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	09/22/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0689 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 adequate supervision was provided for 1 of 7 residents reviewed for accidents and supervision. (Resident #1) The facility failed to ensure Resident#1 received adequate supervision to prevent elopement. Resident #1 eloped from the facility on 09/14/2025 and was located by facility staff approximately 50 feet off facility premises in a tall grassy area with rocks, uneven ground, and cut trees. An IJ was identified on 09/14/2025. The IJ template was provided to the facility on [DATE] at 4:10 p.m. While the IJ was removed on 09/19/2025, the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm because all staff had not been trained on Elopement. This failure could prevent residents from receiving appropriate supervision which could lead to residents sustaining serious injury, harm, or death. Findings included: Record review of Resident #1's electronic facility face sheet dated 09/17/ 2025, indicated he was a [AGE] year-old male admitted to the facility on [DATE]. Diagnosis of cognitive communication deficit generalized anxiety disorder, unspecified symptoms and signs involving cognitive functions. Record review of Resident #1's quarterly MDS assessment, dated 08/10/2025 indicated a BIMS score of 06 indicating Resident #1 was severely cognitive impaired. Resident #1 ambulated independently with no mobilities devices needed. MDS indicated Resident #1 had behaviors related to rejecting care that typically occurred 1 to 3 days. Record review of Resident #1's care plan dated 08/22/2025 indicated he had a behavior problem (Delusions) related to impaired thought process and impaired cognition following Cerebrovascular accident (stroke). Interventions: Anticipate and meet the resident's needs and if reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident. On 09/15/2025 the facility added a new focus to Resident #1 care plan indicating he is an elopement risk/wanderer related to his history of attempting to leave the facility unattended and exit seeking. Interventions: Send to the behavior hospital for evaluation and treat. Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, books. Monitor location every (15) min. Record review of Resident #1's Wandering Risk Scale dated 08/04/2025 indicated a score of 4- low risk. Record review of Resident #1's NSG: Additional admission Assessments (Braden, Morse, etc.) dated 08/05/2025 indicated a low wander risk. Record review of Resident #1's Wandering Risk Scale dated 09/15/2025 indicated a score of 15- high risk. Record review of Resident #1 nursing note dated 09/14/2025 at 5:24 p.m. indicated LVN A documented the following: Resident noted to be wandering the grounds of facility behind the building near a field with high grass. This nurse and other staff approached the resident to guide this resident back into the facility, Resident became belligerent and aggressive stating that he does not need to be in the nursing facility. The resident begins waving his arms and not allowing staff to hold his hands to guide him back into the building. This nurse explained to the resident it is very hot outdoors and dangerous temperatures to be wandering away from the facility. Resident did not want to hear what this nurse was saying but finally was able to get resident back in facility. Record review of LVN A nursing note dated 09/14/2025 at 6:30 p.m. indicated the following: Resident #1 was placed on 15-minute monitoring checks from the dates of 09/13/2025-09/14/2025 starting at 6:00 p.m. Record review of the fifteen-minute monitoring sheet indicated Resident #1's monitoring was initiated on 09/13/2025 at 6:00 a.m. by LVN A. - On the time slot for 10:45 a.m. - 11:45 a.m. there was no staff initials on the line to confirm Resident #1 was being monitored.- On the time slot for 6:00 p.m.- 11:45 a.m. there was a line from 6:00 p.m. to 11:45 a.m. stating no issues. - On the time slot for 7:45 p.m. stated no issues. - On the time slot for 11:00 p.m. stated no issues.- The monitoring sheets were dated for: 09/13/2025- 09/18/2025. Record review of Resident #1's witness statement completed on 09/19/2025, by LVN A indicated This nurse went to do 15 min check on Resident #1 at about 4:45 p.m. and noted resident was not in his room. I started looking around the halls and other staff did as well. Once nobody could find the resident in the building, several staff went outdoors to look for resident, I was walking down towards the (redacted) on 9th avenue by the fields. I looked by the ditches and trees; I did not see him. LVN A wrote in her statement that Resident #1 was walking back from the field where the ground was uneven and had tall grass. Once staff was able to get him back onto facility grounds and inside, he stated why am I here and he needs to go. Resident did state he does not need to be here, nor does he need to be evaluated for any behaviors. During an interview on 09/16/2025 at 4:00 p.m., the DON said Resident #1 had aggressive behaviors present on admission. On 09/13/2025 he chased staff, cussed at them, tried to hit them, and was

