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	10/16/2024

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41057 Based on observation, interview, and record review, the facility failed to ensure that residents who needed respiratory care, including tracheotomy care and tracheal suctioning, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents" goals and preferences for 1 of 1 resident reviewed for tracheotomy care (Resident #284). The facility failed to ensure LVN A followed proper technique during tracheostomy care and suctioning for Resident #284. (Tracheostomy is a hole that surgeons make through the front of the neck and into the windpipe (trachea). A tracheostomy tube is placed into the hole to keep it open for breathing. The inner cannula fits inside the trach tube and acts as a liner that can be removed and cleaned to help prevent the build-up of mucus inside the trach tube. The inner cannula locks into place to prevent accidental removal). This failure could place residents with a tracheostomy requiring tracheostomy care at risk for respiratory distress, hospitalization s, and a decline in their quality of life. Findings included: Record review of Resident #284's face sheet dated 10/14/24 indicated she was a [AGE] year-old-female admitted on [DATE]. Resident #284 had a diagnosis of acute respiratory failure with hypoxia (occurs when the body doesn't have enough oxygen in its tissues). Resident #284 also had a diagnosies of a tracheostomy and was dependent on supplemental oxygen. Record review of Resident #284's BIMS form dated 10/14/24 indicated a BIMS score of 14 indicating she had intact cognition. Record review of Resident #284's care plan dated 10/14/24 indicated she had a tracheostomy related to respiratory failure and received tracheostomy care. Record review of Resident #284's Physician Orders dated 10/14/24 indicated to clean inner cannula every shift and as needed, change disposable inner cannula daily on 10-6 shift with size 6 1/2 replacement, tracheostomy care every shift and as needed, change outer tracheostomy dressing every shift, and change tracheostomy collar every shift. Record review of LVN A's education file indicated education on the following: (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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respiratory Competency Performance for Tracheostomy Care on 11/18/23 for trach care; and Tracheostomy Check Off List on 10/14/24 and an employee in-service for Trach Care. An Employee In-service Record, titled, Tracheal suctioning, humidification, and tracheostomy tube exchange on 10/14/24. During an observation and interview on 10/14/24 at 9:30 a.m., Resident #284 was lying in bed with a tracheostomy tube attached to her neck with oxygen delivered into the tracheostomy by a tracheostomy mask (soft plastic mask that fits over the tracheostomy in which oxygen is delivered) at 3 liters. She said she did not need to be suctioned very often, and the nurses cleaned the tracheostomy and changed it often. During an observation and interview on 10/14/24 at 1:38 p.m., LVN A said she had been educated on tracheostomy care, technique and infection control with a presentation and return demonstration. During tracheostomy care for Resident #284, LVN A pulled out the tracheostomy tube along with the inner cannula. She then laid both on the sterile drape. LVN A then attempted to insert a clean inner cannula without the tracheostomy tube in place. At this time LVN A realized her error and placed oxygen over the open stoma for Resident #284 to have continuous oxygen. The DON and the ADON entered Resident #284's room. The ADON reinserted Resident #284's tracheostomy tube and a new inner cannula with sterile gloves. Resident #284 was assessed by nursing staff. Resident #284 had even unlabored respirations and a pulse oximeter measurement of 97 percent oxygen level. During an interview on 10/14/24 at 2:00 pm, LVN A said she accidently pulled the tracheostomy tube and inner cannula out and panicked when she realized it. She said she had been educated and was aware of how to perform tracheostomy care. She said she did not know what happened. LVN A said she had been trained to only remove the inner cannula during tracheostomy care. She said the DON and the ADON were available should any staff need assistance with procedures or had any questions. She said the risk of improper tracheostomy care was a resident could become short of breath and have respiratory problems. During an interview on 10/14/24 at 3:00 p.m., the DON and the ADON said the nurse providing care for the resident was responsible for proper tracheostomy care. They said all the facility nurses were currently educated on proper tracheostomy care. The DON had scheduled a refresher training on tracheostomy care with a contract respiratory therapist on 10/14/24. The DON said she and the ADON were available to assist with any procedures or questions if needed. They said Resident #284's tracheal tube should not have been removed during tracheostomy care, only the inner cannula was to be changed during care. They said the risk to the resident of improper tracheostomy care was respiratory distress. The DON said her expectation was tracheostomy care to be provided correctly and the nurses to notify herself or the ADON if they were uncomfortable with any procedures and receive extra training. During an interview on 10/14/24 at 3:18 p.m., the Administrator said the nurses were responsible for providing tracheostomy care to the resident and had the ADON and the DON for backup assistance if needed. He said all facility staff nurses were educated on tracheostomy care and would receive refresher training. He said the tracheostomy tube and inner cannula were accidentally removed by LVN A. The Administrator said the risk of improper tracheostomy care was a potential infection issue. He said his expectation was for the nurses to perform to the best of their ability and perform quality tracheostomy care. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility policy dated 07/19/22, titled, Tracheostomy Care Procedure indicated, .Trach care can help the patient breathe easier and can also prevent infection. 5. If the inner cannula is disposable, gently remove, and replace with a clean inner cannula. 7. When replacing trach ties, always leave one hand on the flange (part of the tracheostomy tube that attaches to the neck and stabilizes the tube) to ensure that the tracheostomy stays in the stoma (opening in the neck surgically created to allow air to reach the lungs).

