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 03/29/2024
NAME OF PROVIDER OR SUPPLIER: Cascades at Galveston		STREET ADDRESS, CITY, STATE, ZIP CODE: 3702 Cove View Blvd Galveston, TX 77554	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 48605 Based on observation, interview, and record review, the facility failed to immediately consult with the resident's physician of G- tube dysfunction or malfunction for 1 of 4 residents reviewed for physician notification (Resident #1). The facility failed to immediately consult with the resident's physician when facility staff did not implement physician order due to the inadequate supply of adnominal binder to protect G-tube and G-tube site for 1 of 4 residents reviewed for physician notification (Resident #1). The facility failed to notify the resident's physician of complications related to Resident# 1 G-tube site pain and administering medications to Resident #1 via the G-Tube. The failure resulted in LVN V administering medications by plunger pushing the medications with force into Resident #1 gastrostomy tube instead of administering to gravity, placing the resident at immediate risk for potential harms associated G-Tube blockage and Aspiration (occurs when liquid or food enters the lungs). The facility failed to notify the physician that physician's order for an abdominal binder indicated to prevent complications of gastrostomy tube was not implemented. The facility failure resulted in Resident #1 requiring discharge to the hospital for G-Tube replacement. An Immediate Jeopardy (IJ) was identified on 03/27/2024. The Administrator and DON were informed on 03/27/2024 at 5:40pm. The IJ was lowered on 03/29/23 at 1:33pm, the facility remained out of compliance at a scope of pattern and a severity level of no harm, due to the facility's need to evaluate the effectiveness of the corrective systems. The failures have the potential to cause significant complications, including infections, aspiration, hospitalization s, or death, in residents with gastrostomy tubes. Findings included: Record review of Resident #1's face sheet dated 03/25/2024 revealed resident was admitted to the facility on [DATE], age [AGE] years old female. Resident #1 had a diagnosis of Gastrostomy Status (the creation of an artificial external opening into the stomach for nutritional support or gastric decompression via a G- Tube) and Gastro-Esophageal Reflux Disease (GERD - occurs when stomach acid repeatedly flows back into the tube connecting your mouth and stomach (esophagus) dated 08/26/2023. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675254	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/29/2024
NAME OF PROVIDER OR SUPPLIER Cascades at Galveston		STREET ADDRESS, CITY, STATE, ZIP CODE 3702 Cove View Blvd Galveston, TX 77554	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of clinical record, Resident #1's Care Plan revealed that Resident #1 require to have an abdominal feeding tube. Care Plan Goal: Resident was to remain free of side effect of complication Resident insertion site will be free of sign and symptoms of infection. Interventions Task: Check tube placement and gastric contents/residual volume per facility protocol and record (policy). Monitor/document/ report tube dysfunction or malfunction, abdominal pain, and infection at the tube site provide local care to G-Tube site as ordered administer medication as ordered. Record review of clinical record, Resident #1's MDS revealed that Resident #1 required abdominal feeding tube. Record review of Resident #1's physician's order summary report revealed the following order: every shift for flush feeding tube with 30ml(cc) of water before and after administration of medication pass. clean and change dressing one time a day. Apply abdominal binder, order dated as of 12/07/2023. Record review of clinical record, Resident #1's MAR/TAR revealed no documentation that the physician order for abdominal binder had been followed and implemented from 12/07/2023 thru 03/25/2024. Observation made on 03/25/2024 at 10:30am revealed Resident #1 was not wearing abdominal binder. The surveyor was unsuccessful in attempt to interview Resident #1 due to symptoms related to Dementia (intermittent confusion). Observation and interview with CNA T, on 03/25/2024, at 3:45pm, revealed CNA T positioned Resident #1 to aid in the surveyor's observation of Resident #1's abdominal gastrostomy tube site. Observation revealed Resident #1 was lying flat on her designated bed and was not wearing abdominal binder. Resident #1's abdominal gastrostomy tube site was not clean. There was a visibly soiled dressing, with dark red hanging below the gastrostomy tube site. Abdominal gastrostomy tube site was cover with dark red substance. Resident #1's gastrostomy tube contained dark red substance. Resident #1 was tensed and expressed that there was pain at the gastrostomy tube site. CNA T stated that the Resident often complained that there was pain at the gastrostomy tube site; and Resident #1 was often seen pulling the gastrostomy tube. CNA T stated that he had no knowledge of abdominal binder that was ordered for Resident #1. During observation the surveyor observed that there was signage post on the wall and the head of the resident bed reading resident is to remain in a 45-degree position. CNA T stated that he was aware of the sign but was not sure why the sign was posted. CNA T stated that the resident head of bed was always flat when he worked. Interview on 03/25/2024, at 4:00pm with the DON and Administrator, the Administrator stated that they were aware of the physician's order to implement the abdominal binder. According to the Administrator, Resident #1 was not wearing the abdominal binder due to the facility not having the proper sized abdominal binder. The DON and Administrator did not disclose the date they were made aware of the improper fit; how they were able to determine the appropriate/best size for the resident; why the facility did not have the proper size; and why the proper sized abdominal binder had not been implemented. The Administrator stated that the physician should have been notified that the order was not implemented and did not disclose why the physician was not notified. (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.	Interview on 03/25/2024 at 4:45pm with LVN V, LVN V stated that she had worked at the facility for three months. LVN V stated that she provided care for Resident #1 often since employed with the facility. LVN V stated that she was not aware that Resident #1 had an order to wear an abdominal binder. The surveyor asked LVN V how she was made aware of all orders for any given resident she worked with. She stated that the information was usually communicated during shift ending handoff report. LVN V confirmed that she had access to the clinical record including all active order for resident she was assigned to provide care to. LVN V stated that she did not routinely check the resident order each shift. LVN V stated that Resident #1 often complained of pain at the gastrostomy tube site and the resident was often seen pull on the G-tube. LVN V stated that she had noticed complications with the G-Tube and G-tube site. LVN V that she had not notified the physician of complications related to the G-Tube and site. The surveyor asked LVN V if she had knowledge related to why a resident would be ordered an abdominal binder. LVN V stated that the abdominal binder would usually prevent possible complication with the G-tube. LVN V stated that she noticed that the dressing had not been changed. She stated that the dressing containing the dark red substance appeared to be the dressing from when she cleaned the gastrostomy tube site three days ago, on Friday, 03/22/2024 as the dressing was dated for Friday, 03/22/2024 and not new dress had been applied. LVN V stated that Resident #1's gastrostomy tube site was to be cleaned daily and a clean dressing should be applied. LVN V stated that when orders were missed it could place residents at risk for medical neglect. LVN V stated that by missing the order for the abdominal binder it placed Resident #1 at risk for complications with the G-tube. Interview on 03/26/2024 at 9:45am with RN J, who state that she had worked with Resident # 1 since January/2024. RN J stated that Resident #1 often complained of pain at the gastrostomy tube site and the resident was often redirected from pulling on the G-tube. RN J stated that she had often experienced complications with the G-Tube when administrating medication via the G-Tube. RN J stated that she had not notified the physician of the complications with the G-Tube. RN J stated that she was not aware that Resident #1 had an order to for an abdominal binder prior to the start of her shift on 03/26/2024. RN J was not able to explain how the order was missed. RN J stated that she usually reviewed and confirmed orders in the electronic clinical record for all resident she was assigned to work with each shift. RN J stated that she was made aware at the start of her shift during handoff report that the resident was sent out to the hospital related to complications of the G- tube and G-tube site. The surveyor asked RN J if she had knowledge related to why a resident would be ordered an abdominal binder. RN J stated that an abdominal binder is to protect the G-tube and G- Tube site. RN J stated that she was informed that the resident was provided an abdominal binder that was placed on the resident at the hospital during the hospital visit on 03/15/2024. RN J stated that she had not previously seen the resident wearing an abdominal binder. The surveyor asked what could happen to a resident by not implementing physician orders. RN J stated that Resident #1 could possibly have complications or dislodge her G- Tube. Record review on 03/26/2024 of Resident #1 clinical record, nurse progress note revealed that Resident #1 was sent out to the hospital for G-Tube replacement on 03/25/2024 at 6:20pm. Progress note 03/25/2024 at 11:19 revealed that Resident # 1 was discharged from the hospital with discharge instructions to follow up with gastroenterology specialty service for replacement of G tube. The surveyor was unable to interview the assigned nurse working the night shift (11pm - 6am) who received the Resident # 1 upon return from the hospital. (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.	