STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675231	A. Building B. Wing	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cascades at Jacinto Rehab LP	1405 Holland Houston, TX 77029

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38644 Based on observation, interview, and record review, the facility failed to ensure residents maintained acceptable parameters of nutritional status, such as usual body weight for 1 of 5 residents (Residents #2) reviewed for nutrition. - The facility failed to follow up on the Registered Dietitian's recommendations for Resident #2's severe weight loss. This failure could place residents at risk for weight loss and decline in health status. Findings include: Record review of Resident #2's face sheet revealed a [AGE] year-old female who readmitted to the facility on [DATE]. Her diagnoses included malignant neoplasm of head of pancreas (a type of cancer that begins as a growth of cells in the pancreas), moderate protein-calorie malnutrition, pain, type 2 diabetes, and heart failure. Record review of Resident #2's significant change in status MDS assessment dated [DATE] revealed a BIMS score of 0 out of 15 which indicated severe cognitive impairment. She required partial to moderate assistance from staff with eating. She had a weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months and was not on a physician-prescribed weight-loss regimen. Record review of Resident #2's hospice plan of care dated 10/24/24 indicated her oral intake was generally 100% of meals three times a day plus snacks between meals. Record review of Resident #2's weights revealed: 4/23/24 - 136.1 lbs, 4/29/24 - 135.8 lbs, 5/9/24 - 148.6 lbs, 6/6/24 - 125 lbs, 6/13/24 -125 lbs, (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/20/24 - 124 lbs, 6/25/24 -125 lbs, 7/6/24 - 125.5 lbs, 8/21/24 - 112.5 lbs, 9/16/24 - 115.8 lbs, 9/27/24 - 118.3 lbs, 10/3/24 - 113.7 lbs, 10/10/24 - 114 lbs, 10/17/24 - 113 lbs, 11/5/24 - 115.3 lbs. Record review of Resident #2's Nutrition/Dietary Note dated 10/18/2024 by the Dietitian revealed the resident had significant weight loss. Nursing reported resident ate well overall. Weight trends were: -1.8% x 30 days, -9.4% x 90 days, -16.5% x 180 days. Weight continued to trend down, significant weight loss x 90 and 180 days, BMI 21.5 (normal range). Recommend liquid protein QD 30 ml. Recommend 2.0 supplement TID 90 ml. Record review of the Dietitian's Nutrition Recommendation Form dated 10/18/24 provided by the DON reflected in part, .[Resident #2] Dietitian Recommendation 1. Recommend liquid protein QD 30 mL. 2. Recommend 2.0 supplement TID 90 mL . Record review of Resident #2's Physician's Orders dated 11/13/24 revealed there were no orders for liquid protein or 2.0 supplement. In an interview on 11/14/24 at 8:13 a.m. CNA B said Resident #2's appetite was pretty good, and she had a lot of snacks. In an observation on 11/14/24 at 8:16 a.m. revealed Resident #2 she was sitting up in bed smiling and eating breakfast. Her bedside dresser was stocked with snacks and drinks. In an interview on 11/14/24 at 10:05 a.m. the DON said she was responsible for following up on the Dietitian's recommendations. She said the Dietitian did not send Resident #2's recommendation on an individual form but on a spreadsheet instead. She said she used the individual recommendation form so the MD could sign the recommendation and it could be scanned in the resident's chart. She said she informed the Dietitian that the individual recommendation form was the format needed before her visit on 10/18/24. She said if the Dietitian did not send the recommendation on the individual form, she usually still followed up on the recommendation, but she might have been off that day and would need to follow up to see if Resident #2's recommendations were completed. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 11/14/24 at 11:36 a.m. with Resident #2 said via the interpreter line that she lost weight but had wanted to get back to her normal weight. In an interview on 11/14/24 at 1:45 p.m. the DON said she received the Dietitian's recommendations from the 10/18/24 visit but missed the recommendations on the spreadsheet because she was looking for the individualized forms. She said she did not expect to receive another set of Dietitian recommendations since another Dietitian came to the facility earlier in October 2024 and provided recommendations that were completed. She said Resident #2 had great intake and lost a lot of weight when she went into a manic phase and came back from the hospital. She said she gained some weight and then dropped again. She said the resident would not drink the supplements recommended by the Dietitian, but they could try it. She said the resident not receiving the supplements was not detrimental to her life and there was no risk because she was gaining weight. She said normally the Dietitian would send the recommendation on the form, the DON would review and give to MD and put in medical record. She said she normally followed up on dietitian recommendations the next day or Monday, if received the recommendations on Friday. In an interview on 11/14/24 at 3:03 p.m. the Administrator said the Dietitian did not follow the facility's system for submitting dietary recommendations. She said the system was to provide individualized sheets, but this time they were sent on a spreadsheet. She said Resident #2 was on hospice and she did not believe the recommendations would have helped the patient. She said her expectation was to follow the procedures set up by the facility and for the DON to follow up with the Dietitian if the individualized sheets were not received. In a telephone interview on 11/14/24 at 3:17 p.m. the Dietitian said Resident #2 had quite a bit of weight loss. She said she recommended 2.0 supplement and liquid protein because it would help