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	03/06/2026

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

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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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observation, interview, and record review, the facility failed to provide pain management consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 8 residents (Resident #121) reviewed for pain management. - RN B failed to administer Resident #121's Tramadol when she reported pain at 04 out of 10 and she requested the medication on 03/04/26.- RN B failed to complete a follow-up pain assessment after administering the resident 2 tablets of Acetaminophen 500 mg on 03/04/26. This failure could place residents at risk for decreased quality of life, uncontrolled, irretractable pain, and hospitalization. Findings included: Record review of Resident #121's Face Sheet dated 03/04/26 revealed, an [AGE] year-old female who admitted to the facility on [DATE]. There were no diagnoses listed on her Face Sheet. Record review of Resident #121's Social Worker admission Assessment and Interviews dated 03/04/26 revealed intact cognition as indicated by a BIMS score of 15 out of 15. Record review of Resident #121's undated Baseline Care Plan revealed, Health Conditions/Special Treatment- oxygen therapy, level of consciousness- alert and cognitive status- cognitively intact. Therapy Goals- improve functional status. Focus- risk of pain; Interventions- The resident will not have an interruption in normal activities due to pain through the review date, Monitor/document for side effects of pain medication. Observe for constipation; new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria; nausea; vomiting; dizziness and falls. Report occurrences to the physician. Monitor/record/report to Nurse any s/sx of non-verbal pain: Changes in breathing (noisy, deep/shallow, labored, fast/slow); Vocalizations (grunting, moans, yelling out, silence); Mood/behavior (changes, more irritable, restless, aggressive, squirmy, constant motion); Eyes (wide open/narrow slits/shut, glazed, tearing, no focus); Face (sad, crying, worried, scared, clenched teeth, grimacing) Body (tense, rigid,rocking, curled up, thrashing). Focus: the resident has oxygen therapy r/t chronic respiratory failure, unspecified whether with hypoxia or hypercapnia (excess of carbon dioxide in the blood); Intervention: Oxygen settings per MD orders. Record of Resident #121's Hospital Records dated 03/1/26 revealed,- Tramadol tablet 50 mg Dose: 50 mg Dose: 1 tablet Dose: 50 mg Freq: every 6 (six) hours as needed Route: oral Start: 02/28/2026 Admin Instructions: 50 mg, oral, every 6 hours PRN, moderate pain (score 4-6).- acetaminophen (TYLENOL) tablet 650 mg Dose: 650 mg Dose: 2 tablet Dose: 650 mg Freq: every 6 (six) hours as needed Route: oral. Admin Instructions: 650 mg, oral, every 6 hours PRN, mild pain (score 1-3). Record review of Resident #121's Order Summary Report dated 03/04/26 revealed, - Assess Resident Level of Pain every Shift on 0-10 (least to greatest) Scale . USE 0-10 SCALE(A)FOR ALERT RESIDENTS. - Acetaminophen Oral Tablet 500 MG (Acetaminophen) Give 1 tablet by mouth every 6 hours as needed for mild pain.- Tramadol HCl Oral Tablet 50 MG (Tramadol HCl) Give 1 tablet by mouth every 6 hours as needed for moderate (pain). Record review of Resident #121's Pain Level Summary dated (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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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 0697 Level of Harm - Actual harm Residents Affected - Few	03/04/26 revealed, 3/3/2026 09:16 PM, Value:0, Scale: Numerical3/4/2026 01:52 AM, Value:0, Scale: Numerical3/4/2026 10:33AM, Value:0, Scale: Numerical, Recorded by RN B3/4/2026 10:33AM, Value:4, Scale: Numerical, Recorded by RN B3/4/2026 01:09PM, Value:0, Scale: Numerical, Recorded by RN B Record review of Resident #121's PT Evaluation & Plan of Treatment dated 03/04/26 revealed, Additional Abilities/Underlying Impairment, Pain at Rest- intensity 5/10 (physical therapy) reports she just took pain meds); Frequency/Duration- intermittent, Location; R LE, Pain Description/Type- Aching. Pain with movement- Intensity: 5/10; Frequency/Duration- intermittent, Location; R LE, Pain Description/Type- Aching. Pain Assessment- Pain Assessment Method- patient verbalized pain level; does pain limit patient's functional activities?= YES. Record review of Resident #121's MAR printed on 03/04/26 at 02:07 PM revealed, - Resident #121 had not received any Tramadol since admission on [DATE].- Resident #121 received her first dose of Acetaminophen 500 mg on 03/04/26 at 10:33 AM. Her Pain level was reported as a 4 and the dose was documented as effective by RN B. Record review of Resident #121's Progress Notes printed 03/04/26 at 02:08 PM revealed,03/03/26 at 09:45 PM, Resident arrived @ 8:45pm transported via ambulance via stretcher by 2 EMS staff. Resident remained on skilled nursing services. Vital signs completed. Medication administered as ordered. Bed in lowest position and call light within reach. 03/04/26 at 01:21 AM, Resident observed resting in bed with eyes opened, pleasant lady, able to make needs known. A&O X4 (patient is fully awake, alert, and aware of four key areas: person, place, time, and event). Denies pain or discomfort at this time. Vitals obtained and recorded Temperature 97.4 BP140/62 p 82 o2 sat 95% on 2/L. ADLs completed, call light within reach, bed in the lowest position. Plan of care ongoing. An observation and interview on 03/04/26 at 10:13 AM revealed Resident #121 in bed as she received oxygen via nasal canula. She said her pain level ranged from 5 to 6 out of 10, and the pain stemmed from when she received incontinence care and she was rolled onto her hip. Resident #121 said she told staff it hurt during incontinence care and she had not received any pain medication since she admitted to the facility and she was supposed to receive tramadol. A grimace was not observed on Resident #121's face. In an interview on 03/04/26 at 10:20 AM, the state surveyors notified RN B of Resident #121's reported pain. RN B said she was not notified by any staff or the resident about the reported pain. In an observation and interview on 03/04/26 at 01:49 PM, Resident #121 reported pain at 4 to 5 out of 10 at rest that increased to 7 with movement. She said after she spoke to the surveyors in the morning, RN B talked to her about her pain but she was only administered 2 tablets of acetaminophen 500 mg. Resident #121 said at the hospital she received 50 mg and asked RN B for Tramadol, but RN B said she could only administer acetaminophen because to get approval from the physician to administer Tramadol to Resident #121. She said she was not offered any non-pharmacological (non-medication) options to control her pain and breathing exercises and repositioning helped manage her pain. Resident #121 said overnight her pain was so bad it woke her up and the pain sprung up and down with movement. She said after she received 2 tablets of acetaminophen, the nurse did not follow up with her to see if the treatment was effective, she continued to be in pain and distracted herself with her tablet. During the interview Resident #121 facial expressions and body language showed slight distress and discomfort. She could not confirm if she notified the night nurse of her pain overnight. In an interview on 03/04/26 at 02:42 PM, RN B said she was first notified of Resident #121's pain by the surveyor on the morning of 03/04/26 and the night nurse did not report the resident had pain She said during her morning round she made sure to check on the resident, since she knew Resident #121 was a new resident so she made sure to communicate with the resident who did not report any pain. RN B said after notification by the surveyor, Resident #121 reported pain at 3 to 4 out of 10 and informed the nurse she normally received tramadol. She said even though the resident had orders for tramadol, the reported pain scale of 3 to 4 and her assessment of the resident's facial expressions, indicated Resident #121 did not need tramadol so she offered her acetaminophen first. RN B said after she administered acetaminophen to Resident #121, she did not hear any complaints from her, she never pressed her call (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	bell and when she provided care to Resident #121's roommate she observed Resident #121 to be in no immediate distress. She said mild pain was on a scale of 1 to 3 out of 10, moderate was 4 to 6 out of 10, and severe was 6 to 10 out of 10. RN B said Resident #121 informed her that her pain resulted from turning and repositioning that occurred during therapy. She said she did not perform any turning and repositioning, and when she returned to talk to the resident, she did not ask Resident #121 about her pain level and the resident did not report it so she documented it as a 0. RN B said nurses were expected to manage residents' pain by monitoring them during rounds, asking specific questions about pain and completing a follow-up assessment following the administration on pain medication to determine effectiveness. RN B said she did not ask Resident #121 about her pain because she saw the resident scrolling on her tablet so she used her expressions to determine effectiveness. She said it was a mistake and she should have asked Resident #121 if her pain was controlled after she received acetaminophen. She said failure to administer appropriate pain medication or complete follow up pain assessments place residents at risk of continuation or worsening of pain, discomfort and the ability to complete therapy. In an interview on 03/06/26 at 01:23 PM, the DON said nursing staff were expected to assess residents' pain on each shift, especially if they had an order for pain medication or pain assessments. She said when staff administered any pain medication they must do a follow up assessment 30 minutes to 1 hour after administration and it should be documented in the MAR. The DON said a resident with a BIMS score of 15 should be interviewed and a numerical pain scale should be used. She said mild pain was 1-4, moderate was equal or greater than 4 and when a resident was on the border their preferences should be followed. She said failure to complete a follow up assessment or administer the preferred/appropriate medication placed residents at risk of