Observation and interview of Resident #1's medication administration pass performed by LVN V on 3/26/2024 at 5:45pm revealed LVN V explained to Resident #1 that she was going to administer medication with the standby assistance of CNA T. LVN V prepared Resident #1's medications by crushing them and mixing them in water to dissolve them. LVN V went to the bedside without a stethoscope and there was no stethoscope at the resident's bedside. LVN V removed an enteral feeding and irrigation syringe from an opened package, not dated, at the bedside. LVN V removed the plunger from the syringe, preceded and did not aspirate gastric content from the g-tube. LVN V did not check Resident #1's g-tube for placement by auscultating (listening with a stethoscope) for bowel sounds, visualizing the site to ensure the tube had not become dislodged and or was not infected or compromised in any way. LVN V proceeded by plunger pushing a full 60 ml syringe of water into Resident #1's g-tube. Resident observed guarding her abdomen and yelled it hurt, stop. Resident #1's bed was flat, and the head of the bed was not elevated. The surveyor stopped LVN V and asked her if that was the technique, she normally used to check to assess a resident's g-tube placement. LVN V stated, Yes, if it flushes then it is good to use. When asked if that was the way she had been trained to check for g-tube placement, she said she had only worked at the facility for three months. LVN V stated that she had been trained. LVN V tried to resume the medication administration and was stopped again by the surveyor when LVN V aspirated the medication out of the cup she had used to crush and mix Resident #1's medication with water and began to plunger push the medication with force into Resident #1's g-tube as if giving an injection. When asked to stop and asked if that was how she was trained to administer g-tube medications, LVN V confirmed that was the way she was trained. LVN V stated that she always pushed Resident #1's medications when administering via g-tube. LVN V stated that she knew how to administer g-tube medications to gravity. She then stated that in the past when she attempted to administer Resident #1 medications to gravity, she often experienced complications. LVN V stated that she never reported complications related to the g-tube. LVN V did not disclosed why she did not notify the physician of complications. The surveyor stopped the medication administration observation and requested the DON. LVN V plunger push the medication with force instead of administering medications to gravity. LVN V did not follow physician orders to flush feeding tube with 30ml(cc) of water before and after administration of medication pass. Interview on 03/26/2024, at 6:00pm with DON, Administrator, and Corporate Regional Nurse, the DON confirmed that nursing staff had been trained on medication administration via g-tube and managing the care of Resident's with G-Tubes. Interview on 03/26/2024, at 8:00pm with the facility Physician, the Physician stated that the abdominal binder that was ordered and indicated because Resident #1 continued to attempt to pull out g-tube. The Physician stated that he was not notified that the facility had not implemented the abdominal binder prior to 03/26/2024. The Physician confirmed that the order was a current and active order to prevent complications of the g-tube and comprise to the g-tube site. The Physician confirmed that he should have been notified with related to failure to implement the abdominal binder and any complication related to the G-tube and G-Tube site. Interview on 03/27/2024, at 9:30am with the DON, the surveyor asked what the expectation for nursing staff was related to implementing physician orders. The DON stated that all nursing staff were expected to implement orders. The DON stated that when staff failed to implement orders the failure could have a negative impact and decline related to the resident's overall wellbeing. The facility policy related to implementing doctor's orders and management of G-Tubes was requested. (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 policy related to implementing doctor's orders, medication administration, and management of G-Tubes was requested at 9:30am on 03/37/2024. Proof of in-services and staff training for medication administration. The facility failed to provide requested information as of 03/27/2024 at 5:00pm. Interview on 03/29/24 at 11:30am Central Supply Staff A stated that she started working at the facility in January of 2024. Central Supply Staff A stated that she was made aware on 01/11/2024 that Resident #1 had an order for an abdominal binder. Central Supply Staff A stated that she did not have access to place a supply order for an abdominal binder. She stated that the previous DON was responsible for placing the supply order. She stated she was aware that the order had been placed and that the binder had arrived because there was a big deal about the wrong size being delivered so she re-ordered it at that time in the correct size. She provided invoices for original delivery date of 12/26/23 and reorder on 2/20/24. She said she did not know the resident had been without the abdominal binder. An Immediate Jeopardy (IJ) was identified on 03/27/2024. The Administrator and DON were notified on 03/27/2024 at 5:40pm. Plan of Removal - F580 Notice of Changes (submitted by facility/accepted at 03/28/2024 at 12:00pm) The facility failed to notify the resident's physician when the facility was unable to implement the physician order for abdominal binder. Immediate Action Resident #1 immediately assessed with no signs of distress noted. Abdominal binder obtained and placed on resident 3/25/24. LVN V immediately in serviced by DON and RNC related to g-tube care, checking placement, pushing and medication administration. Resident #1's orders were reviewed on 3/28/2024 and updated as needed to facilitate proper documentation. A gastroenterology follow-up appointment was set up by the facility for the next available day. The first available date was June 6, 2024. However, in consultation with the family and hospice, the g-tube will be removed as the resident is taking adequate PO intake/nutrition and the presence of the g-tube causes her undue distress. The facility reviewed the system for tube feeding and a review of the tube feeding policy was conducted by RNC to address any ambiguities that may have contributed to the incident. The facility revised a system including administrative nurses are reviewing residents that receive nutrition and/or medications via g-tube to assure that orders are followed, and new orders have been implemented as ordered during clinical meeting Monday - Friday. Ad HOC QAPI meeting will be completed with IDT consisting of Administrator, Regional Nurse Consultant, Administrative nurses and Medical Director 3/28/24 at 10 am. Facility interventions were implemented to remove immediate jeopardy: 1. Audit was completed by DON/RNC on 3/26/24 to identify any other residents with g- tubes in place to assure there were no complications related to g-tube care with no issues noted. (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.	2. An audit was conducted by DON/RNC on 3/28/24 to identify other residents with changes of condition in the past 14 days to ensure MD was notified. 3. Education provided 3/26/24 to LVN V DON and RNC related to g-tube care, resident positioning, checking g-tube placement, pushing and medication administration. 4. Education initiated for licensed nursing staff by DON/Designee related to g-tube care, resident positioning, checking placement, pushing and medication administration and steps to take when g-tube is not functioning properly. On 3/28/2024, an in-service with all licensed nursing staff was initiated by RNC to reinforce the importance of maintaining proper positioning with residents receiving feeding by tube feeding and proper placement of abdominal binders. 5. Education was initiated on 3/28/2024 on notification of MD when resident refuses treatment, when a prescribed treatment is not available, or when a full amount of a medication is unable to be administered. This includes g-tube medication administration and site care. 6. Facility will be in compliance 3/28/24 by 1 PM *Education to be completed with all licensed nursing staff working 3/28/2024. Staff who did not receive the training will receive this training prior to their next shift and will not be allowed to provide direct resident care until they have completed the training. State Surveyor Monitored the plan of removal as follows: Interview on 03/28/2024 at 12:13 with RN K (Day shift), RN K stated that General G-Tube Care training and in-service was provided by the facility on 03/27/2024. RN K was able to verbalize knowledge and understanding congruent with facility G- Tube policy. Interview on 03/28/2024 at 12:42 with RN J (Day shift), RN J stated that General G-Tube Care training and in-service was provided by the facility on 03/27/2024. RN J was able to verbalize knowledge related to G-Tube policy. Interview on 03/28/2024 at 6:00pm with, LVN V (2-10 shift), LVN V stated that General G-Tube Care training and in-service was provided by the facility on 03/27/2024. LVN V was able to verbalize knowledge of positioning and administering medications via G-Tube. LVN V was also able to verbalize knowledge related checking placement of a G-Tube, pushing and medication administration, the importance to of an abdominal binder, and the process for notifying the physician and follow up related to change in resident status and inability to implement a physician's orders. Interview on 03/28/2024 at 6:15 with CNA T (2-10pm shift), CNA T stated that training was provided on 03/27/2024 and 03/28/2024 on how to position a resident with and G-Tube. Interview on 03/28/2024 at 6:35pm with MA M (2-10pm shift), MA M stated that training was provided on 03/27/2024 on how to position a resident with and G-Tube. MA was able to verbalize her knowledge related positioning Resident's with G-Tubes. (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.	