STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675254	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cascades at Galveston	3702 Cove View Blvd Galveston, TX 77554

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15976 Based on observation, record review and interview the facility failed to ensure that residents are free of significant medications error for 2 of (Resident #1 and #2) of 5 residents reviewed for medications errors. The facility failed to ensure Resident #1's Midodrine for low blood pressure was held when the SBP was above 100. The facility failed to ensure that Resident #2's, medication Toprol X oral tablet extended release (Metoprolol Succinate) for high blood pressure was given as ordered by the physician. This failure placed all resident who received medications at risk of not getting their medications as ordered which could result in resident not receiving the therapeutic benefits of the blood pressure medication that could result in decreased quality of life. Findings included. Resident #1 Record review of Resident #1's admission face sheet dated 05/17/2024 revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1's diagnoses included essential hypertension (high blood pressure) cerebral infraction (disrupted blood flow in the brain), embolism of the of the right ventral artery (clot get stuck in the artery), depression (mental illness), anxiety (fear and dread), and hypotension (low blood pressure). Review of Resident #1's MDS dated [DATE] revealed a BIMS score of 08, indicating Resident #1's cognitive skills for decision making were moderately impaired. Record review of Resident #1's physician's order dated 4/18/2024 revealed: Midodrine 2.5 mg oral give one tablet by mouth two times a day for hypotension was ordered to be started on 04/18/2024. Hold for SBP above 100. Record review of the blood pressure log for May 2024 revealed the following blood pressures. 5/16/2024 08:00 am was 145 / 88 mmHg (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: 675254	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/17/2024
NAME OF PROVIDER OR SUPPLIER Cascades at Galveston		STREET ADDRESS, CITY, STATE, ZIP CODE 3702 Cove View Blvd Galveston, TX 77554	

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/16/2024 03:30 pm was 143 / 70 mmHg 5/16/2024 04:17 pm was 143 / 70 mmHg 5/15/2024 09:03 pm was 109 / 54 mmHg 5/05/2024 05:17 pm was 81 / 51 mmHg 5/02/2024 01:13:pm was 136 / 80 mmHg Record review of Resident #1's May 2024 Medication Administration Record revealed that Midodrine 2.5 mg oral give one tablet by mouth two times a day for hypotension and was to be held if SBP was above 100 was not held on 5/16/2024 in the AM. It was documented as given when the blood pressure was 145/88 by MA A . In an interview on 5/17/2024 with 3:30pm the ADON stated that the expectation of the medication aides and nurses when instructions were given to give medication that they should follow the physician's order. Further interview revealed that if the physician's orders were not followed the resident's blood pressure could continue to drop or get higher and the resident could get worst. She said she had started in-servicing the staff and she was going to have ongoing auditing for medication administration. She said staff were expected to document the B/P on the MAR. She said she had made adjustment to the MARs so that the blood pressure reading was documented on the MARs and also log in PCC for residents who are on blood pressure medications. She also confirmed that the documentation on the blood pressure log in PCC was not complete. In an interview on 5/17/2024 at 3:59 pm with MA A said she did not know what happened and why the medication was documented as given. She said, she must have overlooked the order. She said she should have held the medication, because giving the medication when the blood pressure was high could cause the blood pressure to be higher and the resident could get sick. She said she would have to pay more attention to the physician's order. She said she would have to double check each time to ensure medications were given as ordered and ensure medication were held as ordered. She said she must be more careful next time. Resident #2 Record review of Resident #2's admission face sheet dated 05/17/2024 revealed Resident #2 was a [AGE] year-old female who was admitted on [DATE]. Resident #2's diagnoses included depression (mental illness), anxiety(fear, dread), renal insufficiency (inability to filter waste from the blood), Coronary Artery disease (limitation of blood flow to the heart), Heart failure (a condition in which the heart cannot pump adequate blood), Gastroesophageal reflux disease (heartburn), hypertension (high blood pressure), hyperlipidemia(high level of fat in the blood), thyroid disorder(dysfunction of the butterfly gland of the neck), arthritis (inflammation of the joints) and osteoporosis (a condition in which the bones become weak and brittle). Review of Resident #2's MDS dated [DATE] revealed a BIMS score of 00, indicating Resident #2's cognitive skills for decision making were severely impaired. Record review of Resident #2's physician's order dated 3/18/2024 revealed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675254	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cascades at Galveston	3702 Cove View Blvd Galveston, TX 77554

