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	04/22/2026

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 - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	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** Based on observation, interview and record review the facility failed to immediately inform the resident, consult with the resident's physician, and notify consistent with his or her authority, the resident representative when there was a need to alter treatment significantly, that is a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment for 1 of 3 residents (Resident #1) reviewed for notification. 1. The facility failed to notify Resident #1's NP or MD when Resident #1 refused her medication/s, nutritional supplements, and meal/s from her facility admission on [DATE] through 04/17/2026. 2. The facility failed to ensure Resident #1's physician was notified when the resident had a change in condition and had difficulty swallowing. An immediate Jeopardy (IJ) situation was identified on 04/18/2026. While the IJ was removed on 04/22/2026, the facility remained out of compliance at a scope of isolated with a potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk for delayed treatment, interventions, and actual harm. Findings Include: Record review of Resident #1's admission record dated 04/17/2026 revealed a-[AGE] year-old female who admitted to the facility on [DATE]. Her diagnoses included Wernicke's encephalopathy (an acute life-threatening neurological emergency caused by a severe deficiency of thiamine [vitamin B1] which damages the brain), aneurysm (a rare, localized, blood-filled bulge in the wall of carotid artery [major blood vessel located on either side of the neck, that supplies oxygen rich blood to the brain, neck and face] and can cause stroke like symptoms), dysphagia (difficulty swallowing) and anorexia (loss of appetite or inability to eat). Resident #1 did not have a diagnosis for her PEG tube (a soft flexible tube inserted through the abdomen directly into the stomach, used for long-term nutrition, hydration, and medication when oral intake is not possible). Record review of Resident #1's admission MDS assessment, dated 03/30/2026, revealed her BIMS score was 14 out of 15 indicating her cognition was considered intact. Review of Section I for Active Diagnoses revealed Resident #1 did not have an active diagnosis for her gastrostomy tube. Continued record review of section K Swallowing/Nutrition Status revealed Resident #1 was coded as having a swallowing disorder that included coughing or choking during meals or when swallowing medications and had a weight of 120lbs and a mechanically altered diet (a diet that required a change in texture of food or liquids.) Record review on 04/17/2026 at 12:03 PM of Resident #1's hospital discharge summary revealed the following diet order: Discharge Orders: Regular Diet: Diet Texture: Pureed 4 Pureed for comfort, not sufficient for nutrition. (sic) Has PEG and should remain NPO (nothing by mouth) otherwise. Record review on 04/17/2026 at 12:07 PM of an undated, unsigned handwritten note located in Resident #1's EMR revealed the following: PEG use (sic) [NAME] @10 am. Pureed/thin (sic) liq diet (pleasure). Jevity 1.5 50 cc NG tube (Tube out). Record review on 04/17/2026 at 1:09 PM of Resident #1's physician order recap report revealed the following active order with a start date of 03/27/2026 and no end date: Regular diet Pureed Texture, regular/thin consistency, for pleasure food. And an active order with a start date of 04/02/2026 and no end date: Enteral feed order every shift. Flush enteral tube with 120 ml water q 8 hours to provide 360 ml water and with 30 ml of water before (continued on next page)

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

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The NP said she would have provided other orders if she had been informed of Resident #1's refusals. In a telephone interview with the MD/Medical Director on 04/17/2026 at 4:07 PM, who stated they were never notified by the facility staff that Resident #1 was not drinking her nutritional supplement or taking her medications, or that there were no orders for enteral feeding formula for Resident #1. The MD said they would have expected to be notified right away because all of those things would be considered a change in the resident's condition. The MD said the first time she rounded and saw Resident #1 she had a pureed meal tray and she was told by the facility staff the resident was tolerating the pureed diet. The MD said there was no excuse for the lack of communication regarding Resident #1's change in condition and it would have been an easy fix to ensure Resident #1 had her medications, and proper nutritional intake since she had a G-tube. The MD said it was a facility system failure all the way around and there had been some recent changes of ownership on or around 04/01/2026. Record review of the facility's policy procedure titled Guidelines for Notifying Physicians of Clinical Problems revealed in part: These guidelines are to help ensure that 1) medical care problems are communicated to the medical staff in a timely, efficient and effective manner and 2) all significant changes in resident status are assessed and documented in the medical record. The floor nurse, charge nurse or supervisor should contact the attending physician at any time if they feel a clinical situation requires immediate discussion and management.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:1. Detailed description of current issue or problem, including a chronological story of symptoms and treatment to date,vital signs, and results of physical assessment.2. Active medical problems (problem list).3. Pertinent information from any recent hospitalizations (hospital discharge summary or admission history and physicalform).4. Current medications (orders).5. Allergies to medications, food, etc. This was determined to be an Immediate Jeopardy (IJ) on 04/18/2026 at 2:56 PM. The Administrator was notified. The Administrator was provided with the IJ template on 04/18/2026 at 2:56 PM. The following Plan of Removal (POR) submitted by the facility was accepted on 04/19/2026 at 11:07 AM:. The plan of removal reflected the following: PLAN OF REMOVAL:F 580 Name of Facility: Date: 04/19/2026According to the IJ Template, the facility failed to ensure that they immediately informed, notified, or consulted with the resident's physician a significant need to alter treatments. Immediate Action: Corrective Action:Resident #1's physician has been notified that there was no current order for the NPO tube feeding. Registered Dietician gave her recommendations regarding the enteral feeding and a correct MD order with appropriate enteral feeding product has been entered. Resident/Responsible party has been notified. The tube feeding has been initiated by the facility. The physician was notified of the medication refusals. Resident #1's medication order has been updated from PO to NPO and to be administered via g-tube. Physician was also notified of the residents' current weight as of 4/18/2026. Identification of Others An audit