A stated she did not see any changes in the resident's clinical record for a change in the oxygen. Observation at this time of Resident #85's oxygen, RN A stated the oxygen was set at 5 liters. RN A stated she had not checked Resident #85's oxygen yet on her shift. RN A stated the risk to the resident was CO2 retention (too much carbon dioxide in the blood could lead to a decreased level of consciousness).</p> <p>In an interview on 11/14/2023 at 3:08 PM, the DON stated the nurses were responsible for making sure the resident's oxygen flow rate was at the proper ordered rate. The DON stated the nurses were responsible for monitoring the oxygen flow rate and the physician's order every shift. The DON stated if a resident needed a change in the oxygen that would be documented in the chart. The DON stated the risk to the resident was high oxygen levels.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27846</p> <p>Based on observation, interview and record review the facility failed to provide pharmaceutical services, which included procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident for 1 of 23 residents (Residents #42) reviewed for pharmacy services.</p> <p>The facility failed to ensure Midodrine (a low blood pressure medication) given to elevate hypotension (low blood pressure) was administered to Resident #42 as ordered by the physician.</p> <p>This failure could place residents at risk of not receiving desired therapeutic outcomes, increased side effects, or a decline in health.</p> <p>Findings include:</p> <p>Record review of Resident #42's admission face sheet dated 11/14/2023, reflected a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #42 had diagnoses which included: rheumatoid lung disease with rheumatoid arthritis on multiple sites (a chronic inflammatory disorder affecting many joints), systemic lupus erythematosus (inflammatory disease caused when the immune system attacks its own tissues), pulmonary fibrosis (scarring of the lung tissue), Sjogren syndrome (an immune disorder characterized by dry eyes and dry mouth), hypertension (elevated blood pressure) and Percutaneous Endoscopic Gastrostomy (PEG) (a flexible feeding tube placed through the abdominal wall to allow nutrition, fluids and medications to be put directly into the stomach).</p> <p>Record review of Resident #42's care plan date initiated 04/15/2022 reflected:</p> <p>Focus: Resident #42 had a diagnosis of altered cardiovascular status related to hypotension (heart condition related to low blood pressure) history.</p> <p>Goal: Resident will remain free from symptoms of cardiac problems through the review date.</p> <p>Interventions: Administer medications per physician's orders.</p> <p>Record review of Resident #42's quarterly MDS, dated 09/16/2023, reflected the resident's BIMS was scored at 15 out of 15, which indicated her cognition was intact. The resident had clear speech. The resident was able to make herself understood. The resident had the ability to understand others. The resident required extensive assistance of one staff for her bed mobility, transfers, dressing, toilet use and personal hygiene. The MDS identified an active diagnosis of medically complex conditions.</p> <p>Record review of Resident #42's Medication Review Report, dated on or before 11/14/2023, reflected Midodrine 10 Mg. Give one tablet by PEG-tube three times a day for hypotension. Hold for systolic blood pressure (the top blood pressure number which measures the pressure in the arteries when the heart beats) greater than 130. Order start dated 02/17/2023.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #42's November 2023 Medication Administration Record, dated 11/01/2023 -11/30/2023, reflected the resident was not administered Midodrine 10 mg on the following dates due to parameters not met:</p> <p>11/04/2023 at 4:00 PM with BP 110/74 and at 8:00 PM with BP 124/60 by LVN B</p> <p>11/05/2023 at 8:00 PM with BP 128/70 by LVN B</p> <p>In an observation and interview on 11/14/2023 at 2:24 PM revealed Resident #42 was sitting in a wheelchair in her room. Resident #42 was alert and oriented. During an interview Resident #42 stated she had no concerns with her medications.</p> <p>In an interview and record review on 11/15/2023 at 9:25 AM, the DON reviewed Resident #42's MAR. The DON stated Resident #42 should have received the Midodrine if the resident's blood pressure was not greater than 130. The DON stated the documentation reflected the Midodrine was held due to blood pressure out of parameters. The DON stated Resident #42's blood pressure was not outside parameters. The DON stated the risk to the resident was her blood pressure could go low. The DON stated the nurse was responsible for medication administration accuracy. The DON stated the ADON was responsible for monitoring the medication administrations accuracy daily. The DON stated the results of the monitoring were discussed during the 24-hour meeting.</p> <p>In an observation and interview on 11/15/2023 at 9:46 AM revealed ADON M reviewed Resident #42' MAR. ADON M stated she monitored the medication administration record twice during her shift for accuracy. ADON M stated she did not see the Midodrine was held. ADON M stated the medication should have been given. ADON M stated the risk of not administering the medication was the resident's blood pressure could go lower. ADON M stated to prevent missing an error in the future, she would monitor the MAR closer.</p> <p>In a telephone interview on 11/15/2023 at 10:03 AM, the Pharmacist stated the medication Midodrine was to be given for low blood pressure. The Pharmacist stated when there was a parameter hold ordered by the physician the order was to be followed. The Pharmacist stated the blood pressure readings when medication was held were not severely low which would not be a bad outcome for the resident.</p> <p>In an interview on 11/15/2023 at 1:30 PM, the Administrator stated her expectations regarding the midodrine was the physician's order be followed. The Administrator stated the medication should not have been held for blood pressures less than 130. The Administrator stated the risk to the resident was her blood pressure could go low. The Administrator stated the medication administration records and physician's order would be monitored closer daily.</p> <p>In an interview on 11/15/2023 at 3:07 PM, LVN B stated when she administered medications, she reviewed the ordered parameters before she gave the medications. LVN B stated after record review of the medication administration record, she should not have given the medication. LVN B stated she may have been confused between the less than sign and the greater than sign. LVN B stated she would be more careful in the future with the two different signs. LVN B stated the risk to the resident was her blood pressure could be low.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility policy titled Administering Medications, revised April 2019, reflected Policy heading Medications are administered in a safe and timely manner, and as prescribed .Policy Interpretation and Implementation .4. Medications are administered in accordance with prescriber orders, including any required time frames</p>		