uncontrolled pain and the facility would not know if the administered pain medication as effective. The DON said pain management was important and staff should push administration of appropriate medication to make sure therapy was successful because with the exercise you are going to see it [pain]. She said RN B should not have documented a follow-up pain score of 0 for Resident #121 when she did not assess her because inaccurate documentation could place residents at risk uncontrolled pain. In an interview on 03/06/26 at 02:56 PM, Resident #121 said she did not need any pain medication at that time, her pain was at baseline and she had received her tramadol. She said she just wanted to break the pain cycle with tramadol and once it was under control she would take acetaminophen. Record review of RN B's Skills Competency Assessments revealed,- On 08/14/25 she acknowledged training on Pain management - pain assessment every shift and PRN - must have pain level. Record review of the facility policy titled System Pathways #4- Pain Management dated 2022 revealed, The community is to recognize the inter-relationship between uncontrolled pain and the decline in functional abilities, leading to an impaired quality of life. The community should: evaluate and identify residents experiencing pain; evaluate the existing pain and the cause(s); determine the type and severity of the pain; and develop a Care Plan for pain management. MONITORING Pain & Medication Effectiveness: Pain should be monitored by the assigned nurse for the resident. Resident MD/NP orders will have the order for Pain Assessment.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review, the facility failed to ensure that assessments accurately reflected residents' status for 2 of 22 residents (Resident #2 and Resident #12) reviewed for accuracy of assessments. - The facility failed to ensure Section E of Resident #12's admission MDS completed on 02/27/26 accurately reflected her behaviors and rejection of care. - The facility failed to ensure Section I of Resident #2's Quarterly MDS completed on 01/13/26, Quarterly MDS completed on 10/13/2025, Annual MDS completed on 08/20/2025 accurately reflected her active diagnoses. These failures could place residents at risk of not having accurate assessments, which could compromise their plan of care. Findings included:Resident #2 Record review of Resident #2's Face sheet dated 03/06/2026 revealed a 74- year- old female who admitted to the facility on [DATE] with diagnoses which included: vascular dementia(a brain condition caused by reduced blood flow, often from brain attack or damaged blood vessels, which deprives brain cells of oxygen) diagnosed on [DATE], paranoid schizophrenia (a chronic, severe brain disorder that causes people to interpret reality abnormally) diagnosed on [DATE]. Record review of Resident #2's Annual Comprehensive MDS dated [DATE] revealed the following: - Active diagnoses: staff marked schizophrenia as an active diagnosis. - Antipsychotic medication review: staff marked antipsychotics were not received. Record review of Resident's Quarterly MDS dated [DATE] revealed the following: - Active diagnoses: staff marked schizophrenia as an active diagnosis. - Antipsychotic medication review: staff marked antipsychotics were not received. Record review of Resident #2's Quarterly MDS dated [DATE] revealed the following: - Active diagnoses: staff marked schizophrenia as an active diagnosis. - Antipsychotic medication review: staff marked antipsychotics were not received. Record review of Resident #2's Hospital Discharge summary dated [DATE] revealed no diagnosis of schizophrenia and no order to start on antipsychotic medications. Record review of resident #2's Provider Orders dated 03/06/2026 revealed no active orders to receive antipsychotic medications. During an interview on 03/06/2026 at 11:35 a.m., the NP stated Resident #2 was not schizophrenic and did not need to be on antipsychotic medications. During an interview on 03/06/2026 at 12:28 p.m., MDS LVN A stated she referred to Resident #2's Diagnoses List, that she updated using Resident #2's admission Notes, to guide her in completing the resident's MDSs when they were due. She stated schizophrenia was a diagnosis that Resident #2 would not come out of, so she decided to use the diagnoses list. She stated she should have reviewed (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #2's provider progress notes for a 7-day look back up-to-date diagnoses especially that Resident #2 was not actively receiving antipsychotic medications and that should have made her question the diagnosis of schizophrenia. MDS LVN A stated an inaccurate MDS could put residents at risk of being wrongly billed for diagnoses that did not exist. During an interview on 03/06/2026 at 12:40 pm, the DON stated she expected MDS LVN A to review the provider's notes to see the current diagnoses and use those diagnoses to complete resident #2's MDSs. The DON stated MDS LVN A should not have used Resident #2's Diagnoses List or keep updating the Diagnoses List without reviewing the recent Provider Notes to complete Resident #2's MDSs. The DON stated the Regional RN signed off on the residents' MDSs after the MDS LVNs completed their assigned MDSs. She stated inaccurate MDS could put Resident #2 at risk of wrong billing and improper treatment plan. The DON stated she shared the responsibility of signing off on the residents' MDSs with the [NAME] MDS RN, who signed off Resident #2's MDSs. During an interview on 03/06/2026 at 1:07 p.m., the Regional MDS RN stated she signed off on the residents' MDSs after the facility's MDS Nurses completed those MDSs. She stated signing off meant the MDS LVNs had the training they needed to complete the residents' MDSs. The Regional MDS RN stated she expected MDS LVN A to review the provider's notes to see the current diagnoses and use those diagnoses to complete Resident #2's MDSs. The Regional MDS RN stated MDS LVN A should not have used Resident #2's Diagnoses List to complete Resident #2's MDSs. She stated MDS LVN A should not have updated Resident #2's Diagnoses List in the first place without reviewing the recent Provider Notes for up-to-date diagnoses. She stated an inaccurate MDS did not affect Resident #2's care or medication regimen and did not cause wrong billing. The Regional MDS RN stated expected MDS LVN A to notice Resident #2's Dementia diagnosis on 08/20/2025 should have overruled (it refers to a situation where a new, often more senior or specialized, medical professional reviews a previous diagnosis and decides it is incorrect, invalid, or no longer applies) the schizophrenia diagnosis and removed the diagnosis from Resident #2's diagnoses List. Record review of the facility policy titled Minimum Data Set Process with no revision date revealed, Purpose: The long-term care facility follows CMS requires per RAI as a policy the facility completes an MDS and codes the Minimum Data Set (MDS) per the RAI manual and coding is based upon clinical assessments, interviews, interventions, etc. The following information can be utilized from the resident medical record to complete the MDS. a. Objective observations: b. Medications administered; c. Treatments or services performed; d. Changes in the resident's condition (also includes labs, radiology, etc.); e. Events, incidents or accidents involving the resident; and f. Behavioral concerns/issues progress toward or changes in the care plan goals and objectives. h. Treatment, Medication orders: new, changes, etc. I. Transfers, discharges. The RAI process has multiple regulatory requirements. [Federal regulations] require that (1) The assessment accurately reflects the resident's status, (2) A registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals, (3) The assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts. Resident #12 Record review of Resident #12's Face Sheet dated 03/05/25 revealed, a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included: sepsis (bacterial infection in the blood), type 2 diabetes, difficulty swallowing, and mild dementia without behavioral disturbance. Record review of Resident #12's admission MDS dated [DATE] revealed, moderately impaired (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cognition as indicated by a BIMS score of 09 out of 15. Section E- Behavior revealed: no potential indicators of psychosis (loss of contact with reality associated with hallucinations (sensing things that are not there), delusions (firm, false believe) and disorganized thinking); no physical behavioral symptoms directed towards others (hitting/kicking/scratching; no verbal behavioral symptoms directed toward others (threatening others, screaming at others, cursing at others); no other behavioral symptoms not directed towards others; and no rejection of care. Section E was completed on 02/27/26 and signed by MDS Nurse B. Record review of Resident #12's undated Care Plan revealed, Focus initiated on 02/23/26: resident has a behavior problem, refuses medications r/t dementia. The interventions included:- Administer medications as ordered. Monitor/document for side effects and effectiveness, If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident. Record review of Resident #12's Progress Notes revealed, - 02/20/26 at 03:29 PM signed by RN B revealed, Resident #12 transferred from [Hospital] via stretcher. On observation patient have hand medical hand mitts to prevent from interrupting treatment. patient observed refusing doing covid test but with help of two [medical transports] covid test performed. - 02/21/6 at 03:03 AM signed by RN I revealed, Resident is currently resting in bed comfortably with bed in a low position and call light within reach. Resident refused her medication this morning and RP was made aware. Resident kept shaking her head: no. - 02/24/26 at 05:39 AM signed by LVN E revealed, Behavior observed when providing ADLs. 2X (2 times per day) staff tried to provide ADLs and resident refused and attempt to hit. Resident refused taking her morning medication, Pantoprazole, Methocarbamol and Tylenol. This nurse attempt 2 times and informed RP about refusal. RP voiced he will be vising (holding) by 8am and try again. Will notify upcoming nurse to follow up with. - 02/24/26 at 03:37 PM signed by RN B revealed, patient have h/o refusing medication and food. RP are aware of it. Patient refuse morning medication. RP in the building and nurse talk to the family and with family member by side nurse succeed administering medication to patient. RP also stated they usually administer medication to patient and help her eat food too. nurse stated nurse/CMA will administer medication with family on patient side. DON/CMA made aware of it. - 02/24/26 at 05:57 PM signed by ADON C revealed, New order received for Psychological/Psych consult related to being combative - RP made aware. - 02/27/26 at 01:39 AM signed by LVN E revealed, Resident has refused drawing blood for the labs. - 02/27/26 at 06:47 AM signed by LVN E revealed, Behavior observed and refused morning medication. Refused ADLs . attempt twice to give medication and changed adults brief but resident has refused. Started acting agitating. An observation on 03/04/26 revealed, Resident #12 well dressed, in no immediate distress, and sitting in her room in a wheelchair. The resident was confused and did not respond to most of the surveyor's questions. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/06/26 at 02:00 pm, MDS Nurse B said she was responsible for the completion of Resident #12's MDS. She said the MDS was completed through observation, interviews and records review and she was responsible for ensuring the resident MDS(s) were accurate. MDS Nurse B said the information from the MDS was expected to reflect the resident in real time and in a look back period. She said while she did not remember Resident #12's behaviors, based on her review of the resident's progress notes the MDS dated [DATE] was inaccurate because it did not document the resident's behaviors and rejection of care. She said Section E should not have reflected no for behaviors and rejection of care.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observation, interview and record review the facility failed to ensure that a resident who needed respiratory care, including tracheostomy care and tracheal suctioning, was provided such care, consistent with professional standards of practice, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preference for 3 of residents (Resident #7, Resident #111, and Resident #121) reviewed for respiratory and tracheostomy care. - ADON C failed to assess Resident #7's respiratory status when he was observed with his oxygen mask off his tracheostomy tube.- RN B failed to assess Resident #7's respiratory status before and after performing tracheostomy (a surgically created opening into the windpipe allowing breathing, bypassing upper airway obstructions) care on 03/04/26.- The facility failed to ensure Resident #7 received O2 as ordered when he was administered 4L instead of 6L as ordered.- The facility failed to ensure the oxygen mask was directly over Resident #7's tracheostomy tube.- RN B failed to assess Resident #111 when she was observed with her nasal canula (tube placed into the nose to provide oxygen) nose) off on 03/04/26.- ADON C failed to assess Resident #111 when she was observed with her nasal canula (tube placed into the nose to provide oxygen) nose) off on 03/05/26. - The facility failed to ensure Resident #121 received O2 as ordered when she was administered 2L instead of 5L as ordered. The failures could place residents at risk for respiratory distress and hypoxia (deficiency of oxygen). Findings Included: Resident #7 Record review of Resident #7's Face Sheet dated 03/05/26 revealed, a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included: respiratory failure with hypoxia, tracheostomy, type 2 diabetes, Parkinson's disease (progressive movement disorder caused by damage to brain nerve cells) and COPD (progressive irreversible lung disease that blocks airflow and makes breathing difficult). Record review of Resident #7's admission MDS dated [DATE] revealed, intact cognition as indicated by a BIMS score of 15 out of 15, no behaviors, no rejection of care, maximum assistance with upper body dressing and total dependence for: eating, bathing, lower body dressing, personal hygiene, roll left to right, move from sit to lying & lying to sitting on side of bed. Tracheostomy status, shortness of breath, respiratory treatments of: continuous oxygen, suctioning and tracheostomy care. Record review of Resident #7's undated Care Plan revealed, Focus: The resident has oxygen therapy r/t emphysema (chronic incurable lung disease, part of COPD, that results from damage to air sacks causing severe breathing difficulty, wheezing and fatigue) / COPD; Interventions- Monitor for s/sx of respiratory distress and report to MD PRN: Respirations, Pulse oximetry, Increased heart rate (Tachycardia), Restlessness, Diaphoresis (profuse, excessive sweating occurring without physical exertion), Headaches, Lethargy, Confusion, Atelectasis (partial or complete collapse of a lung or its lobes), Hemoptysis (coughing up blood or blood stained mucus from lungs), Cough, Pleuritic pain (sharp, stabbing chest pain), Accessory muscle usage, Skin color. Oxygen settings per MD orders. Focus: The resident has a tracheostomy r/tImpaired breathing mechanics; Interventions- Ensure that trach ties are secured at all times, Monitor/document respiratory rate, depth and quality. Check and document q shift/as ordered, oxygen settings: see MD orders. Record review of Resident #7's Order Summary dated 02/20/26 revealed, O2 @ 6 (critically low and incompatible with life) via trach to maintain sats (oxygen saturation) above 92%. The order was discontinued on 03/05/26. Record review of Resident #7's Order Summary Report dated 03/05/26 at 01:54 PM revealed,- Suction trach as needed for airway clearance.- O2 @ 4L via Trach to maintain sats above 92%. Every shift for Hypoxia with order start date of 03/05/26.- Trach care HS shift & PRN as needed An observation on 03/04/26 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	at 10:49 AM revealed Resident #7 lying in bed, well-groomed and in no immediate distress; his breathing was unlabored and rate was normal. The resident had a trach collar (a device worn around the neck to secure a tracheostomy tube in place, preventing dislodgement), his oxygen concentrator delivered O2 at 4 L/min and the oxygen mask was not over his trach. The surveyor alerted ADON C, who entered the room, cleaned Resident #7's trach collar with a towel that sat on his chest and placed the oxygen mask over Resident #7's trach collar. She did not assess Resident #7's blood oxygen levels with a pulse oximeter. Resident #7 coughed as ADON C provided care, so she said she would get his nurse to perform trach suctioning. An observation on 03/04/26 at 10:58 AM revealed RN B entered into Resident #7's room to suction the resident's trach. She gathered her supplies, turned on the machine and began to suction the resident after telling him what she was going to do and instructed him to alert her if he had any discomfort. She did not check Resident #7's oxygen saturation before or after suctioning the resident. Resident #7 was observed to be in no respiratory distress when he was suctioned and had unlabored breathing. Record review of the facility policy titled Suctioning the Lower Airway (Endotracheal [ET] or Tracheostomy Tube) revised 10/2010 revealed, Purpose: The purpose of this procedure is to remove secretions, maintain a patent airway, and prevent infection of the lower respiratory tract. General Guidelines: 1. Complications of suctioning the lower airway include trauma to the airway, infection, hypoxia, hypoxemia (below normal concentration of oxygen in the arterial blood), and cardiac dysrhythmias-irregularity on heart rate (resulting from hypoxemia). To minimize the risk of complications, apply the following guidelines: a. Suction only as needed, based on assessment of the resident's level of respiratory distress; b. Use sterile equipment to avoid widespread pulmonary and systemic infection (Note: Suctioning of the lower airway is a sterile procedure. All equipment that comes in contact with the lower airway must be sterile.); c. If resident has order for O2 - Apply oxygen to help oxygenate resident before and after suctioning 2. Monitor the resident's pulse and oxygen saturation (Pulse Oximetry) before and after the suctioning. If pulse decreases more than 20 beats per minute (BPM) or increases more than 40 BPM, or oxygen saturation drops below 90 percent (or 5 percent from baseline) discontinue suctioning and re-ventilate and re-oxygenate the resident. Resident #111 Record review of Resident #111's Face Sheet dated 03/06/26 revealed, a [AGE] year-old female who admitted to the facility on [DATE] with diagnosis which included: presence of a pacemaker, stomach bleed, falls, long term use of blood thinners and high cholesterol. Record review of Resident #111's admission MDS dated [DATE] revealed, severely impaired cognition as indicated by a BIMS score of 04 out of 15, no behavioral symptoms or rejection of care, use of a walker and wheelchair, total dependence for must ADLs and oxygen therapy while a resident in the facility. Record review of Resident #111's undated Care Plan revealed, Focus- The resident has a behavior problem(removing her clothing, oxygen and foley) r/t Dementia revised 03/04/26; intervention- Psych consult 2/5/26 Date Initiated: 02/10/2026. Focus- The resident has oxygen therapy r/t CHF - resident sometimes removes oxygen and needs reminded she needs to wear it, revised 03/04/26; Interventions: Oxygen settings per MD orders Date Initiated: 01/14/2026, Monitor for s/sx of respiratory distress and report to MD PRN: Respirations, Pulse oximetry, Increased heart rate (Tachycardia), Restlessness, Diaphoresis (sweating), Headaches, Lethargy (tiredness), Confusion. Record review of Resident #111's Order Summary Report dated 03/06/26 revealed, - O2@ 2L via NC CONTINUOUS every shift.- oxygen 2L via NC as needed to maintain oxygen >92% every shift for desaturation (dangerous drop in blood oxygen level dipping below 90% and signaling potential respiratory or cardiac issues). Record review of Resident #111's O2 Sats Summary dated 03/06/26 revealed,3/1/2026 09:08 98.0%3/1/2026 8:42 pm 96.0%3/2/2026 1:23 am 96.0%3/2/2026 7:52 am 96.0%3/2/2026 2:32 pm 96.0%3/2/2026 11:56 pm 96.0%3/3/2026 6:58 am 96.0%3/3/2026 9:59 pm 98.0%3/4/2026 1:50 am 96.0%3/4/2026 7:04 am 96.0%3/4/2026 11:15 am 98.0% @ 2 L/Min3/4/2026 3:56 pm 98.0%3/5/2026 12:18 am 97.0%3/5/2026 9:48 pm 97.0%3/5/2026 11:31 pm 97.0% Record review of Resident #111's Progress Notes revealed, - 03/04/26 at 11:15 AM, patient removed her oxygen via nasal canula. Nurses reconnected oxygen as soon as possible. No sign of (continued on next page)