Interview on 03/29/24 at10:00am CNA J stated she had been trained that if they needed any supplies or supplies were missing, she would let her charge nurse and central supply know. She stated that the facility had been trained on how to make sure the residents with g-tubes were not left flat and that the head of the bed was up to at least 30-45 degrees. She said she had been trained to report any behaviors or changes in resident to charge nurse. She said they did not have access to supplies like abdominal binders so she would have to check with the charge nurse or central supply but if something got soiled or needed to be cleaned or replaced, she would report it to charge nurse. Interview on 03/29/24 at10:16 AM RN J, RN J stated she was recently in-serviced on G-tubes including medication administration processes including flushing, checking placement and medications administered to gravity never pushing. She said she would report any changes in the resident's condition including G-tube function and site to the medical doctor as well as the nurse practitioner. She stated that if a resident refused care, she would always document but leave and try again and if unsuccessful during follow up attempts and would notify the medical doctor and nurse practitioner. She stated that night shift changed g-tube site dressings daily and that she checked her sites underneath the dressings on day shift when she came on-shift. Interview on 03/29/24 at 10:19am RN K stated that she was retrained on G-tube med pass and had been trained upon hire. She stated that if a resident refused care to go away, let them calm down and come back and try again later, if still unsuccessful, or time sensitive, she would notify the medical doctor and nurse practitioner right away. She stated that a g-tube resident should never be left lying flat and that she did sometimes work 300 halls but was not aware Resident #1 had an abdominal binder ordered. She stated that if something was unavailable, she would let medical doctor know so order could be validated, changed, or held. Interview on 03/29/24 at 10:25am RN L stated she had recently been trained on G-tubes, abdominal binder. She said that G- tubes in-service was regarding medication administration and positioning of the resident head elevated at least 30 degrees. She stated that medications were to be administered to gravity and no medications should be push via the G- Tube, as well as, checking placement and site and notifying physician of all changes including if an ordered intervention or medication is not available. She stated that refusals of medications or ordered interventions, therapies were also to be reported to physician and practitioner. She stated she would document accordingly in the resident's clinical record. Interview on 03/29/24 at 10:34am MA M stated she had recently been trained to ensure any residents with G-tubes were not left flat after ADL care and that the head of the bed was elevated to at least 30 degrees. She stated that if anything was different, changed, or abnormal for the resident she would report to her charge nurse. Interview on 03/29/24 at 10:35am MA D stated he had worked at the facility since 2021. He stated he had been trained upon hire but then recently trained on g-tubes and making sure residents with g-tubes are not left flat and have their heads raised to at least 30 degrees to prevent the resident from aspirating. He said that if anything was beeping or leaking or looked abnormal for any resident, he would immediately report it to the charge nurse. MA D stated that it is not in in scope to administer any medications via g-tubes. He stated that if he was working as an aide and he took anything off the resident like a binder during a shower or bath and took it to laundry, he would ensure it was placed back with or on the resident once cleaned, and if not report it to charge nurse so they know it's off. (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.	Interview on 03/29/24 at 10:54am wound care LVN T stated she had recently been trained on G-tubes including medication administration, and only administering via gravity and not pushing medications via G-Tube. She stated that in-service included how to check placement, flushing G- Tube, resident positioning, and if there are any issues with G-Tube how to notify the medical doctor, she stated staff was trained to call medical doctor or nurse practitioner for any changes/refusals of treatment, and document action in the resident clinical record. Interview on 03/29/24 at 11:30am Central Supply Staff A stated that she started working at the facility in January of 2024. She stated she had a recent in-service on G-tube feedings. She stated that residents with g- tubes should be left at a 30-45-degree angle. The surveyor team was able verify that facility implemented the following to remove the immediacy: The facility provided an audit list of residents with G-Tube placement. The physician's order was verified for identified the residents. No additional change condition identified for residents listed. In-service/training records for licensed nurses by regarding the proper care and management of tube feeding residents, including proper procedure for checking g-tube placement, administration techniques, and required actions/documentation when interventions are refused was verified by the surveyor team. Education/training record for LVN V related to g-tube care, resident positioning, checking g-tube placement, and medication administration was verified by the surveyor team. In-service/training records for implementing measures of monitoring, documenting, and reporting G-tube complications, provided care and management to G-Tube was verified by the surveyor team. In-service/training records for importance of maintaining proper positioning with residents receiving feeding by tube feeding and proper placement of abdominal binders provided was verified by the surveyor team. Record of those in attendance for QAPI meeting on 3/28/24 at 10:00am was provided and verified by the surveyor teams. An Immediate Jeopardy (IJ) was identified on 03/27/2024. The Administrator and DON were informed on 03/27/2024 at 5:40pm. The IJ was lowered on 03/29/23 at 1:33pm, the facility remained out of compliance at a scope of pattern and a severity level of no harm, due to the facility's need to evaluate the effectiveness of the corrective systems.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26867 Based on observation, interview and record review, the facility failed to conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity for one (Resident #27) of 20 residents reviewed for comprehensive assessments in that. The facility did not assess the resident #27 for hospice (health care that focuses on the comfort of terminally ill patient) and lack of natural teeth on her oral cavity. These failures could place residents at risk of not having all medical needs assessed and met. Findings Included: Record review of Resident #27's electronic face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, diabetes, malignant neoplasm of ovary (ovarian cancer) major depressive disorder, single episode, abnormalities of gait and mobility, and lack of coordination. Record review of Resident #27's face sheet indicated she was admitted on hospice and had a DNR status. Record review of Resident #27's Admission MDS dated completed on [DATE] revealed a BIMS of 10 which indicated moderate impaired cognition. Review of section B hearing, speech and vision revealed all were checked as adequate . The section on Oral/Dental Status was checked as unable to examine. The section on special treatment (hospice) was left blank . Record review of Resident #27's care plan dated [DATE] revealed the following [Resident #27] has a terminal prognosis related to brain tumor . cirrhosis of the liver, and is on hospice/ palliative comfort. The goal reflected: comfort will be maintained through the review date. Date Initiated: [DATE] Revision on: [DATE]. Target Date: [DATE]. Record review of facility's MDS transmission history revealed Resident #27 had one comprehensive MDS assessment which was admitted d [DATE]. Record review revealed no significant change MDS for Resident #27. Observation and interview on [DATE] at 1:30PM revealed Resident #27 was in the smoking area of the facility. She ambulated by using walker wheelchair. During an interview, she said she discharged herself from hospice services because the hospice company would not allow her to visit her own physician. She said the hospice told her that she could only see the physician from the hospice company. She said she could not remember when she got off hospice but it was sometime last year. She said she needed to see a dentist because she lost a lot of weight during her hospital stay and her dentures were loose and did not fit. She said she could only eat soft food. She said she had told the Social Worker that her dentures were loose, but she had not gotten back to her. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675254	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/29/2024
NAME OF PROVIDER OR SUPPLIER Cascades at Galveston		STREET ADDRESS, CITY, STATE, ZIP CODE 3702 Cove View Blvd Galveston, TX 77554	

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LVN D on [DATE] at 3:20PM she said Resident #27 had told her that her dentures were loose. LVN D said she called the facility's dental services and was told that Resident #27 had to pay for any services provided. She said she was not a social worker but was assisting residents with needed services as much as she could. During an interview with MDS Coordinator B on [DATE] at 1:30PM, she said she was new, had just started and she was in training. She said the Regional MDS Coordinator was responsible for the MDS' before her time. She said the Regional MDS Coordinator was responsible for the MDS'. She said she was not aware that Resident #27 had dentures. The facility's policy on accuracy of MDS was requested from Regional MDS Coordinator on [DATE] at 4:00PM and on [DATE] at 2:0PM. Facility's Administrator and the regional MDS Coordinator said the facility followed the RAI manual and no specific policy on MDS and Care plan . 