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	12/27/2024

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48923 Based on interview and record review, the facility failed to implement their written policies and procedures that prohibit and prevent abuse for 1 (Resident #1) of 7 residents reviewed for reporting abuse. -The facility failed to implement their written policy of abuse when facility staff failed to report to the Administrator when Resident #1 was found in bed tightening his call light wire around his neck and was sent to the hospital for a possible suicide attempt on 12/26/2024. -The facility failed to implement their written policy of abuse when the facility failed to notify the state agency of the allegation of abuse. This deficient practice could place residents at risk of continued and/or unrecognized abuse, neglect, exploitation, or mistreatment. Findings included: Record review of Resident #1's Face sheet dated 12/27/2024, he was a [AGE] year-old male originally admitted on [DATE] and most recently admitted on [DATE]. He was discharged from the facility on 12/26/2024. His medical diagnoses included stroke), Type 2 Diabetes Mellitus without complications, Hypertension (high blood pressure), Hyperlipidemia (high fat content in blood), iron deficiency, chronic pain syndrome, Dementia (unspecified without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety), sleep terrors, history of falling, Major Depressive Disorder (recurrent severe without psychotic features), Anxiety Disorder, Alzheimer's Disorder, and Metabolic Encephalopathy (a brain dysfunction due to the body's metabolism which can cause confusion, memory loss and loss of consciousness). Record review of Resident #1's Quarterly MDS (a resident assessment tool) dated 12/16/2024 revealed the resident had a BIMS score of 14, indicating cognitive intactness. Resident #1 had symptoms of feeling down, depressed, or hopeless several days in a week. Further review reflected he required maximal assistance with showering and bathing and required setup only for eating and supervision with oral hygiene. Record review of Resident #1's care plan last captured 12/27/2024 revealed: (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675231	A. Building B. Wing	12/27/2024

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Date Initiated: 06/19/2024 -Resident #1 was at risk for mood impairment r/t admitted with diagnosis of major depressive disorder, anxiety, Alzheimer's disease, dementia, night/sleep terrors and insomnia, with interventions including monitoring/documenting/reporting PRN any risk for harm to self, including suicidal plan and past attempt at suicide, monitoring/recording/reporting mood patterns of s/sx of depression, anxiety. -Date Initiated: 12/27/2024 - Resident #1 was at risk for suicidal impulsive/ideations of self-harm related to a recent suicide attempt, found on his room with call light around his neck, was sent out to the hospital right away, with interventions including: monitoring and reporting any behavior changes (like appetite/expression, excessive crying), provide Social Service support visits as needed, Immediately reporting if resident verbalizes thoughts of hurting themselves, and for Licensed Staff Member to perform suicide assessment if suicidal ideation is identified. Assess suicidal thoughts by asking the Resident/Patient to share suicidal history, feelings, plans and behavior. Record review of Resident #1's psychological notes revealed he was seen twice per week from 10/28/2024 to 11/25/2024. Resident #1 expressed concerns regarding a lack of adequate nursing care, feeling neglected and lonely. Resident #1 requested help finding social support and was educated on coping skills such as engaging in his environment and reframing negative feelings and experiences. There was no mention of suicidal ideation in the notes. Record review of Resident #1's SBAR (an incident report) done on 12/26/2024 by LVN B revealed Resident #1 had an altered level of consciousness, he had other types of skin condition, and did not have pain. The SBAR reflected a CNA called the nurse to Resident #1's room around 1:33am. The resident was in bed with the call light wrapped around his neck. Resident #1 was lethargic, and his breathing was even and unlabored. His call light was removed from his neck, his vital signs were stable and he was given oxygen at 2L via nasal canula as a precaution. Resident #1 was noted briefly opening his eyes, he responded to verbal and touch stimuli but would not talk. 911 was called at 1:36am; the DON was notified at 1:38am; his RP was notified at 1:42am and the MD was notified. Resident #1 was transported to the hospital by EMS. Record review of Resident #1's pain assessment completed 12/26/2024 at 5:40am by LVN B revealed he had ligature marks to the front and rear of his neck, and he was not in pain according to the faces scale (a range of faces showing no pain to severe pain). The pain assessment also noted the resident had a self-injury and was transferred to the ER. Record review of the intake online portal revealed HHSC received a self-reported intake related to Resident #1's incident on 12/27/2024 at 1:30pm. Record review of CNA C's witness statement dated and signed 12/26 (no year), reflected, at 1:15am, I saw [Resident #1], [Resident #1] had his call light on, I went in his room he wanted me to pull his blankets up on him and he went back to sleep. Interview with Resident #1's RP on 12/27/2024 at 11:28am, he stated he regularly received updates on Resident #1. The RP stated the resident had really good periods where he liked the facility and the people there and that he didn't want to leave, but when his dementia symptoms came, the resident would get suspicious of everyone and express wanting to leave. The RP said Resident #1 had a history of attempting suicide, but he was never told of any suicide attempts by the facility until 12/26/2024. (continued on next page)

