STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675254	A. Building B. Wing	05/29/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26244 26867 Based on observation, interview and record review, the facility failed to accurately assess each resident's status for 3 of 18 residents(Resident #6, #30 and #57) reviewed for accuracy of assessments. --the facility failed to ensure Resident # 6's Significant Change MDS did not code grab bars to aid with bed mobility as restraints --the facility failed to ensure Resident # 30's Significant Change MDS assessment did not have catheter which had been removed prior to the MDS assesement --the facility failed to ensure that Resident #57's Admission MDS assessment accurately reflected she did not have a catheter These failures could place residents at risk of inaccurate care and decline in health. Resident # 6 Record review of Resident # 6's face sheet revealed admitted [DATE], with diagnoses including hemiplegia and hemiparesis following a cerebral infarction (weakness or paralysis on one side of the body following a stroke), dysphagia (difficulty swallowing), chronic obstructive pulmonary disease (lung disease causing restricted airflow), chronic kidney disease (longstanding disease of kidneys leading to kidney failure), heart failure (inability of the heart to pump blood as it should), Bipolar disorder (episodes of mood swings from depressive lows to manic highs), absence of left leg above the knee. Record review of Resident # 6's MDS dated [DATE] revealed he was usually understood by others and usually understands others, BIMS of 08 indicating impaired cognitive skills, maximum assistance for ADLs, and 2 restraints, coded as other used daily. Record review of Resident # 6's undated care plan revealed resident uses 1/4 bars to safely move in bed, with interventions to check every 2 hours for safety. (continued on next page)

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

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview with Resident # 6 on 5/27/25 at 9:30am revealed he was in bed and there were grab bars on each side of the bed. In interview, he said he used the grab bars to turn over and he demonstrated how he used the bars to assist in turning. Interview with the Corporate Regional Nurse and DON on 5/28/25 at 2:20pm revealed Resident # 6 had 2 grab bars on his bed to help him with repositioning and when provided care. The DON looked up Resident # 6's MDS dated [DATE] and said the coding for restraints on the MDS was incorrect, since the bed rails did not restrict his movement. Interview with MDS Coordinator A on 5/28/25 at 4pm revealed the MDS for Resident # 6 would be corrected and said the MDS assessment was a collaborative effort with input from staff, and MDS assessments are coded according to the RAI manual. He said the outcome of an incorrect MDS would be incorrect resident care. Resident # 30 Record review of Resident #30's face sheet revealed admitted [DATE], with diagnoses including Schizoaffective disorder, Bipolar type (manic episodes with periods depression and disorganized thinking), hypertension (high blood pressure), major depressive disorder (persistent feelings of sadness, loss of interest that interfere with daily life), benign prostatic hyperplasia (enlargement of prostate), history of traumatic brain injury (brain injury caused by an outside source). Record review of Resident # 30's Significant Change MDS dated [DATE] revealed usually understood by others and usually understands others, BIMS 03, indicating impaired cognitive skills, maximum assistance required for ADLs, and indwelling catheter. Record review of progress note dated 3/14/25 revealed the catheter was observed lying in bed next to Resident # 30, and resident said, I pulled that tube out. A scant amount of blood was observed in his brief, and resident refused foley catheter reinsertion. Observation and interview with Resident # 30 on 5/27/25 revealed he was in bed, and no catheter drainage bag was observed at bedside. Interview at that time revealed he pulled the catheter out. In an interview on 5/28/25 at 1:15 pm, RN D said she was familiar with Resident # 30's care since she worked on his hall, and he did not have a catheter. Record review of physician orders for 5/2025 revealed no order for indwelling catheter for Resident # 30. In an interview on 5/28/25 at 12:30 pm, the Corporate Regional nurse and DON checked the EMR for Resident # 30 and said he did not have a catheter, the progress note indicated Resident # 30 pulled the tube out on 3/14/25 and refused to have it re-inserted. They said the MDS coordinator completed the MDS and staff provided input for their sections and they used the RAI manual for MDS guidance. They said the risk of having inaccurate information on the MDS would be incorrect care for the resident and it would affect billing. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with MDS Coordinator A on 5/29/25 at 4:00 pm, he said the MDS for Resident # 30 would be corrected, and the MDS was a collaborative effort with input from staff. The RAI manual was referred to as a guide for MDS coding. He said an inaccurate MDS would affect resident care in that they would not get the care they needed. Resident #57 Record review of Resident #57's face sheet dated 05/29/25 revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included Nontraumatic intracranial hemorrhage (Bleeding in the brain , tracheostomy status, (a surgical hole through the front of the neck into the wind pipe for breathing), chronic kidney disease, pressure ulcer of sacral region, essential hypertension (High blood Pressure), encephalopathy, retention of urine, gastrostomy status, generalized muscle weakness, cognitive communication (lack of communication), dysphagia (difficulty swallowing), type 2 