39977 FACILITY Resident Assessment [DATE] 03:39 PM Interview with [NAME] Gehrels RN Regional Corporate MDS who said that she had been working at the facility since 2022. She said that the facility had been without an MDS coordinator but was unsure for how long. She said that T [NAME] was a remote MDS coordinator that had been helping to complete the facility Medicare Assessments and that the facility had recently hired an MDS Coordinator that she [NAME], was actually on-site training and her name was [NAME], LVN. surveyor asked Gehrels to review discharged resident [NAME] Belluscio's EMR and asked her to show where the discharge MDS was located. She said that there was no discharge MDS but there should be one. She said she did no know why there was no discharge MDS of why one had not been done since according to nursing clinical documentation, the resident expired at the facility on ,d+[DATE]. She said that it should have been completed and signed within 14 days. She said that she was responsible for the admit and discharge MDS's until there was a full time, fully trained MDS. [DATE] 04:05 PM telephone interview with [NAME] Remote MDS Coordinator RN [DATE]. No answer left voicemail. She immediately called back and said that she been working for the facility on and off on for one and one half years until about 2 months ago when the facility hired the new MDS coordinator. She said her title was prn MDS Coordinator and she was totally remote and did not come to the facility at all. She said that [NAME] was her oversight and usually would have caught something like the death in facility that was not completed until today ([DATE]). She said that since she was remote working only, she relied solely on the facility census lines for the admits/d/c's and transfers and not sure who BOM or DON was at the time and would have been responsible for updating the census line. She said she did some of the MDS assessments but was not sure if she did or was responsible for the residents MDS at that time.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26867 Based on observation, interview, and record review the facility failed to conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition for one (Resident #27) of 18 residents reviewed for significant change. The facility failed to update Resident #27's MDS assessment within 14 days of the resident being discharge from hospice. This failure could result in residents not receiving the care and coordination of services necessary to meet their needs and/or desires. Findings Included: Record review of Resident #27's electronic face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, Diabetes, malignant neoplasm of ovary (ovarian cancer) major depressive disorder, single episode, abnormalities of gait and mobility, and lack of coordination. Record review of Resident #27's Admission MDS dated completed on 05/19/23 revealed a BIMS of 10 which indicated moderate impaired cognition. Record review of Resident #27's care plan dated 05/15/23 revealed the following [Resident #27]has a terminal prognosis related to brain tumor .cirrhosis of the liver , and is on hospice/ palliative comfort. The goal reflected: comfort will be maintained through the review date. Date Initiated: 05/16/2023 Revision on: 01/30/2024. Target Date: 04/29/2024 . Observation and interview on 03/27/24 at 1:30PM, revealed Resident #27 was in the smoking area of the facility. She ambulates by using walker wheelchair. During an interview, she said she discharge herself from hospice service because the hospice company would not allow her to visit her own physician. She said she was told that she can only see physician from the hospice company. She said she did not remember the month that she left hospice but sometimes last year. During an interview with MDS Coordinator B on 03/27/24 at 3:00pm, she said she was new, had just started and she was in training. She said the Regional MDS Coordinator was responsible for the MDS before her time. She said she started 3 weeks ago. During an interview with Regional MDS Coordinators on 03/28/24 at 1:18 PM, she looked at the care plan and MDS and said the resident should have been assessed for significant change after being discharge from hospice for being on hospice and should have a significant change MDS done after being discharged from hospice. She said she would do a modification . (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The facility's policy on accuracy of MDS was requested from Regional MDS Coordinator on 03/28/23 at 4:00pm and on 03/29/24 at 2:0PM. The Administrator and the Regional MDS Coordinator said the facility followed the RAI manual and no specific policy on MDS and Care plan. Record review of Long-Term Care Facility RAI Manual dated June 2023 version 1.18.11 revealed the following: .For the other comprehensive MDS assessments, Significant Change in Status Assessment the . Completion Date must be no later than . 14 days from the determination date of the significant change in status . An SCSA [Significant Change in Status Assessment] is required to be performed when a terminally ill resident enrolls in a hospice program . The ARD must be within 14 days from the effective date of the hospice election .

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39977 Based on interview and record review, the facility failed to ensure resident assessments were completed within 7 to14 days, and electronically transmitted, encoded accurately and completely, MDS data to the CMS System for discharge and death for 1 of 29 residents (CR #3) reviewed for encoding and transmitting resident assessments, in that: - The facility failed to complete a Death in Facility MDS for CR #3. - CR #3 did not have a Death in Facility MDS transmitted/exported within the required timeframe. These failures could place discharged residents at risk of not having a proper discharge and of not having their assessments transmitted/exported timely. Findings include: Record review of CR# 3's admission record dated [DATE] revealed he was a [AGE] year-old male who admitted to the facility on [DATE] and readmitted to the facility on [DATE] with the following diagnoses: dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment or memory and abstract thinking and often with personality changes, resulting from organic disease of the brain), drug induced systemic lupus (autoimmune phenomenon where a drug exposure leads to the development of systemic lupus, which is an autoimmune illness that occurs when the immune system attacks healthy tissues and organs), hypertension (elevated blood pressure), hyperlipidemia (elevated bad cholesterol), and chronic hepatitis C (an infection caused by a virus that attacks the liver and leads to inflammation). He expired at the facility on [DATE]. Record review of CR #3's Admission MDS assessment dated [DATE], revealed he had a BIMS of 0 of 15 which indicated he was severely cognitively impaired. He required moderate assistance with most ADLs (Activities of Daily Living). Record review of CR #3's nursing clinical progress note dated [DATE] at 5:01pm revealed, Nurses Note: Called to room by certified medication aide. In room to assess resident, resident not responding with sternal rub and no rise and fall of the chest noted. Called [Hospice Company A] to make them aware and RN needed to come and pronounce resident. Called [NP A] with [Dr. A] to make aware of resident's condition. Awaiting (sic) on hospice nurse to arrive to facility. Record review of CR#3's nursing clinical progress note dated [DATE] at 6:19pm revealed, Note text: Hospice nurse in facility to pronounce resident. Time of death per hospice nurse 6:57 pm. Hospice nurse to call hospice guardian to make them aware of resident's condition. Funeral home notified by hospice nurse, awaiting arrival. Will continue to monitor. Record review of CR #3's EMR on [DATE] revealed no death in facility or discharge MDS on record. Record review of CR #3's EMR on [DATE] Assessment History- MDS Assessment Screen, revealed there was no death in facility or discharge MDS on record. (continued on next page)

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

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on [DATE] at 3:39 pm with the Regional MDS RN said they had been working in the role since 2022 and that the facility had been without a permanent regular MDS Coordinator but unsure for how long. They said that MDS Coordinator B had been helping the facility complete MDS assessments remotely with MDS and only worked remotely. The Regional MDS RN said they were the oversight for MDS Coordinator B. The Regional MDS RN said they had just started training a new permanent MDS Coordinator for the facility that had just started. The Regional MDS RN was asked to review the EMR for CR #3 and said there was no discharge or death in facility MDS. The Regional MDS RN said that they did not know why the death in facility MDS had not been completed or even initiated and did not know how it had been missed but said there should be one. The Regional MDS RN said that a death in facility MDS should have been signed and completed within 14 days of [DATE]. The Regional MDS RN said that they were responsible for the admission and discharge MDS' for the facility until there was a full time MDS Coordinator. The Regional MDS RN said they did not have an MDS facility policy or procedure and used the RAI. Telephone interview on [DATE] at 4:05 pm MDS Coordinator B said that they had been working at the facility on and off for almost two years. They said they were prn and worked remotely only. They said they never came on-site to the facility to complete MDS assessments. They said that the Regional MDS RN was their oversight and would have been the one to catch any errors like missing assessments like the missing death in facility assessment for CR #3. The MDS Coordinator B said that CR #3 should have had a death in facility MDS completed back on [DATE] when CR #3 expired and did not know why it had not been initiated or completed until [DATE]. MDS Coordinator B said that since they only worked remotely, they solely depended on the information on the census line in the facility's EMR and if the information on the census line was incorrect, then the MDS would be incorrect as well. The MDS Coordinator B said they had no idea how or why CR #3's death in facility was not recorded on the facilities facility's census line or how it was missed. They said they did not know who was responsible for the facility's EMR entries for the census line. They said they did not have the facility MDS policy or procedure and used the RAI manual. Record review of CR#3's Death in Facility MDS dated [DATE] revealed Section Z Assessment Administration Signature of Persons Completing the Assessment of Entry/Death Reporting, that was signed by Regional MDS RN with Date Section Completed [DATE]. Record review of CMS's RAI Version 3.0 Manual dated [DATE], Chapter 2; ,d+[DATE] revealed the following under required assessment summary: MDS Completion Date No Later Than Discharge (death) Date +7 Calendar days. Transmission Date No Later Than Discharge 9death) Date +14 Calendar days.

