

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675172	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/07/2026
NAME OF PROVIDER OR SUPPLIER Cascades at Port Arthur		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the physician was consulted regarding a need to alter treatment for 1 of 16 residents reviewed for notification of changes. (Resident #5) The facility did not consult with Resident #5's physician about the pattern of low blood pressure over consecutive days and of the blood pressure medication being held for 15 of 31 opportunities in December 2025 or 3 of 6 opportunities for January 2026. This failure could place residents at risk for complications due to delayed or failed physician intervention. Findings included: Record review of the face sheet dated 01/06/2026 indicated Resident #5 was an [AGE] year-old female admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (a lung condition causing airflow blockage, making it hard to breathe) and high blood pressure (common condition where the force of blood against artery walls are consistently too high, making the heart work harder). Record review of physician orders dated September 2024 indicated the orders for Resident #5 included 25 mg carvedilol once daily for high blood pressure. Parameters set by the physician were to hold carvedilol 25 mg if SBP less than 120, DBP less than 60 or heart rate less than 60. (SBP -the top number -is your systolic pressure-that's the force of the blood flow when blood is pumped out of the heart. DBP - the bottom number - is your diastolic pressure which is measured between heartbeats when the heart is filling with blood) Record review of a quarterly MDS assessment dated [DATE] for Resident #5 included diagnoses of high blood pressure and renal disease (Kidneys are damaged and can't filter waste and extra fluid from blood effectively). Her BIMS was 15 which indicated she was cognitively intact. Record review of the care plan dated 07/07/2024 for Resident #5 indicated she had hypertension. The interventions included giving hypertensive medications as ordered. Hold for SBP below 120, DBP below 60 or heart rate less than 60. Record review of the MARs dated December 2025 and January 2026 indicated carvedilol 25 mg once daily for Resident #5 and to hold the medication if SBP less than 120, DBP less than 60 or heart rate less than 60. On the following dates, the dose of the carvedilol 25 mg was held when Resident #5's B/P was outside the parameters ordered by the physician: 12/2/2025, B/P 118/67;12/05/2025, B/P 98/63;12/07/2025, B/P 104/51;12/08/2025, B/P 135/58;12/15/2025, B/P 108/57;12/16/2025, B/P 121/57;12/17/2025, B/P 101/62;12/18/2025, B/P 107/67; 12/21/2025, B/P 107/56;12/22/2025, B/P 100/67;12/23/2025, B/P 100/67;12/25/2025, B/P 108/74;12/26/2025, B/P 108/69;12/29/2025, B/P 103/63;12/30/2025, B/P 94/61;01/01/2026, B/P was 116/72;01/02/2026, B/P was 100/65; and01/05/2026, B/P was 105/67. During an interview and record review on 01/07/2026 at 12:05 p.m., the DON reviewed Resident #5's December 2025 and January 2026 MARs with surveyor. The DON acknowledged that the carvedilol was documented as held due to the prescribed parameters. She had been unaware of Resident #5's medications being held due to low results outside the parameters. She said best practice would be for nursing staff to notify physician when medications with parameters were held on consecutive occasions. The DON said the nursing staff should document in the resident's electronic record when notifying physician of medications being held and acknowledged Resident #5's electronic record gave no indication the physician had been notified of medications being held. Record review of the nurse's notes for (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 675172	Facility ID: 675172 If continuation sheet Page 1 of 17

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #5 dated from 12/05/2025 to 01/05/2026 indicated no documentation of the physician being notified. During an interview on 01/07/2026 at 2:00 p.m., the Administrator said his expectations were for the physician to be notified when a resident's medications were held, or at least every few times. The Administrator said he expected nursing staff to always follow physician orders, to notify of any changes in condition, and to document notifications. Record review of a Employee In-Service Record dated 07/02/2025 indicated the following: . Provider Notification: If there is a pattern of consistently high or low blood pressure, it is the nurse's responsibility to notify the physician (MD) promptly. Documentation and Family Notification.All actions, changes, and responses must be thoroughly documented in the medical record. Record review of policy dated March 2025 titled Administering Medications indicated the following: . Medications are administered in a safe and timely manner, and as prescribed.4. Medications are administered in accordance with prescriber orders.		

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hire a qualified full-time social worker in a facility with more than 120 beds. Based on interview and record review, the facility failed to ensure the hired Social Worker had the required qualifications for 1 of 1 facility reviewed for social worker qualifications. The social worker hired on 10/06/25, as a full-time social worker was not licensed by the Texas State Board of Social Worker Examiners. This failure could place all residents at risk for unmet social services and psychosocial needs. The findings included: Record review of employee file on 01/07/26 indicated the SW was not a licensed social worker and held a bachelor's degree in social work. The facility hired her as a social worker on 10/06/25. Review of facility's job description dated 10/06/25 for Social Worker position indicated Qualifications: Minimum of a bachelor's degree in social work or in human services fields. Licensed per state requirements or eligible for licensure. Record review of the ASWB licensure examinations website process indicated the following: To become a licensed social worker in Texas, you must earn a CSWE-accredited degree in social work, complete a Texas specific jurisprudence exam, pass the relevant Association of Social work boards (ASWB) exam, undergo a fingerprint background check, and fulfill supervised practice hours for clinical licenses, all while applying through the Texas Board of Social Worker Examiners (part of the Texas Behavioral Health Executive Council) to maintain your license. During an interview on 01/07/26 at 12:00 p.m., the Administrator said the SW had been employed at the facility since 10/06/25. The Administrator said the SW had a Bachelor of Science degree in Psychology and had been preparing to take the licensure exam. He said currently, the SW was not licensed. The Administrator said he wanted her to obtain certification for Texas but did not feel it would change anything except she would receive a pay increase. During an interview on 01/07/26 at 1:00 p.m., the SW said she had researched the application process for certification requirement for the state of Texas, however she had not applied yet. Review of CMS Form 3740, Bed Classification dated 01/07/26 indicated the facility was certified for 150 beds.		