diabetes mellitus (when the body cannot use insulin correctly and sugar builds up in the blood) chronic pain, chronic respiratory failure, shortness of breath and urinary tract infection. Record review of Resident #57's admission MDS assessment dated [DATE] indicated Resident #57 was assessed as having a catheter in section H Bladder and bowel. Observation on 05/27/25 at 11:00AM revealed Resident #57 was in bed. Attempt was made to have a communication with Resident #57 but she did not answer. Observation indicated she was alert. Observation revealed no evidence of a catheter bag. During an interview on 05/27/25 at 12:20PM, CNA F said she had not seen Resident #57 with a catheter. During an interview with LVN D on 05/28/25 at 10:00AM, she said Resident #57 did not have a catheter. She said Resident #57 had one prior to being sent to the hospital. She said Resident #57 did not returned to the facility with a catheter. In an interview with Corporate Regional Nurse, DON and MDS Coordinator on 5/29/25 at 1:10PM, the MDS coordinator said he was responsible for ensuring that all MDS assessments accurately reflected the resident's condition. He said he visits residents for observation and uses nurse's documentation to complete the MDS Assessment. He said he would do a modification to the MDS . The Corporate nurse, DON and MDS Coordinator said Resident #57 had a catheter at one point but it was discontinued when she went to the hospital. The DON provided an order for urinary catheter dated 11/01/24 and discontinued on 02/16/25. The Corporate nurse and the DON said an incorrect assessment might affect the facility's billing method. Record review of the RAI manual Restraints and Alarms dated October 2024 revealed, in part, physical restraint is defined by; any manual method of physical or mechanical device, material or equipment attached or adjacent to the resident's body .which restricts freedom of movement . Record review of the RAI manual dated October 2024 revealed, in part: .assessment accurately reflects the resident status .

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 26867 39977 Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and time frames to meet a resident's medical, nursing, mental and psychosocial needs and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical well-being for 2 of 24 residents (Resident #13 and Resident #57) reviewed for care plans. -The facility failed to ensure Resident #13's comprehensive care plan included information regarding his indwelling urinary catheter. -The facility failed to ensure that Resident # 57's care plan included her use of oxygen These failures could place residents at risk of not receiving appropriate care and interventions to meet their needs. Findings included: Resident #13 Record review of Resident #13's Admission Record dated 5/29/2025, revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (a condition where brain dysfunction, caused by imbalance in brain metabolism, causes changes in mental status), peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), age-related osteoporosis (a condition where bone density and strength decline due to aging, making bones more prone to breaking), atrial fibrillation (an irregular often rapid heart rate that causes poor blood flow), and acute urinary retention (sudden difficulty urinating and completely emptying the bladder). Record review of Resident #13's quarterly MDS dated [DATE] revealed a BIMS score of 9 out of 15 that indicated moderate cognitive impairment. MDS also revealed in Section H bowel and bladder, Resident #13 was not coded as having an indwelling urinary catheter. Record review of Resident #13's Hospital A records dated 5/14/25 revealed in part: [Resident #13] [AGE] year-old male admitted for [NAME] (minimally invasive procedure that involves implanting a small parachute-shaped device called a [NAME] in the heart's left atrial appendage (small pouch area where blood clots can develop) aimed at reducing the risk of stroke in people with atrial fibrillation), who experienced difficult Foley (type of indwelling urinary catheter-thin flexible tube inserted into the urethra to drain urine), placement for post procedural acute urinary retention. 16 Coude (bent tip) Catheter placed at bedside . Recommend indwelling foley due to high UOP and bladder over distention .if patient will discharge prior to 2-3 days re-engage urology to arrange follow up appointment for foley removal. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Nurses Note dated 5/15/25 at 6:02 pm revealed in part Note Text: Resident readmitted to facility approx 1600, via WC transport van S/P [NAME] procedure. Vitals WNL. Notified NP/RP of resident's return. No s/sx of acute distress noted. Denies pain upon assessment. No new skin issues noted. 16Fr Foley cath in place r/t urinary retention per MD. Resident to F/U with Urology in 1-2 weeks prior to DC of Foley cath. Record review of Nurses Note dated 5/17/25 at 12:19 pm revealed Note Text: Resident s/p [NAME] procedure. 