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	12/27/2024

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with CNA A on 12/27/2024 at 12:45pm, revealed she worked with Resident #1 and described him as quiet and usually in a good mood with her. She stated Resident #1 was out and about a few days ago, talking and laughing with other residents. She denied any signs of possible suicidal ideation or anything unusual, and she did not think he would have done what he did because staff could tell when he was feeling well or not. Interview with LVN A on 12/27/2024 at 1:26pm, she stated that she worked on Resident #1's hall. She read his chart which reflected he had ligatures around his neck caused by his call light. She denied him having symptoms of suicidal ideation, and that he never expressed loneliness or depressive symptoms. Resident #1 was quiet, polite and very nice. LVN A said Resident #1's roommate discharged recently so he was in his room by himself. She was aware he had a prior suicide attempt at his last facility, but that he never expressed any concerns to her. Interview with the Social Worker on 12/27/2024 at 1:43pm, she said that she was not at the facility during the incident but heard that Resident #1 had a call light wrapped around his neck and a CNA removed it and afterward the resident was conscious and responded to verbal and physical stimuli. She said he did not seem like he would attempt what he did and denied Resident #1 making an attempt at this facility. The Social Worker said he did not talk to a lot of people and did not go to activities such either. The resident and his previous roommate did not talk to each other, but the resident appeared comfortable with the room. swelling on his face, but he denied pain. Attempted to interview with CNA C on 12/27/2024 at 2:41pm, but she did not answer the phone call, and a voicemail was left. Interview with CNA B on 12/27/2024 at 2:59pm, revealed she witnessed and removed the call light around Resident #1's neck. CNA B stated she changed Resident #1's brief at 10:00pm and he was doing fine. At 11:00pm the resident was in bed. When she went back around 1:00am, his call light came on and she walked into the room where CNA B saw Resident #1 with his cord around his throat and pulling it tight. CNA B said Resident #1 was making choking sounds and his eyes looked like they were gonna pop off; she started yelling for help. CNA B was unable to pull the cord from Resident #1's hand because he held onto it tight, so she pulled the cord from the outlet and was able to go in the opposite direction and remove the cord from his neck, but the resident continued to hold onto the cord. Resident #1 did not say anything and laid in bed. The two nurses came to assess and stayed with the resident. CNA B said Resident #1 was nice and sweet, did not ask for a lot and was dependent on staff for brief changes. She said one of the nurses called 911 and Resident #1 left around 20 minutes later. CNA B denied Resident #1 mentioning suicide or wanting to commit suicide to her. (continued on next page)