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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.	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39977 Based on interview, and record review, the facility failed to ensure assessment accurately reflects the resident's status for 1l of 29 (CR #65), residents reviewed for accuracy of assessments, in that -The facility failed to ensure CR #65's Death in Facility assessment accurately reflected her date of death . This failure could place residents at risk for inadequate care, services, and dignity in death. Findings include: Record review of CR #65's Significant change MDS dated [DATE] revealed she was an [AGE] year old female that readmitted to the facility on [DATE] with a diagnosis of hyperlipidemia (high cholesterol), dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment or memory and abstract thinking and often with personality changes, resulting from organic disease of the brain), dysphagia (difficulty or discomfort in swallowing), peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), and combined systolic and diastolic heart failure (heart failure caused by both the hearts inability to produce enough blood pressure to pump blood or relax enough to refill or expand with enough blood). Her BIMS score was 5 out of 15 indicating she had severe cognitive impairments and required maximum to total dependence for most ADL's. Record review of CR #65's nursing clinical progress notes dated [DATE] at 8:54 pm revealed Resident expired at this time no pulse or respirations noted [Hhospice Ccompany A] and RP notified . Record review of CR #65's nursing clinical progress notes dated [DATE] at 10:11 pm revealed, [Hospice Company A] in facility Hospice RN pronounced patient deceased at this time . Record review of CR #65's EMR revealed she had a Death in Facility MDS dated [DATE]. Interview with Regional MDS RN on [DATE] at 5:47 pm revealed the MDS' were completed based on the census line provided by the facility and because they were not always on-site and there had not been an in-house, in-person MDS person at the facility she would need to review CR #65's EMR to see if a corrected or modified Death in Facility MDS needed to be completed. The Regional MDS RN said that they were responsible for monitoring the facilities facility's MDS' for accuracy and they followed CMS' RAI manual as an MDS policy and procedure for completion of facility resident assessments. Record review of CR 65's Death in Facility MDS dated [DATE] revealed Section X Correction Request . Reason for Modification .B. Data Entry Error . Record review of CR #65's Death in Facility MDS dated [DATE] revealed Section Z Assessment Administration Signature of Persons Completing the Assessment of Entry/Death Reporting, that was signed by Regional MDS RN with Date Section Completed [DATE]. (continued on next page)

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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.	Record review of CMS's RAI Version 3.0 Manual dated [DATE], pages ,d+[DATE] revealed the following The RAI process had multiple regulatory requirements . (1) the assessment accurately reflects the resident's status . (3) the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts.

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48605 Based on observation, interview and record review, the facility failed to ensure one of four residents (Resident #1) who were fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding, in that: The facility failed to implement the physician's order for an abdominal binder indicated to prevent complications of gastrostomy tube. The facility failure resulted in Resident #1 requiring discharge to the hospital for G-Tube replacement. LVN V failed to use the facility's identified proper technique and safety precautions for Resident # 1 for administering medications via G- Tube. LVN V's failure resulted in LVN V administering medications by plunger pushing the medications into Resident #1 gastrostomy tube instead of administering to gravity, placing the resident at immediate risk for potential harms associated G-Tube blockage and Aspiration (occurs when liquid or food enters the lungs). The facility failed to implement physician's order to provide gastrostomy tube site care to Resident #1 G-Tube site. The facility failure placed Resident #1 at immediate risk the development of infection. An Immediate Jeopardy (IJ) was identified on 03/27/2024. The Administrator and DON were informed on 03/27/2024 at 5:40pm. The IJ was lowered on 03/29/23 at 1:33pm, the facility remained out of compliance at a scope of pattern and a severity level of no harm, due to the facility's need to evaluate the effectiveness of the corrective systems. The identified failures have the potential to cause significant complications, including infections, aspiration, hospitalization s, or death, in residents with gastrostomy tubes. Findings included: Record review of Resident #1's face sheet dated 03/25/2024 revealed resident was admitted to the facility on [DATE], age [AGE] years old female. Resident #1 had a diagnosis of Gastrostomy Status (the creation of an artificial external opening into the stomach for nutritional support or gastric decompression via a G- Tube) and Gastro-Esophageal Reflux Disease (GERD - occurs when stomach acid repeatedly flows back into the tube connecting your mouth and stomach (esophagus) dated 08/26/2023. Record review of clinical record, Resident #1's Care Plan revealed that Resident #1 require to have an abdominal feeding tube. Care Plan Goal: Resident was to remain free of side effect of complication Resident insertion site will be free of sign and symptoms of infection. Interventions Task: Check tube placement and gastric contents/residual volume per facility protocol and record (policy). Monitor/document/ report tube dysfunction or malfunction, abdominal pain, and infection at the tube site provide local care to G-Tube site as ordered administer medication as ordered. Record review of clinical record, Resident #1's MDS revealed that Resident #1 required abdominal feeding tube. (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of Resident #1's physician's order summary report revealed the following order: every shift for flush feeding tube with 30ml(cc) of water before and after administration of medication pass. clean and change dressing one time a day. Apply abdominal binder, order dated as of 12/07/2023. Record review of clinical record, Resident #1's MAR/TAR revealed no documentation that the physician order for abdominal binder had been followed and implemented from 12/07/2023 thru 03/25/2024. Record review of clinical record, Resident #1 progress notes revealed no documentation of G-tube complication such as dysfunction or malfunction and ongoing reported abdominal pain as of 03/25/2024. Observation made on 03/25/2024 at 10:30am revealed Resident #1 was not wearing abdominal binder. The surveyor was unsuccessful in attempt to interview Resident #1 due to symptoms related to Dementia (intermittent confusion). Observation and interview with CNA T, on 03/25/2024, at 3:45pm, revealed CNA T positioned Resident #1 to aid in the surveyor's observation of Resident #1's abdominal gastrostomy tube site. Observation revealed Resident #1 was lying flat on her designated bed and was not wearing abdominal binder. Resident #1's abdominal gastrostomy tube site was not clean. There was a visibly soiled dressing, with dark red hanging below the gastrostomy tube site. Abdominal gastrostomy tube site was cover with dark red substance. Resident #1's gastrostomy tube contained dark red substance. Resident #1 was tensed and expressed that there was pain at the gastrostomy tube site. CNA T stated that the Resident often complained that there was pain at the gastrostomy tube site; and Resident #1 was often seen pulling the gastrostomy tube. CNA T stated that he had no knowledge of abdominal binder that was ordered for Resident #1. During observation the surveyor observed that there was signage post on the wall and the head of the resident bed reading resident is to remain in a 45-degree position. CNA T stated that he was aware of the sign but was not sure why the sign was posted. CNA T stated that the resident head of bed was always flat when he worked. Interview on 03/25/2024, at 4:00pm with the DON and Administrator, the Administrator stated that they were aware of the physician's order to implement the abdominal binder. According to the Administrator, Resident #1 was not wearing the abdominal binder due to the facility not having the proper sized abdominal binder. The DON and Administrator did not disclose the date they were made aware of the improper fit; how they were able to determine the appropriate/best size for the resident; why the facility did not have the proper size; and why the proper sized abdominal binder had not been implemented. The Administrator stated that the physician should have been notified that the order was not implemented and did not disclose why the physician was not notified. (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Interview on 03/25/2024 at 4:45pm with LVN V, LVN V stated that she had worked at the facility for three months. LVN V stated that she provided care for Resident #1 often since employed with the facility. LVN V stated that she was not aware that Resident #1 had an order to wear an abdominal binder. The surveyor asked LVN V how she was made aware of all orders for any given resident she worked with. She stated that the information was usually communicated during shift ending handoff report. LVN V confirmed that she had access to the clinical record including all active order for resident she was assigned to provide care to. LVN V stated that she did not routinely check the resident order each shift. LVN V stated that Resident #1 often complained of pain at the gastrostomy tube site and the resident was often seen pull on the G-tube. LVN V stated that she had noticed complications with the G-Tube and G-tube site. LVN V that she had not notified the physician of complications related to the G-Tube and