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. Based on interviews and record review, the facility failed to provide required Quality Assurance Performance Improvement (QAPI) training that outlines and informs staff of the elements and goals of the facility's QAPI program, for 9 of 18 (LVN E, LVN F, LVN G, LVN H, CNA J, CNA K, CNA L, CNA M, and CNA N) staff sampled for licensure and training. The facility failed to ensure that LVN E, LVN F, LVN G, LVN H, CNA J, CNA K, CNA L, CNA M, and CNA N had completed their mandatory QAPI training. This failure could place residents at risk of being care for by untrained staff. The findings included: Review of the facility's training log, undated, showed no evidence of training for QAPI for LVN E, LVN F, LVN G, LVN H, CNA J, CNA K, CNA L, CNA M, and CNA N. Record review of employee files indicated the following staff had not completed QAPI training during orientation or annually: * LVN E, hire date 12/12/25; * LVN F, hire date 05/12/25; * LVN G, hire date 07/16/25; * LVN H, hire date 12/04/25; * CNA J, hire date 07/03/25; * CNA K, hire date 10/28/25; * CNA L, hire date 12/30/23; and * CNA M, hire date 10/30/23; * CNA N, hire date 10/29/25. During an interview on 01/07/26 at 11:00 a.m., HR said she was not aware of the new requirement for QAPI training. She said she would check with the interim DON and the Administrator. During an interview on 01/07/26 at 11:30 a.m., the interim DON said she thought the last DON should have completed the QAPI training on the staff however she said she was unable to locate any documentation. During an interview on 01/07/26 at 1:10 p.m., the Administrator said his expectation for the QAPI training was it would have been included in their computerized training system. He said if they do not receive the mandatory training the staff might not be fully trained. Record review of the undated Quality Assurance and Performance Improvement (QAPI) Program Plan indicated . Facility employees are provided the necessary training to enable them to perform their jobs effectively. Topics covered in the training program include but are not limited to: . Regulatory requirements . The QAPI Coordinator is responsible for: Leading the QAPI committee. Facilitating staff education on QAPI principles and practices.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure that alleged violations involving abuse were reported immediately to the Administrator of the facility for 1 of 5 residents (Resident #14) reviewed for reporting abuse and neglect. CNA F failed to report Resident #14's complaint of neglect (Resident #14 told LVN E that she was having shortness of breath and requested a breathing treatment. LVN E allegedly told her she could breathe because she just talked on the phone) to the Administrator on 12/25/2025 at 4:00 p.m. when the incident occurred. This failure could potentially result in residents' complaints or incidents of abuse not being reported to the Administrator. The findings include: Record review of Resident #14's face sheet dated 01/05/2026 indicated she was a [AGE] year-old female with a re-admission date of 10/24/2025. Pertinent diagnoses included chronic obstructive pulmonary disease (inflammation and damage to lungs.) type 2 diabetes (high blood sugar.) obesity, shortness of breath, hypertension (high blood pressure). Record review of Resident #14's quarterly MDS assessment dated [DATE] indicated she had a BIMS of a 15 indicating she was cognitively intact. In section B - Hearing, Speech, and Vision indicated Resident #14 had the ability to hear adequately with no difficulty. She could make herself understood. Record review of Resident #14's care plan dated 09/15/2025 indicated she had an altered respiratory status related to her chronic obstructive pulmonary disease with a goal of: maintaining normal breathing pattern. Interventions: position resident with proper body alignment for optimal breathing pattern (to be completed by- LPN, RN). She had asthma with a goal of: remaining free from complications of asthma. Interventions: give medications as ordered. Monitor/ document side effects and effectiveness. (to be completed by- LPN, RN.) Give nebulizer treatments and oxygen therapy as ordered. (to be completed by- LPN, RN.) Monitor vital signs per physician orders, skin color, pulse oximetry, airway functioning and degree of restlessness which may indicate hypoxia (low oxygen in the body). (to be completed by-CNA, LPN, RN.) Record review of Resident #14's nurses' notes written in the month of November and December 2025 indicated there were no documented complaints or incidents. Record review of the facility's Grievance log dated November and December 2025 indicated there was no grievance report for Resident #14 regarding her complaint/ incident involving LVN E. Record review of the facility's Incident report dated November and December 2025 indicated there was no incident report for Resident #14 regarding her complaint/ incident involving LVN E. During an interview with Resident #14 on 01/05/2026 at 10:40 a.m. she said she does not like how LVN E talked to her a couple of days ago when she had shortness of breath. She said she told LVN E that she was having shortness- of breath and requested a breathing treatment. She said LVN E told her she could breathe because she was just talking on the phone. She said LVN E had given her the breathing treatment but told her she could not get her scheduled one. She said she reported her complaint to CNA F the day it happened on the a.m. shift. During an interview with CNA F on 01/05/2026 at 11:07 a.m. she said Resident #14 verbally