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 36214 Based on interview and record review, the facility failed to use the services of a registered nurse for 8 at least consecutive hours 7 days a week for 1 of 4 quarters of 2023 (Quarter 1 - October 01, 2023, through December 31, 2023) PBJ reports reviewed for RN coverage. The facility did not have RN coverage for 10/07/2023, 11/11/2023, 11/12/23, 11/25/23, 12/03/23, 12/16/23, and 12/17/2023. This failure could place residents at risk of lack of nursing oversight and a higher level of care. Findings included: Record review of the CMS PBJ reports indicated: Quarter 1 2023 (October 01, 2023, through December 31, 2023) there were no RN hours on 10/07/23 (Saturday), 11/11/23 (Saturday), 11/12/23 (Sunday), 11/25/23 (Saturday), 12/03/23 (Sunday), 12/16/23 (Saturday), and 12/17/23 (Sunday). During an interview on 10/14/24 at 2:27 p.m., the Corporate Nurse said PBJ reports were submitted by the facility's corporate office. She said the facility did not have RN coverage for 10/07/23, 11/11/23, 11/12/23, 11/25/23, 12/03/23, 12/16/23, and 12/17/23. She said the possible negative outcome of not having an RN working 8 hours a day 7 days a week was the facility not having a supervisor present in the facility to oversee resident care. During an interview on 10/16/24 at 8:52 a.m., the DON said she could not provide any documentation of RN coverage for 10/07/23, 11/11/23, 11/12/23, 11/25/23, 12/03/23, 12/16/23, and 12/17/23. She said she was not working on those days because she was out on approved leave. During an interview on 10/16/24 at 9:15 a.m. the Administrator said there was not 8 hours of RN coverage for the days noted on the PBJ report. He said the facility had a difficult time hiring RNs due to being a rural area. He said the facility had contracted with a telehealth company that provided 24-hour RN consultation, and his Corporate Nurse (RN) was always available by phone. He said from October 2023 through December 2023 the facility was using agency RNs to provide the needed 8 hours of coverage, but they often did not show up for work. He said there was no possible negative outcome of not providing 8 consecutive hours of RN coverage daily because the nurses always had the Corporate Nurse and the telehealth RNs available. Record review of facility policy titled Departmental Supervision, Nursing, revised August 2022, indicated, . A registered nurse provides services at least eight (8) consecutive hours every 24 hours, seven (7) days a week. RNs may be scheduled more than eight (8) hours depending on the acuity needs of the resident.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30664 Based on observation, interview, and record review, the facility failed to ensure based on the comprehensive assessment of a resident, residents who use psychotropic drugs, behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs for 1 of 21 residents (Resident #39); and PRN orders for psychotropic drugs are limited to 14 days unless the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order for 2 of 21 residents (Residents #55 and #61) all reviewed for unnecessary medications. The facility failed to monitor Resident #39 for behaviors and side effects of the antipsychotic (class of drugs that treat symptoms of psychosis and other mental health disorders) medication Seroquel. The facility did not have an appropriate indication for Resident #55's Ativan (antianxiety medication) and did not discontinue after 14 days or have the attending physician or prescribing practitioner's rationale in the resident's medical record and indicate the duration for the PRN order. The facility did not discontinue Resident #61's Ativan after 14 days or have the attending physician or prescribing practitioner's rationale in the resident's medical record and indicate the duration for the PRN order. These failures could place residents at risk for adverse consequences such as dizziness, drowsiness, oversedation, agitation, restlessness, and suicidal thoughts related to the use of psychotropic medications. Findings included: 1. Record review of a face sheet dated 10/15/24 indicated Resident #39 was a [AGE] year-old female admitted on [DATE] with diagnoses included psychosis (a mental disorder characterized by a disconnection from reality) and anxiety (a mental disorder characterized by feelings of worry or fear that are strong enough to interfere with one's daily activities). Record review of physician orders dated 10/15/24 indicated Resident #39 was prescribed Seroquel 25 mg daily for psychosis with a start date of 08/16/24. Record review of a care plan revised 09/26/24 indicated Resident #39 received an antipsychotic medication for psychosis with interventions of monitor for side effects and effectiveness every shift and monitor, document, and report adverse reactions. Record review of a quarterly MDS dated [DATE] indicated Resident #39 had a BIMS score of 13 indicating intact cognition. The MDS indicated Resident #39 had a diagnosis of anxiety and psychotic disorder and received antipsychotic medication during the 7 day look back period. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a MAR dated October 2024 indicated Resident #39 received Seroquel 25 mg daily for psychosis from 10/01/24 to 10/15/24 with a start date if 08/16/24. Record review of the electronic record for Resident #39 from 03/04/24 to 10/16/24 indicated the nurses did not document monitoring of side effects or behaviors of the antipsychotic medication daily with medication administration. During an observation on 10/14/24 at 10:50 a.m., Resident #39 was lying in bed. She said she was treated well and received needed care. During an interview and record review on 10/16/24 at 11:10 a.m., LVN A said she was providing care for Resident #39 today. She said Resident #39's Seroquel should have been monitored for behaviors and side effects and was not. LVN A said the nurses providing care for the resident were responsible for adding the monitoring into the computer system. She said it was overlooked. LVN A said she was educated on monitoring antipsychotic medication for side effects and behaviors. She said the risk of a resident not monitored for behaviors and side effects for antipsychotic medication was a resident could have behaviors and side effects the nurses were unaware to watch for. She said she would add monitoring into the computer system now. 2. Record review of the October 2024 physician orders indicated Resident #55 had an order dated 03/10/24 for lorazepam (Ativan) 1mg every 4 hours as needed for anxiety with no stop date. He also had an order dated 04/24/24 for Seroquel 25mg two times a day for agitation/sundowning. Record review of a care plan dated 04/29/24 indicated Resident #55 used psychotropic medications (antipsychotic) related to behavior management (agitation/sundowning) with intervention to administer psychotropic medications as ordered by physician. Record review of the current MDS dated [DATE] indicated Resident #55 had severely impaired cognition; he had no behaviors; he had active diagnoses of dementia and Alzheimer's disease; and he was taking an antipsychotic medication but was not taking an antianxiety medication. Record review of a care plan dated 08/19/24 indicated Resident #55 used anti-anxiety medications related to anxiety with intervention to administer anti-anxiety medications as ordered by physician. Record review of a pharmacist recommendation dated 08/28/24 indicated the pharmacist wrote Resident #55 needed a consent for the Abilify. Record review of a pharmacist recommendation dated 09/22/24 indicated the pharmacist wrote Resident #55 needed a consent for the Abilify, needed an appropriate diagnosis for the Abilify, and the prn Ativan to discontinue or offer a benefit risk as to why the medication was to continue over 14 days. During an observation and interview on 10/14/24 at 10:01a.m. Resident #55 was in the bed. He was clean, neat, and had no odors. He was not able to answer questions appropriately. 3. Record review of the face sheet dated 10/16/24 indicated Resident #61 was an [AGE] year-old male admitted on [DATE]. His diagnoses included Alzheimer's disease, dementia, major depressive disorder, and adjustment issues. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the October 2024 physician orders indicated Resident #61 had an order dated 08/15/24 for Ativan 0.5 MG every 4 hours as needed for anxiety. There was no stop date. Record review of the current MDS dated [DATE] indicated Resident #61 had severely impaired cognition; he had no behaviors; he had active diagnoses Alzheimer's disease, dementia, and depression; he had not taken any antipsychotic or antianxiety medications. Record review of a care plan dated 09/16/24 indicated Resident #61 used anti-anxiety medications related to adjustment issues with interventions including administer anti-anxiety medications as ordered by the physician. Record review of a pharmacist recommendation dated 08/28/24 indicated the pharmacist wrote Resident #61 needed to discontinue or offer a benefit risk