was completed on 4/17/2026 to identify any other residents with enteral feeding orders. This was completed by the NHA or designee. No other deficient practices were identified.An audit was completed on 4/18/2026 to identify any residents currently residing in the facility who had a change of condition within the last 72-hours without physician notification. Audit was completed by nurse manager team, or designee. MD was notified of any deficiencies. System Changes- The ADON, or designee, had started educating all nursing staff on guidelines for notifying (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	the resident. In interviews conducted on 04/22/2026 between 8:30 AM and 3:00 PM with licensed nurses and nursing staff who worked the 6:00AM-2:00PM, 2:00PM-10:00PM and 10:00PM-6:00AM shifts who were all knowledgeable of the step-by-step process for monitoring, identifying and reporting procedures for changes in condition to the provider using the SBAR as a communication tool and for unlicensed staff reporting any changes in condition to the charge nurses and then following the chain of command for reporting which included ADON to DON to Administrator if concerns not resolved. All nursing staff, RN E, CNA T, (10:00 PM-06:00 AM) SW and DOR (06:00 AM-06:00 PM) gave examples of changes of condition that could include, refusing showers, medications, meals and or having pain, changes to skin or vital signs and said they would report per chain of command, which for the CNA's included reporting to charge nurse first and then to ADON/DON and then Administrator and for licensed nurses, who said they would report and changes in condition to the residents MD, RP and DON and document in the resident EMR. All licensed staff at that time said they would immediately report any changes in condition and follow up at the beginning and end of each shift and document all communications and reporting in the residents EMR and facility 24-hour shift to shift reports. All licensed nursing staff said they would check, verify, and clarify admission and physician orders and they would initiate SBAR for the specific resident change in condition and notify the MD and RP for the resident. Record reviews on 04/19/2026, 04/20/2026, 04/21/2026 and 04/22/2026 revealed nursing staff in-services with guidelines for notifying physicians of changes in condition, notifying the RD, notifying the DON and or ADON or designee and following physician orders which had been completed prior to any staff working as of 04/19/2026. The Administrator was informed the immediacy was removed on 04/22/2026 at 2:02PM. The facility remained out of compliance at a severity of no actual harm with the potential for more than minimal harm that is not immediate and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the resident assessment accurately reflected the resident's status for 1 of 14 residents (Resident#1) reviewed for accuracy of assessments. The facility failed to ensure Resident#1's admission MDS assessment accurately reflected her gastrostomy tube status. This failure could place residents at risk of receiving inadequate care and services. The findings include: Record review of Resident #1's admission record, dated 04/17/2026, revealed a-[AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included Wernicke's encephalopathy (an acute life-threatening neurological emergency caused by a severe deficiency of thiamine [vitamin B1] which damages the brain), aneurysm (a rare, localized, blood-filled bulge in the wall of carotid artery [major blood vessel located on either side of the neck, that supplies oxygen rich blood to the brain, neck and face] and can cause stroke like symptoms), dysphagia (difficulty swallowing) and anorexia (loss of appetite or inability to eat). Resident #1 did not have a diagnosis for her PEG tube (a soft flexible tube inserted through the abdomen directly into the stomach, used for long-term nutrition, hydration, and medication when oral intake is not possible). Record review of Resident #1's admission MDS assessment, dated 03/30/2026, revealed her BIMS score was 14 out of 15, which indicated her cognition was considered intact. Section I for Active Diagnoses revealed Resident #1 did not have an active diagnosis for her gastrostomy tube. Section K Swallowing/Nutrition Status revealed Resident #1 was coded as having a swallowing disorder that included coughing or choking during meals or when swallowing medications and had a weight of 120 lbs. and a mechanically altered diet (a diet that required a change in texture of food or liquids.) Record review of Resident #1's hospital discharge summary revealed the following diet order: Discharge Orders: Regular Diet: Diet Texture: Pureed 4 Pureed for comfort, not sufficient for nutrition. (sic) Has PEG and should remain NPO (nothing by mouth) otherwise. Record review on of Resident #1's physician order recap report revealed the following active order with a start date of 03/27/2026 and no end date: Regular diet Pureed Texture, regular/thin consistency, for pleasure food. And an active order with a start date of 04/02/2026 and no end date: Enteral feed order every shift. Flush enteral tube with 120 ml water q 8 hours to provide 360 ml water and with 30 ml of water before and after medication administration. Observation and interview with Resident #1 on 04/17/2026 at 11:00 AM revealed she was seated in a wheelchair, at a table alone, in the common area located directly adjacent to the dining room, her breakfast tray was in front of her with a plate that was uncovered and appeared to have pureed eggs, a pureed dark colored substance and a smaller tan colored substance. There was an uncovered bowl of oatmeal and 2 clear colored drink cups full of liquid and covered. The residents' utensils were unwrapped and were clean of any food debris and an unused napkin sat to the right side of the tray. State surveyor introduced herself to Resident #1 who said the tray was her breakfast tray and she needed help eating it, but no one had come to help her eat her breakfast tray. The State Surveyor remained with the resident and requested a passerby to get the DON. In a follow up interview and observation with Resident #1, in her room, on 04/17/2026 at 1:44 PM, she said she had not had an appetite over the last month or so and had a tube placed in her stomach when she was in the hospital. Resident #1 lifted her gown and exposed a gastrostomy tube. Resident #1 said that staff pushed water through her tube daily, but she did not receive any medications or feeding formulas through the tube. In an interview with the DON on 04/17/2026 at 2:12 PM, the DON said the admitting nurse was responsible for entering the resident diagnoses and the MDS should also review admission records and the resident clinical information to obtain diagnoses. The DON said the MDS nurse should also interview residents at the bedside or in person whenever possible, to help ensure accuracy of assessments. The DON said she was not aware Resident #1 had no diagnosis entered in her EMR for her gastrostomy status. The DON said if a resident did not have the correct diagnoses documented it could put them at risk for not receiving the (continued on next page)