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	676482	A. Building B. Wing	03/06/2026

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	distress, shortness of breath, labored breath noted. Nurse comforted the patient, patient didn't complain of distress and discomfort. RP in the building and notified. RP stated understanding. Will continue monitoring patient for oxygen saturation and discomfort. Will continue plan of care.- 3/5/2026 05:39 AM, Resident observed removing her NC multiple times and this nurse placed it back and O2 saturation monitored every time she has removed her NC. O2 saturation maintained 97%. An observation on 03/04/26 at 09:57 AM revealed Resident #111 in bed. Her oxygen canula was out of her nose, in her hand and the resident appeared sedated. She was drifting in and out, not interviewable, could not keep her eyes open and was confused. The surveyor immediately notified RN B, who entered the resident's room, placed the nasal canula in the resident's nose and left the room after talking to the resident. She did not perform any assessments on Resident #111, and did not check the resident's blood oxygen saturation level or oxygen settings. An observation on 03/05/26 at 09:57 AM revealed Resident #111 eating breakfast with her nasal canula out of her nose. She was responsive to the surveyor's questions and was not in respiratory distress. The surveyor immediately notified ADON C, who entered the resident's room, placed the nasal canula in the resident's nose and left the room after talking to Resident #111. She did not perform any assessments on Resident #111, and did not check the resident's blood oxygen saturation level or oxygen settings. In an interview on 03/04/26 at 02:42 PM, RN B said nurses were expected to assess residents who received O2 every shift to ensure it was administered as ordered. She said when she was notified by the surveyor she failed to check Resident #111's sats because it happened too fast. She said failure to check oxygen saturation levels of residents who were found without their continuous oxygen placed them at risk of difficulty breathing, and hypoxia. Resident #121 Record review of Resident #121's Face Sheet dated 03/04/26 revealed, an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses. There were no diagnoses listed on her Face Sheet. Record review of Resident #121's undated Baseline Care Plan revealed, Health Conditions/Special Treatment- oxygen therapy, level of consciousness- alert and cognitive status- cognitively intact. Therapy Goals- improve functional status. Focus- risk of pain; Interventions- The resident will not have an interruption in normal activities due to pain through the review date, Monitor/document for side effects of pain medication. Observe for constipation; new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria; nausea; vomiting; dizziness and falls. Report occurrences to the physician. Monitor/record/report to Nurse any s/sx of non-verbal pain: Changes in breathing (noisy, deep/shallow, labored, fast/slow); Vocalizations (grunting, moans, yelling out, silence); Mood/behavior (changes, more irritable, restless, aggressive, squirmy, constant motion); Eyes (wide open/narrow slits/shut, glazed, tearing, no focus); Face (sad, crying, worried, scared, clenched teeth, grimacing) Body (tense, rigid,rocking, curled up, thrashing). Focus: the resident has oxygen therapy r/t chronic respiratory failure, unspecified whether with hypoxia or hypercapnia (excess of carbon dioxide in the blood); Intervention: Oxygen settings per MD orders. Record review of Resident #121's Order Summary Report dated 03/04/26 revealed, - O2 @ 5L VIA Nasal Cannula to maintain sats above 92% every shift for hypoxia/ copd. Record review of Resident #121's Progress Notes revealed,03/04/26 at 01:21 AM, Resident observed resting in bed with eyes opened, pleasant lady, able to make needs known. Alert &Oriented X4. Denies pain or discomfort at this time, but ask that we bear with her as she just lost her [partner] in January and still grieving. Vitals obtained and recorded Temperature 97.4 degrees Fahrenheit, BP 140/62, p 82, O2 sat 95% on 2/L. An observation on 03/04/26 at 10:13 AM revealed Resident #121 was in bed with a nasal cannula in place that administered oxygen at 2L/min. She was in no respiratory distress, her breaths were unlabored. An observation and interview of 03/04/26 at 01:45 PM revealed Resident #121 in bed with a nasal canula in place that administered oxygen at 2 L/min. She said she never received oxygen at 5 L/min, had not experienced any respiratory distress and her oxygen saturation was always between 97-100 %. In an interview on 03/06/26 at 10:05 AM, RN B said Resident #7 had limited ability to move his neck since he had the trach placed. She said the resident's oxygen mask should always be over his trach and she (continued on next page)

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	676482	A. Building B. Wing	03/06/2026

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	did not know it was off prior to ADON C requesting her to perform trach care on 03/04/26. RN B said nurses must check O2 sats, before, during and after trach care to ensure the resident received enough oxygen. She said she failed to check Resident #7's O2 sats when she provided trach care because she was just freaked out. RN B said if a resident failed to have their ordered continuous oxygen in place they could experience hypoxia so it was importance to check their saturation levels after reapplying the oxygen. She said she never observed Resident #7, Resident #111 or Resident #121 in respiratory distress on 03/04/26. In an interview on 03/06/26 at 11:55 AM, ADON C said Resident #7 had limited mobility of his head, neck, shoulder and arms. She said he required continuous oxygen via his trach and prior to performing trach care and suctioning staff must check the resident's oxygen saturation with a pulse oximeter to ensure they are adequately oxygenated. She said oxygen must be administered as ordered by the physician and if a resident that required continuous oxygen was found without their oxygen delivery device (nasal canula or mask) in place by staff, the staff must first apply the residents device as ordered and then check for their oxygen saturation to ensure they were ok. ADON C said if a resident failed to receive continuous oxygen as ordered they could desaturate, have difficulty breathing and experience respiratory distress (critical condition marked by difficulty breathing, rapid heart rate, and increased respiratory effort). She said failure to assess residents who experienced interrupted oxygen delivery would place the resident at risk of unknown blood oxygen levels. In an interview on 03/06/26 at 01:23 PM, the DON said Resident #7 had a stable tracheostomy, had no complaints of shortness of breath and required continuous oxygen. She said when staff performed trach care they were expected to hyperventilate the resident by increasing their oxygen administration to 4-5 L/min and monitor oxygenation before, during and after trach care such as suctioning to ensure the resident received sufficient oxygen. She said failure to monitor oxygenation during trach care could place residents at risk of hypoxia and respiratory distress. The DON said when a resident was found without their oxygen delivery device on staff were expected to apply the device and then check the residents O2 sats to know their blood oxygen levels. She said she should not apply the mask and leave the resident unattended because the resident's respiratory status was unknown and they may experience a change of condition. The DON said oxygen should be administered as ordered and nursing staff were expected to check the administration rate against the TAR and check the residents oxygen saturation rate. She said failure to administer oxygen as ordered could place residents at risk of SOB and hypoxia. Record review of RN B's Clinical Nursing Validation Review Checklist dated 08/14/25 revealed, she was assessed for:- Infection Control- sharps disposal- Respiratory- pulse oximeter, oxygen mask/nasal canula, tracheal suctioning, trach care. The competencies were met. Record review of ADON C Clinical Nursing Validation Review Checklist dated 02/20/26 revealed, she was assessed for:- Respiratory- pulse oximeter, oxygen mask/nasal canula, tracheal suctioning, trach care. The competencies were met. Record review of the facility policy tilted Oxygen Administration with no revision date revealed, Purpose: A resident will receive oxygen therapy when ordered by a physician. The resident's disease, physical condition, and age will help determine the most appropriate method of administration. 5. Monitor the resident's response to oxygen therapy. Check pulse oximetry as indicated if ordered by physician/FNP or change in condition. 6. Monitor the resident for signs of hypoxemia as appropriate, such as: a. level of consciousness, b. pulse oximetry, c. vital signs, d. skin and mucous membrane color , e. breathing patterns, f. dyspnea, g. cyanosis, cool, clammy skin. 2. Record review of Resident #57's face sheet, dated 03/05/26, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #57 had diagnoses which included: respiratory failure, high cholesterol, paralysis of the left nondominant side following a stroke (brain damage caused by the cut off of blood), blood infection and diarrhea.Record review of Resident #57's admission MDS, dated [DATE], revealed severely impaired cognition as indicated by a BIMS score of 03 out of 15. Resident #57 used a wheelchair and had no behaviors or rejection of care.Record review of Resident #57's, undated, Care Plan revealed, Focus-altered cardiovascular status due to history of stroke, high cholesterol and hypertension (high blood (continued on next page)

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	676482	A. Building B. Wing	03/06/2026