reported to her that she wanted to talk to someone about LVN E talking mean to her. CNA F said Resident #14 told her she could not breathe but LVN E told her she was breathing fine while on the phone so she could breathe. CNA F said she reported Resident #14's complaint/ incident to the Social Worker immediately. CNA F said she told the Social Worker Resident#14 had a complaint but did not tell her the details of what was told to her. She said administration did not come to her to discuss or investigate the complaint nor was she asked to write a statement on what was reported to her by Resident #14. CNA F said she had been trained on abuse and neglect and knew the complaint should have been reported to the abuse coordinator within 2 hours of becoming aware of the complaint. She said she did not report the complaint/ incident to the Administrator who is the Abuse Coordinator. She said, he was not in the facility so that was why she did not tell the Administrator. CNA F said she is responsible for reporting to the abuse coordinator about any abuse or neglect (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	complaints immediately. She said she did not tell LVN E about the complaint. During an interview with the Administrator on 01/05/2026 at 11:25 a.m. he said he did not have any reportable incidents or intakes. He said he had not been aware of any grievances or incidents involving interactions between residents and staff, nor any complaints involving Resident #14. He said he is the abuse coordinator and had educated staff on when and how to report any complaints or incidents involving abuse and neglect. He said his phone number is posted in clear sight for anyone to call and report any complaint or incident. He said CNA F should have made him aware of the complaint/ incident between Resident #14 and LVN E immediately. He said staff is responsible for reporting any complaint/ incident to him. The Administrator said the associated potential risk was Resident complaints and incidents would go unreported to him resulting in complaints not being investigated. During an interview with the Social Worker on 01/05/2026 at 11:40 a.m. she said when she received a complaint, she goes to talk to the resident about the complaint. After she gathered the details of the complaint, she completes a written grievance report and presents it at the morning meeting. The Social Worker said she sends the written grievance report to the department heads. She said she logs all complaints in the grievance book. The Social Worker said she did not recall any grievances from Resident #14. She said CNA F never reported anything to her regarding LVN E and Resident #14's incident. She said if she had been made aware of the complaint/ incident she would have interviewed Resident #14, filed the complaint and reported it to the interim DON and the Administrator. She said she was responsible for filing the complaints and presented them at the meeting. She said it was staff's responsibility to report any complaints/ grievances to the abuse coordinator immediately. The Social Worker said the associated potential risk was Resident complaints and incidents would not be investigated. During an interview on 01/05/2026 at 4:49 p.m. with LVN E she said she had worked for the facility for 4.5 months. She said she had residents with asthma before and knows how to care for them. She said residents can experience shortness- of- breath while talking. She said Resident #14 is one of the residents she watches because she can go from breathing good to having difficulty breathing in a split second. She said she worked with Resident #14 over the past 3 days and had to administer PRN breathing treatments every shift because she had been sick. She said Resident #14 had her Breathing treatment orders changed from every 6 hours to 4 hours due to her difficulty breathing. She said the resident asked for the breathing treatment after she got off the phone, and she said she gave the scheduled one instead of the PRN. She said Resident #14 had no signs or symptoms of difficulty breathing. She said her oxygen level was 98% while on 2 liters of oxygen. She said she never told Resident #14 that she was on the phone so she could breathe. She said she never had any issues with the residents. She said she never felt like Resident #14 had any issues with her. During an interview on 01/06/2026 at 9:10 a.m. with the Regional Nurse Consultant (interim DON) she said she was not made aware of any complaints/ incidents involving Resident #14 and LVN E. She said had she been made aware of the complaint/ incident, she would have reported it to the abuse coordinator and assisted in the investigation process. She said the potential associated risk is complaints going unreported and uninvestigated. She said all staff were responsible to report complaints/ incidents to the abuse coordinator. Record review of the facility's policy Abuse and Neglect - Clinical Protocol review dated: March 2018 indicated in part: Definitions1. Abuse is defined at 83.5 as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. 2. Neglect, as defined {483.5, means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Treatment/Management:1. The facility management and staff will institute measures to (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	address the needs of residents and minimize the possibility of abuse and neglect.2. The management and staff, with physician support, will address situations of suspected or identified abuse and report them in a timely manner to appropriate agencies, consistent with applicable laws and regulations.		