site. The surveyor asked LVN V if she had knowledge related to why a resident would be ordered an abdominal binder. LVN V stated that the abdominal binder would usually prevent possible complication with the G-tube. LVN V stated that she noticed that the dressing had not been changed. She stated that the dressing containing the dark red substance appeared to be the dressing from when she cleaned the gastrostomy tube site three days ago, on Friday, 03/22/2024 as the dressing was dated for Friday, 03/22/2024 and not new dress had been applied. LVN V stated that Resident #1's gastrostomy tube site was to be cleaned daily and a clean dressing should be applied. LVN V stated that when orders were missed it could place residents at risk for medical neglect. LVN V stated that by missing the order for the abdominal binder it placed Resident #1 at risk for complications with the G-tube. Interview on 03/26/2024 at 9:45am with RN J, who state that she had worked with Resident # 1 since January/2024. RN J stated that Resident #1 often complained of pain at the gastrostomy tube site and the resident was often redirected from pulling on the G-tube. RN J stated that she had often experienced complications with the G-Tube when administrating medication via the G-Tube. RN J stated that she had not notified the physician of the complications with the G-Tube. RN J stated that she was not aware that Resident #1 had an order to for an abdominal binder prior to the start of her shift on 03/26/2024. RN J was not able to explain how the order was missed. RN J stated that she usually reviewed and confirmed orders in the electronic clinical record for all resident she was assigned to work with each shift. RN J stated that she was made aware at the start of her shift during handoff report that the resident was sent out to the hospital related to complications of the G- tube and G-tube site. The surveyor asked RN J if she had knowledge related to why a resident would be ordered an abdominal binder. RN J stated that an abdominal binder is to protect the G-tube and G- Tube site. RN J stated that she was informed that the resident was provided an abdominal binder that was placed on the resident at the hospital during the hospital visit on 03/15/2024. RN J stated that she had not previously seen the resident wearing an abdominal binder. The surveyor asked what could happen to a resident by not implementing physician orders. RN J stated that Resident #1 could possibly have complications or dislodge her G- Tube. Record review on 03/26/2024 of Resident #1 clinical record, nurse progress note revealed that Resident #1 was sent out to the hospital for G-Tube replacement on 03/25/2024 at 6:20pm. Progress note 03/25/2024 at 11:19 revealed that Resident # 1 was discharged from the hospital with discharge instructions to follow up with gastroenterology specialty service for replacement of G tube. The surveyor was unable to interview the assigned nurse working the night shift (11pm - 6am) who received the Resident # 1 upon return from the hospital. (continued on next page)

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

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Observation and interview of Resident #1's medication administration pass performed by LVN V on 3/26/2024 at 5:45pm revealed LVN V explained to Resident #1 that she was going to administer medication with the standby assistance of CNA T. LVN V prepared Resident #1's medications by crushing them and mixing them in water to dissolve them. LVN V went to the bedside without a stethoscope and there was no stethoscope at the resident's bedside. LVN V removed an enteral feeding and irrigation syringe from an opened package, not dated, at the bedside. LVN V removed the plunger from the syringe, preceded and did not aspirate gastric content from the g-tube. LVN V did not check Resident #1's g-tube for placement by auscultating (listening with a stethoscope) for bowel sounds, visualizing the site to ensure the tube had not become dislodged and or was not infected or compromised in any way. LVN V proceeded by plunger pushing a full 60 ml syringe of water into Resident #1's g-tube. Resident observed guarding her abdomen and yelled it hurt, stop. Resident #1's bed was flat, and the head of the bed was not elevated. The surveyor stopped LVN V and asked her if that was the technique, she normally used to check to assess a resident's g-tube placement. LVN V stated, Yes, if it flushes then it is good to use. When asked if that was the way she had been trained to check for g-tube placement, she said she had only worked at the facility for three months. LVN V stated that she had been trained. LVN V tried to resume the medication administration and was stopped again by the surveyor when LVN V aspirated the medication out of the cup she had used to crush and mix Resident #1's medication with water and began to plunger push the medication with force into Resident #1's g-tube as if giving an injection. When asked to stop and asked if that was how she was trained to administer g-tube medications, LVN V confirmed that was the way she was trained. LVN V stated that she always pushed Resident #1's medications when administering via g-tube. LVN V stated that she knew how to administer g-tube medications to gravity. She then stated that in the past when she attempted to administer Resident #1 medications to gravity, she often experienced complications. LVN V stated that she never reported complications related to the g-tube. LVN V did not disclosed why she did not notify the physician of complications. The surveyor stopped the medication administration observation and requested the DON. LVN V plunger push the medication with force instead of administering medications to gravity. LVN V did not follow physician orders to flush feeding tube with 30ml(cc) of water before and after administration of medication pass. Interview on 03/26/2024, at 6:00pm with DON, Administrator, and Corporate Regional Nurse, the DON confirmed that nursing staff had been trained on medication administration via g-tube and managing the care of Resident's with G-Tubes. Interview on 03/26/2024, at 8:00pm with the facility Physician, the Physician stated that the abdominal binder that was ordered and indicated because Resident #1 continued to attempt to pull out g-tube. The Physician stated that he was not notified that the facility had not implemented the abdominal binder prior to 03/26/2024. The Physician confirmed that the order was a current and active order to prevent complications of the g-tube and comprise to the g-tube site. The Physician confirmed that he should have been notified with related to failure to implement the abdominal binder and any complication related to the G-tube and G-Tube site. Interview on 03/27/2024, at 9:30am with the DON, the surveyor asked what the expectation for nursing staff was related to implementing physician orders. The DON stated that all nursing staff were expected to implement orders. The DON stated that when staff failed to implement orders the failure could have a negative impact and decline related to the resident's overall wellbeing. The facility policy related to implementing doctor's orders and management of G-Tubes was requested. (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	The policy related to implementing doctor's orders, medication administration, and management of G-Tubes was requested at 9:30am on 03/37/2024. Proof of in-services and staff training for medication administration. The facility failed to provide requested information as of 03/27/2024 at 5:00pm. Interview on 03/29/24 at 11:30am Central Supply Staff A stated that she started working at the facility in January of 2024. Central Supply Staff A stated that she was made aware on 01/11/2024 that Resident #1 had an order for an abdominal binder. Central Supply Staff A stated that she did not have access to place a supply order for an abdominal binder. She stated that the previous DON was responsible for placing the supply order. She stated she was aware that the order had been placed and that the binder had arrived because there was a big deal about the wrong size being delivered so she re-ordered it at that time in the correct size. She provided invoices for original delivery date of 12/26/23 and reorder on 2/20/24. She said she did not know the resident had been without the abdominal binder. An Immediate Jeopardy (IJ) was identified on 03/27/2024. The Administrator and DON were notified on 03/27/2024 at 5:40pm. Plan of Removal - F693 Tube Feeding Management (submitted by facility/accepted at 03/28/2024 at 12:00pm) PLAN OF REMOVAL: F693 Tube Feeding Management The facility failed to implement the physician's order for abdominal binder, and medication administration through the gastrostomy was not performed in accordance with facility policy and procedure. Immediate Action Resident #1: An abdominal binder was placed on 3/25/2024 per physician's orders. LVN V immediately in serviced by DON and RNC related to g-tube care, checking placement, pushing and medication administration. The resident was immediately assessed by DON for adverse effects from gastrostomy feeding on 3/26/24. The resident was offered site care, and the refusal of care was documented. An incident report was completed related to the incorrect feeding procedure, missed dose of lactulose, and missed documentation of gastrostomy tube site care refusal. Resident #1's orders were reviewed on 3/28/2024 and updated as needed to facilitate proper documentation. A gastroenterology follow-up appointment was set up for June 6, 2024. However, in consultation with the family and hospice, the g-tube will be removed as the resident is taking adequate PO intake/nutrition and the presence of the g-tube causes her undue distress. The facility reviewed the system for tube feeding and a review of the tube feeding policy was conducted by RNC to address any ambiguities that may have contributed to the incident. The facility revised a system including administrative nurses are reviewing residents that receive nutrition and/or medications via g-tube to assure that proper procedures are followed during clinical meeting Monday - Friday. Ad HOC QAPI meeting will be completed with IDT consisting of Administrator, Regional Nurse Consultant, Administrative nurses and Medical Director 3/28/24 at 10 am. (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Facilities Plan to ensure compliance quickly: Facility interventions were implemented to remove immediate jeopardy: 1. An audit was completed by RNC on 3/27/2024 of all residents receiving tube feedings to validate that physician's orders were implemented and that the g-tube and g-tube site were clean and functioning. No further issues were identified. 