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Toprol X oral tablet extended release 24-hour 25mg (Metoprolol Succinate) Give one tablet by mouth one time at day for HTN, hold for SBP less than 110, DBP or HR less than 60. 2. Spironolactone Oral tablet, giver 12.5mg by mouth time a day or HTN hold for SBP less than 110, DBP or HR less than 60. Record review of Resident #2's May 2024, MAR revealed that medications, Spironolactone Oral tablet 12. 5mg and Toprol X 25mg were administered by MA A on 05/02/2023 at 9:00am, when the DBP was 131/58, and on 5/11/2024 and 5/12/2024 when the SBP was 105/68. In an observation and interview on 05/17/2024 at 10:30 am revealed Resident #2 was sitting in her room with her daughter . Resident #2 was alert and oriented and could make her needs known. She was clean and well-groomed with no offensive odor. Resident #2 said she was going to be discharged that day and she was happy to be leaving. She had no complaints regarding her stay at the facility. In an interview on 05/17/2024 at 3:30 pm, the ADON said that medication should not be given because the blood pressure was within the parameter that it should be held . She stated her expectations were that physician's orders were followed and the staff were not giving medications when they are within the parameters they should be held. In an interview on 5/17/2024 at 3:59pm with Medication Aide A she said she usually held medications when they are within parameter's they should be held. She said she might have overlooked it. She said giving medications when they were supposed to be held could cause the resident's blood pressure to drop lower and could make her dizzy and may cause her to pass out. She said moving forward she will be paying more attention to physician's order and what she documents on the medication administration records. Further in interview on 05/17/2024 at 5:20pm the ADON said Resident #2's blood pressure could drop when the medication that was to be held was given. That could cause the resident to become dizzy, lightheaded and fall and injury could occur. She said they would educate the staff regarding blood pressure parameters, and they would be auditing blood pressure medications to ensure they have parameters in place. The plan going forward was to in-service the staff and supervise the blood pressure medication administration. Record review of the facility policy titled Pharmacy Services Overview dated April 2019 reflected in part . Purpose: The facility shall accurately and safely provide or obtain pharmaceutical services, including the provision and of routine and emergency medications and biologicals. Pharmacy services consists of: a. The process of receiving and interpreting prescriber's order-dispensing, administering, and monitoring of all medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675254	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/17/2024
NAME OF PROVIDER OR SUPPLIER Cascades at Galveston		STREET ADDRESS, CITY, STATE, ZIP CODE 3702 Cove View Blvd Galveston, TX 77554	

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15976 Based on observation, interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 2 of 5 Residents (Resident #1 and Resident #2) reviewed for medical records accu.[NAME], in that: Resident #1 and Resident #2's May 2024 MARs did not reflect documentation for medication given. The deficient practices could affect residents whose records are maintained by the facility and could place them at risk for errors in care, and treatment. Findings Included: Resident #1 Record review of Resident #1's admission face sheet dated 05/17/2024 revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1's diagnoses included essential hypertension (high blood pressure) cerebral infraction (disrupted blood flow in the brain), embolism of the of the right ventral artery (clot get stuck in the artery), depression (mental illness), anxiety (fear and dread), and hypotension (low blood pressure). Review of Resident #1's MDS dated [DATE] revealed a BIMS score of 08, indicating Resident #1's cognitive skills for decision making were moderately impaired. Record review of Resident #1's physician's order revealed: Midodrine 2.5 mg oral give one tablet by mouth two times a day for hypotension was ordered on 04/18/2024 to be started on 04/18/2024. Hold SBP was above 100. Record review of Resident #1's MAY 2024 Medication Administration Record revealed: Midodrine 2.5 mg oral give one tablet by mouth two times a day for hypotension was to be held for SBP if it was above 100. Further review of Resident #1's MARs for May 2024 revealed documentation that the Midodrine HCL 2.5mg was documented as given in the AM on 5/1/2024-5/14/2024, 5/16/2024 and 5/17/2024 and was held on 5/15/2024 in the AM. The medication was held on 5/1/2024-5/10/2024, 5/13/2024-5/16/2024 in the PM and was documented as given on 5/11/2024 and 5/12/2024 in the PM. Record review of the blood pressure log revealed no documentation that the blood pressure was taken on 5/1/2024, 5/3/2024, 5/4/2024, 5/6/2024, 5/7/2024, 5/8/2024, 5/9/2024, 5/10/2024, 5/11/2024/ 5/11/2024, 5/12/2024/, 5/13/2024 and 5/14/2024. Documented blood pressures for the following dates and time: 5/16/2024 08:00 was 145 / 88 mmHg (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675254	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/17/2024
NAME OF PROVIDER OR SUPPLIER Cascades at Galveston		STREET ADDRESS, CITY, STATE, ZIP CODE 3702 Cove View Blvd Galveston, TX 77554	