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Cascades at Galveston	3702 Cove View Blvd Galveston, TX 77554

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	appropriate care and treatments and the MDS assessments should be coded correctly for every resident. The DON said the MDS nurse was responsible for ensuring resident diagnoses were accurate and correct and did not know why Resident #1's diagnoses and admission assessment were incorrect. In an interview with the Administrator on 04/17/2026 at 5:30 PM, she said her expectation was the resident MDS assessments to be coded correctly and all of the facility residents should have accurate and current diagnoses documented. The Administrator said she was unaware Resident #1 did not have a diagnosis for her gastrostomy tube in her EMR and she was not sure who was responsible for entering resident diagnoses. The Administrator said she would add Resident #1's gastrostomy tube status to her diagnosis list in the EMR. The Administrator was part of the new company who acquired the facility and said they were working on correcting and establishing various systems that had not been in place. Interview with MDS nurse on 04/22/2026 at 1:11 PM, who said Resident #1's diagnosis had been corrected in the EMR, after the State Surveyor intervention. The MDS Nurse said whichever nurse admitted Resident #1 would have been responsible for entering resident diagnoses, but she did not know who the nurse was. The MDS Nurse said Resident #1 should have had a diagnosis for gastrostomy status and tube because she had one and the omission of the diagnosis on her admission MDS was an oversight. The MDS Nurse said if a resident did not have accurate diagnoses, it could affect reimbursement and could result in a resident not receiving the appropriate care. The MDS Nurse said she interviewed and observed Resident #1 but somehow missed coding her for her gastrostomy tube. The MDS Nurse said she would modify Resident #1's MDS by the end of the business day. The MDS Nurse said she used the RAI manual as the policy and procedure she followed for accuracy in completing the MDS. Record review of CMS's RAI Version 3.0 Manual, dated October 2025, revealed in part: Section I: Active Diagnoses Intent: The items in this section are intended to code diseases that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death. One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's current health status.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and time frames to meet resident's medical, nursing, mental, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 14 residents (Resident #1) reviewed for care plans. 1. The facility failed to develop or implement a care plan for Resident #1 to address the resident's gastrostomy tube status. 2. The facility failed to develop or implement a care plan for Resident #1 to address the residents' diet. These failures could place residents at risk of not receiving care and services tailored to their identified needs. Findings include: Record review of Resident #1's admission record, dated 04/17/2026, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included Wernicke's encephalopathy (an acute life-threatening neurological emergency caused by a severe deficiency of thiamine [vitamin B1] which damages the brain), aneurysm (a rare, localized, blood-filled bulge in the wall of carotid artery [major blood vessel located on either side of the neck, that supplies oxygen rich blood to the brain, neck and face] and can cause stroke like symptoms), dysphagia (difficulty swallowing) and anorexia (loss of appetite or inability to eat). Resident #1 did not have a diagnosis for her PEG tube (a soft flexible tube inserted through the abdomen directly into the stomach, used for long-term nutrition, hydration, and medication when oral intake is not possible). Record review of Resident #1's admission MDS assessment, dated 03/30/2026, revealed her BIMS score was 14 out of 15, which indicated her cognition was considered intact. Section I for Active Diagnoses revealed Resident #1 did not have an active diagnosis for her gastrostomy tube. Section K Swallowing/Nutrition Status revealed Resident #1 was coded as having a swallowing disorder which included coughing or choking during meals or when swallowing medications and had a weight of 120 lbs. and a mechanically altered diet (a diet that required a change in texture of food or liquids.) Record reviewResident #1's hospital discharge summary revealed the following diet order: Discharge Orders: Regular Diet: Diet Texture: Pureed 4 Pureed for comfort, not sufficient for nutrition. (sic) Has PEG and should remain NPO (nothing by mouth) otherwise. Record review on 04/17/2026 at 1:09 PM of Resident #1's physician order recap report revealed the following active order, with a start date of 03/27/2026 and no end date: Regular diet Pureed Texture, regular/thin consistency, for pleasure food. And an active order with a start date of 04/02/2026 and no end date: Enteral feed order every shift. Flush enteral tube with 120 ml water q 8 hours to provide 360 ml water and with 30 ml of water before and after medication administration. Record review on 04/17/2026 at 2:00 PM of Resident #1's comprehensive care plan, dated as initiated and revised on 04/18/2026, revealed the following: [Resident #1] has a G-tube r/t oropharyngeal dysphagia (difficulty initiating a swallow causing food to stick to the throat) following recent aneurysm and severe protein calorie malnutrition. Currently receiving a puree diet for pleasure feeds with refusals to eat at times. [Resident #1] is NPO for main source of nutrition. Continued record review revealed the following entry, dated as initiated on 04/17/2026 and revised on 04/17/2026, [Resident #1] is receiving a mechanically altered diet due to oropharyngeal dysphagia. Observation and interview with Resident #1 on 04/17/2026 at 11:00 AM, revealed she was seated in a wheelchair, at a table alone, in the common area located directly adjacent to the dining room with her breakfast tray in front of her with a plate which was uncovered and appeared to have pureed eggs, a pureed dark colored substance and a smaller pureed tan colored substance. There was an uncovered bowl of oatmeal and 2 clear colored drink cups that were full of liquid and covered. The residents' utensils were unwrapped and were clean of any food debris and an unused napkin sat to the right side of the tray. State surveyor introduced herself to Resident #1 who said the tray was her breakfast tray and she needed help eating it, but no one had come to help her (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	eat her breakfast tray. The State Surveyor remained with resident and requested a passerby to get the DON. During an interview and observation with Resident #1, in her room, on 04/17/2026 at 1:44 PM, she said she had not had an appetite over the last month or so and had a tube placed in her stomach when she was in the hospital. Resident #1 lifted her gown and exposed a gastrostomy tube. Resident #1 said staff pushed water through her tube daily, but she did not