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pressure). Record review of Resident #57's Order Summary Report, dated 03/05/26, revealed Accucheck (blood sugar check) AC/HS. Record review of Resident #57's Blood Sugar Summary, dated 03/05/26, revealed RN checked Resident #57's blood sugar on 03/04/26 at 08:33 AM. The reading was 109 mg/dL.An observation and interview on 03/04/26 at 09:44 AM revealed, Resident #57 in a wheelchair accompanied by a family member in the resident's room. There was a white and purple lancet on the nightstand located on the left side of the resident's bed, the safety cover of the needle was absent, the purple button was depressed and the hole containing the retracted needle was visible. Resident #57 and his family were unaware of the lancing device.In an observation and interview on 03/04/26 at 09:45 AM, the DON was notified of the presence of the unused lancing device. She entered into Resident #57's room, retrieved the lancing device and discarded it in the sharps container affixed to the wall in the inside of the resident's room.In an interview on 03/04/26 at 10:05 AM revealed, RN B said she checked Resident #57's blood sugar on the morning of 03/04/26. She said when a nurse checked a resident's blood sugar they were expected to discard the disposable lancet after the blood sample was retrieved and applied to the glucometer (device used to measure blood sugar) and the lancet should never be left unattended. RN B said she did not use the white and purple lancet observed in Resident #57's room in the morning but all staff who entered a resident's room should make rounds to ensure there were no safety concerns. She said an unattended lancet could place residents at risk of injury or infection if already used.In an interview on 03/06/26 at 01:23 PM, the DON said a used lancet should not be left unattended and must be discarded in a sharps container immediately. She said an unattended lancet could place residents at risk of injury if they pricked themselves with it and infection control if it was used.Record review of the facility's policy and procedures on Suctioning the Lower Airway (Endotracheal [ET] or Tracheostomy Tube) (revised October 2010) read in part: The purpose of this procedure is to remove secretions, maintain a patent airway, and prevent infection of the lower respiratory tract.Assemble the equipment and supplies as needed.Use sterile equipment to avoid widespread pulmonary and systemic infection (Note: Suctioning of the lower airway is a sterile procedure. All equipment that comes in contact with the lower airway must be sterile.).The following equipment and supplies will be necessary when performing this procedure: Sterile suction catheter kit; Sterile drape; Sterile cup; Sterile gloves; #10 to #16 French [size] catheter; Sterile gauze; Sterile saline or sterile water.Perform hand antisepsis. Put on gloves. Turn on suction unit and adjust to appropriate negative pressure. Remove gloves. Open suction catheter kit. Place sterile drape across the resident's chest. Remove sterile cup, touching only the outside. Fill cup with sterile saline or sterile water. Apply sterile gloves. Recommend: The dominant hand will remain sterile. Holding the catheter in dominant hand and the tubing in the non-dominant hand, connect the catheter to the tubing. Suction a small amount of water from the cup to verify negative pressure. Rest catheter tip on sterile surface (e.g., sterile drape or open catheter kit). Remove oxygen or humidity delivery device using non-dominant hand. Instruct the resident to inhale. Upon inhalation, insert the catheter into airway (ET tube or tracheostomy tube) without applying suction. Advance the catheter until resistance is met and/or resident coughs (at the [NAME] [base of windpipe where it splits into left and right lung). Pull back 1 to 2 cm. Apply intermittent suction and slowly withdraw catheter while rotating between thumb and forefinger. Limit suction time to no more than 10 seconds. Re-ventilate and oxygenate the resident for a minimum of one minute between suctions. Rinse catheter and tubing with sterile saline or sterile water until clear.Limit suction passes to a maximum of three.Record review of the facility's policy and procedure on Tracheostomy Care (revised August 2013) read in part: The purpose of this procedure is to guide tracheostomy care and the cleaning of reusable tracheostomy cannulas. Open tracheostomy cleaning kit. Set up supplies on sterile field. Maintaining sterile field.Open four gauze pads and saturate with hydrogen peroxide. Open two gauze pads and saturate with antiseptic solution. Open two gauze pads and saturate with sterile saline. Open two gauze pads; keep them dry. Put on sterile gloves. Secure the outer neck plate with non-dominate gloved hand. Unlock the inner cannula with gloved dominate (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hand. Gently remove the inner cannula, rotating counterclockwise while lifting away from the resident. Remove and discard gloves into appropriate receptacle. Wash hands and put on fresh gloves. Replace the cannula carefully and lock in place.Apply clean gloves. Clean the stoma with two peroxide-soaked gauze pads (using a single sweep for each side). Rinse the stoma with saline-soaked gauze pads (using a single sweep for each side). Wipe with dry gauze (using a single sweep for each side). Apply a fenestrated gauze pad around the insertion site.Record review of the facility's policy titled Blood-Sampling- Capillary (Finger Sticks revised 09/2014 revealed, Purpose: The purpose of this procedure is to guide the safe handling of capillary-blood sampling devices to prevent transmission of bloodborne diseases to residents and employees . Steps in the Procedure: 5. Wipe the area to be lanced with an alcohol pad/wipe. 6. Obtain the blood sample, following the manufacturer's instructions for the device. 7. Discard lancet and platform into the sharps container . Record review of the facility's policy and procedures on Infection Prevention and Control Program (revised August 2016) read in part: The infection prevention and control program is a facility-wide effort involving all disciplines and individuals and is an integral part of the quality assurance and performance improvement program. The elements of the infection prevention and control program consist of coordination/oversight, policies/procedures.prevention of infection .The infection prevention and control program is coordinated and overseen by an infection prevention specialist (infection preventionist).Important facets of infection prevention include:.educating staff and ensuring that they adhere to proper techniques and procedures.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide pharmaceutical services to meet the needs of each resident for 5 of 5 medical supplies, (including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals,) reviewed for medication storage and labeling.The facility failed to ensure the medication room was free from expired medical supplies on [DATE].This failure could place residents at risk of using items that were less effective or risky due to a change in their chemical composition (change of a substance into something else, often making it weaker, useless, or harmful), and could cause infections due to compromised sterile equipment.Findings included: During an observation of 300 hall's medication cart and interview on [DATE] at 10:28 a.m., revealed staff stored expired eSwab tubes (a system of a liquid-based, FDA-cleared device for collecting and transporting wound cultures) count 2, both expired on [DATE]. LVN J stated he checked the medication cart every day for expired items. He stated he should have noticed the expired tubes and discarded them. LVN J stated leaving expired unopened wound culture tubes in medication carts could cause inaccurate lab results and improper treatment plans based on those wrong results.During observation of the medication room and interview with ADON B on [DATE] at 10:35 a.m., revealed, staff stored the following expired medical supplies:- Unopened eSwab tubes count 7, all expired on [DATE].- Unopened eSwap tubes count 2 expired on [DATE].- Unopened 20 urine analysis transfer straw kits (used to move urine from a collection cup into test tubes to test it) count 20 expired in February 2026.- Unopened flu test kits count 90 expired on [DATE].- Unopened gastric (in the stomach) feeding tubes count 3 expired on [DATE], [DATE], [DATE].- Unopened intravenous (in the vein) administration sets count 40 expired on [DATE]. ADON B stated staff did not use those tubes recently. She stated she checked the medication room every month for expired items but did not notice the expired items. She stated using expired medical supplies could cause inaccurate laboratory results, improper treatment plans and infections.During an interview on [DATE] at 12:00 p.m., the DON stated she expected ADON B to check the medication room every month and expected nurses sand MAs to check medication carts every day for expired items. She stated she did random audits every week on medication carts and the medication room for expired items. The DON stated using expired medical supplies could cause inaccurate laboratory results, improper treatment plans and infections.Record review of the facility's, undated, Medical Supplies Inventory Policy revealed .1. It should be best practice to rotate supplies and move older supplies to the front and use first. 2. Such practices help with reducing waste and the likelihood of expired products being used. 3. Conducting regular audits such as at least monthly the medical supply person/designee maintains oversight of medical supplies and their expiration dates/status. These audit checks should be scheduled at consistent intervals, any supplies nearing their expiry dates are identified and addressed promptly. 4. Direct care staff should look at medical supplies before use and if expired date is noted it is to be thrown away and obtain another item that is not expired. 5. Direct care staff should notify the DON and medical supply person if an expired item is found to help consider conducting an audit sooner that monthly occurrence.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for food procurement. -The facility failed to ensure food items were labeled and dated. This failure could place residents at risk of foodborne illness and disease.Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for food procurement. - The facility failed to ensure food items were labeled and dated. This failure could place residents at risk of foodborne illness and disease. Findings include: Observation of the facility's kitchen on 3/4/2026 at 8:18 a.m. revealed the following: An open container of Homestyle Mayonnaise, 1 gallon, in the refrigerator were not dated. In an interview on 3/6/2026 at 10:18 a.m. with the Kitchen Manager, she stated everything in the refrigerator was labeled except the mayonnaise. She stated she did not know why the mayonnaise was not labeled, it was possibly overlooked. She stated it was the kitchen staff and her responsibility to ensure all food in the refrigerator were labeled. When asked if she understood the risk to the residents if the food in the refrigerator was not dated, she responded, Possibly not knowing how long the food is in the refrigerator. She stated the mayonnaise should have been discarded due to not knowing how long it had been in the refrigerator. Record review of the facility's Food Storage policy, revised on 6/1/2019, stated: d. Date, label, and tightly sealed all refrigerated foods using clean, nonabsorbent, covered containers that are approved for food storage.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observation, interview, and record review the facility failed to administer parenteral fluids consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences for 1of 3 (Resident #70) residents reviewed for parenteral fluids. - The facility failed to ensure the dressing of Resident #70's IV line was changed weekly as ordered. This failure could place residents at risk for unwanted infections and further decrease in quality of life. Findings included: Record review of Resident #70's Face Sheet dated 03/05/26 revealed, a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included: skin infection (cellulitis) of the left upper limb, type 2 diabetes, anxiety and obesity (excessive fat accumulation). Record review of Resident #70's admission MDS dated [DATE] revealed, intact cognition as indicated by a BIMS score of 15 out of 15, no indication of hallucinations (feeling things that aren't there), delusions (firm believes that are not real), no behavioral symptoms and rejection of care that occurred 1 to 3 days, surgical wounds, application of nonsurgical dressings, antibiotic use and IV access while a resident at the facility. Record review of Resident #70's undated Care Plan revealed, Focus- risk for complications associated with antibiotic IV therapy related to left upper arm cellulitis. The interventions included- Change dressing to IV access site as ordered. Focus- resistance to care r/t adjustment to nursing home. The interventions included- Give clear explanation of all care activities prior to an as they occur during each contact. Record review of Resident #70's Physician's order on 03/01/26 revealed, PICC line (a long thin, flexible tube inserted through a vein in the upper arm for longterm intravenousaccess for medications, fluids, or blood draws) dressing and cap change weekly using sterile technique per protocol: in the morning every sun for dressing change. Record review of Resident #70's Temperature Summary dated 03/05/26 revealed no documented fever (rise in body temperature over 100.4 degree F).3/1/2026 01:25 AM 98.8 F3/1/2026 08:45 AM 97.8 F3/1/2026 08:56 PM 98.7 F3/2/2026 01:26 AM 98.8 F3/2/2026 07:54 AM 97.2 F3/2/2026 09:54 AM 97.2 F3/2/2026 09:29 PM 97.8 F3/2/2026 11:52PM 97.7 F3/3/2026 12:38 PM 97.8 F3/3/2026 04:51 PM 97.8 F3/4/2026 01:47 AM 97.7 F3/4/2026 01:50 PM 97.4 F3/4/2026 05:20 PM 97.7 F3/5/2026 12:23 AM 98.0 F Record review of Resident #70's March 2026 MAR revealed, LVN J documented the dressing on Resident #70's PICC line was changed on Sunday, 03/01/26. Record review of Resident #70's Progress Notes revealed,-03/01/26 at 08:32 AM signed by the RN, Resident is currently resting in bed comfortably with bed in a low position and call light within reach. No current distress or pain observed. Resident is adjusting to facility well. Resident is tolerating PT and OT well. Residents peripheral IV site has a dressing that is clean, dry and intact. No s/s of pain or infiltration to site area. No s/s of infection observed to site area.There was no documentation regarding the change of Resident #70's PICC line dressing or the resident rejecting the dressing change. An observation and interview on 03/04/26 at 10:29 AM revealed, Resident #70 was in no immediate distress in bed. The resident had a dressing on her right upper arm covering a PICC line and a dressing on her left shoulder. The dressing on the right arm was clean and read 02/22/26, while the dressing on the left arm read 03/03/26. Resident #70 said she received IV antibiotics for a bacterial skin infection in her left shoulder and she didn't know the last time her IV dressing was changed but the line stopped working so it was scheduled to be changed. There was no redness or swelling observed around the area of the IV dressing. In an interview on 03/06/26 at 10:05 AM, RN B said nurses were expected to check residents' PICC lines daily as used and change the dressings every week to prevent infection. (continued on next page)