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to conduct a comprehensive assessment of a resident within 14 days after the facility determines or should have determined that there has been a significant change in the resident's physical or mental condition for 1 of 16 residents (Resident #34) reviewed for comprehensive assessments and timing. The facility failed to ensure an MDS Significant change Assessment for Resident #34 was completed within 14 days after hospice admission. This failure could place residents at risk for improper or incorrect care and services necessary for their physical, mental, and psychosocial well-being. Findings included: Record review of a face sheet dated 01/05/26 indicated Resident #34 was an [AGE] year-old- male admitted on [DATE] and readmitted [DATE]. His diagnoses included heart failure (the heart cannot pump enough oxygen rich blood to meet the body's needs and causing shortness of breath), cardiomyopathy (disease of the heart muscle that makes it harder for the heart to pump blood causing it to become enlarged and leading to symptoms including shortness of breath), cerebral infarct (an area of tissue death due to blood vessel blockage in the brain) and chronic obstructive pulmonary disease (a progressive lung condition that blocks airflow, making it hard to breathe). Record review of the most recent significant change MDS assessment dated [DATE] indicated Resident #34 had a BIMS score of 13 indicating intact cognition and active diagnoses including chronic obstructive pulmonary disease, heart failure, cerebral infarct and cardiomyopathy and indicated did not receive hospice services. Record review of an undated list of MDSs for Resident #34 included an open quarterly MDS assessment dated [DATE], a completed significant change MDS assessment dated [DATE] and a completed entry MDS assessment dated [DATE]. Record review of a physician's order dated 12/13/25 indicated Resident #34 was admitted on hospice services for congestive heart failure (heart's inability to pump blood effectively due to structural or functional impairments). Record review of physician's orders dated 01/05/26 indicated Resident #34 was admitted to hospice services for congestive heart failure with an order date of 12/12/25. Record review of Resident #34's care plans with a target date of 02/10/26 indicated he had a terminal prognosis and received hospice services for congestive heart failure. During an observation on 01/05/2026 at 9:07 a.m., Resident #34 was lying in bed, and said he received hospice services but was unsure which one. During an interview on 01/07/26 at 10:00 a.m., LVN A said she was providing care for Resident #34 today. She said he received hospice services. During an interview on 01/07/2026 at 10:27 a.m., MDS Nurse B said 01/05/26 was her first day of training on completing MDSs. She said she was now responsible for the MDSs in the facility. She said the backup was the Senior Director of Reimbursement that double checked some MDSs for accuracy. She said MDS Nurse C gave notice on 12/12/25 and was now PRN. MDS Nurse B said she was in the process of being trained to complete MDSs. She said the Significant change MDS for Resident #34 was overlooked when he admitted to hospice services and should have already been completed. MDS Nurse B said the resident risk of a significant change assessment not being completed for a resident admitted on hospice services was not following facility policy. During an interview on 01/07/2026 at 10:55 a.m., the DON said MDS Nurse B was responsible for the MDSs in the facility. She said MDS Nurse B started training on 01/05/26. She said the Senior Director of Reimbursement was the back up. The DON said Resident #34's significant change MDS was overlooked during the period of vacancy of the MDS and DON positions. The DON said the resident risk of a significant change MDS not completed after a resident signed on hospice services was not following facility policy. She said her expectation was all MDSs be completed per RAI manual. She said the facility followed the RAI for a facility policy on MDS. During an interview on 01/07/2026 at 11:05 a.m., the Administrator said MDS Nurse B was responsible for the MDSs in the facility, and she started training on 01/05/26. He said the Senior Director of Reimbursement was the back up. He said Resident #34's significant change MDS was overlooked during the period of vacancy (continued on next page)		

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the MDS and DON positions. The Administrator said the resident risk of a significant change MDS not completed after a resident admitted on hospice services was not following facility policy. He said his expectation was all MDSs be completed per the RAI manual. During an interview on 01/07/2026 at 1:11 p.m., Senior Director of Reimbursement said MDS Nurse C was responsible for completing MDS in the facility in December 2025. She said MDS Nurse B was currently in training and had not started completing MDSSs. She said she was the backup and did routine accuracy checks on random MDSs. Senior Director of Reimbursement said she did not check every MDS for accuracy. She said she opened MDS in the system and MDS Nurse C completed them. She said the facility did not notify her Resident #34 admitted on hospice services, so she did not open a significant change MDS and it was overlooked. Senior Director of Reimbursement said the resident risk was not following facility policy by not completing a significant change MDS when a resident was admitted on hospice services. During an interview on 01/07/26 at 1:35 p.m., MDS Nurse C said her last full-time day was 12/04/25 and she was currently PRN but had only worked a few days since then. MDS Nurse C said she was unaware Resident #34 had been admitted on hospice service and the backup; Senior Director of Reimbursement did not open a significant change MDS in the system for Resident #34. She said it was overlooked. She said she was educated on the completion of MDSs and was the MDS nurse for 4 years in the facility. MDS Nurse C said the resident risk was that the Resident's care plan may not be updated with the changes from the Significant change MDS due to the care plan was triggered by the MDS. She said there was no direct resident risk. Record review of the mds-3.0-rai-manual-v1.19.1_October_2024 indicated . An SCSA is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. The ARD must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than). An SCSA