receive any medications or feeding formulas through the tube. In an interview with the DON on 04/17/2026 at 2:12 PM, the DON said the RN admitting the resident was responsible for initiating a resident care plan. The DON said the MDS Nurse was responsible for the comprehensive care plans. The DON said the MDS Nurse should have reviewed the admission records and the resident clinical information to obtain the information needed to complete the MDS and care plans. The DON said she was not aware Resident #1 had no care plan for her gastrostomy tube, no care plan for her diet, and no care plan for her enteral feeding status. The DON said up until the recent facility company change, she was unable to monitor or keep up with all of the clinical systems like checking new admission paperwork for diagnoses and care plans. The DON said if a resident did not have a care plan, it could put them at risk of not receiving the appropriate care and treatments. The DON said Resident #1 should have had a care plan for her gastrostomy tube status, and diet upon admission and did not know why she had not already been care planned for those needs. The DON said the IDT was responsible for reviewing and updating resident care plans. The DON said there had been inconsistencies within the IDT, and they had not been able to meet or conduct reviews due to the recent facility changes in ownership and staff changes. The DON said she was part of the IDT but had not had a chance to review Resident #1's care plans. In an interview with the Administrator on 04/17/2026 at 5:30 PM, she said her expectation was all of the facility residents should have accurate and current care plans. The Administrator said she was unaware Resident #1 did not have a care plan for her gastrostomy tube, or diet in her EMR. The Administrator said the nurses were responsible for initiating the care plans and the MDS Nurse was responsible for updating the comprehensive care plans. The Administrator said she was part of the new company which acquired the facility and they were working on correcting and establishing various systems that had not been in place. Interview with the MDS nurse on 04/22/2026 at 1:11 PM, who said Resident #1's gastrostomy tube status and diet should have been care- planned from her admission on [DATE]. The MDS Nurse said she updated Resident #1's comprehensive care plans the same day the state surveyor entered the facility and began asking questions about Resident #1's gastrostomy status and diet orders. The MDS Nurse said whichever nurse admitted Resident #1 would have been responsible for initiating the care plans, but she did not know who the nurse was. The MDS Nurse said she updated resident care plans whenever she completed the residents' assessments. The MDS Nurse said if a resident did not have a comprehensive person-centered care plan, it could result in a resident not receiving the appropriate care. The MDS Nurse said there had been a recent change in company ownership, and they were getting all of the systems, which included care plans, back on track. Record review of the facility's policy and procedure titled Care Plans, Comprehensive Person-Centered, dated Revised March 2022, revealed, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being, including: (3) which professional services are responsible for each element of care.c. includes the resident's stated goals upon admission and desired outcomes.d. builds on the resident's strengths; ande. reflects currently recognized standards of practice for (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	problem areas and conditions. 12. The interdisciplinary team reviews and updates the care plan:a. when there has been a significant change in the residents' condition.b. when the desired outcome is not met.c. when the resident has been readmitted to the facility from a hospital stay; andd. at least quarterly, in conjunction with the required quarterly MDS assessment.

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrated that this was not possible or resident preferences indicated otherwise for 1 of 3 residents (Resident #1) reviewed for nutrition status. 1. The facility failed to ensure Resident #1 did not have a significant weight loss of 19% due to losing 23lbs in 12 days. 2. The facility failed to provide Resident #1 with feeding and nutrition via her PEG tube. 3. The facility failed to ensure Resident #1 had dietary recommendations in place from her admission on [DATE] until 4/17/2026, the date of State Surveyor facility entrance. 4. The facility failed to ensure Resident #1 had weekly weights obtained per physician order. 5. The facility failed to address Resident #1's risk of impaired nutrition related to her newly inserted PEG tube status and therapeutic diet orders. An immediate Jeopardy (IJ) situation was identified on 04/18/2026. While the IJ was removed on 04/22/2026, the facility remained out of compliance scope of a pattern with a potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of their corrective systems. These failures could place residents at risk for compromised nutrition, decline in function, unplanned weight changes, and actual harm. Findings Include: Record review of Resident #1's admission record dated 04/17/2026 revealed a-[AGE] year-old female who admitted to the facility on [DATE]. Her diagnoses included Wernicke's encephalopathy (an acute life-threatening neurological emergency caused by a severe deficiency of thiamine [vitamin B1] which damages the brain), aneurysm (a rare, localized, blood-filled bulge in the wall of carotid artery [major blood vessel located on either side of the neck, that supplies oxygen rich blood to the brain, neck and face] and can cause stroke like symptoms), dysphagia (difficulty swallowing) and anorexia (loss of appetite or inability to eat). Resident #1 did not have a diagnosis for her PEG tube (a soft flexible tube inserted through the abdomen directly into the stomach, used for long-term nutrition, hydration, and medication when oral intake is not possible). Record review of Resident #1's admission MDS assessment, dated 03/30/2026, revealed her BIMS score was 14 out of 15 indicating her cognition was considered intact. Review of Section I for Active Diagnoses revealed Resident #1 did not have an active diagnosis for her gastrostomy tube. Continued record review of section K Swallowing/Nutrition Status revealed Resident #1 was coded as having a swallowing disorder that included coughing or choking during meals or when swallowing medications and had a weight of 120lbs and a mechanically altered diet (a diet that required a change in texture of food or liquids.) Record review on 4/17/26 at 12:03 PM of Resident #1's hospital discharge summary revealed the following diet order: Discharge Orders: Regular Diet: Diet Texture: Pureed 4 Pureed for comfort, not sufficient for nutrition. (sic)Has PEG and should remain NPO (nothing by mouth) otherwise. Record review on 04/17/2026 at 12:07 PM of an undated, unsigned handwritten note in Resident #1's EMR revealed the following: PEG use (sic)tom@10 am. Pureed/thin (sic) liq diet (pleasure). Jevity 1.5 50 cc NG tube (Tube out). Record review on 04/17/2026 