16F foley catheter intact. Foley bag draining yellow/clear urine. Resident denies pain or discomfort. Resident #13 urology follow up appointment on 6/4/25. Record review of Resident #13's Order Summary Report dated 5/29/25 revealed physician's order 16 coude catheter (type of urinary catheter with a curved tip, designed to help navigate obstructions in the urethra (duct from which urine passes out of the body from the bladder), particularly in men with enlarged prostate glands (walnut sized gland in men that surrounds the urethra at the base of the bladder) in place with order date of 5/15/25. Record review of Resident #13's care plan on 5/29/25 at 10:25 am revealed no mention regarding indwelling urinary, or Foley catheter. In an interview with Corporate Regional Nurse and DON on 5/29/25 at 1:00 pm they both said there was not any other place in Resident #13's clinical record to find the care plan for the indwelling catheter. They both said Resident #13 should have a comprehensive care plan for his indwelling urinary catheter. The DON said that MDS Coordinator A and the IDT were responsible for resident care plans. The DON and Corporate Regional Nurse said they would have to look at Resident #13's care plans and get back to surveyor. The DON said they had only been the DON at the facility for about 1 month. In an interview with MDS Coordinator A on 5/29/25 at 1:23 pm they said they were not sure if Resident #13's indwelling foley catheter had been care planned. MDS Coordinator A checked Resident #13's comprehensive care plan in the EMR and said they did not see a care plan for an indwelling foley catheter for Resident #13. MDS Coordinator A said there should be a care plan for Resident #13's indwelling urinary catheter and did not know why there was not one. MDS Coordinator A said that care plans were important and helped guide staff on how to care for a resident. MDS Coordinator A said that if the care plan was not accurate or complete, it could negatively affect the resident's care because the resident may not receive appropriate care based on specific needs. Record review of Resident #13's care plan printed 5/29/25 at 3:17 pm revealed the following Focus .The resident has indwelling Foley Catheter. Date Initiated: 05/29/2025 .Revision on: 05/29/2025 .Goal .The resident will be/remain free from catheter -related trauma through review date. Date Initiated: 05/29/2025 . Target Date: 04/22/2025 .The resident will show no s/sx of Urinary infection through review date. Date Initiated: 05/29/2025 .Target Date: 04/22/2025. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a follow up interview with Corporate Regional Nurse on 5/29/25 at 3:25 pm they said they just updated and completed the care plan for Resident #13 because the indwelling urinary/foley catheter care plan was not there and should have been. They said MDS Coordinator A was responsible for care plans and updating and completing the resident care plans. The Corporate Regional Nurse did not know why Resident #13's indwelling urinary catheter had not been care planned and said it had been corrected after surveyor asked about the care plan earlier that same day. Observation of Resident #13 on 5/29/25 at 3:47 pm revealed he was seated in his wheelchair with an indwelling urinary catheter in place secured with leg strap anchor and privacy bag. The tubing was unkinked and draining clear yellow urine positioned below the kidneys to gravity. Resident #13 said he had the catheter inserted after a cardiac procedure because he was having trouble urinating and readmitted to the facility with it a couple of weeks ago. Resident #13 said he did not have an indwelling urinary catheter prior to his 5/15/25 hospitalization . Resident #13 said he had no care concerns regarding the catheter and was scheduled to have it removed or changed by a urologist on 6/4/25. Resident #57 Record review of Resident #57's face sheet dated 05/29/25 revealed a -[AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included Nontraumatic intracranial hemorrhage (Bleeding in the brain without Trauma) , tracheostomy status (asurgical procedure where a hole is created in the neck) chronic kidney disease, pressure ulcer of sacral region, essential hypertension (High blood Pressure), encephalopathy, retention of urine, gastrostomy status, generalized muscle weakness, cognitive communication (lack of communication), dysphagia (difficulty swallowing), type 2 diabetes mellitus (when the body cannot use insulin correctly and sugar builds up in the blood) chronic pain, chronic respiratory failure, shortness of breath and urinary tract infection. Record review of Resident #57's care plan dated 10/28/24 with a revision date of 02/09/25 revealed no evidence of a care plan for oxygen. Record review of physician orders dated May 2025 revealed an order for Oxygen at 2 liters per minutes. The start date was 02/16/25. Record review of Resident #57's Admission MDS dated [DATE] indicated Resident #57 was assessed as receiving oxygen therapy. Observation on 05/27/25 at 11:00AM revealed Resident #57 was in bed; she had a tracheostomy on and was on oxygen on at 2 liters per minutes via the tracheostomy tube. Attempt was made to communicate with Resident #57 but she did not answer. Observation revealed she was alert but not communicative. During an interview on 05/27/25 at 11:00AM LVN D said Resident was admitted with Oxygen and a trach. She said Resident #57 has been on oxygen therapy. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Corporate Regional Nurse, DON and MDS Coordinator on 5/29/25 at 1:00 pm, Tthe MDS coordinator said he was responsible for ensuring that all care plans reflected the resident's condition. He said he visits residents for observation and uses nurse's documentation to complete the care plan. He looked at the care plan and said nothing. MDS coordinator said Hhe would update Resident #57's care plan. The Cooperate Corporate nurse, DON and MDS Coordinator looked at Resident #57's care plan and acknowledged that Resident #57 was on continuous oxygen and it should have been care planned. MDS coordinator said an incorrect care plan might prevent the resident from receiving needed care and services. The Corporate nurse and the DON said an in correct care plan might affect the facility's payment. Record review of facility's policy Care Planning- Interdisciplinary Team revised March 2022 revealed The interdisciplinary team is responsible for the development of resident care plans. 2. Comprehensive person-centered care plans are based on resident assessments and developed by an interdisciplinary team (IDT).