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	03/06/2026

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

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She said when she observed Resident #70's IV dressing on 03/04/26 it read 02/22/26 and nursing staff talked about care of the dressing during the previous week. RN B said she administered IV antibiotics to Resident #70 on 03/03/26 and assessed the resident's dressing and she did know why she didn't change the dressing but the resident did not show any signs of infection (fever, swelling and redness at the site). In an interview on 03/06/26 at 11:17 AM, LVN J said IV dressing were changed every week to prevent infection. He said the new dressing must be signed, dated and initialed and documented in real time in the resident's chart. He said falsely documenting an IV dressing change placed residents at risk for missed treatments and infection, because once documented, the task was removed and only returned as a due task 1 week later. LVN J said on 03/01/26, he administered Resident #70s IV antibiotic and he did not remember any incidents that stopped the change of Resident #70's IV dressing or that Resident #70 refused the change of her IV dressing. LVN J reviewed Resident #70's EMR and said he documented the dressing change on 03/01/26 at 08:46 AM, but since the dressing was not changed, he must have just missed it. He said every time nursing staff rounded on a resident, or administered IV antibiotics they were expected to inspect the dressing and if necessary change it if it was over 1 week old. In an interview on 03/06/26 at 11:23 AM, NP Q said she was notified that Resident #70's IV line failed so she gave orders to have it replaced. She said the frequency by which nursing changed the resident's IV dressing was based on the facility policy but, dressings must be changed in order to prevent infection. NP Q said failure to change IV dressings as ordered placed resident at risk of infection or worsening of their current infections but Resident #70 had not displayed any signs of infection such as redness or swelling at the site. In an interview on 03/06/26 at 12:40 PM, Resident #70 said she had not experienced any signs and symptoms of infection such as swelling, pain, or redness at her IV site. She said on 03/04/26 her PICC line was changed, and she continued to receive her IV antibiotic. In an interview on 03/06/26 at 01:23 PM, the DON said IV dressings should be changed every week to prevent infection and the dressing must be dated when changed. She said failure to change the dressing placed residents at risk of infection that could go to their blood. The DON said inaccurate documentation of dressing changes could result missed treatment because it would remove the task from the MAR, but nurses were expected to assess the dressing and changed it if necessary when they provided care/administered IV antibiotics. Record review of RN B's Clinical Nursing Validation Review Checklist dated 08/14/25 revealed, she was assessed for:- Infection Control: Aseptic Dressing Change. The competency was met. Record review of the facility policy titled PICC or Midline Catheter Sterile Dressing Change with no revision date revealed, Purpose: A PICC (Peripherally Inserted Central Catheter) and a Midline catheter are special types of IV lines that can be used to give IV medicines or fluids. A dressing is needed to cover and protect your catheter site to help lower the risk of infection. Sterile technique will be used when doing the dressing change. How often does a dressing need to be changed?: Change the dressing every 7 days or as soon as possible if it is wet, soiled, loose, or open to the air or if physician states differently.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, interview and record review the facility failed to ensure the medication error rate was not 5% or greater. The facility had a medication error rate of 6.0%, based on two errors out of 29 opportunities, which involved 2 of 4 residents (Residents #3 and #64) and 2 of 2 (RN B and MA C) staff observed during medication administration reviewed for medication errors. -The facility's staff failed to administer scheduled medications to Residents #3 and #64.-This failure could place residents at risk of receiving less than optimal results from their medication regimen.Findings included:. Record review of Resident #64's Physician Orders, dated 03/05/2026, revealed active orders of the following medications:- Amlodipine oral (by mouth) tablet 10 mg. Give 1 tablet by mouth one time a day for High blood pressure.- Aspirin low dose oral tablet 81 mg. Give 1 tablet by mouth one time a day related to paroxysmal atrial fibrillation (irregular heart rhythm).- Buspirone tablet 5 mg. Give 2 tablet by mouth three times a day for anxiety (the body's response to stress, characterized by feelings of fear, dread, apprehension, and uneasiness).- Cholecalciferol oral tablet 25 mcg. Give 1 tablet by mouth every 12 hours for vitamin D deficiency (when the body does not have enough vitamin D).- Docusate oral capsule 100 mg. Give 2 capsules by mouth in the morning for constipation.- Finasteride oral tablet 5 mg. Give 1 tablet by mouth one time a day for BPH (noncancerous enlargement of the prostate).- Losartan oral tablet 25 mg. Give 1 tablet by mouth one time a day for high blood pressure.- Methocarbamol oral tablet 500 mg. Give 1 tablet by mouth three times a day for spasm.- Metoprolol ER oral tablet Extended Release 25 mg. Give 1 tablet by mouth one time a day for CAD (a heart disease, occurring when plaque builds up inside the arteries that supply blood to the heart, causing them to narrow and harden).- Omega-3 oral Capsule. Give 3 capsules by mouth one time a day for Heart health.- Ondansetron tablet 4 mg. Give 1 tablet by mouth one time a day for nausea and vomiting.- Oxycodone oral tablet 5 mg. Give 1 tablet by mouth every 4 hours for severe pain.- Sertraline oral tablet 50 mg. Give 1 tablet by mouth one time a day for depression.- Vitamin C oral tablet 500 mg. Give 1 tablet by mouth one time a day for vitamin C deficiency.- Allopurinol oral tablet 300 mg. Give 1 tablet by mouth one time a day for gout (a type of inflammatory arthritis that causes pain and swelling in your joints).During an observation on 03/05/2026 at 7:57 a.m., revealed RN B prepared and administered the following medications to Resident #64: Aspirin tablet 81 mg, cholecalciferol tablet 25 mcg, finasteride tablet 5 mg, methocarbamol tablet 500 mg, ondansetron tablet 4 mg, Fish Oil (brand name for Omega-3) 3 capsules, vitamin C tablet 500 mg, buspirone tablet 10 mg, sertraline tablet 50 mg, Docusate 100 mg 2 capsules, oxycodone tablet 5 mg, metoprolol tablet 25 mg, amlodipine tablet 10 mg, losartan tablet 25 mg. RN B did not administer allopurinol tablet 300 mg. RN B concluded administering Resident #64's medications and started to prepare medications for another resident. Further observation revealed allopurinol was available in the medication cart.During an interview on 03/05/2026 at 11:45 a.m., RN B stated she gave all the scheduled medications to Resident #64 including allopurinol.2. Record review of Resident #3's Physician Orders, dated 03/05/2026, revealed active orders of the following medications:- Baclofen oral tablet 10 mg. Give 1 tablet by mouth two times a day for spasm.- Ergocalciferol oral capsule 1.25 mg. Give 1 capsule by mouth one time a day, every Thursday for supplement.- Lacosamide oral tablet 100 mg. Give 1 tablet by mouth two times a day for seizure (a sudden, temporary burst of uncontrolled electrical activity in the brain that disrupts normal function).- Metformin ER tablet extended release 500 mg Give 1 tablet by mouth one time a day for Diabetes.- Metoprolol oral tablet extended release 25 mg. Give 1 tablet by mouth one time a day for high blood pressure.- Rifaximin oral tablet 550 mg. Give 1 tablet by mouth two times a day for liver diseases.- Rivaroxaban oral tablet 2.5 mg. Give 1 tablet by mouth every 12 hours for peripheral artery disease (condition where plaque builds up in the arteries that carry blood to your legs or arms, causing them to narrow).- Sodium chloride oral tablet 1 gm. Give 2 tablet by mouth two times a day for low sodium levels.- Urea oral packet 15 gm. Give 1 packet by mouth two times a day for low sodium levels.- Sulfasalazine oral tablet 500 mg. Give 1 tablet by mouth two times a day for (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Rheumatoid arthritis (a chronic disease where the immune system mistakenly attacks the lining of the joints, causing painful inflammation, stiffness, and swelling).During an observation on 03/05/2026 9:25 a.m., revealed MA C prepared and administered the following medications to Resident #3:Metoprolol tablet 25 mg, urea oral packet 15 gm, metformin tablet 500 mg, sodium chloride tablet 1 gm, baclofen tablet 10 mg, ergocalciferol tablet 1.25 mg, rivaroxaban tablet 2.5 mg, rifaximin tablet 550 mg, lacosamide tablet 100 mg. MA C did not administer Sulfasalazine oral tablet 500 mg. MA C concluded administering Resident #3's medications and started to prepare medications for another resident. Further observation revealed sulfasalazine was available in the medication cart.During an interview on 03/05/2026 at 11:00 a.m., MA C stated she gave all the scheduled medications to Resident #3, including sulfasalazine.During an interview on 03/05/2026 at 12:55 p.m., the DON stated she expected all nurses and MAs to administer all scheduled medications. She stated staff should have double checked residents' MARs and medication containers before they administered medications and made sure, they did not miss any medication. She stated if staff did not administer scheduled medications, residents would suffer from delay in their treatment plans. The DON stated she performed random audits every day while staff passed medications. She stated she did not perform an audit on the day of the observation due to state survey.During an interview on 03/06/2026 at 11:30 a.m., the NP stated she expected all nurses and MAs to notify her when they missed any medication administration. She stated Residents #3 and #64, who missed one dose of their medications, could experience mild pain and required to adjust their medication scheduled times on the day when both missed their medications.Record review of the facility's Administering Medications Policy, dated April 2019, revealed, .2.The director of nursing services supervises and directs all personnel who administer medications and/or have related functions.10.The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.