as to why the medication was to continue over 14 days. Record review of the EMR from 08/28/24 through 10/16/24 for Resident #61 indicated there was no documentation of the physician or NP discontinuing or giving a reason for continuation. During an observation on 10/14/24 at 10:14 a.m. Resident #61 was in bed. He was clean, neat, and had no odors. He was calm and had no indication of agitation. During an interview on 10/16/24 at 12:35 p.m. the DON said she would fax the pharmacy recommendations over to the physicians and they would send them back. She said if she did not get one back she would talk with the physician when they came to the facility. She said the PRN medications were not to be continued without documentation from the physician or NP. During an interview on 10/16/24 at 11:15 a.m., the DON said the nurse providing care for the resident was responsible for adding the monitoring for side effects and behaviors into the computer system. She said Resident #39 should have been monitored for behaviors and side effects for Seroquel and was not. The DON said she and the ADON double checked for medication monitoring and Resident #39's Seroquel was overlooked. She said the nurses were educated on monitoring antipsychotic medication for behaviors and side effects. The DON said the risk of not monitoring a resident that received antipsychotic medication for behaviors and side effects was the staff could possibly miss a behavior or side effect caused by the medication. The DON said her expectation was all psychotropic medication monitored for behaviors and side effects as required. During an interview on 10/16/24 at 11:18 a.m., the ADON said the nurse providing care for the resident was responsible for adding monitoring for side effects and behaviors into the computer system. She said Resident #39 should have been monitored for behaviors and side effects for Seroquel and was not. The ADON said she and the DON double checked medication for monitoring of side effects and behaviors weekly by running reports to check for monitoring. She said Resident #39's Seroquel was overlooked. She said the nurses were educated on monitoring psychotropic medication for behaviors and side effects. The ADON said the risk of not monitoring a resident that received antipsychotic medication for behaviors and side effects was staff could possibly miss a behavior or side effect caused by the medication. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/16/24 at 11:44 a.m., the Administrator said the floor nurses were responsible for monitoring a resident receiving psychotropic medication for behaviors and side effects and the ADON and the DON double checked the computer system to ensure monitoring. He said it was overlooked. The Administrator said the risk of a psychotropic medication not monitored for behaviors and side effects was a potential missed change in condition for a resident. The Administrator said his expectation was a plan in place for GDR (gradual dose reduction) and a resident receive the highest quality of life that their condition allowed, and psychotropic meds monitored per policy. Record review of an undated facility policy, titled, Psychotropic Medication Informed Consent, Dose Reduction and Behavior Monitoring indicated, .1. An informed consent will be obtained for all facility residents utilizing psychotropic medication. An informed consent will be completed for each psychotropic medication class . 4. Psychotropic medication use and treatment goals, efficacy in addressing target symptoms/distressed behaviors and continued need, will be reviewed with the resident/responsible party quarterly and as needed to ensure ongoing understanding and consent. 7. Target behaviors/distressed behavior for which psychotropic medication/s have been ordered to address, will be monitored utilizing class specific monthly tracking flow sheet records. Record review of a facility's policy, dated July 2022, titled, Psychotropic Medication Use indicated: . Residents will not receive medications that are not clinically indicated to treat a specific condition. Psychotropic medication management includes: . adequate monitoring for efficacy and adverse consequences; and e. preventing, identifying, and responding to adverse consequences. 41057