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	12/27/2024

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LVN B on 12/27/2024 at 3:31pm, she was the charge nurse for Resident #1's hall during the incident. She said when she started her shift on 12/26/2024 at 6:00pm, the resident was sitting at the side of his bed and there were no concerns. At 1:10am , CNA B had answered Resident #1's call light but LVN B did not remember what the resident needed at that time. About 15 minutes later, LVN B heard CNA B call out. When LVN B arrived to Resident #1's room, CNA B told her that Resident #1 had a cord around his neck and was choking himself so she removed it. LVN B and LVN C were the two nurses during the night shift, so LVN C assessed Resident #1's vitals and oxygen and LVN B called 911 at 1:36am. At the time, Resident #1 did not say anything, and from what she remembered his vitals were pretty good. Resident #1's only skin abnormality was his obvious ligature marks around his neck. Resident #1e retracted when a sternum rub was performed but was not otherwise responsive, and he was not asleep. 911 arrived at 1:42am, they did assessments, questioned staff, and discussed if Resident #1 needed to be transferred or not. LVN B said she told them he needed to be transferred because it was an active suicide attempt, and they went ahead and took him. LVN B said EMS' assessments revealed normal pupil dilation, but when they attempted a blood sugar check, Resident #1 snatched his hands away. LVN B notified the DON who responded right away. Interview with the DON on 12/27/2024 at 3:41pm, she said LVN B notified her of Resident #1's incident on 12/26/2024 around 1:30am to 2:30am. The DON told LVN B to do a total assessment including a skin and pain assessment. LVN B told her she sent Resident #1 to the ER and notified the MD and family and completed a Change in Condition assessment. The DON began her investigation and found that during medication review, Resident #1 was placed on Zyrtec on 12/20/2024 which could cause suicidal ideation. The DON said Resident #1 was rolling through the hallway and she did not see any symptoms of suicidal ideation from him. She said Resident #1 was care-planned for suicidal ideation because he came to the facility from a behavioral hospital for a suicide attempt, but he never had an attempt at the facility. The family did not share his previous suicide attempt. The DON said no residents showed signs of suicidal ideation. The DON said she did not report the abuse to the State because according to the new State guidelines, Resident #1 did not have an injury of unknown origin and that he did not expire at the facility and that the facility got Resident #1 help immediately. She said that the Administrator reported when she found out today. The DON did not suspect foul play since Resident #1 was found in his room alone. Interview with the Administrator on 12/27/2024 at 4:15pm, she stated that she first heard of the incident on 12/27/2024 around 1:00pm. She stated she was concerned that no one told her because that was something she needed to report. She conducted interviews, looked at his skin and pain assessments, called the Ombudsman, and notified the family. The Administrator said from her investigation, Resident #1 was happy, and the facility did not know what happened in the 15 minutes between his call light being answered the first and second time. The Administrator said that if she knew about the incident, she would have reported it immediately, and that anything out of the ordinary should be reported. She said reporting in a timely manner was to protect the residents. Record review of the facility's Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating policy statement revised September 2022 revealed if resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. Record review of the facility's Identifying Neglect policy revised September 2022, the facility's employees, volunteers and contractors are expected to be able to identify neglect as it may occur against residents, and that staff and service providers are (continued on next page)

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	12/27/2024

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	expected to report deficiencies in processes or practices that may lead to resident neglect.

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	12/27/2024

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 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** 48923 Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 24 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury to other officials including to the State Survey Agency in accordance with State law through established procedures for 1 (Resident #1) of 7 residents reviewed for reporting. -The facility staff failed to report to the Administrator when Resident #1 was found in bed tightening his call light wire around his neck and was sent to the hospital for a possible suicide attempt on 12/26/2024. -The facility failed to report within the required time frame to the state agency when Resident #1 was found in bed tightening his call light wire around his neck and was sent to the hospital for a possible suicide attempt on 12/26/2024. This deficient practice could place residents at risk of continued and/or unrecognized neglect. Findings included: Record review of Resident #1's Face sheet dated 12/27/2024, he was a [AGE] year-old male originally admitted on [DATE] and most recently admitted on [DATE]. He was discharged from the facility on 12/26/2024. His medical diagnoses included stroke), Type 2 Diabetes Mellitus without complications, Hypertension (high blood pressure), Hyperlipidemia (high fat content in blood), iron deficiency, chronic pain syndrome, Dementia (unspecified without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety), sleep terrors, history of falling, Major Depressive Disorder (recurrent severe without psychotic features), Anxiety Disorder, Alzheimer's Disorder, and Metabolic Encephalopathy (a brain dysfunction due to the body's metabolism which can cause confusion, memory loss and loss of consciousness). Record review of Resident #1's Quarterly MDS (a resident assessment tool) dated 12/16/2024 revealed the resident had a BIMS score of 14, indicating cognitive intactness. Resident #1 had symptoms of feeling down, depressed, or hopeless several days in a week. Further review reflected he required maximal assistance with showering and bathing and required setup only for eating and supervision with oral hygiene. Record review of Resident #1's care plan last captured 12/27/2024 revealed: -Date Initiated: 06/19/2024 -Resident #1 was at risk for mood impairment r/t admitted with diagnosis of major depressive disorder, anxiety, Alzheimer's disease, dementia, night/sleep terrors and insomnia, with interventions including monitoring/documenting/reporting PRN any risk for harm to self, including suicidal plan and past attempt at suicide, monitoring/recording/reporting mood patterns of s/sx of depression, anxiety. (continued on next page)

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	12/27/2024

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Date Initiated: 12/27/2024 - Resident #1 was at risk for suicidal impulsive/ideations of self-harm related to a recent suicide attempt, found on his room with call light around his neck, was sent out to the hospital right away, with interventions including: monitoring and reporting any behavior changes (like appetite/expression, excessive crying), provide Social Service support visits as needed, Immediately reporting if resident verbalizes thoughts of hurting themselves, and for Licensed Staff Member to perform suicide assessment if suicidal ideation is identified. Assess suicidal thoughts by asking the Resident/Patient to share suicidal history, feelings, plans and behavior. Record review of Resident #1's psychological notes revealed he was seen twice per week from 10/28/2024 to 11/25/2024. Resident #1 expressed concerns regarding a lack of adequate nursing care, feeling neglected and lonely. Resident #1 requested help finding social support and was educated on coping skills such as engaging in his environment and reframing negative feelings and experiences. There was no mention of suicidal ideation in the notes. Record review of Resident #1's SBAR (an incident report) done on 12/26/2024 by LVN B revealed Resident #1 had an altered level of consciousness, he had other types of skin condition, and did not have pain. The SBAR reflected a CNA called the nurse to Resident #1's room around 1:33am. The resident was in bed with the call light wrapped around his neck. Resident #1 was lethargic, and his breathing was even and unlabored. His call light was removed from his neck, his vital signs were stable and he was given oxygen at 2L via nasal canula as a precaution. Resident #1 was noted briefly opening his eyes, he responded to verbal and touch stimuli but would not talk. 911 was called at 1:36am; the DON was notified at 1:38am; his RP was notified at 1:42am and the MD was notified. Resident #1 was transported to the hospital by EMS. Record review of Resident #1's pain assessment completed 12/26/2024 at 5:40am by LVN B revealed he had ligature marks to the front and rear of his neck, and he was not in pain according to the faces scale (a range of faces showing no pain to severe pain). The pain assessment also noted the resident had a self-injury and was transferred to the ER. Record review of the intake online portal revealed HHSC received a self-reported intake related to Resident #1's incident on 12/27/2024 at 1:30pm. Record review of CNA C's witness statement dated and signed 12/26 (no year), reflected, at 1:15am, I saw [Resident #1], [Resident #1] had his call light on, I went in his room he wanted me to pull his blankets up on him and he went back to sleep. Interview with Resident #1's RP on 12/27/2024 at 11:28am, he stated he regularly received updates on Resident #1. The RP stated the resident had really good periods where he liked the facility and the people there and that he didn't want to leave, but when his dementia symptoms came, the resident would get suspicious of everyone and express wanting to leave. The RP said Resident #1 had a history of attempting suicide, but he was never told of any suicide attempts by the facility until 12/26/2024. Interview with CNA A on 12/27/2024 at 12:45pm, revealed she worked with Resident #1 and described him as quiet and usually in a good mood with her. She stated Resident #1 was out and about a few days ago, talking and laughing with other residents. She denied any signs of possible suicidal ideation or anything unusual, and she did not think he would have done what he did because staff could tell when he was feeling well or not. (continued on next page)

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	12/27/2024

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LVN A on 12/27/2024 at 1:26pm, she stated that she worked on Resident #1's hall. She read his chart which reflected he had ligatures around his neck caused by his call light. She denied him having symptoms of suicidal ideation, and that he never expressed loneliness or depressive symptoms. Resident #1 was quiet, polite and very nice. LVN A said Resident #1's roommate discharged recently so he was in his room by himself. She was aware he had a prior suicide attempt at his last facility, but that he never expressed any concerns to her. Interview with the Social Worker on 12/27/2024 at 1:43pm, she said that she was not at the facility during the incident but heard that Resident #1 had a call light wrapped around his neck and a CNA removed it and afterward the resident was conscious and responded to verbal and physical stimuli. She said he did not seem like he would attempt what he did and denied Resident #1 making an attempt at this facility. The Social Worker said he did not talk to a lot of people and did not go to activities such either. The resident and his previous roommate did not talk to each other, but the resident appeared comfortable with the room. swelling on his face, but he denied pain. Attempted to interview with CNA C on 12/27/2024 at 2:41pm, but she did not answer the phone call, and a voicemail was left. Interview with CNA B on 12/27/2024 at 2:59pm, revealed she witnessed and removed the call light around Resident #1's neck. CNA B stated she changed Resident #1's brief at 10:00pm and he was doing fine. At 11:00pm the resident was in bed. When she went back around 1:00am, his call light came on and she walked into the room where CNA B saw Resident #1 with his cord around his throat and pulling it tight. CNA B said Resident #1 was making choking sounds and his eyes looked like they were gonna pop off; she started yelling for help. CNA B was unable to pull the cord from Resident #1's hand because he held onto it tight, so she pulled the cord from the outlet and was able to go in the opposite direction and remove the cord from his neck, but the resident continued to hold onto the cord. Resident #1 did not say anything and laid in bed. The two nurses came to assess and stayed with the resident. CNA B said Resident #1 was nice and sweet, did not ask for a lot and was dependent on staff for brief changes. She said one of the nurses called 911 and Resident #1 left around 20 minutes later. CNA B denied Resident #1 mentioning suicide or wanting to commit suicide to her. Interview with LVN B on 12/27/2024 at 3:31pm, she was the charge nurse for Resident #1's hall during the incident. She said when she started her shift on 12/26/2024 at 6:00pm, the resident was sitting at the side of his bed and there were no concerns. At 1:10am , CNA B had answered Resident #1's call light but LVN B did not remember what the resident needed at that time. About 15 minutes later, LVN B heard CNA B call out. When LVN B arrived to Resident #1's room, CNA B told her that Resident #1 had a cord around his neck and was choking himself so she removed it. LVN B and LVN C were the two nurses during the night shift, so LVN C assessed Resident #1's vitals and oxygen and LVN B called 911 at 1:36am. At the time, Resident #1 did not say anything, and from what she remembered his vitals were pretty good. Resident #1's only skin abnormality was his obvious ligature marks around his neck. Resident #1e retracted when a sternum rub was performed but was not otherwise responsive, and he was not asleep. 911 arrived at 1:42am, they did assessments, questioned staff, and discussed if Resident #1 needed to be transferred or not. LVN B said she told them he needed to be transferred because it was an active suicide attempt, and they went ahead and took him. LVN B said EMS' assessments revealed normal pupil dilation, but when they attempted a blood sugar check, Resident #1 snatched his hands away. LVN B notified the DON who responded right away. (continued on next page)

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	12/27/2024

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DON on 12/27/2024 at 3:41pm, she said LVN B notified her of Resident #1's incident on 12/26/2024 around 1:30am to 2:30am. The DON told LVN B to do a total assessment including a skin and pain assessment. LVN B told her she sent Resident #1 to the ER and notified the MD and family and completed a Change in Condition assessment. The DON began her investigation and found that during medication review, Resident #1 was placed on Zyrtec on 12/20/2024 which could cause suicidal ideation. The DON said Resident #1 was rolling through the hallway and she did not see any symptoms of suicidal ideation from him. She said Resident #1 was care-planned for suicidal ideation because he came to the facility from a behavioral hospital for a suicide attempt, but he never had an attempt at the facility. The family did not share his previous suicide attempt. The DON said no residents showed signs of suicidal ideation. The DON said she did not report the abuse to the State because according to the new State guidelines, Resident #1 did not have an injury of unknown origin and that he did not expire at the facility and that the facility got Resident #1 help immediately. She said that the Administrator reported when she found out today. The DON did not suspect foul play since Resident #1 was found in his room alone. Interview with the Administrator on 12/27/2024 at 4:15pm, she stated that she first heard of the incident on 12/27/2024 around 1:00pm. She stated she was concerned that no one told her because that was something she needed to report. She conducted interviews, looked at his skin and pain assessments, called the Ombudsman, and notified the family. The Administrator said from her investigation, Resident #1 was happy, and the facility did not know what happened in the 15 minutes between his call light being answered the first and second time. The Administrator said that if she knew about the incident, she would have reported it immediately, and that anything out of the ordinary should be reported. She said reporting in a timely manner was to protect the residents. Record review of the facility's Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating policy statement revised September 2022 revealed if resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. Record review of the facility's Identifying Neglect policy revised September 2022, the facility's employees, volunteers and contractors are expected to be able to identify neglect as it may occur against residents, and that staff and service providers are expected to report deficiencies in processes or practices that may lead to resident neglect.