must be performed regardless of whether an assessment was recently conducted on the resident. This is to ensure a coordinated plan of care between the hospice and nursing home is in place. A Medicare-certified hospice must conduct an assessment at the initiation of its services. This is an appropriate time for the nursing home to evaluate the MDS information to determine if it reflects the current condition of the resident, since the nursing home remains responsible for providing necessary care and services to assist the resident in achieving their highest practicable well-being at whatever stage of the disease process the resident is experiencing. The ARD must be less than or equal to 14 days after the IDT's determination that the criteria for an SCSA are met (determination date + 14 calendar days). The MDS completion date . must be no later than 14 days from the ARD (ARD + 14 calendar days) and no later than 14 days after the determination that the criteria for an SCSA were met. This date may be earlier than or the same as the CAA(s) completion date, but not later than.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment for 1 of 4 residents (Resident #14) reviewed for care plans. The facility failed to develop and implement a comprehensive care plan for significant change in condition on 12/04/2025 for Resident #14 when she was placed on hospice. This failure could place residents at risk of receiving inadequate care and services. Findings included: Record review of Resident #14's face sheet dated 01/05/2026 indicated she was a [AGE] year-old female with a re-admission date of 10/24/2025. Pertinent diagnoses included chronic obstructive pulmonary disease (inflammation and damage to lungs.) type 2 diabetes (high blood sugar.) obesity, shortness of breath, hypertension (high blood pressure). Record review of Resident #14's significant change MDS assessment dated [DATE] indicated she had a BIMS of a 15 indicating she was cognitively intact. Section A- Identification Information indicated the type of assessment was (04.) significant change in status assessment for hospice. Record review of Resident #14's care plan had a review start date of 12/1/2025 and a target completion date of 12/17/2025 indicated the care plan was not initiated nor completed for her change in condition related to her being placed on hospice. Record review of Resident #14's census list dated 01/07/2026 indicated she had a payer change on 12/04/2025. Record review of Resident #14's order summary dated 01/05/2026 indicated she had a change in condition on 12/04/2025 when she was admitted to hospice. During an interview on 01/07/2026 at 10:47 a.m. with the Regional Nurse Consultant (interim DON) she said the administrative admission team (MDS, DON, (interim DON), ADON) is responsible for updating residents' care plan. She said her expectation was for significant changes to be added to the care plans in a timely and accurate manner. She said she believed Resident #14's care plan was overlooked by her and the ADON due to the facility's MDS and DON vacancy. She said Resident #14's hospice significant change in condition should have been added to her care plan. She said if significant changes are not added to the care plans, then it could place residents at risk for not receiving needed care. She said the facility did not have a policy on care plans and that they used the RAI manual. During an interview on 01/07/2026 at 11:00 a.m. with the ADON she said the DON, MDS nurse, and herself were responsible for initiating, updating, and completing care plans. She said the Regional Nurse Consultant (interim DON) and herself were responsible for care plans due to the MDS and DON vacancy. She said Resident # 14's care plan should have been done when she was placed on hospice but had been overlooked. She said the potential risk to residents would be a lapse in care if the hospice significant change is not added to the care plans. During an interview on 01/07/2026 at 2:14 p.m. with the Administrator he said he expected care plans to be completed on time. The Administrator said the MDS nurse, the Regional Nurse Consultant (interim DON), and the ADON were responsible for the care plans. He said Resident #14's significant change was when she was placed on hospice. He said the hospice significant change should have been added to her care plan. He said they had a DON and MDS vacancy at that time. He said the potential associated risk would be hospice residents not having a care plan that reflected there current condition. Record review of CMS's RAI Version 3.0 Manual dated October 2025 indicated in part: Significant Change in Status (SCSA) (Comprehensive) A0310A = 04 14th calendar day after determination that significant change in resident's status occurred (determination date + 14 calendar days). CAA(s) Completion Date + 7 calendar days Care Plan Completion Date + 14 calendar days. Comprehensive Assessments OBRA-required comprehensive assessments include the completion of both the MDS and the CAA process, as well as care planning. Comprehensive assessments are completed upon admission, annually, and when a significant change in a resident's status has occurred or a significant correction to a prior comprehensive assessment is required. They consist of: admission Assessment Annual (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assessment Significant Change in Status Assessment Significant Correction to Prior Comprehensive Assessment.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a resident who is unable to carry out activities of daily living receives necessary services to maintain good grooming and personal hygiene for 1 (Resident #11) of 16 residents reviewed for activities of daily living. The facility failed to remove unwanted facial hair from Resident #11's chin area observed on 01/05/2026. This failure placed residents at risk for psychological embarrassment, sadness, and decrease in quality of life. Findings included: Record review of Resident #11's face sheet dated 01/05/2026, reflected she was a [AGE] year-old female originally admitted on [DATE] with medical diagnoses including type 2 diabetes mellitus (high blood sugar), dementia (declining brain function related to thinking and judgement that is severe enough to impact daily life), generalized anxiety disorder (prolonged excessive worry), and hypertension (high blood pressure). Record review of Resident #11's MDS dated [DATE] reflected her BIMS as 14 which indicated cognitive ability was intact