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	04/29/2026

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident by providing care including assessing, evaluating, planning and implementing resident care plans and responding to resident's needs for 1 (Resident #1) of 7 residents reviewed for nursing services. The facility failed to ensure that skin assessments were completed completely and correctly for Resident #1. This failure could place residents at risk of worsening skin conditions or infection. Findings included: Record review of Resident #1's face sheet dated 4/28/26, revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including aphasia following cerebral infarction (inability to comprehend or communicate following a stroke) and anemia (deficiency of red blood cells) in chronic kidney disease. Record review of Resident #1's Entry MDS on 4/24/26 revealed admission date of 4/24/26. Record review of Resident #1's Medication Review Report revealed a physician order for weekly skin assessments with order date of 4/24/26 and start date of 4/25/26. Record review of Daily Sign In Sheets revealed the following staff members were assigned to Resident #1: on 4/24/26 from 2 p.m. to 10 p.m. was LVN A and CNA A, on 4/24/26 from 10 p.m. to 6 a.m. was LVN B and CNA B, and on 4/25/26 from 6 a.m. to 2p.m. was LVN C and CNA C. Record review of Resident #1's admission Clinical Evaluation - V2 dated 4/24/26 revealed description of redness to sites of front and rear right thigh. Section K (Skin) states Complete a thorough head to toe skin assessment. Identify any abnormalities and indicate on the diagram below. (e.g. pressure injuries, non-pressure injuries, skin tears, arterial ulcers, redness, bruises, senile purpura (benign skin condition in older adults characterized by purplish bruises on sun-exposed areas due to fragile blood vessels and thinning skin) , scabs, swelling, corns, bunions, callouses, rashes, dryness). Record review of Resident #1's Progress Note dated 4/24/26 at 8:04 p.m. revealed Resident #1 was admitted to the facility. Record review of Resident #1's Progress Note dated 4/25/26 at 8:25 a.m. revealed Resident #1 was to go to a local hospital for feeding tube replacement. Record review of Resident #1's Daily Skilled Documentation - V 4.0 - V 1 dated 4/25/26 completed by LVN C revealed under section J. Skin no was documented for question Note skin issues new and old. A. Does the resident have any skin conditions?Record review of Resident #1's documentation from a local hospital dated 4/25/26 at 1:10 p.m. revealed skin integrity was positive for redness and bruising to right hip, back and leg. Record review of Resident #1's Progress Note dated 4/25/26 at 7:26 p.m. revealed the DON spoke with a doctor from a local hospital where Resident #1 was transferred to regarding bruising that was getting progressively worse on Resident #1's leg. The progress note said the DON discussed in detail with the doctor that this bruising was present on admission to the facility but not as large. During interview on 4/26/26 at 5:07 p.m., LVN C said she cared for Resident #1 on 4/25/26 from 6 a.m. to 2 p.m. shift and transferred him to a local hospital around 10:30 to 11 a.m. but could not remember the exact time. LVN C said Resident #1 had some excoriation (condition where skin becomes red and painful) on his bottom and groin and a healed great toe amputation but no large (continued on next page)

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

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	it was a pressure ulcer then it could get worse, infection, sepsis (life-threatening condition caused by the body's extreme response to an infection), and would depend on the nature and extent of the wound. The DON said if redness was documented regarding skin assessment, then it could mean excoriation or skin color and it would tell them there was some kind of skin impairment. The DON said the effect it could have on the resident if a bruise was getting larger but not documented would depend on which stage the bruise was as it starts off as red and goes to purple and would depend on where they are at in the healing process. During interview on 4/28/26 at 1:01 p.m., the Administrator said they changed computer charting systems recently with their company change and have had to add onto the electronic medical record system and tell them there were features that they need so as they go along they were having to add on new features that they need and this was probably one of the features they need and they just need to educate the nursing staff regarding the new features and programs. Record Review of facility's policy Skin Management dated June 2022 revealed Residents receive care to aid in the prevention or worsening of wounds and/or pressure ulcers. Individuals at risk for skin compromise are identified, assessed and provided treatment to promote healing, prevent infection, and prevent new pressure injuries from developing. Ongoing monitoring and evaluation are provided for optimal resident outcomes.