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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 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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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 0755 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 interview and record review, the facility failed to provide pharmaceutical services (the process of receiving and interpreting prescriber's orders and to provide procedures that assure the accurate acquiring, receiving, dispensing, and administration of all drugs) to meet the needs of each resident for one (Resident #2) of four residents reviewed for pharmaceutical services.The facility failed to ensure Resident #2's hospital discharged medication regimen was accurately reviewed and implemented. Resident #2 was readmitted to the hospital with respiratory failure and COPD. The noncompliance was identified as past noncompliance (PNC). The IJ began on 02/07/2025 and ended on 02/10/2025. The facility had corrected the noncompliance before the state's investigation began.This failure could place residents at risk for not receiving medications as ordered by their physician or per manufacturer's directions. Findings included:Record review of Resident #2's PPS MDS assessment dated [DATE] indicated Resident #2 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of hypertension (high blood pressure), COPD (a group of lung diseases that block airflow and make it difficult to breathe). The MDS also indicated a BIMS score of 14 (suggested no cognitive impairment).Record review of Resident #2's baseline care plan dated 02/07/2025 indicated Resident #2 used oxygen continuously due to COPD. Record review of Resident #2's hospital H&P dated 02/04/2025 (prior to facility admission) indicated Resident #2 was admitted to the hospital on [DATE] for complaints of a 2-3-week history of gradual worsening shortness of breath, cough, and wheezing. Resident #2 was hypoxic (an inadequate supply of oxygen o the body's tissues) and was placed on BIPAP (a non-invasive ventilation therapy that uses 2 different levels of air pressure to assist breathing). Record review of Resident #2's hospital Discharge summary dated [DATE] indicated 3 new medications upon discharge: -budesonide 0.5 mg/2 ml (breathing treatment) per nebulizer twice daily;-prednisone 20 mg(anti-inflammatory) by mouth before breakfast; and-levalbuterol HCL 0.63mg/3 ml (breathing treatment) every 6 hours via nebulizer. Additionally, Resident #2 was to continue previous home medications:-omeprazole 20 (reduces stomach acid) mg daily;-Levothyroxine 100 mcg (used to treat underactive thyroid) daily;-Memantine 10 mg (used to treat moderate to severe Alzheimer's) daily;-hydrochlorothiazide 12.5 mg (used to treat high blood pressure and fluid retention) daily;-Magnesium oxide 400 mg (supplement used to regulate muscle and nerve function) daily;-Duloxetine 30 mg (used to treat mood disorders and chronic pain) twice daily;-Ibuprofen 600 mg (anti0inflammatory) twice daily as needed;-losartan 25 mg (for blood pressure) daily; -atorvastatin 40 mg (used to reduce cholesterol levels) every evening; and -tramadol 50 mg (for pain) four times daily. Record review of Resident #2's admission orders and MAR dated 02/07/2025 indicated the facility ordered and administered 11 medications that were not Resident #2's discharge medications with multiple doses to Resident #2 from 02/07/25-02/10/25. Resident #2 was administered the following: *Amiodarone 200 mg 5 doses (blood pressure) -Plavix 75 mg 3 doses (blood thinner), -Eliquis 5 mg 5 doses (blood thinner), -Lexapro 5 mg 3 doses (anti-depressant), -Lasix 40 mg 3 doses (diuretic), -Metolazone 5 mg 3 doses (diuretic), - Gemtesa 75 mg 3 doses (for bladder spasms), -Valsartan 320 mg 3 doses (blood pressure) , -Levothyroxine 137 mcg 2 doses(for thyroid - receives 100 mcg at home), -Docusate 100 mg 2 doses (stool softener) and,-Melatonin 5 mg 2 doses (helps sleep).Record review of Resident #2's nurses notes written by LVN P indicated Resident #2 experienced shortness of breath and anxiety within 72 hours of admission to facility, resulting in decreasing oxygen saturation levels and Resident #2 being transferred to hospital for evaluation. She was admitted