2. On 3/26/2024, an in-service was initiated with all licensed nurses by DON regarding the proper care and management of tube feeding residents, including proper procedure for checking g-tube placement, administration techniques, and required actions/documentation when interventions are refused. 3. 3/28/2024, a review of the Point Click Care enteral feeding batch orders was conducted by RNC, and orders were reviewed to validate they prompt the nurse to document each shift that they were implemented or refused. 4. On 3/28/2024, an in-service with licensed nurses was initiated by RNC to reinforce the importance of maintaining proper positioning with residents receiving feeding by tube feeding and proper placement of abdominal binders. 5. On 3/28/2024, a review of the facility in-service schedule was conducted by RNC and updated to implement quarterly in-services regarding the care of residents receiving enteral feeding. 6. Facility will be in compliance by 3/28/2024 at 1pm. *Education to be completed with all nurses working 3/28/2024. Staff who did not receive this training will receive this training prior to their next shift and will not be allowed to provide direct resident care until they have completed the training. State Surveyor Monitored the plan of removal as follows: Interview on 03/28/2024 at 12:13 with RN K (Day shift), RN K stated that General G-Tube Care training and in-service was provided by the facility on 03/27/2024. RN K was able to verbalize knowledge and understanding congruent with facility G- Tube policy. Interview on 03/28/2024 at 12:42 with RN J (Day shift), RN J stated that General G-Tube Care training and in-service was provided by the facility on 03/27/2024. RN J was able to verbalize knowledge related to G-Tube policy. Interview on 03/28/2024 at 6:00pm with, LVN V (2-10 shift), LVN V stated that General G-Tube Care training and in-service was provided by the facility on 03/27/2024. LVN V was able to verbalize knowledge of positioning and administering medications via G-Tube. LVN V was also able to verbalize knowledge related checking placement of a G-Tube, and medication administration, the importance to of an abdominal binder, and the process for notifying the physician and follow up related to change in resident status and inability to implement a physician's orders. Interview on 03/28/2024 at 6:15 with CNA T (2-10pm shift), CNA T stated that training was provided on 03/27/2024 and 03/28/2024 on how to position a resident with and G-Tube. (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Interview on 03/28/2024 at 6:35pm with MA M (2-10pm shift), MA M stated that training was provided on 03/27/2024 on how to position a resident with and G-Tube. MA was able to verbalize her knowledge related positioning Resident's with G-Tubes. Interview on 03/29/24 at10:00am CNA J stated she had been stated that she had been trained if they needed any supplies or supplies were missing, she would let her charge nurse and central supply know. She stated that the facility had been trained on how to make sure the residents with g-tubes were not left flat and that the head of the bed was up to at least 30-45 degrees. She said she had been trained to report any behaviors or changes in resident to charge nurse. She said they did not have access to supplies like abdominal binders so she would have to check with the charge nurse or central supply but if something got soiled or needed to be cleaned or replaced, she would report it to charge nurse. Interview on 03/29/24 at10:16 AM RN J , RN J stated she was recently in-serviced on G-tubes including medication administration processes including flushing, checking placement and medications administered to gravity never pushing. She said she would report any changes in the resident's condition including G-tube function and site to the medical doctor as well as the nurse practitioner. She stated that if a resident refused care, she would always document but leave and try again and if unsuccessful during follow up attempts and would notify the medical doctor and nurse practitioner. She stated that night shift changed g-tube site dressings daily and that she checked her sites underneath the dressings on day shift when she came on-shift. Interview on 03/29/24 at 10:19am RN K stated that she was retrained on G-tube med pass and had been trained upon hire. She stated that if a resident refused care to go away, let them calm down and come back and try again later, if still unsuccessful, or time sensitive, she would notify the medical doctor and nurse practitioner right away. She stated that a g-tube resident should never be left lying flat and that she did sometimes work 300 halls but was not aware Resident #1 had an abdominal binder ordered. She stated that if something was unavailable, she would let medical doctor know so order could be validated, changed, or held. Interview on 03/29/24 at 10:25am RN L stated she had recently been trained on G-tubes, abdominal binder. She said that G- tubes in-service was regarding medication administration and positioning of the resident head elevated at least 30 degrees. She stated that medications were to be administered to gravity and no medications should be push via the G- Tube, as well as, checking placement and site and notifying physician of all changes including if an ordered intervention or medication is not available. She stated that refusals of medications or ordered interventions, therapies were also to be reported to physician and practitioner. She stated she would document accordingly in the resident's clinical record. Interview on 03/29/24 at 10:34am MA M stated she had recently been trained to ensure any residents with G-tubes were not left flat after ADL care and that the head of the bed was elevated to at least 30 degrees. She stated that if anything was different, changed, or abnormal for the resident she would report to her charge nurse. (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Interview on 03/29/24 at 10:35am MA D stated he had worked at the facility since 2021. He stated he had been trained upon hire but then recently trained on g-tubes and making sure residents with g-tubes are not left flat and have their heads raised to at least 30 degrees to prevent the resident from aspirating. He said that if anything was beeping or leaking or looked abnormal for any resident, he would immediately report it to the charge nurse. MA D stated that it is not in in scope to administer any medications via g-tubes. He stated that if he was working as an aide and he took anything off the resident like a binder during a shower or bath and took it to laundry, he would ensure it was placed back with or on the resident once cleaned, and if not report it to charge nurse so they know it's off. Interview on 03/29/24 at 10:54am wound care LVN T stated she had recently been trained on G-tubes including medication administration, and only administering via gravity and not pushing medications via G-Tube. She stated that in-service included how to check placement, flushing G- Tube, resident positioning, and if there are any issues with G-Tube how to notify the medical doctor, she stated staff was trained to call medical doctor or nurse practitioner for any changes/refusals of treatment, and document action in the resident clinical record. Interview on 03/29/24 at 11:30am Central Supply Staff A stated that she started working at the facility in January of 2024. She stated she had a recent in-service on G-tube feedings. She stated that residents with g- tubes should be left at a 30-45-degree angle. The surveyor team was able verify that facility implemented the following to remove the immediacy: The facility provided an audit list of residents with G-Tube placement. The physician's order was verified for identified the residents. In-service/training records for licensed nurses by regarding the proper care and management of tube feeding residents, including proper procedure for checking g-tube placement, administration techniques, and required actions/documentation when interventions are refused was verified Record review of MAR/TAR and nursing progress note revealed that nursing staff have implemented measures of monitoring, documenting, and reporting G-tube complications, provided care and management to G-Tube. In-service/training records for importance of maintaining proper positioning with residents receiving feeding by tube feeding and proper placement of abdominal binders provided was verified by the surveyor team. Record of those in attendance for QAPI meeting on 3/28/24 at 10:00am was provided and verified by the surveyor teams. An Immediate Jeopardy (IJ) was identified on 03/27/2024. The Administrator and DON were informed on 03/27/2024 at 5:40pm. The IJ was lowered on 03/29/23 at 1:33pm, the facility remained out of compliance at a scope of pattern and a severity level of no harm, due to the facility's need to evaluate the effectiveness of the corrective systems.