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	11/19/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview and record review, the facility failed to store drugs and biologicals in locked compartments during medication storage inspection for 4 (medication Cart #1, #2, #3 and #4) of 6 medication carts reviewed for storage. The facility failed to ensure Medication Cart #1, #2, #3 and #4 were locked and secured while unattended. This failure could place residents at risk of drug diversion.Based on observation, interview and record review, the facility failed to store drugs and biologicals in locked compartments during medication storage inspection for 4 (medication Cart #1, #2, #3 and #4) of 6 medication carts reviewed for storage. The facility failed to ensure Medication Cart #1, #2, #3 and #4 were locked and secured while unattended. This failure could place residents at risk of drug diversion. Findings included:During an observation on 11/18/2025 at 11:17 a.m. Medication Cart #1, on hall 100, was unattended and unlocked with residents, visitors and staff within two ft of the unlocked cart. During an interview on 11/18/2025 at 11:20 a.m. the ADON stated Medication Cart #1 belonged to RN C's cart. She stated the nurse was taking a break. The ADON stated the medication cart should have been locked at all times when unattended. During an interview on 11/18/2025 at 11:23 a.m., RN C stated the unlocked cart was hers and she should have locked it before she walked away from it. RN C stated residents could have opened the drawers of the medication cart and had an allergic reaction with the possibility of cardiac arrest and/or fall. She stated there were just PRN's on the cart. She stated this cart was for hall 100 and contained 19 resident medications that consisted of nebulizers, insulin, BP meds, pain, anxiety, epileptic meds, and OTC drugs. RN C stated the narcotics were locked and residents, visitors or staff were not able to get anything. She stated the narcotics were supposed to have been locked under two locks and not one. During an observation on 11/19/2025 at 4:55 a.m., Medication Cart #2, #3, and #4 were observed to be unlocked and unattended with the keys placed on top of each cart at the nurse's station, facing outward and out of eyesight of staff. There were residents and staff observed within two ft of the unlocked carts. All unlocked medication carts were observed as having prescription heart medications (amiodarone, amlodipine, metoprolol), prescription depression medications (trazodone), prescription diuretics (metolazone), prescription antinausea (meclizine, ondansetron), prescription diabetes medications (glucagon, insulin), prescription inhalation medications (albuterol, ipratropium bromide, budesonide), prescription anti-yeast medication. (nystatin powder and cream), OTC pain medication (aspirin, Tylenol), OTC constipation medication (MiraLAX) and narcotics. During an observation on 11/19/2025 at 4:57 AM, Medication Cart #1 was in the middle of hall 100 in front of the door leading to the men's restroom and employee lounge. The medication cart was not locked, and drawers were not closed, including the top middle drawer, second to the top middle drawer, and second to the top right narcotic drawer. There was a laptop on top of the cart with a cell phone to the right of the laptop and keys under the cell phone on a blue ribbon. There were no staff in eyesight of the medication cart or observed on hallway 100. Cart #1 was unlocked and observed to have prescription heart medications (amiodarone, amlodipine, metoprolol), prescription depression medications (trazodone), prescription diuretics (metolazone), prescription antinausea (meclizine, ondansetron), prescription diabetes medications (glucagon, insulin), prescription inhalation medications (albuterol, ipratropium bromide, budesonide), narcotics (hydrocodone, tramadol), antiepileptic (Gabapentin, Depakote), prescription anti-yeast medication (nystatin powder and cream), OTC pain medication (aspirin, Tylenol), OTC constipation medication (MiraLAX), OTC multivitamins, alcohol wipes, insulin syringes, and lancets (needle to draw blood for diabetes monitor). During an observation and interview on 11/19/2025 at 4:57 a.m., RN B was observed walking out of a door to the right of the medication cart. She stated she was responsible for the medication cart on 100 hall at this time. She stated the medication cart should be locked and added she had an emergency where a resident was about to fall. She stated there was water on the floor and she went to prevent the fall. She stated she came out of the employee lounge door when observed and denied any residents being in the employee lounge. She stated not locking the cart could lead to residents' medications missing. She stated she left the cart in a hurry and that was the only reason the medication cart was left unlocked and opened. During an interview on 11/19/2025 at 5:10 a.m., RN A stated the carts were everyone's responsibility to keep the med carts locked. She stated residents could have possibly gotten medications that were not theirs. During an interview on 11/19/2025 at 6:20 AM, RNC stated she was the acting DON. RNC stated the facility policy stated the medication carts were locked at all times when unattended or out of the direct sight of the nurses. She stated it was the nurse's responsibility assigned that