at 1:09 PM of Resident #1's physician order recap report revealed the following active order with a start date of 03/27/2026 and no end date: Regular diet Pureed Texture, regular/thin consistency, for pleasure food. And an active order with a start date of 04/02/2026 and no end date: Enteral feed order every shift. Flush enteral tube with 120 ml water q 8 hours to provide 360 ml water and with 30 ml of water before and after medication administration. Record review on 04/17/2026 at 1:15 PM of Resident #1's physician order report revealed Resident #1 had an active order dated 03/30/2026 for Consult with Registered Dietician for tube feeding management. Continued record review also revealed an active order dated 04/01/2026 with a start date of 04/02/2026 for Ensure Plus three times a day, 237 ml PO (by mouth) TID. The active order was 6 days after Resident #1 was admitted to the facility on [DATE]. Record review on 04/17/2026 at 1:22pm of Resident #1's Medication Administration record dated April 1, 2026, through April 30, 2026, (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	revealed Ensure Plus three times a day, 237ml PO TID at 7 AM, 12 Noon and 6 PM. Continued record review revealed Resident #1 refused all three administration times on 8 days, (04/03/2026, 04/06/2026, 04/07/2026, 04/08/2026, 04/10/2026, 0 4/14/2026, 04/15/2026 and 04/16/2026). There were 3 days that there was no documentation of administration and the time slots were completely blank (04/04/2026, 04/11/2026 and 04/12/2026) and 2 days that staff documents at 6pm that Resident #1 was nauseated/vomited or asleep (04/09/2026 and 04/13/2026). Record review on 04/17/2026 at 5:05 PM of Resident #1's EMR for weights revealed a weight of 120.0 lbs., dated 04/03/2026 at 11:45 AM, 7 days after Resident #1's admission. The 04/03/2026 weight of 120.0lbs was crossed out with a single line by the DON on 04/16/2026 at 12:13 PM. The DON documented Correction. The second weight entry was dated 4/15/2026 at 12:15PM and a weight of 96.5lbs. Continued record review of the hospital admission records for Resident #1 revealed no weights in the documents sent to the facility. Observation and interview with Resident #1 on 04/17/2026 at 11:00 AM. She was seated in a wheelchair, at a table alone, in the common area located directly adjacent to the dining room with her breakfast tray was in front of her with a plate that was uncovered and appeared to have pureed eggs, a pureed dark colored substance and a smaller pureed tan colored substance. There was an uncovered bowl of oatmeal and 2 clear colored drink cups that were full of liquid and covered. The residents' utensils had been unwrapped and were clean of any food debris and an unused napkin sat to the right side of the tray. State surveyor introduced herself to Resident #1 who said the tray was her breakfast tray and she needed help eating it, but no one had come to help her eat her breakfast tray. The State Surveyor remained with resident and requested a passerby to get the DON. Continued observation and interview with Resident #1 with DON present on 04/17/2026 at 11:03 AM the DON said she did not know why the resident was seated in front of her uncovered, uneaten breakfast tray and would have to get the nurse. While the DON was at the table with the resident, surveyor asked the resident again, if she was hungry and Resident #1 replied, yes. The DON said she was going to get the residents nurse and or CNA. Surveyor remained with Resident #1. Continued observation and interview with Resident #1 on 04/17/2026 at 11:08 AM with RN A who said they were the nurse assigned to Resident #1 and did not know why she was still seated in front of her breakfast tray or why the breakfast tray remained uncovered and not eaten. RN A went to look for CNA E who was assigned to Resident #1. Surveyor remained with Resident #1. Continued observation and interview with Resident #1 on 4/17/26 at 11:23 am the facility Receptionist passed by and offered to reheat Resident #1's breakfast tray and assist her with feeding. The Receptionist said she was not sure where RN A or CNA E were, and just as the receptionist completed reheating Resident #1's breakfast tray, RN A returned and said he could not locate CNA E. RN A said he would take over from the Receptionist, and he would feed Resident #1. RN A said he was not aware that Resident #1 had not eaten breakfast. In a telephone interview on 04/17/2026 at 12:20 PM with the RD, who said their first visit to the facility was on 04/14/2026 and they were in the process of completing the evaluation for Resident #1. The RD said they were not familiar with Resident #1 and was not sure what Resident #1's weight was. The RD said they could complete evaluations remotely and had evaluated Resident #1 in person earlier that week. The RD said they usually evaluated new admission and readmission residents as well as residents with gastrostomy tubes, wounds, dialysis, or other risk factors. The RD said they usually completed a monthly evaluation of the resident census and conducted evaluations PRN. In a follow up observation and interview with Resident #1 on 04/17/2026 at 1:44 PM, she said she had not had much of an appetite over the last month and had a tube placed in her stomach while she was in the hospital. Resident #1 lifted her gown and exposed a gastrostomy tube. Resident #1 said staff pushed water through her tube daily, but she did not receive any medications or feeding formulas through the tube since she was admitted to the facility. Resident #1 said she could swallow and did not have pain when she swallowed, but the food sometimes seemed like it got stuck. Resident #1 said sometimes she did not like the mushy baby food the facility served. Resident #1 said some of the food served resembled dog food and she would eat what she liked and if (continued on next page)

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	675254	A. Building B. Wing	04/22/2026

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 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	she did not like the look, smell, or taste of the food she was not going to eat it. Resident #1 said the hospital would give her a milk-like formula through a tube that went from her nose to her stomach (NG Tube) and before she got to the facility, the hospital removed that tube from her nose and put the new tube directly into her stomach. In an interview with RN A on 04/17/2026 at 1:52 PM, who said they did not know Resident #1 was not taking her Ensure supplement until 04/17/2026, after the State Surveyor arrived at the facility. RN A said he had not yet reported this to the NP or MD. In an interview with the DON on 04/17/2026 at 1:57 PM, the DON stated she did not know Resident #1 had no enteral feeding formula order since her admission on [DATE] and she did not know Resident #1 was refusing her nutritional supplements, or meals. The DON said she would have notified the NP/MD immediately, so she could have obtained appropriate orders for Resident #1 if she had been notified of the issues and refusals, but she knew nothing about them. In an interview with MA C on 04/17/2026 at 2:00 PM, who said Resident #1 had not really been taking her Ensure supplement since the first day of admission, because she could not swallow. Interview with MA D on 04/17/2026 at 2:39 PM, who said Resident #1 regularly refused all of her medications and supplements and just would not take anything orally since she admitted to the facility. MA D said she did not know if Resident #1 had lost weight and did not know if Resident #1was refusing her meals but would not be surprised. Telephone interview with Resident #1's RP on 04/17/2026 at 3:00 PM, who said Resident #1 had not been eating after the aneurysm and the hospital suspected she had a stroke. The RP said Resident #1 lost the use of her right side which included her right arm and hand and had difficulty feeding herself. The RP said on at least 2 separate occasions within the last week, they were alarmed and angered Resident #1 was seated in front of various meal trays that had not been eaten and had no staff to help her eat. The RP said they confronted RN A about the issue the other day and was told by RN A Resident #1 needed to learn how to use her left hand to feed herself so she could go back home. The RP said they told RN A Resident #1 was right-handed prior to her illness, hospitalization, and surgery and needed help regardless because she was never left-handed. Resident #1's RP said Resident #1 had the G-tube placed while she was hospitalized because she was not eating enough to sustain herself. Resident #1's RP said they had not been notified that Resident #1 was refusing medications and nutritional supplements. During a telephone interview with the NP on 04/17/2026 at 3:06 PM she stated that Resident #1's actual enteral feeding formula order would normally come from the hospital discharge records but she was told by facility staff there were none, so she ordered an RD consultation to ensure the residents' caloric needs came from the dietician. The NP said she knew nothing about Resident #1's weight loss or refusals of nutritional supplements and had been told Resident #1 was tolerating a puree diet. The NP said she would have provided other orders if she had been informed of Resident #1's refusals. In a telephone interview with MD/Medical Director on 04/17/2026 at 4:07pm who stated they were never notified by facility staff that Resident #1 was not drinking her nutritional supplement, weight loss or that there were no orders for enteral feeding formula for Resident #1. The MD said the first time she rounded and saw Resident#1 she had a pureed meal tray and she was told by facility staff resident was tolerating the pureed diet. The MD said it would have been an easy fix to ensure Resident #1 had proper nutritional intake since she had a G-tube. The MD said it was a facility system failure all the way around and that there had been a recent change of ownership on or around 04/01/2026. In an interview with the DON on 04/18/2026 at 10:36AM, she said Resident #1 was supposed to have weekly weights upon admission and it just had not gotten done weekly due to changes and consistency issues with the CNA's completing the weights. The DON said she crossed out Resident #1's initial weight of 120 lbs on 04/03/2026 in the EMR because she just did not believe that was an accurate weight. When asked if she knew what Resident #1's current weight was she said she did not know. When asked if she knew what Resident #1's admission weight was, she said she did not know. When asked who was supposed to be completing the weekly weights for residents she said she did not know who was responsible for that duty with this company. Observation and interview with CNA F of attempt to weight Resident #1 on 04/18/2026 at 10:42 AM, CNA F said she (continued on next page)

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	675254	A. Building B. Wing	04/22/2026

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	was new and normally she would look for the weight of the wheelchair that would be written somewhere on the chair and subtract that from whatever the total weight on the scale was, and the remaining number would be the resident's weight. CNA F said she had no formal training at this facility on how to weigh a resident. She said she did not know if there was someone specifically assigned to obtain resident weights. The wheelchair Resident #1 was seated in at that time, did not have a weight for the chair located anywhere on the chair and Resident #1 declined to be transferred out of the wheelchair. CNA F was unable to weigh the wheelchair separately and Resident #1 declined to be weighed at that time. Record review on 04/18/2026 at 11:00 AM of RD recommendations, dated 04/17/2026, revealed the following: Dietary Recommendations:continue weekly weights to monitor weight trend.MD to consider D/C ensure TIDMD order for Jevity 1.5 continuous overnight at 55cc/hr x 10 hours (provides 550cc formula: 824kcal, 35g protein, 418cc water)Start TF at slow rate (25-30ml/hr) and increase 10ml/hr every 2 hoursRefer to MD for consult of protein-calorie malnutrition dx. Record review on 04/18/2026 at 1:44 PM of Resident #1's physician order report revealed an order, dated 4/17/2026, for Mirtazapine Oral tablet 15 mg. Give 1 tablet by mouth for prophylaxis related to her history of anorexia. There was no order to give the appetite stimulant medication through her gastrostomy tube. Record review on 04/18/2026 at 1:45 PM of nursing progress note, dated 4/18/26, revealed Resident #1 was initiated on continuous enteral feeding via PEG tube this shift per MD order. Feeding (Jevity 1.5) started at ordered initial rate of 25mL/hr. Rate titrated incrementally as ordered to current rate of 55mL/hr under nurse supervision. Record review of the facility policy procedure titled Nutrition (Impaired)/ Unplanned Weight Loss - Clinical Protocol and dated as revised September 2017 revealed in part: Nutrition (Impaired)/Unplanned Weight Loss -Clinical ProtocolAssessment and RecognitionThe nursing staff will monitor and document the weight and dietary intake of residents in a format which permits comparisons over time.The staff and physician will define the individual's current nutritional status(weight, food/fluid intake, and pertinent laboratory values) and identify individuals with anorexia, weight loss or gain, and significant risk for impaired nutrition; for example, high risk residents with acute symptoms such as vomiting, diarrhea, fever and infection, or those taking medications that maybe causing weight gain or increasing the risk of anorexia or weight loss.The staff will report to the physician significant weight gains or losses or any abrupt or persistent change from baseline appetite or food intake. This was determined to be an Immediate Jeopardy (IJ) on 04/18/2026 at 2:56 PM. The Administrator was notified. The Administrator was provided with the IJ template on 04/18/2026 at 2:56 PM. The following Plan of Removal (POR) submitted by the facility was accepted on 04/19/2026 at 11:07 AM: PLAN OF REMOVAL:F 692 Name of Facility:Date: 04/19/2026According to the IJ Template, the facility failed to maintain acceptable parameters of nutritional status such as usual body weight or desirable body