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48605 Based on observation, interview, and record review, the facility failed to ensure that it was free of medication error rate of 5 percent or greater. Twenty-five opportunities were observed with a total of four errors, resulting in a 16 percent medication error rate involving 1 resident (Residents #1) and 1 of 4 staff (LVN V) reviewed for medication error, in that: LVN L administered the wrong dose of Lactulose (medication is a laxative used to treat constipation) to Resident #1. LVN V flushed Resident #1's g-tube with the wrong volume of water as evidenced by pushing a full 60 ml syringe of water instead of the physician ordered volume of 30ml into Resident #1's g-tube before and after administering medication. LVN V administered Resident #1's medications not according to physician orders, as evidenced by resident was lying flat in a supine (on back) position, and head of bed was not elevated putting the resident at risk for aspiration (occurs when liquid or food enters the lungs). These failures placed residents at risk for not receiving medications as ordered by the physician and not receiving the intended therapeutic benefit of their medications. Findings included: Record review of Resident #1's face sheet dated 03/25/2024 revealed resident was admitted to the facility on [DATE], age [AGE] years old female. Resident #1 had a diagnosis of Gastrostomy Status (the creation of an artificial external opening into the stomach for nutritional support or gastric decompression via a G- Tube) and Gastro-Esophageal Reflux Disease (GERD - occurs when stomach acid repeatedly flows back into the tube connecting your mouth and stomach (esophagus) dated 08/26/2023. Record review of clinical record, Resident #1's Care Plan revealed that Resident #1 require to have an abdominal feeding tube. Care Plan Goal: Resident was to remain free of side effect of complication Resident insertion site will be free of sign and symptoms of infection. Interventions Task: Check tube placement and gastric contents/residual volume per facility protocol and record (policy). Monitor/document/ report tube dysfunction or malfunction, abdominal pain, and infection at the tube site provide local care to G-Tube site as ordered administer medication as ordered. Record review of clinical record, Resident #1's MDS revealed that Resident #1 required abdominal feeding tube. Record review of Resident #1's physician's order summary report revealed the following order: every shift for flush feeding tube with 30ml(cc) of water before and after administration of medication pass. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of Resident #1's physician orders dated 03/18/2024 revealed an order for Lactulose, give 30mls via G Tube two times a day for Hyperammonemia (a metabolic condition characterized by the raised levels of ammonia). Record review of the facility's policy for Administering Medications through an Enteral Tube (not dated) revealed the following in part: -Medication are administer in accordance with prescriber orders . - Remove plunger from syringe. Add medication and appropriate amount of water to dilute. -Assist the resident to semi-Fowler's position (30 to 45) - Administer medication by gravity flow - Verify placement of G-tube - Check the label and confirm the medication name and dose with the MAR. Observation and interview of Resident #1's medication administration pass performed by LVN V on 3/26/2024 at 5:45pm revealed LVN V explained to Resident #1 that she was going to administer medication with the standby assistance of CNA T. LVN V prepared Resident #1's medications by crushing them and mixing them in water to dissolve them. LVN V went to the bedside without a stethoscope and there was no stethoscope at the resident's bedside. LVN V removed an enteral feeding and irrigation syringe from an opened package, not dated, at the bedside. LVN V removed the plunger from the syringe, preceded and did not aspirate gastric content from the g-tube. LVN V did not check Resident #1's g-tube for placement by auscultating (listening with a stethoscope) for bowel sounds, visualizing the site to ensure the tube had not become dislodged and or was not infected or compromised in any way. LVN V proceeded by plunger pushing a full 60 ml syringe of water into Resident #1's g-tube. Resident observed guarding her abdomen and yelled it hurt, stop. Resident #1's bed was flat, and the head of the bed was not elevated. The surveyor stopped LVN V and asked her if that was the technique, she normally used to check to assess a resident's g-tube placement. LVN V stated, Yes, if it flushes then it is good to use. When asked if that was the way she had been trained to check for g-tube placement, she said she had only worked at the facility for three months. LVN V stated that she had been trained. LVN V tried to resume the medication administration and was stopped again by the surveyor when LVN V aspirated the medication out of the cup she had used to crush and mix Resident #1's medication with water and began to plunger push the medication with force into Resident #1's g-tube as if giving an injection. When asked to stop and asked if that was how she was trained to administer g-tube medications, LVN V confirmed that was the way she was trained. LVN V stated that she always pushed Resident #1's medications when administering via g-tube. LVN V stated that she knew how to administer g-tube medications to gravity. She then stated that in the past when she attempted to administer Resident #1 medications to gravity, she often experienced complications. LVN V stated that she never reported complications related to the g-tube. LVN V did not disclosed why she did not notify the physician of complications. The surveyor stopped the medication administration observation and requested the DON. LVN V plunger push the medication with force instead of administering medications to gravity. LVN V did not follow physician orders to flush feeding tube with 30ml(cc) of water before and after administration of medication pass. (continued on next page)

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Interview on 03/28/2024 at 6:00pm with, LVN V, LVN V stated that General G-Tube Care training and in-service was provided by the facility on 03/27/2024. LVN V was able to verbalize knowledge of positioning and administering medications via G-Tube. LVN V was also able to verbalize knowledge related checking placement of a G-Tube and medication administration, the importance to of an abdominal binder, and the process for notifying the physician and follow up related to change in resident status and inability to implement a physician's orders. In an interview on 03/29/2024 at 6:05p.m. the DON stated that medications was to be checked for the correct dosage and route with each medication pass. The DON stated that the Resident #1 head of bed should have been elevated to 45 degrees as posted on the resident's wall. The DON stated that it was a safety concerns and was able to follow up with LVN V related to G-tube medication administration. The DON stated pushing medications with force can cause discomfort or even harm to the patient. It was essential to ensure a gentle and safe administration method. The DON stated that when medications was administered in error via the wrong route and dose that it can cause serious, sometimes long-term effects to the resident. The DON stated that all nurses and MA staff have been trained are knowledgeable of the medication administration policy. The DON stated that additional training will be provided. Education/training record for LVN V related to g-tube care, resident positioning, checking g-tube placement, and medication administration was verified by the surveyor team.

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 03/29/2024
NAME OF PROVIDER OR SUPPLIER Cascades at Galveston		STREET ADDRESS, CITY, STATE, ZIP CODE 3702 Cove View Blvd Galveston, TX 77554	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hire a qualified full-time social worker in a facility with more than 120 beds. 48315 Based on record review and interview the facility, with the capacity of more than 120 beds, failed to employ a qualified social worker on a full-time basis. The facility, licensed for 150 beds, did not employ a full-time social worker. This failure could affect all residents in need of social services and place them at risk of psychosocial decline and poor quality of life. The findings included: Record review of the facility census report on 3/25/24 revealed a current census of 73 residents and capacity was 150 residents. Record review of five months the employee files, provided by facility, revealed the Social Worker's last day of employment was on 11/23/23. Resulting facility being without a social worker for four months. Record review of the job description for social worker position reflected, Title: Social Services Supervisor/Resident Advocate. Requirements: High school diploma and or bachelor's degree in social work along with an LCSW or LMSW. Record review of a job posting revealed the posting was from 1/18/24 to 3/28/24 and reposted 3/11/24 to 4/10/24. Interview with HR, on 3/28/24 at 9:00am revealed the Social Worker's last day was sometime in November 2023 and the position was not filled. She stated she was told to put LVN D in place as acting social services. Interview with the Administrator on 3/28/24 at 10:30 am revealed when he came on board on 1/16/24 and there was no social worker, and the position was vacant for a while. She stated he was actively looking for a social worker and had several interviews however the candidates were not licensed, and he was having a hard time filling the position. He stated that he hired LVN D to act as social services designee to address resident concerns, needs and discharge plans. The Administrator also stated that he was waiting on corporate to approve their sister facility Social Worker to assist for 2- or 3-days, and approval was still pending. The Administrator stated the risk of not having a full time qualified social worker in the facility could place the resident at risk of not having their needs met. A confidential interview with Resident #1, Resident #2, Resident #3, resident #4 on 3/26/2024 at 10:00am in a resident council meeting revealed the facility had not had a social worker in the last 5 months. The residents stated a nurse was acting as a social worker and the administrative staff said they were trying to find a social worker. They stated in the meantime the nurse would assist them however, they did not understand what was taking the facility so long to hire someone.