to the hospital on [DATE] with an exacerbation of COPD and anxiety. Record review of a Medication Error form completed by the corporate nurse and dated 02/10/2025 for Resident #2 indicated the following: . Family brought to the facilities attention that the medications that [Resident #2] was receiving at the facility did not match their understanding of what medications the resident should be on. Upon investigation, it was discovered that the 2 pages (pages 33 and 34) of the hospital paperwork containing the discharge medications that the family brought to the facility with the resident had a different resident's name on them. This resulted in [Resident #2] being placed on the wrong medications from 2/7 through 2/10. During an interview on 09/17/2025 at 09:30 a.m., the regional nurse said Resident #2's family member came to the facility and had asked if Resident #2 had been given her breathing treatment over the weekend. The corporate nurse said upon review of Resident #2's medical record, she had noticed the diagnoses, and the medication list did not look right. Upon further reviewing, the corporate nurse said out of the 60+ pages, she found that the medication list provided by the discharging hospital had a different

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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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 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 interview and record review, the facility failed to ensure residents were free of significant medication errors for 1 of 19 residents reviewed for significant medication errors. (Resident #2)The facility must ensure that its residents are free of any significant medication errors. Resident #2 received multiple doses of medications that were not prescribed to her to include 2 blood thinners and blood pressure medications. Also, Resident #2 did not receive prescribed breathing treatments and anti-inflammatory medications and was re-hospitalized with COPD.The noncompliance was identified as past noncompliance (PNC). The IJ began on 02/07/2025 and ended on 02/10/2025. The facility had corrected the noncompliance before the state's investigation began.This failure could place residents at risk for not receiving medications as ordered by their physician or per manufacturer's directions. Findings included:Record review of Resident #2's PPS MDS assessment dated [DATE] indicated Resident #2 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of hypertension (high blood pressure), COPD (a group of lung diseases that block airflow and make it difficult to breathe). The MDS also indicated a BIMS score of 14 (suggested no cognitive impairment).Record review of Resident #2's baseline care plan dated 02/07/2025 indicated Resident #2 used oxygen continuously due to COPD.Record review of Resident #2's hospital H&P dated 02/04/2025 (prior to facility admission) indicated Resident #2 was admitted to the hospital on [DATE] for complaints of a 2-3-week history of gradual worsening shortness of breath, cough, and wheezing. 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Additionally, Resident #2 was to continue previous home medications:-omeprazole 20 (reduces stomach acid) mg daily;-Levothyroxine 100 mcg (used to treat underactive thyroid) daily;-Memantine 10 mg (used to treat moderate to severe Alzheimer's) daily;-hydrochlorothiazide 12.5 mg (used to treat high blood pressure and fluid retention) daily;-Magnesium oxide 400 mg (supplement used to regulate muscle and nerve function) daily;-Duloxetine 30 mg (used to treat mood disorders and chronic pain) twice daily;-Ibuprofen 600 mg (anti0inflammatory) twice daily as needed;-losartan 25 mg (for blood pressure) daily;-atorvastatin 40 mg (used to reduce cholesterol levels) every evening; and-tramadol 50 mg (for pain) four times daily. Record review of Resident #2's admission orders and MAR dated 02/07/2025 indicated the facility ordered and administered 11 medications that were not Resident #2's discharge medications with multiple doses to Resident #2 from 02/07/25-02/10/25. 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Record review of a Medication Error form completed by the corporate nurse and dated 02/10/2025 for Resident #2 indicated the following: . Family brought to the facilities attention that the medications that [Resident #2] was receiving at the facility did not match their understanding of what medications the resident should be on. Upon investigation, it was discovered that the 2 pages (pages 33 and 34) of the hospital paperwork containing the discharge medications that the family brought to the facility with the resident had a different resident's name on them. This resulted in [Resident #2] being placed on the wrong medications from 2/7 through 2/10. During an interview on 09/17/2025 at 09:30 a.m., the regional nurse said Resident #2's family member came to the facility and had asked if Resident #2 had been given her breathing treatment over the weekend. The corporate nurse said upon review of Resident #2's medical record, she had noticed the diagnoses, and the medication list did not look right. Upon further reviewing, the corporate nurse said out of the 60+ pages, she found that the medication list provided by the discharging hospital had a different person's medication list