and she required supervision or assistance for personal hygiene: The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene). Record review of Resident #11's care plan dated 10/01/2025 reflected ADL self-care performance deficit, with interventions including personal hygiene/oral care requiring staff participation with personal hygiene and oral care. There was no refusal of ADLs, and personal grooming or shaving documented in Resident #11's care plan. Record review of Resident #11's December 2025 aide flowsheet reflected Resident #11 did not refuse baths or personal hygiene. During an observation and interview on 01/05/2026 at 1:00 p.m., Resident #11 said she did not understand why CNA P did not remove her facial hair when she bathed her this morning and said it had been a long time since she was shaved. Resident #11 said she likes her chin hair shaved with her bath. She said she had not complained about it. The hair under her chin was approximately 15 dark curly hairs. During an interview on 01/06/2026 at 8:07 a.m., CNA P said she should have removed the Resident facial hair with her bath yesterday. She said the residents must always be ready for visitors. She said it makes the residents and families feel good about the residents' appearance. During an interview on 01/06/2026 at 8:20 a.m., the interim DON said the residents should be kept without long facial hair unless they refuse. She said she expected the lady residents to be without facial hair. She said she would provide the policy on facial hair and maintaining ADLs. She said the lack of personal hygiene could cause a decline in the resident dignity. During an interview on 01/06/2026 at 8:30 a.m., LVN O said the facial hair should be removed during bath unless the resident refuses. She said Resident #11 does not refuse. During an interview on 01/06/2026 at 1:00 p.m. the Administrator said his expectation was for facial hair to be removed unless the resident refused. Record review of the facility's policy on ADL services last revised March 2018, indicated, Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living. Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene .		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5 percent. There were 2 errors out of 30 opportunities, resulting in a 6.67% percent medication error involving 2 of 5 residents reviewed for medication pass. (Resident #54 and Resident #58) LVN D administered an incorrect dose of bupropion HCL ER (used to treat depression) to Resident #54 on 01/06/2026 during medication pass. LVN D administered carvedilol 3.125 mg tablet (used to treat high blood pressure) to Resident #58 when the heart rate was outside the parameters ordered by the physician. These failures could place residents at risk for inaccurate drug administration resulting in decline in health and decreased quality of life. 1. Record review of a face sheet for Resident #54 indicated admitted to facility on 02/20/2021 with diagnoses including paranoid schizophrenia and major depressive disorder. Record review of Resident #54's quarterly MDS assessment dated [DATE] revealed a BIMS score of 15 out of 15 which indicated intact cognition. She required partial/moderate assistance from staff with ADL care. Record review of Resident #54's care plan updated 12/03/2025 indicated use of psychotropic medications related to depression and schizophrenia. Interventions included administering psychotropic medications as ordered by physician. Observe for and report to nurse any side effects and effectiveness. Record review of Resident #54's Physician Orders dated January 2026 indicated Resident #54 was to receive bupropion HCL ER 150 mg. tablet. Instructions indicated to give 2 tablets by mouth one time a day for depression. Record review of Resident #54's MAR dated January 2026 indicated an order of bupropion HCL ER 150 mg. tablet. Give 2 tablets by mouth one time a day for depression. During an observation of the medication pass on 01/06/2026 at 08:19 a.m., LVN D prepared and administered 2 bupropion HCL ER 300 mg. tablets to Resident #54. During a record review and interview on 01/06/2026 at 09:00 a.m., LVN D acknowledged she had administered an incorrect dose of bupropion HCL ER to Resident #54 during today's medication pass at 08:19 a.m. Resident #54's MAR dated January 2026 indicated an order of bupropion HCL ER 150 mg. tablet. Give 2 tablets by mouth one time a day for depression. Resident #54's medication blister pack indicated bupropion 300 mg tablets were available. She said she gave two 300 mg tablets when she should have given one of the 300 mg tablets. LVN D said she should have noticed the blister pack containing bupropion HCL ER 300 mg. tablets and not the 150 mg. During an interview on 01/07/2026 at 12:05 p.m., the DON said she expected medications to be available and administered by physician orders. She said Resident #54 had been receiving two bupropion 150 mg HCL ER tablets to equal 300 mg. She said when the pharmacy later sent bupropion 300 mg HCL ER tablets, nursing should have been aware and reflected the dosage on the MAR to avoid mistakes. She said she had completed a Med Error report, and the physician had been notified. Resident #54 had been monitored for negative outcomes with none noted. During a phone conversation on 01/07/2026 at 12:10 p.m., the Pharmacy Consultant was interviewed re: Resident #54 having received an incorrect dose of bupropion 300 mg HCL ER. He said since it had been over 24 hours, since the incident had occurred, most likely if there were any negative outcomes, they would have already occurred. He said bupropion 300 mg HCL ER was eliminated quickly in the body. The pharmacy consultant added that the facility was correct in having monitored for standard side effects. 