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30664 Based on observation, interview, and record review, the facility failed to ensure in accordance with professional standards of practices, the medical records on each resident were accurately documented for 3 of 9 residents reviewed for accurate medical records. (Residents #15, #55, and #61) The facility did not ensure staff documented on the MARs medications were administered to Residents #15, #55, and #61. This failure could place residents at risk of not receiving care and services to meet their needs. Findings included: 1. Record review of October 2024 physician orders for Resident #15 indicated she was a [AGE] year-old female admitted on [DATE]. Her diagnoses included chronic obstructive pulmonary disease ((COPD) a lung disease that blocks airflow making it difficult to breathe), gastro-esophageal reflux disease ((GERD) stomach contents leak backward from the stomach into the esophagus (food pipe)), hyperlipidemia (abnormally high levels of fats (lipids) in the blood), hypertension (a condition in which the force of the blood against the artery walls is too high), anxiety (persistent and excessive worry that interferes with daily activities), protein-calorie malnutrition (a nutritional status in which reduced availability of nutrients leads to changes in body composition and function), and urinary tract infection ((UTI) an infection in the kidneys, ureters, bladder, or urethra). Record review of the current MDS dated [DATE] indicated Resident #15 had moderately impaired cognition; she required substantial/maximum assistance for toileting hygiene; she was always incontinent of bladder; she had active diagnoses including hypertension, hyperlipidemia, depression, anxiety, and COPD; and she received antidepressant and antianxiety. Record review of the current care plan revised 08/27/24 for Resident #15 indicated the following: * she had impaired cognitive function/dementia or impaired thought processes with interventions including administer medications as ordered; * she had coronary artery disease related to myocardial infarction with interventions including give medications for hypertension and give medications to control cholesterol level as ordered by the physician; * she had has hypertension with interventions including give anti-hypertensive medications as ordered; * she had an alteration in neurological (dizziness) related to vertigo and lack of coordination with medication of antiemetic with interventions including give medications as ordered; (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* she had COPD/Emphysema related to history of smoking with interventions including give aerosol or bronchodilators as ordered; * she had GERD and acid reflux related to hyperacidity with interventions including give medications as ordered; and * she had nausea and vomiting related to GERD and the use/side effects of medications with interventions including administer antiemetics as ordered. Further review of the October 2024 physician orders for Resident #15 indicated she had the following orders: * dated 10/03/24 for Nitrofurantoin (antibiotic) 100 mg give 1 capsule by mouth two times a day for UTI for 7 days; * dated 09/07/24 for Cefpodoxime Proxetil (antibiotic) 100 mg give 1 tablet by mouth two times a day for UTI for 14 Days; * dated 08/27/24 for Remeron (antidepressant) 15 mg (Mirtazapine) give 15 mg by mouth at bedtime for depression/appetite; * dated 02/22/24 for Atorvastatin (to treat hyperlipidemia) 20 mg give 1 tablet by mouth at bedtime for hyperlipidemia; * dated 02/23/24 for Pantoprazole (to treat GERD) Delayed Release 40 mg give 1 tablet by mouth one time a day for GERD; * dated 05/28/24 for Famotidine (to treat GERD) 20 mg give 1 tablet by mouth two times a day for acid reflux; * dated 02/22/24 for Fluticasone Propionate (to treat nasal congestion) Nasal Suspension 50 mcg/act 1 spray in each nostril two times a day for congestion; * dated 02/22/24 for Meclizine (antiemetic to treat nausea) 25 mg give 1 tablet by mouth two times a day for nausea; * dated 02/22/24 for Metoprolol Tartrate (antihypertensive) 25 mg give 1 tablet by mouth two times a day for hypertension; * dated 04/09/24 for buspirone (antianxiety)10 mg give 1 tablet by mouth three times a day for anxiety; * dated 02/22/24 for Ipratropium-Albuterol (asthma/COPD therapy) Solution 0.5-2.5 mg/3ml 1 vial inhale orally via nebulizer four times a day related to chronic obstructive pulmonary disease. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 10/14/24 at 10:03 a.m. Resident #15 was in bed with the bed in low position and had an air mattress. She was clean, neat, and had no odors. She was not able to answer questions appropriately. Record review of the September 2024 MAR for Resident #15 indicated the following: * on 09/08 and 09/22, did not have documentation she received the 05:00 a.m. dose of Pantoprazole Sodium Delayed Release 40 mg. * on 09/07, did not have documentation she received the 05:00 p.m. dose of: Famotidine 20 mg; Fluticasone Propionate Nasal Suspension 50 mcg/act; Meclizine HCl 25 mg; Metoprolol Tartrate 25 mg; buspirone HCl 10 mg; and Ipratropium-Albuterol Solution 0.5-2.5 mg/3ml. * on 09/07, 09/17, 09/18, and 09/22, did not have documentation she received the 08:00 p.m. dose of Atorvastatin 20 mg. * on 09/07, 09/17, 09/18, and 09/22, did not have documentation she received the 09:00 p.m. dose of: Remeron 15 mg; Cefpodoxime Proxetil 100 mg; and Ipratropium-Albuterol Solution 0.5-2.5 mg/3ml. All of the entries were left blank. Record review of the October 2024 MAR for Resident #15 indicated the following: * on 10/09, did not have documentation she received the 05:00 a.m. dose of Pantoprazole Sodium Delayed Release 40 mg. * on 10/07, 10/08, and 10/11, did not have documentation she received the 08:00 p.m. dose of Atorvastatin Calcium 20 mg. * on 10/07 and 10/08, did not have documentation she received the 09:00 p.m. dose of Nitrofurantoin Macrocrystal Oral Capsule 100 mg; (continued on next page)

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	10/16/2024

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

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* on 10/07, 10/08, and 10/11, did not have documentation she received the 09:00 p.m. dose of Remeron 15 mg; and * on 10/04, 10/07, 10/08, and 10/11, did not have documentation she received the 09:00 p.m. dose of Ipratropium-Albuterol Solution 0.5-2.5 mg/3ml. All of the entries were left blank. 2. Record review of a face sheet dated 10/16/24 indicated Resident #55 was an [AGE] year-old male admitted on [DATE]. His diagnoses included dementia (loss of cognitive functioning), Alzheimer's disease (progressive disease that destroys memory and other important mental functions), and hypertensive heart disease without heart failure (caused by chronically high blood pressure). Record review of the current MDS dated [DATE] indicated Resident #55 had severely impaired cognition; he was dependent on staff for toileting hygiene; he was always incontinent of bladder; he had active diagnoses including hyperlipidemia, Alzheimer's disease, and dementia; and he received medications of antipsychotic and antidepressant. Record review of the current care plan for Resident #55 indicated he had a care plan: * revised on 04/29/24, he had hyperlipidemia with interventions including administer meds as ordered; * initiated on 10/14/24, he had a current acute infection and is on antibiotics: (UTI) with interventions including treatment(s) as ordered by MD/NP; * initiated on 07/22/24, he had a behavior problem such as making sexual comments at staff while self-pleasuring and placed on antidepressant with interventions including administer medications as ordered; * initiated on 01/29/24, he was physically aggressive touching staff inappropriately and hitting staff related to dementia with interventions including administer medications as ordered. Record review of the October 2024 physician orders for Resident #55 indicated he had the following orders: * dated 10/10/24 for Ciprofloxacin (antibiotic) 500 mg give 500 mg by mouth two times a day for UTI for 10 days; * dated 04/04/23 for Atorvastatin (to treat hyperlipidemia) calcium 20 mg give 1 tablet by mouth at bedtime related to hypertensive heart disease without heart failure; * dated 04/20/24 for Mirtazapine (antidepressant) 30 mg give 1 tablet by mouth at bedtime related to dementia; and (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* dated 04/25/24 for Seroquel (antipsychotic) 25 mg (Quetiapine Fumarate) give 25 mg by mouth two times a day for agitation/sundowning. During an observation and interview on 10/14/24 at 10:01a.m. Resident #55 was in the bed. He was clean, neat, and had no odors. He was not able to answer questions appropriately. Record review of the September 2024 MAR for Resident #55 indicated the following: * on 09/17, 09/18, and 09/22, did not have documentation he received the 08:00 p.m. dose of Atorvastatin Calcium 20 mg; and * on 09/17, 09/18, and 09/22, did not have documentation he received the 09:00 p.m. dose of: Remeron 15 mg; Seroquel Oral Tablet 25 mg. All of the entries were left blank. Record review of the October 2024 MAR for Resident #55 indicated the following: * on 10/07, 10/08, and 10/11, did not have documentation he received the 08:00 p.m. dose of Atorvastatin Calcium 20 mg; * on 10/07, 10/08, and 10/11, did not have documentation he received the 09:00 p.m. dose of: Mirtazapine 15 mg; Seroquel Oral Tablet 25 mg; and * on 10/11, did not have documentation he received the 09:00 p.m. dose of Ciprofloxacin 500 mg. All of the entries were left blank. 