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	10/30/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure residents received adequate supervision for 1 of 5 residents (CR #1) reviewed for accidents. CR #1 eloped from the facility on 03/23/2025 while in the secured unit, through the window. CR #1 was found at a previous residence on 03/24/2025 and refused to return to the facility. The non-compliance was identified as Past Non-Compliance. The Immediate Jeopardy (IJ) began on 03/23/2025 and ended on 03/24/2025. The facility corrected the non-compliance before the investigation, began on 10/14/2025. This failure could place the residents with exit seeking behaviors at risk for injury or death. Findings included:Record review of CR #1's previous facility note text, dated 01/01/2025 stated staff went to the resident's room and noted the window was open in the secured unit, resident was not found in the room. Staff immediately initiated their elopement protocol.Record review of CR #1's previous facility note text, dated 01/01/2025 stated resident was found by staff and escorted back to the facility and placed into the secured unit where his room was. CR #1 stated the reason why he left out the window is wanting to go shopping. CR #1 was placed on 1:1 supervision until transfer to another facility for further evaluation. Record review of CR #1 face sheet, unknown date revealed a [AGE] year-old male who was admitted to the facility on , 01/17/2025. CR #1 had diagnosis which included lack of coordination, dementia, depressive disorder, mild cognitive impairment, and persistent mood disorders. Record review of CR #1's Social Services Note by SW L dated 01/17/2025 met with Social Worker from previous facility who shared general information regarding CR #1 to include, the resident is polite and no behaviors at this time. However, residents attempted escape through the window at previous facility. The family desired for the resident to be moved to Houston area to be close to family. Record review of CR #1's Nurses Note by LVN S dated 01/17/2025 met with new resident in the lobby. CR #1 was able to independently walk. Vision and hearing is within normal limits. Secured unit has assessed his belongings and documented. MD was notified and has reconciled medications for the resident. Record review of CR #1's Care Plan dated 01/22/2025 revealed an elopement risk/wanderer with history of attempts to leave prior facility unattended, impaired safety awareness. Presently admitted to the memory care/secured unit. Interventions included distracting resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, and books. To also include monitor location during rounds and document wandering behavior and attempted diversional interventions in behavior log. Record review of CR #1's Wandering Risk Scale dated 02/17/2025 stated the resident has been at the facility for 1 month and had no episodes of wandering in the past 3 months, with a high-risk wanderer rating of 13(rating above 11 is considered high risk). Record review of CR #1's Quarterly MDS, dated [DATE] revealed a BIMS score of 14 of 15, which indicated no significant signs of cognitive impairment. CR #1 coded 0 for behaviors not exhibited for wandering; rejection of care, verbal behavioral symptoms, and physical behavioral symptoms directed toward others. CR #1 did not require assistance for ADL care and at the time of this assessment, CR #1 was not at risk for elopement. Record review of CR #1's Progress Note dated 03/13/2025 written by MD stated, resident unable to obtain due to cognitive impairment/dementia/inability to cooperate. Psychiatric alert and oriented x1. A discussion was assisted with SW L with the resident stated, patient surrogate decision maker was family, and the patient does not have the capacity to make decisions for himself at this time and needs assistance with decisions. With the diagnosis of mood disorder with psychosis, consult behavioral health services, patient to remain in secured unit and monitor for any agitation or aggression. Record review of the facility's undated self-report read in part, .Incident Details: Date/Time you first learned of incident: Reported to Administrator . patient (CR #1) went through the window from the secure unit. Approxiametly (sic) at 5:30 - 5:45 pm. Police have been called . Date/Time the incident occurred: approximately Sunday March 23rd approximately 5:30 - 5:45. Record review of Reporting to HHSC Complaint and Incident Intake dated 03/23/2025 at 7:33pm by ADMN stated, at this time, CR #1 eloped from the secure unit, via e-mail. Record review of Reporting to HHSC Complaint and Incident Intake dated 03/23/2025 at8L27 pm by ADMN stated, at this time, CR #1 is found safe, approximately 8:20pm near his home. Follow up with Ombudsman and family has been done, via e-mail. Record review of CR #1's Nurses Note dated 03/23/2025 at 10:55pm written by LVN W stated the on-call supervisor was contacted and dispatch was notified of Resident #9 eloping from the facility. Record review of CR #1's Social Service Note dated 03/23/2025 written by SW L stated resident has eloped from the facility and police were notified. The family was contacted, and SW L received an address for where CR #1

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure Residents who are incontinent of bowel and bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extend possible for 1 of 5 residents (Resident #1) reviewed for incontinent care. CNA A failed to place the urine collection bag of the indwelling urinary catheter below Resident #1's bladder after transferring from bed to chair.The failure could place residents with indwelling urinary catheters at risk for infection from potential backflow of urine into the bladder. Findings included:Record review of Resident #1's face sheet dated 10/16/25 revealed a [AGE] year old admitted to the facility on [DATE]. Resident #1's diagnoses included chronic kidney disease, and retention of urine.Record review of Resident #1's annual MDS dated [DATE] revealed a BIMS score of 10 out of 15 indicating moderate impaired cognition. Resident #1 was dependent on staff for most ADLs and had an indwelling urinary catheter.Record review of Resident #1's undated care plan included the following: * Resident #1 had renal insufficiency r/t acute kidney disease and acquired absence of kidney. Goal included: The resident will be free from infection through the review date, target date was 11/29/25. Interventions included: monitor for signs and symptoms (s/sx) of acute renal failure. *Resident#1 had a foley catheter d/t obstructive uropathy and urinary retention. Goal: The resident will show no s/sx of urinary infection through the review date. Interventions did not include keep urinary foley bag at a level below the resident's bladder.Record review of Resident #1's active order summary report dated 10/16/25 revealed and order for Cefdinir 300 mg capsules by mouth two times a day for urinary tract infection (UTI) for 7 days. Start date was 10/11/25.Observation on 10/15/25 at 1:35PM, Resident #1 was asleep in a recliner inside the resident's room. The urine collection bag was hooked on the armrest of the recliner which was at a level above Resident #1's bladder. In an interview and observation on 10/15/25 at 1:35 PM, LVN B stated the urine collection bag was higher than Resident #1's bladder and it should not be at or above the bladder d/t risk of infection as the urine could back up into the bladder. LVN B stated Resident #1 was being treated for a UTI. LVN B repositioned the urine collection bag below the level of the bladder.In an interview on 10/15/25 at 1:45PM, CNA A stated she and another CNA transferred Resident #1 from the bed to the recliner at 10:15 AM and said the collection bag should be below the bladder. CNA A stated the risk would be infection. CNA A asked the surveyor if she left the bag in the wrong place. CNA A stated she was rushing to get to another resident after transferring Resident #1.In an interview on 10/15/25 at 1:57 PM, the DON stated urinary collection bags should be below the level of the bladder for drainage and the risks were infection such as UTI. The DON stated Resident #1 gets UTI's frequently due to refusals of care. The DON stated the CNA's were responsible to ensure the urine collection bag was placed properly.Record review of the facility policy for Urinary Catheter Care revised on August 2022 read in part: The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections. Maintaining Unobstructed Urine Flow.3. Position the drainage bag lower than the bladder at all times to prevent urine from flowing back into the urinary bladder.