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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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observation, interview and record review the facility failed to ensure each resident received and the facility provided food prepared in a form designed to meet individual needs for 1 of 22 Residents (Resident #65) reviewed for food prepared in a form designed to meet individual needs. The facility failed to ensure Resident #65's dietary orders and preference of a mechanical soft diet when were followed when the resident was served dry lightly toasted toast for breakfast and boiled potatoes with the skin for lunch on 03/05/2026. This failure could place residents at risk of difficulty chewing, choking and weight loss. Findings include: Record review of Resident #65's face sheet, dated 03/05/26, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #65 had diagnoses which included: paralysis and weakness on the right dominant side following a stoke (brain damage caused by a blockage in a blood vessel do to lack of oxygen and nutrients), Parkinsonism (group of neurological disorders causing motor symptoms similar to Parkinson's disease), high blood pressure, high cholesterol and speech disorders affecting articulation (formation of clear and distinct sounds in speech). Record review of Resident #65's admission MDS, dated [DATE], revealed moderately impaired cognition as indicated by a BIMS score of 11 out of 15. Resident #65 required supervision or touching assistance with eating. Record review of Resident #65's, undated, Care Plan revealed Focus: The resident has potential nutritional problem r/t No Added Salt (NAS) diet, Mechanical Soft texture, Regular Liquids consistency; Interventions: Monitor/document/report PRN any s/sx of dysphagia (difficulty swallowing): Pocketing, Choking, Coughing, Drooling, Holding food in mouth, Several attempts at swallowing, Refusing to eat, Appears concerned during meals. Provide, serve diet as ordered. Monitor intake and record Q meal. Record review of Resident #65's Order Summary Report, dated 03/05/26, revealed No Added Salt (NAS) diet Mechanical Soft texture, Regular Liquids consistency, please give orange juice and fruit punch with meals. Started 01/30/26. Record review of Resident #65's Progress Notes revealed, -01/30/26 at 01:15 PM signed by RN B, patient downgraded to mechanical soft since patient and family member concerned about patient having difficulty in swallowing regular food from before while being in hospital. An observation on 03/05/26 at 08:30 AM revealed Resident #65 sat in his room eating breakfast. His plate had scrambled eggs, chopped breakfast sausage covered in white gravy and 2 slices of toast. The toast was full, uncut, dry and lightly toasted. Resident #65's meal ticket read diet: mechanical soft, regular liquids, no added salt. There were no notes, alerts, standing orders or dislikes documented on the meal ticket. In an interview on 03/05/26 at 01:04 PM, the Dietary Manager said a resident's dietary orders were entered into the EMR which was integrated into the kitchen system that provided instructions on how to prepare meals for each diet type. She said a mechanical soft diet was typically ordered due to swallowing issues, chewing issues or a residents preference. She said the cooks assembled the meals based on the information printed by the facility system on the individual resident's meal tickets and those with mechanical soft diets received chopped meats and mashed potatoes without skins for ease of chewing for today's lunch. She said the kitchen systems still allowed those on mechanical soft diets to eat bread like dinner rolls and lightly toast since they could not eat anything hard. The Dietary Manager said failure to provide residents with food that met their orders, needs and preference placed residents at risk for difficulty chewing and possibly choking. An observation and interview on 03/05/26 at 01:17 PM revealed Resident #65 sitting in his wheelchair eating lunch. His plate contained a dinner roll, chopped meat, boiled/ baked (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	potato and green leafy steamed vegetables. The potatoes had skin covering majority of the surface and was un-mashed. The potatoes and the dinner roll were left untouched. Resident #65 said his mechanical soft diet was a preference, he did not have swallowing issues, but he found a regular diet tough to chew. He said it was tough to: chew the skins on potatoes, bread such as a dinner roll and the toast was even harder to chew. Resident #65 said when his meals were not soft, they did not prevent him from eating but just made it hard to eat. He said he had not suffered from any weight loss. An observation on 03/05/26 at 02:00 PM of the requested mechanical soft test tray revealed, chopped meat, mashed potatoes with no skin, steamed vegetables and a dinner roll. Record review of the facility's policy titled Alternate Food Choices and Substitutions Policy Number: 02.004and Honoring Preferences approved 10/01/18 revealed, Policy: The facility believes that adequate nutrition is essential to each resident's well-being and good health. An alternate entree and vegetable will be offered at each meal. The facility also supports resident choice and allowing residents to choose foods by honoring their food preferences. Other substitutions will also be available in the event a resident does not choose the main meal or the alternate. 2. The Nutrition & Foodservice Manager or designee will obtain the resident's food preferences upon admission and record preferences in the tray card system.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observation, interview and record review the facility failed to establish and 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 2 of 5 residents (Residents #7 and Resident #57) reviewed for infection control practices.1. ADON C failed to follow infection control practices when she cleaned Resident #7's trach with a towel that sat on the resident's chest on 03/04/26.2. RN B failed to follow infection control practices and did not use aseptic (sterile) technique when she suctioned Resident #7's Trach on 03/04/26 and 03/05/26.3. The facility failed to ensure a used single use push button lancet (a device with a hiding needle used to prick the skin for blood samples) was not left on Resident 57's nightstand on 03/04/2026. These failures could place residents at risk of bloodborne pathogens, cross contamination and respiratory infections.Findings include:1. Record review of Resident #7's, undated, face sheet revealed a [AGE] year old male who was admitted to the facility on [DATE]. Resident #7 had diagnoses which included acute respiratory failure with hypoxia (lungs cannot adequately transfer oxygen to the blood), tracheostomy status (hole into windpipe to help with breathing), gastrostomy (hole into stomach for nutrition), and type 2 diabetes mellitus (body does not produce insulin or resists it).Record review of Resident #7's admission MDS assessment, dated 2/21/26, revealed a BIMS score of 15 out of 15, which indicated normal cognition. Resident #7 was dependent (helper does all the effort and resident does none of the effort) with all ADLs. According to the MDS, the resident was on oxygen continuously, received PRN suctioning, and received trach care.Record review of Resident #7's Care Plan, dated 2/20/26, revealed the resident had a tracheostomy r/t impaired breathing mechanics, and a history of cervical radiculopathy (nerve in neck is compressed/inflamed causing pain down arm/hand with numbness, tingling, weakness). The goal was for the resident to have clear and equal breath sounds bilaterally through the review date. The interventions included ensuring the trach ties were secured at all times, suctioning as necessary, and keeping the oxygen settings as ordered.Record review of Resident #7's Progress Note, from 2/27/26 by NP O, revealed .Tracheostomy in place and patent on trach collar. Continue routine tracheostomy care and suctioning as needed.Record review of Resident #7's Physician Orders revealed the following orders from MD A:- Aspiration (breathing in food or liquid) Precautions-Sit up 90 degrees, every shift. Ordered 2/19/26.- Change Disposable Inner Canula QD on 10pm-6am shift. Ordered 2/19/26.- Change Suction Canister as needed. Ordered 2/19/26.- Change Trach Mask Q Week, every night shift, every Sunday. Ordered 2/19/26.- Clean Inner Canula #6 Shiley (type of trach) QS & PRN. Ordered 2/20/26.- Clean Trach Collar, every night, every Sunday. Ordered 2/19/26.- Emergency Supplies at Bedside, every shift. Ordered 2/19/26.- O2 @ 4L via Trach to maintain sats above 92%, every shift for hypoxia (not enough oxygen in blood). Ordered 3/5/26.- O2 @ 6L via Trach to maintain sats above 92%, every shift for hypoxia. Ordered 2/20/26.- Suction Trach as needed for airway clearance. Ordered 2/19/26.- Trach Care HS Shift & PRN, as needed for soiled. Ordered 2/19/26.- Trach Care HS Shift & PRN, every night shift. Ordered 2/19/26.Record review of Resident #7's Nurse's Note, from 3/4/26 from LVN E, revealed the resident was alert and oriented to person, place, and time and had no confusion. His lungs were clear and he had no cough. Resident #7 had a trach collar and no shortness of breath.An observation on 03/04/26 at 10:49 AM revealed, Resident #7 lying in bed, well-groomed and in no immediate distress, his breathing was unlabored and rate was normal. The resident had a trach collar (a device worn around the neck to secure a tracheostomy tube in (continued on next page)

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	676482	A. Building B. Wing	03/06/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	place, preventing dislodgement), his oxygen concentrator delivered O2 at 4 L/min and the oxygen mask was not over his trach. The state surveyor alerted ADON C, who entered the room, cleaned Resident #7's trach collar with a non-sterile towel that sat on his chest and placed the oxygen mask over Resident #7's trach collar. An observation on 03/04/26 at 10:58 AM revealed, RN B entered into Resident #7's room to suction the residents trach. She gathered her supplies, and donned sterile gloves. With her sterile gloves on, she opened drawers and gathered nonsterile supplies, unsheathed the sterile suction canula from its wrapper and then re-sheathed it while she adjusted the resident. RN B then unsheathed the suction canula, turned on the machine and suctioned the resident after telling him what she was going to do and instructing him to alert her if he had any discomfort. While unsheathing and re-sheathing the suction canula, RN B touched the canula with her contaminated gloves. Resident #7 displayed no signs of respiratory distress through the process.In an observation on 3/5/26 at 1:26 PM, revealed Resident #7 was sitting up in bed with a moderate amount of thick, yellow, mucus coming out of his trach. There was a suction machine and Ambu bag (used to deliver breaths during CPR) at the bedside. RN B washed her hands, donned a gown and then gloves. RN B applied a pulse oximeter (measures heart rate and percentage of oxygen in blood) to the resident's finger and left it there during the whole treatment. Resident #7's pulse oxygen stayed in the upper 90s, which was normal. She then wiped away the mucus with a tissue, took off her dirty gloves and applied clean gloves. She then removed the dirty gauze that was around the trach, removed her dirty gloves, washed her hands, and applied sterile gloves. RN B then prepared the bedside table with supplies. She opened a sterile trach care kit, she opened a new inner canula and then opened three packages of sterile gauze without touching them and attempted to have them land on the sterile field, but one of them landed halfway on the sterile field and halfway off. She also poured sterile water into a cup and put it on the bedside table. She applied a sterile drape over the resident's chest and then opened the suction catheter from the sterile package and attached it to the suction tubing, leaving the tip of the suction in the sterile package. She removed her dirty gloves and then applied the sterile gloves from the trach kit. RN B picked up the suction catheter and removed it from the sterile package and turned on the suction machine with the back of her sterile hand. Then she removed the resident's inner canula and placed it on the drape on his chest. The nurse suctioned the resident's trach three times as she was pulling the suction catheter out. She waited a few seconds between each suction to give the resident time to re-oxygenate. When RN B was done suctioning, she turned off the suction machine with her sterile hand and then balled up the wrapper from the suction catheter, along with the dirty suction catheter, and threw it away. She did this with her sterile gloves on. The nurse then picked up a sterile inner canula with the same gloves she had on and inserted it into Resident #7's trach. Then she picked up sterile gauze and wiped around the outside of the resident's trach to clean up the mucus, with the same dirty gloves. RN B finished care as the State Surveyor stepped out.In an interview on 3/5/26 at 1:46 PM, ADON B said in-services on trachs were given annually, every 6mths, and they used the dummy as a simulation for new hires. She said they had just had in-services on trachs and trach care. The ADON said they did not get trach resident's often, but they had had about 5 residents in the last 4-5 months. She said all the nurses were trained on trachs. The ADON said if the sterile technique was broken during trach care/trach suctioning there would be a risk for infection.In an interview on 3/5/26 at 2:00 PM, RN B said she was so nervous she was unsure of what mistakes she had made. She said a break in the sterile technique could cause an infection. She said this was the first time the resident had yellow mucus and she was going to call the provider and let them know about it.In an interview on 3/6/26 at 11:41 AM, the DON said sterility during suctioning was very important. She said it was important to have all the supplies available and opened before starting, and it had to be done using the sterile technique. The DON said one hand would remain sterile while the other remained clean, when suctioning. She said then once suctioning was done, the sterile hand would pick up the inner canula and insert it into the trach. The DON said if the sterile hand touched other things and then inserted the inner canula, it would introduce germs into the trach and could (continued on next page)

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	03/06/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cause an infection.Record review of the facility's policy and procedures on Suctioning the Lower Airway (Endotracheal [ET] or Tracheostomy Tube) (revised October 2010) read in part: The purpose of this procedure is to remove secretions, maintain a patent airway, and prevent infection of the lower respiratory tract.Assemble the equipment and supplies as needed.Use sterile equipment to avoid widespread pulmonary and systemic infection (Note: Suctioning of the lower airway is a sterile procedure. All equipment that comes in contact with the lower airway must be sterile.).The following equipment and supplies will be necessary when performing this procedure: Sterile suction catheter kit; Sterile drape; Sterile cup; Sterile gloves; #10 to #16 French [size] catheter; Sterile gauze; Sterile saline or sterile water.Perform hand antisepsis. Put on gloves. Turn on suction unit and adjust to appropriate negative pressure. Remove gloves. Open suction catheter kit. Place sterile drape across the resident's chest. Remove sterile cup, touching only the outside. Fill cup with sterile saline or sterile water. Apply sterile gloves. Recommend: The dominant hand will remain sterile. Holding the catheter in dominant hand and the tubing in the non-dominant hand, connect the catheter to the tubing. Suction a small amount of water from the cup to verify negative pressure. Rest catheter tip on sterile surface (e.g., sterile drape or open catheter kit). Remove oxygen or humidity delivery device using non-dominant hand. Instruct the resident to inhale. Upon inhalation, insert the catheter into airway (ET tube or tracheostomy tube) without applying suction. Advance the catheter until resistance is met and/or resident coughs (at the [NAME] [base of windpipe where it splits into left and right lung). Pull back 1 to 2 cm. Apply intermittent suction and slowly withdraw catheter while rotating between thumb and forefinger. Limit suction time to no more than 10 seconds. Re-ventilate and oxygenate the resident for a minimum of one minute between suctions. Rinse catheter and tubing with sterile saline or sterile water until clear.Limit suction passes to a maximum of three.Record review of the facility's policy and procedure on Tracheostomy Care (revised August 2013) read in part: The purpose of this procedure is to guide tracheostomy care and the cleaning of reusable tracheostomy cannulas. Open tracheostomy cleaning kit. Set up supplies on sterile field. Maintaining sterile field.Open four gauze pads and saturate with hydrogen peroxide. Open two gauze pads and saturate with antiseptic solution. Open two gauze pads and saturate with sterile saline. Open two gauze pads; keep them dry. Put on sterile gloves. Secure the outer neck plate with non-dominate gloved hand. Unlock the inner cannula with gloved dominate hand. Gently remove the inner cannula, rotating counterclockwise while lifting away from the resident. Remove and discard gloves into appropriate receptacle. Wash hands and put on fresh gloves. Replace the cannula carefully and lock in place.Apply clean gloves. Clean the stoma with two peroxide-soaked gauze pads (using a single sweep for each side). Rinse the stoma with saline-soaked gauze pads (using a single sweep for each side). Wipe with dry gauze (using a single sweep for each side). Apply a fenestrated gauze pad around the insertion site.Record review of the facility's policy titled Blood-Sampling- Capillary (Finger Sticks revised 09/2014 revealed, Purpose: The purpose of this procedure is to guide the safe handling of capillary-blood sampling devices to prevent transmission of bloodborne diseases to residents and employees . Steps in the Procedure: 5. Wipe the area to be lanced with an alcohol pad/wipe. 6. Obtain the blood sample, following the manufacturer's instructions for the device. 7. Discard lancet and platform into the sharps container . Record review of the facility's policy and procedures on Infection Prevention and Control Program (revised August 2016) read in part: The infection prevention and control program is a facility-wide effort involving all disciplines and individuals and is an integral part of the quality assurance and performance improvement program. The elements of the infection prevention and control program consist of coordination/oversight, policies/procedures.prevention of infection .The infection prevention and control program is coordinated and overseen by an infection prevention specialist (infection preventionist).Important facets of infection prevention include:.educating staff and ensuring that they adhere to proper techniques and procedures.

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Number of residents sampled: Number of residents cited: Based on observation, interview, and record review, the facility failed to ensure that the daily staffing was posted and readily accessible for review for 1 of 1 facility reviewed for required postings. - The facility failed to post the Daily Staffing Hours in a location visible to all by posting it on the wall on the left side of the building between the 100 and 200 Hall from 03/04/26 to 03/06/26.- The facility failed to include the resident census and the total number and actual hours worked by direct care per shift on the Nursing Staffing information from 03/04/26 to 03/06/26. These failures could affect residents, facility visitors, vendors, and emergency personnel by placing them at risk of not having access to information regarding daily nursing staffing in a timely manner. Findings Include: An observation on 03/04/26 at 8:24 AM revealed, the Daily Staffing Hours was posted on the left side of the hall in a clear placard by the DON's office between the 100 and 200 halls. The date reflected 03/03/26, and included the number of staff, number of hours and total number of hours worked per position (RN, LVN, CNA and MA). It did not include the resident census or the shifts worked by the direct care staff. An observation on 03/05/26 at 9:00 AM revealed, the Daily Staffing Hours was posted on the left side of the hall in a clear placard by the DON's office between the 100 and 200 halls. The date reflected 03/05/26, and included the number of staff, number of hours and total number of hours worked per position (RN, LVN, CNA and CMA). It did not include the resident census or the shifts worked by the direct care staff. An observation on 03/06/26 at 8:34 AM revealed, the Daily Staffing Hours was posted on the left side of the hall in a clear placard by the DON's office between the 100 and 200 halls. The date reflected 03/06/26, and included the number of staff, number of hours and total number of hours worked per position (RN, LVN, CNA and CMA). It did not include the resident census or the shifts worked by the direct care staff. In an interview on 03/04/26 at 12:17 PM, the Administrator said the receptionist filled out the Daily Staffing Hours posting using the provided template every morning. In an interview on 03/04/26 at 12:39 PM, the Administrator said after reviewing the TAC the expectation of the nurse staffing posting was that it included: the facility name, date, census, and the total number of hours scheduled and worked for each staff type per shift and its purpose was to notify all in the building the resident to staff ratio and it must be posted in a common area. She said the posting was located by the DON's office and visitors that went exclusively to the 100, 300 and 400 halls would not see the posting due to its location. The Administrator said failure to include the different shifts, the resident census, and to not post it in a prominent location would leave people unaware of the staff to resident ratio across the different shifts In an interview on 03/06/26 at 03:24 PM, the Administrator said the facility did not have a policy addressing the required staffing policy. She said they used the regulations as listed in the Texas Administrative Code (TAC).