STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675172	A. Building B. Wing	08/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cascades at Port Arthur	6600 Ninth Ave Port Arthur, TX 77642

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675172	A. Building B. Wing	08/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cascades at Port Arthur	6600 Ninth Ave Port Arthur, TX 77642

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 2 of 7 residents (Resident #1 and Resident #2) reviewed for abuse.The facility failed to ensure Resident #1 was free from resident to resident sexual abuse when Resident #2 touched her vaginal area inappropriately on 08/14/2025 and was witnessed by Resident #3.The noncompliance was identified as PNC. The IJ began on 08/14/2025 and ended on 08/14/2025. The facility had corrected the noncompliance before the survey began.This failure could place residents at risk for emotional distress, fear, decreased quality of care, and further abuse. Findings include:1. Record review of Resident #1's face sheet, dated 08/16/2025, indicated a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included PTSD (a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event), adjustment disorder with anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), altered mental status (a disorder that affects a person's ability to think, feel, and behave clearly) and auditory and visual hallucinations (seeing and hearing things that are not there).Record review of Resident #1's annual MDS assessment, dated 06/21/2025, indicated she made herself understood and usually understood others. She had severe cognitive impairment, identified with a BIMS score of 4. She required supervision or touching assistance with most activities of daily living.Record review of Resident #1's care plan, dated 06/24/2024 and revised on 08/14/2025, indicated Resident #1 had increased risk for anxiety/acute stress reaction r/t unwanted sexual contact from another resident. She was not having any negative effects from history of anxiety/acute stress. Interventions included to encourage resident to verbalize feelings and provide safe and supportive environment. Social Services to provide counseling and provide emotional support in a private setting.Record review of Resident #1's facility incident report, dated 08/15/2025 at 12:08 p.m., documented in the Resident description section .he (Resident #2) came in here and told me to lie back and when I asked him for what and picked up my teddy bear to put in front of me. He (Resident #2) moved my bear out of the way and put it right the foot of the bed and did like this pushing her shoulder back and put his hand in there and I asked him what are you doing and he said you're going to like it and put his hand in there some more. Nursing description section read in part: .resident noted sitting with her feet dangling over the side of the bed leaning sideways to left towards the foot of her bed using her stuffed animal for support and another resident had his hand in her brief digitally penetrating her. Immediate action taken section read in part: . other resident removed from this resident's room resident educated on resident to resident incidents and was ensured of safety, head to toe assessment as well as pain assessment complete no abnormalities noted social worker, psych-counselor, NP and RP notified. Resident #1 was assessed, and no injuries were noted.Record review of Resident #1's social services notes, dated 08/14/2025 at 1:13 p.m., indicated social services was notified of an alleged incident of non-consensual sexual contact between Resident #1 and Resident #2. Upon interview, Resident #1 stated she was seated on her bed when fellow Resident #2, alleged perpetrator, entered her room sat beside her and placed his hands inside her brief despite her telling him to stop. She denied any vaginal penetration and expressed that she did not consent to the contact she reported feeling upset and surprised as she previously considered him Resident #2 a friend. Social services provided emotional support validated Resident #1's feelings and assured her that steps were being taken to ensure her safety. Resident #1 was informed that Resident #2 would be relocated and instructed her to notify staff immediately if he approaches her. Resident #1 verbalized understanding and agreed to report any further concerns. Social services coordinated with nursing, administration and the investigation team to ensure separation of residents. Witnesses' interviews, completion of body skin assessment and initiation of the formal investigation. Ongoing emotional support and monitoring will be provided.Record review of Resident #1's social services notes, dated 08/14/2025 at 1:40 p.m., indicated Resident #1 carries a diagnosis of dementia which impacts her judgement, impulse control and reliability of self-reported information due to her cognitive impairment, statements made by Resident #1 cannot be considered fully reliable without corroborating information. Social services will continue to monitor Resident #1 for safety, provide redirection as needed and collaborate with nursing and the interdisciplinary team to address ongoing behavioral concerns.Record review of Resident #1's social services notes, dated 08/15/2025 at 10:02 a.m., indicated social services met with Resident #1 to review and have her sign the