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	05/16/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45328 Based on observation, interviews, and record review, the facility failed to consult with the resident's physician when there was a significant change in resident condition for 1 (Resident #2) of 5 residents reviewed for notification of changes. -The facility failed to notify Resident #2's physician after testing positive at the hospital for THC (psychoactive compound found in cannabis) on 04/25/25. This failure could place residents at risk for not receiving necessary medical care. The findings included: Record review of Resident #2's Admission Record, dated 05/15/25, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included wedge compression fracture of fifth lumbar, paraplegia (form of paralysis that primarily affects the lower half of the body), asthma (chronic lung disease characterized by the inflammation and narrowing of the airways, which makes breathing difficult), and chronic obstructive pulmonary disease (lung condition caused by damage to the airways that limit airflow). Record review of Resident #2's Quarterly MDS Assessment, dated 04/03/25, revealed a BIMS score of 15, indicating cognition was intact. Record review of Resident #2's Care Plan Report, undated, revealed resident was not care planned for substance abuse. Record review of Resident #2's physician orders revealed she did not have an order for THC. Active physician orders included the following: lithium (mood stabilizer), risperidone (antipsychotic), duloxetine (antidepressant), and methocarbamol (muscle relaxer). Record review of Resident #2's progress notes, dated 04/25/25 at 21:55 [9:55 p.m.], revealed resident was sent out to the hospital for altered mental status. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's hospital encounter notes, dated 04/26/25, read in part .Arrival 04/25/25 22:43 [10:43 p.m.] .Chief Complaint altered mental status, comment gummies and THC pen .4/26/25 .patient came in as a THC overdose .Urine Drug (Immunoassay) - Comprehensive Drug Screen W/O Reflex - Abnormal; Notable for the following components .THC presumptive positive .collected 04/25/25 .04/26/25 .awaiting patient to be more alert so that she may be discharged back to [facility Name] with a prescription of Augmentin for her UTI . Record review of Resident #2's Psychiatric Subsequent Assessment, dated 04/25/25, read in part .Drug use: history of marijuana use . During an interview on 05/15/25 at 12:13 p.m., the DON said she was not employed at the facility when Resident #2 was sent out to the hospital on 04/25/25. During an interview on 05/15/25 at 1:21 p.m., Nurse A said she has been working at the facility since April 21, 25 and at that time the facility had an Interim DON for about a month. She said Resident #2 was sent out to the hospital on 04/25/25 for altered mental status. She said Nurse B believed the resident may have ingested some type of drug. She said the resident had a marijuana vape with her and another resident reported Resident #2 took a 2000 mg marijuana gummy. She said she notified the Administrator and Interim DON. She said the Administrator was going to have an officer come out to provide education on drug use and its legal ramifications and told them it could lead to a 30-day discharge notice if the behavior continues. During an interview on 05/15/25 at 2:04 p.m., the Administrator said all he knew was that Resident #2 went out to the hospital on 04/25/25 for altered mental status and returned back to the facility the following day. He said he was not aware she had a vape pen or what would have been in her vape pen. He said she was educated on admission that all smoking paraphernalia should be kept under lock and key and there have been several reeducations with the residents. He said residents were taking recreational drugs while out of the facility, he cannot control that, and the residents were their own RP. He said they could document and care plan. He said he did not know of any such measures to monitor because they cannot search a resident without consent, and it is not within their admission packet to gain such consent. He said they do not [NAME] residents or conduct random drug tests. During an interview on 05/16/25 at 9:01 a.m., the Physician said she just started rounding in the building about 6 weeks ago, mid-March. She said she was not aware Resident #2 tested positive at the hospital for THC on 04/25/25. She said the patients are going outside the premises, could go get substances, and has addressed it with the Administrator. She said if they cannot follow the rules, then it would be her recommendation the resident did not remain at the facility. During a telephone interview on 05/16/25 at 9:27 a.m., the Interim DON said she was the Interim DON from the end of March 2025 until the beginning of May 2025. She said she was not notified verbally by the hospital about Resident #2's positive drug test and did not review the hospital report. She said the admissions nurse would be the one to review the hospital records and bring anything to her attention. She said she does not review all the hospital reports. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/16/25 at 9:37 a.m., Nurse B said Resident #2 was sent out to the hospital on 04/25/25 for altered mental status. She said the resident went out earlier that day and when she returned, she later presented with altered mental status. She said she was made aware of the positive drug test result during a verbal report from the outgoing nurse. She said she did not remember the name of the nurse who gave the report. She said when someone returns back to the facility, they contact the NP/Physician to let them know. She said the police showed up at the facility (does not know who called them) and found a THC vape pen/cartridge on Resident #2 during her send out to the hospital. She said another resident told her she thought the resident purchased a big 1000 mg cannabinoid gummy from the vape shop/convenience store. During an interview on 05/16/25 at 11:04 a.m., Nurse C said she was not able to read Resident #2's hospital records from 04/25/25 because they did not give her any paperwork when she returned to the facility. She said they might have just put it down at the nurses station, and she did not read them. She said if she was not able to get the paperwork, she would not know about the positive drug test. During a telephone interview on 05/16/25 at 12:17 p.m., the NP said she was not comfortable talking about the residents at the facility when asked if she was made aware of Resident #2's positive drug test completed at the hospital on 04/25/25. Record review of the facility's Guidelines for Notifying Physicians of Clinical Problems, revised September 2017, read in part .These guidelines are intended to help ensure that 1) medical problems are communicated to the medical staff in a timely, efficient and effective manner and that 2) all significant changes in resident / patient status are assessed and documented in the medical record .When contacting the practitioner, especially at night and on weekends (when physicians not familiar with the residents may be on call), the nurse should have the following information available: .3. Pertinent information from any recent hospitalization s (hospital discharge summary or admission history and physical form) .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45328 Based on observation, interviews, and record reviews, the facility failed to revise the comprehensive care plan for 2 (Resident #1 and Resident #2) of 5 residents reviewed for care plan timing and revision. -The facility failed to revise Resident #1's care plan after testing positive for benzodiazepines (class of psychotropic medications that help relieve nervousness, tension, and other symptoms by slowing the central nervous system) and THC (psychoactive compound found in cannabis) at the hospital on 05/07/25. -The facility failed to revise Resident #2's care plan after testing positive for THC (psychoactive compound found in cannabis) at the hospital on 04/25/25. This failure could place residents at risk of not receiving the appropriate care and services to maintain the highest practical well-being. The findings included: Resident #1 Record review of Resident #1's Admission Record, dated 05/15/25, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included hepatic encephalopathy (condition that occurs when the liver fails to filter toxins from the blood effectively), alcohol cirrhosis of liver (advanced form of liver disease caused by excessive alcohol consumption) with ascites (abnormal buildup of fluid in the abdominal cavity), other psychoactive (affecting the mind) substance abuse uncomplicated, and hypertensive heart disease with heart failure (chronic high blood pressure causing heart complications). Record review of Resident #1's Quarterly MDS Assessment, dated 03/15/25, revealed a BIMS score of 10, indicating moderate impaired cognition. Record review of Resident #1's Care Plan Report, undated, revealed resident was not care planned for substance abuse. Record review of Resident #1's physician orders revealed he did not have an active order for benzodiazepines or THC. Active physician orders included the following: trazadone (antidepressant), lidocaine external patch (local anesthetic), and duloxetine (antidepressant). Record review of Resident #1's progress notes, dated 05/07/25 at 12:09 p.m., revealed resident was sent out to the hospital for altered mental status. Record review of Resident #1's hospital record, dated 05/07/25 read in part .[lab] results .Urine Drug (Immunoassay) - Comprehensive Drug Screen .Collected: 05/07/25 .(Abnormal) .Specimen: Urine, Clean Catch .[NAME] U presumptive positive .THC presumptive positive . (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 05/15/25 at 10:32 a.m., Resident #1 was lying in bed, was alert, oriented, and showed no signs of distress. Resident #1 said he did not use drugs or bring drugs into the facility. Resident #1 said he signs himself out when he wants to leave the facility. Resident #2 Record review of Resident #2's Admission Record, dated 05/15/25, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included wedge compression fracture of fifth lumbar, paraplegia (form of paralysis that primarily affects the lower half of the body), asthma (chronic lung disease characterized by the inflammation and narrowing of the airways, which makes breathing difficult), and chronic obstructive pulmonary disease (lung condition caused by damage to the airways that limit airflow). Record review of Resident #2's Quarterly MDS Assessment, dated 04/03/25, revealed a BIMS score of 15, indicating cognition was intact. Record review of Resident #2's Care Plan Report, undated, revealed resident was not care planned for substance abuse. Record review of Resident #2's physician orders, undated, revealed she did not have an order for THC. Record review of Resident #2's progress notes, dated 04/25/25 at 21:55 [9:55 p.m.], revealed resident was sent out to the hospital for altered mental status. Record review of Resident #2's hospital encounter notes, dated 04/26/25, read in part .Arrival 04/25/25 22:33 [10:43 p.m.] .Chief Complaint altered mental status, comment gummies and THC pen .04/26/25 .patient came in as a THC overdose .Urine Drug - Comprehensive Drug Screen W/O Reflex - Abnormal; Notable for the following components .THC presumptive positive .collected 04/25/25 .04/26/25 .awaiting patient to be more alert so that she may be discharged back to [facility name] with a prescription of Augmentin for UTI . During an observation and interview on 05/15/25 at 10:25 a.m., Resident #2 was lying in bed, was alert, oriented, and showed no signs of distress. Resident #2 said she did not use drugs. During an interview on 05/15/25 at 11:53 p.m., HR Manager/Admissions Director said Resident #1 has been known to illicit outside activities. During an interview on 05/15/25 at 12:04 p.m., Nurse B said the hospital called a couple of times during his stay and at one point reported to her that Resident #1 had THC and benzodiazepines in his urine. She said he was not prescribed any of those substances. She said she reported it to the Administrator and the DON. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/15/25 at 12:33 p.m., the Administrator said he has been working at the facility since January 6, 25. He said since he has been in the building he has been told residents would go out and get alcohol or to the vape shop which has since been closed. He said he attended a resident council meeting and went over expectations when leaving the facility and using any contradicting medications or drugs. He said he informed them that it is not ok to mix drugs and alcohol, and that they must sign out according to the facility's process. He said he had all residents that were going to the store, sign an acknowledgement form saying if they are caught with illegal substances or alcohol, they would be given a 30-day discharge notice. He said he had several conversations with Resident #1, and he said his last change of condition was sometime last week. He said he was notified on 05/08/25 at approximately 7:24 p.m., about Resident #1's positive drug results at the hospital. During a telephone interview on 05/16/25 at 9:27 a.m., the Interim DON said she was the Interim DON from the end of March 2025 until the beginning of May 2025. She said she was not notified verbally by the hospital about Resident #2's positive drug test and did not review the hospital report. She said the admissions nurse would be the one to review the hospital records and bring anything to her attention. She said she does not review all the hospital reports. During an interview on 05/16/25 at 8:38 a.m., the DON said it should be care planned that they have a history of substance abuse would be appropriate. She said they are adding it to their care plans. She said she does not know what day it was but a nurse from the hospital called her and informed her, in passing, of Resident #1's positive drug test results. She said the Social Worker also offered him a drug rehabilitation program but Resident #1 told them he did not do drugs. She said she does not know why it has not been added to their care plan. She said nursing would communicate changes to MDS or nursing will update the care plans. During a follow-up interview on 05/16/25 at 12:02 p.m., the DON said they follow the RAI (resident assessment manual) when related to care plans.