weight range for Resident #1 who lost 23.5 pounds in 12 days. She averaged 120 lbs. prior to admission and weighed 96.5 lbs. on 04/15/2026. This is a 19% weight loss in 12 days. Immediate Action: Corrective Action:Registered Dietician has completed a comprehensive nutritional assessment of Resident #1 and has recommended appropriate enteral feeding product. The physician was notified and the order was given and implemented. The CNA received training with the DON, or designee, on 04/18/2026, in regard to how to weigh a resident. Identification of Others The DON, or designee, completed an audit for all other residents with an enteral feeding order to verify that the order is complete, accurate, timely and implemented and that the residents are receiving their ordered enteral feeding product. It was verified that the current residents with enteral tube feeding are receiving the correct product at the correct rate by 04/19/2026. There were no other deficiencies found. System Changes IDT and nursing staff were educated on nutrition and weight management system on 04/19/2026 by the designee. Facility has recently been acquired, as of 04/01/2026, and the IDT was educated to the SNF Clinical system regarding the weight management system which is utilized by the SNF. The facility did not utilize this system prior. The NHA or designee provided the education to the IDT team which includes but is not limited to the DON, ADON, MDS, RT, SSD, Medical Records, (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Director of Rehab, etc. Record reviews on 04/19/2026, 04/20/2026, 04/21/2026 and 04/22/2026 revealed the IDT and nursing staff in-services with guidelines for nutrition and weight management which had been completed Registered Dietician educated by the facility RN consultant, or designee, on reviewing residents monthly that are receiving enteral tube feeding on 4/18/2026. The Registered Dietician is contracted through Company A. The facility currently has a consultant dietician. This was completed on 04/18/2026. IDT were educated by the NHA, or designee, on the importance of obtaining accurate resident weight per physician order/facility policy by 04/19/2026. Scale will be correctly calibrated per manufacturers recommendations. The Director of Plant Operations, or designee, will be completed per recommendations. Director of Plant Operations has confirmed calibration schedule with the manufacturer by 04/19/2026. Record review of manufacturers recommendations on 04/19/2026 revealed facility had monthly scale service and calibration per manufacturer recommendations. The ADON, or designee, educated nursing staff on timely physician notification of any significant weight loss by 4/19/2026.All nursing staff who cannot complete training by 4/19/2026 will not be placed on the schedule until training is completed. Record reviews on 04/19/2026, 04/20/2026, 04/21/2026 and 04/22/2026 revealed the IDT and nursing staff in-services with guidelines for timely physician notification of any significant weight loss which had been completed. Monitoring The facility RN consultant, or designee will complete training for monitoring physician orders daily (five days a week) to include but not limited to enteral tube feeding orders via the daily clinical meeting process by 4/19/2026. DON, or designee, will audit daily (five days a week) to ensure that the correct enteral feeding product is hanging and being administered as per order to include the correct flow rate. DON, or designee, will monitor physician orders daily (five days a week) to include but not limited to enteral tube feeding orders via the daily clinical meeting process. DON, or designee, will audit daily (five days a week) to ensure that the correct enteral feeding product is hanging and being administered as per order to include the correct flow rate. DON, or designee, will audit weights per physician order and facility policy and report results of all audits to QAPI monthly. The MD was notified of the IJ by NHA and DON on 4/18/2026. IDT (which includes but is not limited to the DON, ADON, MDS, RT, SSD, Medical Records, Director of Rehab, etc) and nursing staff were educated on the nutrition and weight management system on 4/19/2026 by the Administrator or designee. Facility has recently been acquired, as of 4/1/2026, and the IDT was educated to the SNF Clinical system regarding the weight management system which is utilized by SNF. The facility did not utilize this system prior. Upon review it is evidenced that the facility did not follow any weight loss management system prior to the acquisition. This is evidenced by missing weights, incorrect weights, lack timely entry, weights not being completed weekly, and orders not being followed, and physician notifications. QAPI was completed by NHA, DON, and facility RN consultant, Director of Operations by 4/19/2026. This was communicated to the IDT team which includes but is not limited to the DON, ADON, MDS, RT, SSD, Medical Records, Director of Rehab, etc. on 4/19/2026. The Plan of Removal was confirmed for the IJ by monitoring from 04/18/2026 through 04/22/2026 as follows: Interview with IDT which included NHA, DON, ADON, DOR, MDS, Maintenance Director and SSD on 04/19/2026 at 10:09 AM on the new SNF nutrition and weight management systems. They were all knowledgeable of the step-by-step process for monitoring, identifying, and reporting the procedures outlined in each system that included following physician orders, obtaining accurate weights, scale calibration and obtaining and following RD consultations and recommendations. In interviews on 04/19/2026 between 10:00AM and 5:00PM with licensed nurses and nursing staff who worked the 6:00AM-6:00PM, 6:00AM-2:00PM and 2:00PM-10:00PM shifts who were all knowledgeable of the step-by-step process for monitoring, identifying and reporting procedures for weight loss, weighed residents and changes in condition to the provider using the SBAR as a communication tool and for unlicensed staff reporting any changes in condition to the charge nurses and then following the chain of command for reporting which included the ADON to the DON to the Administrator if concerns not resolved. The Wound Care Nurse, ADON, MDS Nurse and DON (who worked 06:00 AM -06:00 PM) said any changes from a residents (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	baseline clinical status would be considered a change in condition and included things like vital signs outside of parameter, refusals of medications, meals or other care, weight loss and or skin changes would all be examples of changes in condition to report to the residents physicians. They said scales X2 at the facility (wheelchair/walk-on scale and Hoyer) all had to be serviced and calibrated quarterly and PRN. All licensed nurses, RN A, LVN A, LVN B, (who worked 06:00 AM- 06:00 PM) and nursing staff, MA E, (06:00 AM-02:00 PM), MA H, (02:00 PM- 10:00 PM) CNA F and CNA G, (06:00 AM- 02:00 PM), gave examples of changes of condition that could include, weight loss and were able to articulate the steps for following physician orders and accurately obtaining resident weights using any of the 2 scales on-site at the