with intake and nutrient support. She said she sent an email to the facility with the recommendations on 10/18/24 and it was up to the MD and facility to implement the recommendations. She said she would need to clarify with the DON if there was a certain form needed to send the recommendations, but she sent her recommendations on the nutrition form. She said no one from the facility contacted her about the 10/18/24 recommendations. She said Resident #2's weight was stable now and her wound healed but she would have to do another assessment on the resident to determine if any changes in recommendations were needed. Record review of the facility's policy titled Nutrition (Impaired)/Unplanned Weight Loss - Clinical Protocol dated September 2017 read in part, . Treatment/Management 1. The staff and physician will identify pertinent interventions based on identified causes and overall resident condition, prognosis, and wishes. 2. The physician will authorize appropriate interventions, as indicated . Monitoring 1. The physician and staff will monitor nutritional status, an individual's response to interventions, and possible complications of such interventions . Record review of the facility's policy titled, Weight Assessment and Intervention dated March 2022 read in part, .Resident weights are monitored for undesirable or unintended weight loss or gain . Weight Assessment . 3. Any weight change of 5% or more since the last weight assessment is retaken the next day for confirmation. a. If the weight is verified, nursing will immediately notify the dietitian in writing . Interventions for undesirable weight loss are based on careful consideration of the following: (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Resident choice and preferences; b. Nutrition and hydration needs of the resident; c. Functional factors that may inhibit independent eating; d. Environmental factors that may inhibit appetite or desire to participate in meals; e. Chewing and swallowing abnormalities and the need for diet modifications; f. Medications that may interfere with appetite, chewing, swallowing, or digestion; g. The use of supplementation and/or feeding tubes; and h. End of life decisions and advance directives. 2. Interventions for undesired weight gain consider resident preferences and rights .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38644 Based on observation, interview, and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate administering of all drugs and biologicals) to meet the needs of each resident for 1 of 6 residents (Resident #2) reviewed for pharmacy services. MA K administered Resident #4's Gabapentin (used to prevent and control seizures, and to relieve nerve pain) to Resident #2. This failure could place residents at risk of misappropriation of property and medication errors. Findings include: Record review of Resident #2's face sheet revealed a [AGE] year-old female who readmitted to the facility on [DATE]. Her diagnoses included malignant neoplasm of head of pancreas (a type of cancer that begins as a growth of cells in the pancreas), pain, type 2 diabetes, and heart failure. Record review of Resident #2's significant change in status MDS assessment dated [DATE] revealed a BIMS score of 0 out of 15 which indicated severe cognitive impairment. She required assistance from staff with ADL care. Record review of Resident #2's Physician Orders revealed an order for Gabapentin 300 mg give 1 capsule by mouth three times a day for nerve pain, order date 10/20/24. In an observation on 11/14/24 at 8:22 a.m. MA K retrieved medication blister packs from the medication cart. She began preparing Resident #2's medications which included Clonazepam, Creon, and Divalproex. The next blister pack in her hand read Gabapentin 300 mg but had Resident #4's name on it. MA K placed Resident #4's Gabapentin 300 mg into the medication cup and continued preparing the rest of Resident #2's morning medications. After prepping all medications, MA K entered the room and administered the medications to Resident #2. In an interview on 11/14/24 at 8:35 a.m. MA K said she was unsure which Gabapentin 300 mg she administered to Resident #2 because she did not verify the resident's name while preparing the medications. She said she checked to make sure the medication and strength were correct. She said she was unsure how Resident #4's Gabapentin got mixed in with Resident #2's medications. She said they were roommates, and their medications were stored next to each other. She said she could not use another resident's medications for Resident #2 because it was prescribed for a different person, and it could be detrimental. She said she was trained to verify the right resident, medication name, dose, and route. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 11/14/24 at 1:48 p.m. the DON said nursing staff could not use another resident's medication because it could cause the other resident's supply to run out early. She said she expected nursing staff to verify the resident's name, room number, amount, and directions every time because the orders changed often. She said if a medication blister pack was stored in the wrong spot it should be stored in the right spot. She said the person who administered the medication was responsible for ensuring the resident received the right medication. In an interview on 11/14/24 at 3:03 p.m. the Administrator said she expected nursing staff to follow the medication guidelines policies and procedures and check the patient and medication name. She said the facility should not use other residents' medications because they had to follow guidelines. Record review of the facility's Administering Medications policy April 2019 read in part, .Medications are administered in a safe and timely manner, and as prescribed .10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication .