

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 03/18/2026
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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan to meet a resident's medical, mental, and psychosocial needs for 1 (Resident #1) of 5 residents reviewed for comprehensive care plans. The facility failed to ensure Resident #1's care plan was not cancelled on 01/19/26. This failure could have placed residents at risk of his needs not being monitored and cared for at the facility. Findings included: Resident #1 Record review of Resident #1's face sheet dated 3/18/25 revealed he was a [AGE] year-old male who was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1 had diagnoses which included: convulsions (sudden uncontrollable shaking or jerking of the body), hypertension (high blood pressure), and traumatic brain injury (damage to the brain caused by an external force). Record review of Resident #1's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 03 of 15, indicating severely impaired cognition. Further review revealed Resident #1 required extensive assistance to total care with ADL care with one staff assistance. Record review of Resident #1's care plan revealed it was canceled on 01/19/26, and Resident #1 did not have any current care plan. During an interview on 03/18/24 at 4:44 p.m., the MDS Coordinator said she did not cancel the care plan and that it was canceled on 01/29/26 by her supervisor, and she did not know why it was cancelled. The MDS Coordinator said she was not aware Resident #1's care plan was cancelled until the surveyor asked for Resident #1's care plan. She said care plans were reviewed every quarter, and she reviewed the care plan when she completed MDS. She said she finished the quarterly MDS earlier that month but had not reviewed the care plan. The MDS Coordinator said her supervisor cancelled Resident #1's care plan and she did not know why she cancelled it. She did not respond when she was asked how it would have affected the care provided for Resident #1 without a care plan. During a telephone interview on 03/18/26 at 4:55 p.m., the surveyor attempted to reach the MDS Supervisor; she did not answer. During an interview on 03/18/26 at 5:03 p.m., with the Administrator and the DON, the DON said the care plan was the MDS Coordinator's responsibility, and she was not aware why Resident #1's care plan was cancelled. The DON said the care plan was used to provide care for the residents and without it could have affected Resident #1's care. The Administrator said Resident #1 should have had a current care plan while in the facility and it was used to communicate with providers and nursing staff about Resident #1's care. The DON said the regional nurse stated the facility did not have a care plan policy and the facility followed the RAI manual. The DON said every resident should have had a care plan and it should have been updated every quarter.</p>		

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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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**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 skill sets to provide nursing and related services to assure resident safety for 3 of 6 (Resident #1, Resident #2, and Resident #3) residents reviewed for staffing, in that: The facility failed to ensure RN K's control count sheet for Resident #1 matched the actual Lacosamide, and Resident #2's tramadol blister packet seal was broken and exposed. The facility failed to ensure LVN J's control count sheet for Resident #3 matched Acetaminophen-COD#3 in the blister packet. These failures could place residents at risk of not being provided care by nursing staff with sufficient skills/training. Findings included: Resident #1 Record review of Resident #1's face sheet dated 3/18/25 revealed he was a [AGE] year-old male initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1 had diagnoses which included: convulsions (sudden uncontrollable shaking or jerking of the body), hypertension (high blood pressure), and traumatic brain injury (damage to the brain caused by an external force). Record review of Resident #1's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 03 of 15, indicating severely impaired cognition. Further review revealed Resident #1 needed extensive assistance to total care with ADL care with one staff assistance. Record review of Resident #1's care plan was canceled on 01/19/26, and Resident #1 did not have any current care plan. Record review of Resident #1's March 2026 order summary report read in part, Lacosamide oral solution 10MG/ML, give 20ML via G-tube two times a day, active date 03/14/25. Record review of Resident #1's control count sheet for Lacosamide oral solution 10MG/ML, give 20ML via G-tube two times a day read 480ML. During an observation and interview of nurse's medication cart A control count for all of 300 hall and half of 200 and 400 halls on 03/18/26 at 2:33 p.m., with RN K, it was revealed that Resident #1's Lacosamide was 110 ML from the two medication bottles; one bottle was 400ML and the second bottle was 110ML, while the control count sheet read 480 ML. RN K said the first bottle was full and not opened and had 400 ML, and the second bottle had 110ML. RN K said there was a discrepancy because the combined medication bottles were 510 ML while the medication control count sheet read 480 ML for both bottles. She said she did not know what to do and maybe would tell the DON. She said there may have been a mistake in documentation, or the medication was not measured accurately when drawn out of the bottle. She said she had not had any skill check-off on medication administration or control count since she started working in the facility 3 weeks prior. RN K did not respond to what could have happened to Resident #1 if he did not get the required dose of medication for seizures. During an interview on 03/18/26 at 3:22 p.m., the DON said if Resident #1's Lacosamide medication had been overfilled, RN K should have told her, and they would count the medication and, when the pharmacist came to the facility, she would waste the difference with the pharmacist. When she was asked what could have happened to Resident #1 if the medication was not given as prescribed, since the medication was ordered for seizures, she did not respond. Resident #2 Record review of Resident #2's face sheet dated 3/18/25 revealed he was a [AGE] year-old male initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #2 had diagnoses which included: dementia (decline in mental ability such as memory and thinking), hypertension (high blood pressure), and diabetes mellitus (high blood sugar). Record review of Resident #2's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 11 of 15, indicating moderately impaired cognition. Further review revealed Resident #2 needed supervision to partial assistance with ADL care with one staff assistance. Record review of Resident #2's care plan revision dated 12/19/23 read in part, .Resident #2 was at risk for pain related to generalized pain. Intervention: administer medication per order. Record review of Resident #2's March 2026 order summary report read in part, .tramadol HCL oral tablet by mouth every 6 hours as needed for pain, initiated date 12/21/25. During an observation and interview of (continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>nurse's medication cart A control count for all of 300 hall and half of 200 and 400 halls on 3/18/26 at 2:38 p.m., with RN K, it was revealed that Resident #2's tramadol 50 mg blister packet had one of the seals punched open and the medication was half exposed. RN K said the medication seal was punched and she did not know what to do. RN K said she had not had any training on medication administration or control count. RN K did not respond when she was asked what could have happened to the medication since the seal was broken. During an interview on 03/18/26 at 3:20 p.m., the DON said if Resident #2's tramadol blister pack had a breakage on the seal, RN K should have wasted the medication with another nurse and signed the control sheet. The DON said they were not sure if the medication in the opened blister packet was the original medication. The DON said if the tramadol in the punched seal was not taken out and destroyed, the medication could have gone missing and would have been reportable for drug diversion. She said the nurse may not have known that, and this was something she had to go over with the nurses. Resident #3 Record review of Resident #3's face sheet dated 3/18/25 revealed she was a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #3 had diagnoses which included: obesity (an excessive amount of body fat that poses risks to health), hypertension (high blood pressure), and diabetes mellitus (high blood sugar). Record review of Resident #3's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 15 of 15, indicating intact cognition. Further review revealed Resident #3 needed independence to supervision assistance with ADL care with one staff assistance. Record review of Resident #3's care plan revision dated 11/10/25 read in part, .resident was on pain medication therapy related to status post right posterior abscess. Intervention: administer analgesic medications as ordered by physician. Record review of Resident #3's March 2026 order summary report read in part, acetaminophen-codeine oral tablet 300-30 mg, give 1 tablet by mouth every 4 hours as needed for pain, start date 10/13/25. Record review of Resident #3's control count sheet for acetaminophen-codeine oral tablet 300-30 mg, give 1 tablet by mouth every 4 hours as needed for pain read 16 tablets. During an observation of nurse's medication cart B control count for all of 100 hall and half of 200 and 400 halls on 3/18/26 at 3:01 p.m., with LVN J, it was revealed that the blister packet for Resident #3's Acetaminophen-COD#3 had 15 pills while the control count sheet read 16. During an observation and interview on 03/18/26 at 3:05 p.m., LVN J said she had administered 1 tablet of acetaminophen-codeine oral tablet 300-30 mg to Resident #3 at 1:30 p.m., and she forgot to sign it out on the control sheet or sign it off on the MAR. When she was asked when she should have signed the control book and the MAR when she administered controlled medication to Resident #3, she shrugged her shoulders. LVN J said she had not had any training on medication administration since she started working in the facility 3 weeks ago, but she had 3 days of floor orientation. During an interview on 03/18/26 at 3:30 p.m., the DON said LVN J should have followed the facility protocol which was to sign out acetaminophen-codeine medication immediately when she pulled Resident #3's medication and administered it to the resident. The DON said if it was not signed out when it was pulled, it would look like drug diversion. During an interview on 03/18/26 at 3:39 p.m., the DON said the nurse had done orientation, but she had not had time for comprehensive nursing training because she was still filling positions for the shifts. The DON said the nurses were taught how to count control medications and what to do if there were discrepancies in nursing school. The DON did not respond when she was asked if the nurse would have cared for the residents effectively if the facility did not train the nurses. She did not respond but said she was DON, ADON, staff coordinator, and floor nurse and was doing the best she could at that time. During an interview on 03/18/26 at 5:41 p.m., the Administrator said the nursing managers were responsible for training the nurses, and he did not respond when he was asked how effectively the nurses would have performed their duties if they were not trained properly. Record review of the facility policy on staffing, sufficient and competent nursing dated 2001 MED-PASS, Inc., read in part, .policy statement. The facility provided sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility (continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>assessment.competent staff #2.All nursing staff must have met the specific competency requirements of their respective licensure and certification requirements defined by state law.#5.Competency requirements and training for nursing staff were established and monitored by nursing leadership with input from the medical director to ensure;programming for staff training resulted in nursing competency. gaps in education were identified and addressed.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to provide pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals and a system of medication records that enables periodic accurate reconciliation and accounting of all controlled medications to meet the needs of 3 of 6 residents (Resident #1, Resident #2, and Resident #3) reviewed for pharmacy services, in that: The facility failed to ensure RN K control count sheet for Resident #1 matched with the actual Lacosamide. The facility failed to ensure Resident #2's tramadol blister packet seal was not broken and exposed. The facility failed to ensure LVN J control count sheet for Resident #3 matched Acetaminophen-COD#3 in the blister packet. This failure could place residents at risk of not receiving their adequate dose of medication and drug diversion. Findings include:Resident #1Record review of Resident #1's face sheet dated 3/18/25 revealed she was a [AGE] year-old male initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1 had diagnoses which included: convulsions (sudden uncontrollable shaking or jerking on the body), hypertension (high blood pressure), and traumatic brain injury (damage to the brain cause by an external force).Record review of Resident #1's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 03 of 15, indicating severely impaired cognition. Further review revealed Resident #1 needed extensive assistance to total care with ADL care with one staff assistance.Record review of Resident #1's care plan was canceled on 01/19/26 and Resident #1 did not have any current care plan.Record review of Resident #1's March 2026 order summary report read in part, Lacosamide oral solution 10MG/ML, give 20MLvia G- tube two times a day active date 03/14/25. Record review of Resident #1's control count sheet for Lacosamide oral solution 10MG/ML, give 20MLvia G- tube two times a day read 480ML. During an observation and interview of nurse's medication cart A control count for all off 300 hall and half of 200, and 400 halls on 03/18/26 at 2:33 p.m., with RN K revealed Resident #1 Lacosamide was 110 ML from the two-medication bottle, one bottle was 400ML and the second bottle was 110m. while the control count sheet read 480 ML. RN K said the first bottle was full and not opened and it had 400 ml, and the second bottle was 110ml. RN K said there was a discrepancy because the combined medication bottles was 510 ML while the medication control count sheets read 480 ML for both bottle. She said she did not know what to do, maybe tell the DON. She said maybe there was a mistake in documentation, or the medication was not measured accurately when the medication was drawn out of the bottle. She said she had not had any skill check off on medication administration or control count snice she started working in the facility 3 weeks ago. RN K did not respond to what could happen Resident #1 if he did not get the required dose of medication for seizure. During an interview on 03/18/26 at 3:22 p.m., the DON said if Resident #1's Lacosamide medication was overfilled RN K should have told her, and they would count the medication and when the pharmacist came to the facility, she would waste the difference with pharmacist. When she was asked what could happen to Resident #1 if the medication was not given as prescribed because the medication was ordered for seizure and she did not respond. Resident #2Record review of Resident #2's face sheet dated 3/18/25 revealed she was a [AGE] year-old male initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #2 had diagnoses which included: dementia (decline in mental ability such as memory and thinking), hypertension (high blood pressure), and diabetes mellitus (high blood sugar).Record review of Resident #2's Quarterly MEDS assessment dated [DATE] revealed a BIMS score of 11 of 15, indicating moderately impaired cognition. Further review revealed Resident #2 needed supervision to partial assistance with ADL care with one staff assistance.Record review of Resident #2's care plan revision date 12/19/23 read in part . Resident #2 at risk for pain related to generalized pain. Intervention: administer medication per order.Record review of Resident #2's March 2026 order summary report read in part . tramadol (continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>HCL oral table by mouth every 6 hours as needed for pain-initiated date 12/21/25. During an observation and interview of nurse's medication cart A control count for all of 300 hall and half of 200, and 400 halls 3/18/26 at 2:38 p.m., with RN K revealed Resident #2's tramadol 50 mg blister packet had one of the seals punched open and the medication was half exposed. RN K said the medication seal was punched and did not know what to do. RN K said she had not had any training on medication administration or control count. RN K did not respond when she was asked what could happen to the medication snice the seal was broken. During an interview on 03/18/26 at 3:20 p.m., THE DON said if Resident #2's tramadol blister pack has a breakage on the seal RN K should waste the medication with another nurse and sign the control sheet. The DON said they were not sure if the medication in the opened blister packet was the original medication. The DON said if the tramadol in the punched seal was not taken out and destroyed the medication could come up missing and it would be reportable for drug diversion. She said the nurse may not know that and this is something she have to go over with the nurses. Resident #3 Record review of Resident #3's face sheet dated 3/18/25 revealed she was a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1 had diagnoses which included: obesity (an excessive amount of body fat that poses risks to health), hypertension (high blood pressure), and diabetes mellitus (high blood sugar).Record review of Resident #3's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 15 of 15, indicating intact cognition. Further review revealed Resident #2 needed independence to supervision assistance with ADL care with one staff assistance.Record review of Resident #3's care plan revision date 11/10/25 read in part . resident is on pain medication therapy related status post right posterior abscess. Intervention administer analgesic medications as ordered by physician.Record review of Resident #1's March 2026 order summary report read in part, acetaminophen-codeine oral tablet 300-30 mg give 1 tablet by mouth every 4 hours as needed for pain start date 10/13/25.Record review of Resident #3's control count sheet for, acetaminophen-codeine oral tablet 300-30 mg give 1 tablet by mouth every 4 hours as needed for pain read 16 tablets.During an observation of nurse's medication cart B control count for all of 100 hall and half of 200, and 400 halls 3/18/26 at 3:01 p.m., with LVN J revealed the blister packet for Resident #3's Acetaminophen -COD#3 had 15 pills while control count sheet read 16. During an interview on 03/18/26 at 3:05 p.m., LVN J said she had administered 1 tablet of acetaminophen-codeine oral tablet 300-30 mg to Resident #3 at 1:30 p.m., and she forgot to sign it out on the control sheet or sign it off on the MAR. When she was asked when she should sign the control book and the MAR when she administered control medication TO Resident #3, she shrugged her shoulder. LVN J said she had not had any training on medication administration snice she started working in the facility, but she did 3 days on the floor orientation. During an interview on 03/18/26 at 3:30 p.m., The DON said the facility protocol LVN J should have followed was to sign out acetaminophen-codeine medication immediately when it pounced Resident #3's medication and administered it to the resident. The DON said if it is not signed out when it was pull it would look like drug diversion. During an interview on 03/18/26 at 3:39 p.m., the DON said the nurse had done orientation, but she had not time for comprehensive nursing training because she was still filling positions the shifts. The DON said the nurses were taught how to count control and what to do if there were discrepancies in nursing school. The DON did not respond when she was asked if the nurse would care for the resident effectively if the facility did not train the nurses, she did not respond but said she was DON, ADON, staff coordinator and floor nurse and she was doing the best she could at this time. Record review of the facility on pharmacy services overview dated 2001 MED- PASS, Inc. read in part . policy interpretation and implementation . #1a. the processes of receiving . receiving, storing, controlling, administering . all medications. Surveyor requested policy on 03/18/26 at 3:18 p.m., for drug diversion and it was not provided upon exit. Record review of the facility policy on medication administration dated 2001 MED-PASS, Inc read in part . policy interpretation and implementation .#22.the individual administering the medication initials the resident MAR on the appropriate line after giving each medication and before administering the next ones.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection control program designed to prevent the development and transmission of infection for 1 of 4 residents (Resident #4) observed for infection control. The facility failed to ensure LVN J followed appropriate infection control procedures while counting prefilled morphine syringes for Resident #4. This failure could have placed the residents at risk for infection. Findings included: Record review of Resident #4's face sheet dated 3/18/25 revealed she was a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #4 had diagnoses which included: diabetes mellitus (high blood sugar), hypertension (high blood pressure), and cerebral infarction (when a blood vessel in the brain was blocked, cutting oxygen to the brain). Record review of Resident #4's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 8 of 15, indicating severely impaired cognition. Further review revealed Resident #4 needed extensive assistance to total care with ADL care with one staff assistance. Record review of Resident #4's care plan revision on 07/15/25 read in part, . Resident #4 had a terminal prognosis related to CVA and was on hospice care. Intervention. observe resident closely for signs of pain, administer pain medication as ordered. Record review of Resident #4's March 2026 order summary report read in part, . Morphine Sulfate (concentrate) oral solution 100 MG/5ML (Morphine Sulfate) Give 0.25 ml by mouth every 3 hours as needed for Pain . Observation on 03/18/26 at 3:08 p.m. of nurse's medication cart B for 100 hall, half 300 and 400, revealed LVN J was counting Resident #4's prefilled morphine syringes and one of the prefilled morphine syringes fell on the floor in the 100 hallway. LVN J picked up the prefilled syringe and placed it with the bunch of the other 9 syringes. The surveyor intervened. During an interview on 03/18/26 at 3:10 p.m., LVN J said she should have wiped or destroyed the syringe with another nurse because the morphine syringe fell on the floor and became contaminated. She said she had contaminated the other 9 syringes. LVN J did not respond when she was asked what could happen to Resident #4 if she was administered morphine from the contaminated syringe. During an interview on 03/18/26 at 3:38 p.m., the DON said Resident #4's morphine syringe which fell on the floor should have been wasted by LVN J and another nurse, and both nurses would have signed the count sheet. The DON said when the morphine syringe fell on the floor, the syringe became contaminated, and when LVN J placed the syringe that fell on the floor with the other syringes, she contaminated the other syringes, and it was an infection control issue. The DON said organisms on the syringe could have been transferred to Resident #4 and could have caused the resident to become sick. Record review of the facility policy on medication administration dated 2001 MED-PASS, Inc. (Revised April 2019) read in part . policy interpretation and implementation #25. staff follow established facility infection control procedures. Infection control policy was requested from the administrator on 03/18/26 at 3:18 p.m., and it was not provided upon exit.</p>		