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure all drugs and biological were stored in accordance with currently accepted professional principles for 1 of 3 medication carts (300 hall) reviewed for storage of medication and biologicals.The facility failed to ensure 4 tablets of Ondansetron 8mg (medication used for nausea and vomiting) expired 10/31/24, had been expired for 322 days, were removed from use. The facility failed to ensure 5 tablets of Clonidine 0.1mg (medication used for high blood pressure) expired 07/31/24, had been expired for 414 days, were removed from use.These failures could place residents at risk of adverse reactions to medications, misappropriation of medications, and not receiving therapeutic effects of medication.Findings included:Observation on 09/18/25 at 10:45 a.m. of the facility 300 Hall medication storage cart indicated in the second draw the following:- an individual medication card with 4 untouched tablets of Ondansetron 8mg with an expiration date of 10/31/24 and fill date of 11/06/23, the medication had been expired for 322 days and had not been removed from use in the medication cart. - an individual medication card with 5 tablets of Clonidine 0.1mg (medication used for high blood pressure) expired 07/31/24 and fill date 08/11/23, had been expired for 414 days, were removed from use.During an interview on 09/18/25 at 10:45 a.m. LVN A said the Ondansetron 8mg medication had been expired since 10/31/24 and she said 4 out of 10 tablets were left and 5 out of 30 tablets of Clonidine 0.1mg were left and had expired 07/31/24. LVN A said she was new and had started working with the facility about 3-4 days ago and this was her first day working by herself. LVN A said she was responsible for administering medication out of the 300-hall medication cart but had not given any of the expired Ondansetron or Clonidine. LVN A said she had been trained by the facility on medication storage, making sure meds are not expired before giving medication and keeping the cart stocked, free of expired medications and spills. LVN A said if residents were administered expired medications it could lead to medication poisoning or sickness. LVN A said she would remove the expired medications from the cart.During an interview on 09/18/25 at 1:10 p.m., the DON said there should be no expired medications inside the medication room or inside the medication carts. The DON said the Nurse working on the medication cart checked the medication cart every time they work on the medication cart. The DON said nurses are to check for expired medications and discharged residents' medication to be removed for disposal. The DON said she was responsible in ensuring that the nurses were checking the medication carts for removal and disposal of expired medications and she said was not sure how it got over looked. The DON said if the medication were not given for months then they could expire and be overlooked on the medication cart. She said the effects of expired medications could range from reduced effectiveness to unfavorable side effects.Record Review of the facility pharmacy monthly medication review for storage dates 7/2025 to 9/2025 indicated no evidence of expired medications on the medication carts needing removal.Record review of the facility undated policy titled Medication Storage reflected in part:. Policy: It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation and security.5. Staff should observe proper storage and labeling requirements for all medications and vaccines during the performance of their daily task and should demonstrate safety in regards to the medication's integrity such duties should include but are not limited to: c. Remove any expired medications from active stock and discard medications according to facility policy.