2. Record review of a face sheet for Resident #58 indicated admitted to facility on 04/24/2025 with diagnoses including heart failure and hypertension. Record review of Resident #58's quarterly MDS assessment dated [DATE] indicated a BIMS score of 13 which indicated intact cognition. She required substantial - partial/moderate assistance from staff with ADL care. Record review of Resident #58's care plan 05/29/2025 indicated use of antihypertensive medications used to treat high blood pressure. Interventions included giving anti-hypertensive medications as ordered. Monitor for side effects such as orthostatic hypotension and increased heart rate. Hold for BP 110/60 or heart rate 60. Record review of Resident #58's Physician Orders dated January 2026 indicated Resident #58 was to receive carvedilol 3.125 mg (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	twice daily related to hypertension. Instructions included hold for B/P less than 110/60 or heart rate less than 60. Record review of Resident #58's MAR dated January 2026 indicated an order of carvedilol 3.125 mg twice daily related to hypertension. Instructions included hold for B/P less than 110/60 or heart rate less than 60. During an observation of the medication pass on 01/06/2026 at 08:09 a.m., LVN D prepared and administered carvedilol 3.125 mg to Resident #54. Prior to administration, LVN D was observed obtaining Resident #58's B/P and heart rate which were B/P 167/82 and heart rate of 58. During an interview on 01/06/2026 at 09:00 a.m., LVN D acknowledged she had administered carvedilol 3.125 mg Resident #58 during today's medication pass at 08:19 a.m. when the medication should have been held due to heart rate below 60. LVN D said she had overlooked the parameters and made a mistake in administering. She said she had been educated on parameters prescribed by the physicians and to follow physician orders when administering medications. During an interview on 01/07/2026 at 12:05 p.m., the DON said she expected medications to be administered by physician orders. She said Resident #58 had physician ordered parameters regarding administration of the carvedilol 3.125 mg. She said her expectations were for the nursing staff administering medications to be diligent in following the prescribed orders while observing parameters. She said she had completed a Med Error report, and the physician had been notified. Resident #58 had been monitored for negative outcomes with none noted. During a phone conversation on 01/07/2026 at 12:10 p.m., the Pharmacy Consultant was interviewed re: Resident #58 having received the carvedilol 3.125 mg. when the heart rate was outside the prescribed parameters. He said a possible negative outcome was bradycardia (when your heart beats too slowly, typically under 60 beats per minute for adults). The pharmacy consultant said carvedilol's elimination half-life was short (usually 7-10 hours). The pharmacy consultant added that the facility was correct in having monitored for standard side effects. Record review of the facility's Administering Medications policy dated March 2025 indicated the following: . Medications are administered in a safe and timely manner, and as prescribed. 4. Medications are administered in accordance with prescribers' orders. 10. The individual administering the medication checks the label 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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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure all drugs and biologicals were stored in accordance with currently accepted professional principles for 2 of 2 medication carts reviewed for storage of medications and biologicals. (Hall 300 Medication cart and Hall 400 Medication cart) The facility failed to ensure Hall 300 medication cart was free of loose pills at the bottom of the medication cart drawer. The facility failed to ensure Hall 400 medication cart was free of loose pills at the bottom of the medication cart drawer. These failures could place residents at risk of not receiving prescribed drugs. During an observation and interview on [DATE] at 9:00 a.m., an inspection of Hall 300 medication cart with LVN A was discovered 7 whole miscellaneous pills and 6 broken pills loose in drawer 2 of the medication cart. LVN A said she was responsible for the medication cart today. She said the ADON double checks the medication carts weekly for scattered pills and debris. She said they were overlooked. LVN A said she was in-serviced to check her medication cart for loose pills. She said she usually cleans her medication cart later in the day during her shift and had not had time to clean it yet. LVN A said the resident risk of loose pills in the medication cart was that a resident may run out of their medication before they are scheduled for a refill. During an observation and interview on [DATE] at 9:33 a.m., an inspection of Hall 400 Nurse's medication cart with the ADON was discovered 3 whole pills and 1 broken pill loose in drawer 2 of the medication cart. She said she was giving medication to Residents on Hall 400 today and was responsible for the medication cart. The ADON said she was the backup that double checked the medication carts every Friday for cleanliness, loose medication and expired medication. She said the loose pills were overlooked. The ADON said she was in-serviced on cleaning the medication cart and checking for expired medication and loose pills. She said the resident risk of loose pills on a medication cart was that a resident may be short on medication and it may need to be reordered sooner than normal. During an interview on [DATE] at 9:54 a.m., the DON said the nurse giving medication off the medication cart was responsible for ensuring no loose pills were on the medication cart. She said the ADON and DON were the back up to double check the medication carts weekly for loose medication. The DON said she checked the medication room and hall 200 medication cart on Tuesday ([DATE]). She said the loose pills were overlooked. She said the Resident risk was that a resident could need their medication ordered too soon. The DON said her expectation was all medication be administered per physician orders and all medication carts be checked to ensure they were up to standard. During an interview on [DATE] at 11:00 a.m., the Administrator said all nurses giving medication off the medication cart were responsible for ensuring no loose pills were left on the medication cart. He said the ADON and DON were the back up to double check the medication carts weekly for loose medication. The Administrator said the loose pills were overlooked. He said the Resident risk was a resident could need their medication ordered too soon. The Administrator said his expectation was all medication be administered per physician orders and all medication carts be checked to ensure they were up to standard. Record review of a facility policy titled Medication Labeling and Storage dated revised 02/23 indicated, .The facility stores all medication and biologicals in locked compartments under proper temperature, humidity and light controls. 1. Medications and biologicals are stored in the packaging, containers or other dispensing systems in which they are received.		