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/16/2024 03:30 was 143 / 70 mmHg 5/16/2024 04:17 was 143 / 70 mmHg 5/15/2024 09:03 was 109 / 54 mmHg 5/05/2024 05:17 was 81 / 51 mmHg 5/02/2024 01:54 was 136 / 80 mmHg Record review of Resident #1's nurse's notes for May 2024 revealed no documentation as to why the blood pressure was not done. Further record review revealed no documentation as to why the medication was not held when the blood pressure was in the parameter that it should be held. Resident #2 Record review of Resident #2's admission face sheet dated 05/17/2024 revealed Resident #2 was a [AGE] year-old female who was admitted on [DATE]. Resident #2's diagnoses included depression (common mental disorder), anxiety (feeling of fear, dread), renal insufficiency (in ability to remove waste and balance fluids), Coronary Artery disease (is the narrowing of blood vessel that supply blood and oxygen to the heart., Heart failure(a condition in which the heart is not pumping blood as it should), Gastroesophageal reflux disease (heartburn), hypertension(high blood pressure), hyperlipidemia(high level of fat in the blood), thyroid disorder(dysfunction of the butterfly gland at the base of the neck), arthritis (joint inflammation) and osteoporosis (a condition in which the bones become weak and brittle). Review of Resident #2's MDS dated [DATE] revealed a BIMS score of 00, indicating Resident #2's cognitive skills for decision making were severely impaired. Record review of Resident #2's physician's order summary report revealed: 1. Toprol X oral tablet extended release 24-hour 25mg (Metoprolol [NAME] uccinate) Give one tablet by mouth one time at day for HTN, hold for SBP less than 110, DBP or HR less than 60. 2. Spironolactone Oral tablet, giver 12.5mg by mouth one time a day for HTN . hold for SBP less than 110, DBP or HR less than 60. Record review of Resident #2's MAR revealed that medications, Spironolactone Oral tablet 12.5mg and Troprol X 25mg were administered by MA A on 05/02/2023 at 9:00am, when DBP was 131/58, 5/11/2024 and 5/12/2024 when SBP was 105/68 and on 5/13/2024 when DBP was 117/56 . Review of Resident #2's nurses notes, for May 2024 revealed no documentation as to why the medications were not held when the blood pressure was in parameter when they should be held on 05/02/2024 was 131/58, 5/11/2024 and 5/12/2024 when SBP was 105/68 and on 5/13/2024 when DBP was 117/56 . (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	

In an observation and interview on 05/17/2024 at 10:30 am revealed Resident #2 was sitting in her room with her da family member . Resident #2 was alert and oriented and could make her needs known. She was clean and well-groomed with no offensive odor. Resident #2 said she was going to be discharged that day and she was happy to be leaving. She said she had no complaints regarding her stay at the facility.

In an interview on 5/17/2024 at 3:59 pm with Medication Aide A she said she usually take the blood pressure before the blood pressure medications were given and document on the MARs. It was pointed out that there were missing blood pressure documentation but no answer was given. She said she usually held medications when they are within the parameters's that they should be held. She said she might have overlooked the orders and not holding medications when they were supposed to be held could cause the resident's blood pressure to dropped lower or get higher. She said when blood pressure medications were given when tthey should be held could dizziness and the resident could passed out. She said moving forward she will be paying more attention to the physician's order and what was documented on the medication administration records .

In an interview on 05/17/2024 at 5:20pm, the ADON said medication should not be given when the blood pressure was within the parameter that it should be held and they should document in the progress notes or on the MAR the reason the reason/reasons. She stated her expectations was that physician's orders were followed and the staff were not giving medications when they are within the parameters to be held. She said the plan going forward was to in-service the staff and supervise the blood pressure medication administration. She said she was also in the process of auditing medication administration.

Record review of the facility's policy and procedures on Charting and Documentation title; Clinical Record reflected in part:

Policy Statement: All services provided to the resident, progress toward the care plan goals or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.

Policy Interpretation and Implementation

1. Documentation in the medical record may be electronic, manual or a combination.

2. The following information is to be documented in the resident medical record:

a. Objective observations.

b. Medications administered.

c. Treatments or services performed.

d. Changes in the resident's condition.

3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.

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NAME OF PROVIDER OR SUPPLIER Cascades at Galveston		STREET ADDRESS, CITY, STATE, ZIP CODE 3702 Cove View Blvd Galveston, TX 77554	

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Documentation of procedures and treatments should include care-specific details, including: a. The date and time the procedure/treatment was provided. b. The name and title of the individual(s) who provided the care. c. The assessment data and/or any unusual findings obtained during the procedure/treatment. d. How the resident tolerated the procedure/treatment. e. Whether the resident refused the procedure/treatment. f. Notification of family, physician or other staff, if indicated; and g. The signature and title of the individual documenting.