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	11/20/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs for 1 of 7 residents (Resident #1) reviewed for comprehensive person-centered care plans. Resident #1 did not have a care plan completed for her diagnosis of generalized anxiety. Resident #1 did not have a care plan completed after she was prescribed Buspirone/Buspar (anti-anxiety medication) on 10/16/25 for anxiety. This failure could place residents at risk for not receiving proper care and services. Findings included: Record review of Resident #1's face sheet dated 11/19/25 indicated she was an [AGE] year old female, admitted on [DATE], and her diagnoses included Parkinsonism (conditions that affect movement), diabetes (condition that affects blood sugar levels), cognitive communication deficit (difficulties in communication due to impaired cognitive function), and generalized anxiety disorder-onset 02/01/23 (a mental health condition that causes fear, a constant feeling of being overwhelmed and excessive worry about everyday things). Record review of Resident #1's annual MDS assessment dated [DATE] indicated she usually made herself understood, usually understood others, and had moderate cognitive impairment (BIMS-11). Resident #1's active diagnoses included anxiety disorder. Resident #1 was taking an antianxiety medication. Record review of Resident #1's care plans dated 11/01/24 through 11/20/25 indicated there was no care plan related to Resident #1's diagnosis of generalized anxiety disorder or Buspirone/Buspar start date or discontinuation. Record review of Resident #1's physician orders dated 10/16/25 indicated Buspirone tablet 5 mg 1 tablet by mouth BID for anxiety. Record review of Resident #1's behavioral assessment dated [DATE], completed by LPC J indicated Resident #1 was referred for psychology and psychiatric services due to memory loss, short term memory problems and long term memory problems. Her diagnoses included generalized anxiety disorder. She was alert, coherent and oriented. She was pleasant and cooperative. Resident #1 indicated living at the nursing home was difficult for her. She demonstrated anxious behavior, such as unable to stay in places long. She was open to therapy sessions to help her adjust to being at the nursing home and learn to reduce and manage her anxiety. Resident #1 had the cognitive ability to learn and apply interventions to help with adjustment, reduce anxiety, memory loss and improve quality of life at the nursing home. She had mild anxiety and the goal for therapy was reduction of anxiety. Her treatment plan would address: adjustment, anxiety, confusion, depression, irritability, loss of pleasure/interest, memory loss, nervous/worried, pain, stress, and withdrawal. Record review of Resident #1's Psychological Service Progress Note dated 10/14/25, completed by LPC J, indicated Resident #1 was alert, coherent and oriented. The patient appeared anxious, nervous and unable to remain still. The assessment plan indicated generalized anxiety disorder would be treated with Buspar 1 tablet 5 mg. Record review of Resident #1's psychiatric assessment dated [DATE], completed by PMHNP O, indicated Resident #1 presented in an anxious state. Resident #1 endorsed current symptoms of excessive worry, restlessness, irritability/agitation and impaired concentration During an interview on 11/19/25 at 1:55 p.m., Resident #1 said she doesn't remember all of the names of her medications. She said the medications help her. She said the medications do not make her feel bad. She said if she needed medication for anxiety or depression she would take it. She said she enjoyed talking with LPC J and PMHNP O. During an interview on 11/19/25 at 3:36 p.m., PMHNP O indicated Resident #1 presented with increased anxiety during her psychological visits. She said she prescribed the Buspar on10/16/25 to assist with anxiety management. She said LVN P reported the medication appeared to be effective. She said the medication was discontinued on 11/12/25 at the request of Resident #1's family member. During an interview on 11/20/25 at 8:10 a.m., the DON said she did not know why Resident #1's care plan did not include generalized anxiety or the medication Buspar to address the anxiety. She said normally the MDS Coordinator would update the care plans. She said the MDS Coordinator was not informed of the changes. She said it was just missed. She said typically acute care plans were done by the nurses. She said LVN P should have completed a care plan for Resident #1's Buspar. She said she (the DON) and the ADON reviewed resident charts and the dashboard in the electronic record to ensure the care plans were updated and current. She said it was her expectations the care plans were completed as required. She said residents were at risk of not receiving required services if the care plans were not completed. During an interview on 11/20/25 at 9:10 a.m., the ADON said said she did not know why