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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. 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 4 residents (Resident# 4 and Resident # 6) observed for Enhanced barrier precautions. The facility failed to ensure the enhanced barrier precaution sign was on Resident #4's and Resident #6's door. This failure could place residents and staff at risk for cross-contamination and development of infections. The findings included: Record review of Resident #4's care plan dated initiation of 02/21/2025 indicated he was placed on enhanced barrier precautions for his stage 4 sacrum wound. Enhanced Barrier Precautions (per protocol): Use gloves and gown to provide high contact care use face mask if there is a risk of splash or spray. Record review of Resident #6's care plan revision date of 09/16/2025 indicate she was placed on enhanced barrier precautions for her pressure injurie(s): Stage 2: right superior hip, stage 3: left hip. Enhanced Barrier Precautions (per protocol): Use gloves and gown to provide high contact care use face mask if there is a risk of splash or spray. During observation on 01/05/2026 at 9:30 a.m. there was no enhanced barrier precaution sign on Resident #4 and Resident #6's door. During observation on 01/06/2026 at 12:00 p.m. there was no enhanced barrier precaution sign on Resident #4 and Resident #6's door. During observation on 01/07/2026 at 10:30 a.m. there was no enhanced barrier precaution sign on Resident #4 and Resident #6's door. During interview on 01/07/2026 at 12:30 p.m. LVN A said the enhanced barrier precaution sign was not on the door and said it should have been there so staff would know what needs to be worn during care and to allow the staff and visitors to protect themselves. She said Resident #6 was on enhanced barrier precautions for her tube feedings and wounds on her left and right foot. LVN A said she was responsible for ensuring the enhanced barrier sign was on Resident #6's door for her shift because she is the charge nurse of the residents' assigned hall. She said the associated potential risk was cross contamination. During an interview on 01/07/2026 at 1:05 p.m. with the ADON she said the enhanced barrier precaution sign was not on the door and said it should have been there so staff would know which protective equipment to put on to protect themselves from cross contamination. She said she was the assigned nurse for Resident #4 for the shift and should have noticed the sign was not on the door. She said Resident #4 is on enhanced barrier precautions for his sacrum wound. She said the associated potential risk was cross contamination. During an interview on 01/07/2026 at 1:20 p.m. with the Regional Nurse Consultant (interim DON) she said residents with wounds and tube feedings should be on enhanced barrier precautions. She said the enhanced barrier precautions protect residents and staff from passing germs and infections to each other. She said staff had been educated and in-serviced on enhanced barrier precautions in- person and on computer-based training. She said it was the staff's responsibility to ensure the enhanced barrier precaution signs are on residents' doors that are on enhanced barrier precautions or are high contact residents. She said she expected staff to follow facility policy on enhanced barrier precautions with high contact residents to prevent infection. During an interview on 01/07/2026 at 2:15 p.m. with the Administrator he said he expected enhanced barrier precaution signage to be up for the residents that are required to have it posted. He said it was staff's responsibility to ensure the enhanced barrier precaution signs were on the appropriate residents' doors to avoid the associated potential spread of infection. Record review of facility policy titled Enhanced Barrier Precautions dated August 2022 indicated in part: Policy Statement Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents. Policy Interpretation and Implementation 1. Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDROs) to residents. 2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. 1. Gloves and gown are applied prior to performing the high (continued on next page)		

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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	contact resident care activity (as opposed to before entering the room).2. Personal protective equipment (PPE) is changed before caring for another resident.3. Face protection may be used if there is also a risk of splash or spray.3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include:1. dressing;2. bathing/showering;3. transferring;4. providing hygiene;5. changing linens;6. changing briefs or assisting with toileting;7. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.); and8. wound care (any skin opening requiring a dressing).4. EBPs are indicated (when contact precautions do not otherwise apply) for residents infected or colonized with the following:1. Pan-resistant organisms;2. Carbapenemase-producing carbapenem-resistant Enterobacterales;3. Carbapenemase-producing carbapenem-resistant Pseudomonas spp;4. Carbapenemase-producing carbapenem-resistant Acinetobacter baumannii;5. Candida auris;6. Methicillin-resistant Staphylococcus aureus (MRSA);7. ESBL-producing Enterobacterales;8. Vancomycin-resistant Enterococci (VRE);9. Multidrug-resistant Pseudomonas aeruginosa; and10. Drug-resistant Streptococcus pneumonia.5. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization.6. EBPs remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at increased risk.7. The use of EBPs does not impose limitations on group activities or room restrictions for residents.8. Standard precautions apply to the care of all residents regardless of suspected or confirmed infection or colonization status.9. Staff are trained prior to caring for residents on EBPs.10. Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required.11. PPE is available outside of the resident rooms.12. Residents, families and visitors are notified of the implementation of EBPs throughout the facility.		