facility. All licensed staff at that time said they would immediately report any changes in condition and follow up at the beginning, and end of each shift, and document all communications and reporting in the residents EMR and facility 24-hour shift to shift reports. All licensed nursing staff said they would check, verify, and clarify admission and physician orders and they would initiate SBAR for the specific resident change in condition and notify the MD and RP accordingly. All nursing staff said that new and readmission residents required weekly weights X 4 weeks and following up to ensure residents have the correct diet and are eating meals as ordered. Interview with the ADON and the DON on 4/20/2026 who were able to articulate and show audits for how they were monitoring physician orders daily (five days a week) to include but not limited to enteral tube feeding orders via the daily clinical meeting process and ensuring that the correct enteral feeding product is hanging and being administered as per order to include the correct flow rate and an audit of resident weights per physician order and following the facility policy. In interviews on 04/20/2026 between 9:00 AM and 6:00 PM with licensed nurses and nursing staff who worked the 6:00AM-2:00PM and 2:00PM-10:00PM shifts who were all knowledgeable of the step-by-step process for monitoring, identifying and reporting procedures for weight loss, weighing residents and changes in condition to the provider using the SBAR as a communication tool and for unlicensed staff reporting any changes in condition to the charge nurses and then following the chain of command for reporting which included ADON to DON to Administrator if concerns not resolved. The Wound Care Nurse, ADON, MDS Nurse and DON (who worked 06:00 AM- 06:00 PM) said any changes from a residents baseline clinical status would be considered a change in condition and included things like vital signs outside of parameter, refusals of medications, meals or other care, weight loss and or skin changes would all be examples of changes in condition to report to the residents physicians. They said scales X2 at the facility (wheelchair/walk-on scale and Hoyer) all had to be serviced and calibrated quarterly and prn. All licensed nurses, and nursing staff, RN C, (06:00 AM-02:00 PM) CNA I, CNA J, CNA K, CNA L, CNA M, (6:00 AM-02:00 PM), CNA N, CNA O, MA F and AD/CNA P (02:00PM-10:00PM) gave examples of changes of condition that could include, weight loss and were able to articulate the steps for following physician orders and accurately obtaining resident weights using any of the 2 scales on-site at the facility. All licensed staff at that time said they would immediately report any changes in condition and follow up at the beginning, and end of each shift, and document all communications and reporting in the residents EMR and facility 24-hour shift to shift reports. All licensed nursing staff said they would check, verify, and clarify admission and physician orders and they would initiate SBAR for the specific resident change in condition and notify the MD and RP accordingly. All nursing staff said that new and readmission residents required weekly weights X 4 weeks and following up to ensure residents have the correct diet and are eating meals as ordered. They said scales X2 at the facility (wheelchair/walk-on scale and Hoyer) all had to be serviced and calibrated quarterly and prn. In interviews conducted on 04/21/2026 between 8:00 AM and 6:00 PM with licensed nurses and nursing staff who worked the 6:00AM-2:00PM and 2:00PM-10:00PM shifts who were all knowledgeable of the step-by-step process for monitoring, identifying and reporting procedures for weight loss, weighing residents and changes in condition to the provider using the SBAR as a communication tool and for unlicensed staff reporting any changes in condition to the charge nurses and then following the chain of command for reporting which included ADON to DON to Administrator (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	if concerns not resolved. All nursing staff, LVN G, RN D, (06:00 AM- 02:00PM), CNA P, CNA Q, CNA R(10:00 PM- 06:00 AM), CNA S, MA A, MA D (02:00 PM-10:00 PM) and DM (06:00 AM-06:00 PM) gave examples of changes of condition that could include, weight loss and were able to articulate the steps for following physician orders and accurately obtaining resident weights using any of the 2 scales on-site at the facility. All licensed staff at that time said they would immediately report any changes in condition and follow up at the beginning, and end of each shift, and document all communications and reporting in the residents EMR and facility 24-hour shift to shift reports. All licensed nursing staff said they would check, verify, and clarify admission and physician orders and they would initiate SBAR for the specific resident change in condition and notify the MD and RP accordingly. All nursing staff said that new and readmission residents required weekly weights X 4 weeks and following up to ensure residents have the correct diet and are eating meals as ordered. They said scales X2 at the facility (wheelchair/walk-on scale and Hoyer) all had to be serviced and calibrated quarterly and PRN. In interviews conducted on 04/22/2026 between 8:30 AM and 3:00 PM with licensed nurses and nursing staff who worked the 6:00AM-2:00PM, 2:00PM-10:00PM and 10:00PM-6:00AM shifts who were all knowledgeable of the step-by-step process for monitoring, identifying and reporting procedures for changes in condition to the provider using the SBAR as a communication tool and for unlicensed staff reporting any changes in condition to the charge nurses and then following the chain of command for reporting which included ADON to DON to Administrator if concerns not resolved. All nursing staff, RN E, CNA T, (10:00 PM-06:00 AM) SW and DOR (06:00 AM-06:00 PM) gave examples of changes of condition that could include weight loss and were able to articulate the steps for following physician orders and accurately obtaining resident weights using any of the 2 scales on-site at the facility. They said scales X2 at the facility (wheelchair/walk-on scale and Hoyer) all had to be serviced and calibrated quarterly and prn. All licensed staff at that time said they would immediately report any changes in condition and follow up at the beginning, and end of each shift, and document all communications and reporting in the residents EMR and facility 24-hour shift to shift reports. All licensed nursing staff said they would check, verify, and clarify admission and physician orders and they would initiate SBAR for the specific resident change in condition and notify the MD and RP accordingly. All nursing staff said that new and readmission residents required weekly weights X 4 weeks and following up to ensure residents have the correct diet and are eating meals as ordered. The Administrator was informed the immediacy was removed on 04/22/2026 at 2:02PM. The facility remained out of compliance at a severity of no actual harm with the potential for more than minimal harm that is not immediate and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.