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 infection control for 3 of 4 residents (Resident #3, Resident #4, Resident #5), and 2 of 2 therapists, (PT #1 and OT #2.) The facility failed ensure PT #1 and OT #1 used hygiene and wipe down therapy equipment between Resident's use. These failures could place residents at risk of cross-contamination and development of infections. Findings included: During observation on 09/21/2025 at 4:20 p.m. indicated while in the Physical therapy room, PT#1 touched 3 residents (Resident #3, Resident #4, Resident #5), gait belt, 2 walkers, and 3 residents (Resident #3, Resident #4, Resident #5) wheelchairs while wearing the same pair of used gloves. PT#1 did not take used gloves off nor use hand hygiene after working with residents and touching 2 walkers, and 3 residents (Resident #3, Resident #4, Resident #5) wheelchairs. During observation on 09/21/2025 at 4:28 p.m. PT#1 and OT#1 did not use hand hygiene before assisting a Resident #4 to a standing position from his wheelchair. During observation on 09/21/2025 at 4:38 p.m. PT#1 was working with a Resident #4 on the parallel bars. After the resident completed the exercise, PT#1 put Resident #3 on the parallel bars without disinfecting the parallel bars in-between resident use. During observation on 09/21/2025 at 4:45 p.m. OT#1 was physically working between Resident #4 and Resident #5 and did not use hand hygiene in between residents during their exercise. During observation 09/21/2025 at 4:50 p.m. PT#1 washed his hands then dried his hands with paper towels. PT#1 used the same paper towels he dried his hands with to wipe the visible sweat off his forehead then wiped his hands with the same paper towels. PT#1 did not perform hand hygiene before touching Resident #3 and Resident #4 after wiping his visible sweat off his forehead. During observation 09/21/2025 at 4:45 p.m. PT#1 had an open cut with flesh exposed on his index finger approximately 0.5 inches. PT#1 did not have a band-aid covering on his index finger while working with the resident's. During Interview on 09/21/2025 at 4:50 p.m. PT#1 said he was wearing gloves because one of the residents in therapy was very sweaty and he did not want the sweat to get into the open cut on his finger. PT#1 said he should have had his finger covered especially when working with the residents to prevent the risk of cross contamination. PT#1 said he should have used hand hygiene before and after resident contact to prevent infection. PT#1 said he should not have wiped his hands with used paper towels he used to wipe his sweat off with. PT#1 said he disinfected the used equipment only at the end the day not in-between residents. He said the only time he disinfected equipment during the day was if a Resident was in isolation. PT#1 said he was trained on infection control by hospitals but not by the facility nor by the DON. During Interview on 09/21/2025 at 5:05 p.m. OT#1 said he should have used hand hygiene before and after working with the resident. He said not using hand hygiene or disinfecting used equipment can potentially put staff and Residents at risk of passing and contracting infections. OT#1 said he has completed infection control modules from his contracting company but has not completed a skill check-off on infection control for the facility. During an observation and Interview on 09/21/2025 at 5:20 p.m. the DON said she was the infection control preventionist and has not trained the Rehabilitation department on infection control. The DON observed PT#1 open cut on index finger and said the cut should always be covered to prevent cross contamination. She said PT#1 should have discarded his used paper towels and rewashed his hands to prevent his body fluids getting on the residents. The DON said her expectation was for staff to disinfected used equipment in-between residents. During Interview on 09/22/2025 at 11:55 a.m. the Director of Rehabilitation said she had not completed skill check off's, trainings, nor education on infection control/ hand hygiene. She said most of her staff know to disinfect equipment. The Director of Rehabilitation said all equipment including the parallel bars should be disinfected after each use to prevent the spread of germs. She said the DON told her PT#1 should have had his index finger covered to prevent cross contamination. The Director of Rehab said she has not been in-serviced by the facility on infection control but has completed infection control computer modules. She said her expectation was for her staff to disinfect equipment after each use, wash hands before and after working with the residents. During interview 09/22/2025 at 3:38 p.m. indicated the Administrator said his expectation was for therapy to be in-serviced by the DON on infection control before working with Residents. He said he expected therapy to wash their hands before and after working with the residents and clean equipment between usage. Record review of [company] (online education) Certificate of Course Completion dated 04/25/2025 indicated The Director of Rehabilitation