3. Record review of the face sheet dated 10/16/24 indicated Resident #61 was an [AGE] year-old male admitted on [DATE]. His diagnoses included Alzheimer's disease (progressive disease that destroys memory and other important mental functions), dementia (loss of cognitive functioning), major depressive disorder (mental illness that negatively affects how you feel, the way you think and how you act), hypertension (a condition in which the force of the blood against the artery walls is too high), and tremors (involuntary movements of the body). Record review of the current MDS dated [DATE] indicated Resident #61 had severely impaired cognition and he had active diagnoses including hypertension, Alzheimer's disease, dementia, and depression. Record review of the current care plan revised on 10/01/24 for Resident #61 indicated: * he had hypertension with interventions including give anti-hypertensive medications as ordered; (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* he had tremors and received anticonvulsant medication with interventions including give medications as ordered by the physician; * he had constipation related to decreased mobility with interventions including administer medications as ordered; * he had impaired cognitive function and impaired thought process related to Alzheimer's disease with interventions including administer medications as ordered; and * he had depression and received an anticonvulsant with interventions including administer medication as ordered by physician. Record review of the October 2024 physician orders for Resident #61 indicated he had the following orders: * dated 12/01/22 for Donepezil (to treat Alzheimer's disease) 10 mg give 10 mg by mouth at bedtime for Alzheimer; * dated 09/04/24 for Metoprolol Succinate (antihypertensive) Extended Release 25 mg give 1 tablet by mouth at bedtime for hypertension; * dated 11/07/22 for Docusate Sodium (stool softener) 100 mg give 1 capsule by mouth two times a day related to constipation; * dated 10/11/23 for Depakote (anticonvulsant) Delayed Release 125 mg (Divalproex Sodium) give 125 mg by mouth three times a day for depression; and * dated 10/10/23 for Primidone (anticonvulsant) 50 mg give 50 mg by mouth three times a day for tremors. During an observation on 10/14/24 at 10:14 a.m. Resident #61 was in bed. He was clean, neat, and had no odors. He was calm and had no indication of agitation. Record review of the September 2024 MAR for Resident #61 indicated the following: * on 09/28, did not have documentation he received the 01:00 p.m. dose of: Depakote Delayed Release 125 mg; Primidone 50 mg; and * on 09/17, 09/18, and 09/22, did not have documentation he received the 09:00 p.m. dose of: Donepezil 10 mg Metoprolol Succinate Extended Release 25 mg All of the entries were left blank. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the October 2024 MAR for Resident #61 indicated the following: * on 10/07, 10/08, and 10/11, did not have documentation he received the 09:00 p.m. dose of: Donepezil 10 mg; and Metoprolol Succinate Extended Release 25 mg. All of the entries were left blank. During an interview on 10/16/24 at 12:30 p.m., the DON said she expected the nurses to document when they gave medications at the time they give the medications. She said missed documentation of medications could make it appear the resident did not receive their medications and could cause double dosing. During an interview on 10/16/24 at 12:45 p.m., the DON said she contacted the nurses for the night shift on the days of the missing medication documentation. She said RN C told her the hall was split between her and another nurse. She said RN C told her she gave her medications. During a phone interview on 10/16/24 at 12:55 p.m., RN C said had Residents #15, # 55, and #61 on the evenings of the missed medications. She said she may have forgotten to document that the medications were given but she did give them. She said missed documentation of medications could make it appear the resident did not receive their medications and could cause double dosing. Record review of a Charting and Documentation policy revised July 2017 indicated Policy Interpretation and Implementation: 3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate