STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675541	A. Building B. Wing	03/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cascades at Senior Rehab	8825 Lamplighter LN Port Arthur, TX 77642

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25115 Based on interview and record review, the facility failed to provide adequate supervision to prevent accidents for 1 of 14 residents (Resident #1) reviewed for accidents. The facility failed to ensure CNA D had assistance from another staff member during incontinent care on 01/13/24 which resulted in Resident #1 rolling off the bed and being transferred to the hospital where she was diagnosed with a small left anterior frontal scalp hematoma. The noncompliance was identified as PNC. The Immediate Jeopardy began on 01/13/24 and ended on 01/15/24. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk for falls resulting in injury, pain, and hospitalization . Findings included: Record review of Resident #1's face sheet dated 03/11/24 indicated she was a [AGE] year-old female admitted [DATE], and her diagnoses included quadriplegia (a symptom of paralysis that affects all a person's limbs and body from the neck down), gastrostomy (an opening into the stomach from the abdominal wall, made surgically for the introduction of food status, tracheostomy (a procedure to help air and oxygen reach the lungs by creating an opening into the trachea (windpipe) from outside the neck) status, and aphasia (loss of ability to understand or express speech, caused by brain damage). Record review of Resident #1's MDS assessment dated [DATE] indicated she was rarely/never understood, had severely impaired cognitive skills, and was totally dependent with two+ persons physical assist for bed mobility, transfers, and toilet use. Record review of Resident #1's care plan dated 05/23/22 (revised 05/09/23) indicated she was totally dependent on two staff for bed mobility, toilet-use, bathing/showering, dressing, and transfers. Record review of Resident #1's Kardex (electronic care task utilized by care staff) dated 03/11/24 indicated she was totally dependent on two staff for bed mobility, toilet-use, bathing/showering, dressing, and transfers. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's progress note dated 01/13/24 at 10:30 p.m., completed by LVN C, indicated CNA D approached the nurse station and requested assistance with Resident #1. CNA D stated Resident #1 had fallen on the floor. Resident #1 was lying face up, awake and alert, and responded to stimuli. There was a hematoma on the left side of her forehead. The physician, family member, DON, and Administrator (abuse coordinator) were notified. Resident #1 was transported to the hospital for evaluation and treatment. Record review of Resident #1's progress note dated 01/14/24 at 3:04 a.m., completed by RN E indicated hospital reported Resident #1 was stable. CT results were pending. Record review of Resident #1's progress note dated 01/14/24 at 4:33 a.m., completed by RN E indicated the hospital reported Resident #1's CT showed no irregularities and would be transported back to the facility. Record review of Resident #1's progress note dated 01/14/24 at 5:40 a.m., completed by RN E indicated Resident #1 returned to the facility. She had a slightly raised area to the middle left side of her forehead. Record review of Resident #'s hospital CT record dated 01/14/24 indicated a small left anterior frontal scalp hematoma. Record review of the facility's investigation report dated 01/16/24 indicated on 01/13/24 at 10:30 p.m., CNA D provided incontinent care to Resident #1 by herself. CNA D attempted to reposition Resident #1 in her bed. Resident #1 rolled off the bed and fell on to the floor. Resident #1 sustained a small hematoma to the left side of her forehead. Resident #1 was transferred to the hospital for treatment. Resident #1 returned to the facility on [DATE]. At 5:40 a.m. Resident #1's CT dated 01/14/24 indicated no irregularities. During an interview on 03/11/24 at 10:30 a.m., the Administrator said CNA D was providing incontinent care to Resident #1 without a second staff on 01/13/24. She said Resident #1 fell off the bed and sustained a small hematoma to the left side of her forehead. She said there was no reason for CNA D to provide Resident #1's incontinent care without a second staff. She said the facility was not short staffed. She said CNA D did not request assist for any of the other CNA on shift or any of the nurses on shift. She said it was her expectation CNA D and all staff would follow the care guide on Resident #1's Kardex. She said Resident #1 could have sustained a more serious injury. She said CNA D was suspended pending the facility's investigation. She said CNA D was trained during her orientation to provide care per Resident #1's Kardex care guide. She said CNA D and all staff were retrained on following resident care guide on 01/14/24 and 01/15/24. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 03/11/24 at 12:18 p.m., CNA D said she provided incontinent care to Resident #1 without a second staff to assist on 01/13/24. She said she did not see any available CNA to ask for assistance. She said she did not ask any of the nurses for assistance. She said she went to reposition Resident #1 in the bed and Resident #1 rolled off the bed on to the floor. She said she went to the nurse station to report the fall and get assistance to put Resident #1 in bed. She said LVN C assessed Resident #1 and checked for injuries. She said Resident #1 had a small bump and bruise on her left forehead area. She said Resident #1 was crying. She said EMS arrived at the facility and transported Resident #1 to the hospital. She said she was trained on the Kardex and resident care guide. She said she thought Resident #1 was a 1-person or a two-person assist. She said she was told by CNA E during her orientation that if she felt comfortable, she could do Resident #1's care by herself. She said she did not check the Kardex to verify Resident #1's level of care or assistance required for ADLS. During an interview on 03/11/24 at 2:03 p.m., CNA F said she was retrained to follow the Kardex resident care guide after Resident #1 fell off her bed on 01/13/24. She said she had performed Resident #1's incontinent care by herself and without staff second staff on previous occasions but Resident #1 had not fallen off the bed. She said CNA D did not ask other staff for assistance on 01/13/24. She said she did not know why CNA D had performed Resident #1's care without a second staff. She said CNA D said she was a new staff and did not feel comfortable without a second staff. She said there was other staff available to assist with Resident #1's care but CNA D had not asked anyone for assistance. During an interview on 03/13/24 at 10:30 a.m., the Administrator said all staff were trained on the Kardex during orientation. She said the Kardex was not specifically listed on the check-off list. She said it was added as a separate check off and skills packet to the orientation packet after Resident #1 fell from her bed on 01/13/24. During an interview on 03/13/24 at 10:30 a.m., the RNC said the facility started retraining staff on 01/14/24 and 01/15/24 to use the Kardex to ensure they provide the required level of care for each resident. She said all staff were retrained and passed a test and were able to access the Kardex and provide the required level of care. The surveyor attempted to contact LVN C for an interview on 03/11/24 1:29 p.m. She did not respond. The surveyor attempted to contact RN E for an interview on 03/11/24 at 1:31 p.m. She did not respond. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's Safety and Supervision of Residents policy dated 2001 (revised July 2017) indicated, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. 4. Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards, and try to prevent avoidable accidents. Individualized, Resident-Centered Approach to Safety 1. Our individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents. 3. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. Systems Approach to Safety 1. The facility-oriented and resident-oriented approaches to safety are used together to implement a systems approach to safety, which considers the hazards identified in the environment and individual resident risk factors, and then adjusts interventions accordingly. 2. Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment. On 03/13/24, the surveyor confirmed the facility implemented appropriate measures to ensure the safety of residents after the incident on 01/14/24-01/15/24 involving Resident #1 by: Observations of staff on 03/11/24 and 03/13/24 providing care indicated no observed concerns. During interviews on 03/11/24 from 9:30 a.m. through 4:00 p.m., and 03/13/24 from 9:30 a.m. through 2:20 p. m., 5 LVN's (on all shifts) 10 CNA's (on all shifts) and the ADON said they received training prior to the incident and after the incident on 01/13/24 from the DON and the RNC regarding resident abuse, neglect, rights and resident Kardex care levels. The nursing staff verbalized understanding of the trainings and were able to give examples of resident Kardex care levels, they would ask for assistance if required, they would report any non-compliance of care level to the Administrator, DON, or charge nurse. Interviews conducted on 03/11/24 and 03/13/24 with 3 residents who required 2 person assist with ADLS indicated they had no complaints or concerns with their care and always had two staff as required. They would report to the Administrator or the DON if staff attempted to provide care without a second staff. Record review of staff re-training dated 01/14/24 and 01/15/24 indicated all facility nursing staff were retrained on the residents' Kardex and level of care and continued to 3/07/24 with new hires. The facility tested and competency assessed all nursing staff for Kardex and level of care on 01/15/24. All nursing staff passed the test and check off skills for the Kardex and resident care system. Record review of the auditing and monitoring of three random residents and staff conducted by the Administrator and DON weekly from 01/14/24 through 03/13/24 indicated no additional issues or concerns related to resident care were identified. The facility retrained CNA D on 01/18/24, related to the Kardex, level of care and 2-person required for bed mobility for the Kardex system and to check for proper assist level. As of 03/13/24, the facility continued to randomly monitor 3 staff per week to ensure staff provide the required level of care. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of QAPI notes dated 01/2024 showed a meeting was held to discuss the incident with Resident #1 on 01/13/24. Members present included the Administrator, DON, Medical Director, MDS Coordinator, and ADON A and ADON B. The interventions and plan for correction included: retraining all CNAs and LVNs and new hires on 2-person assist and how to check the Kardex. Record review of the staff in-services dated 01/14/24 through 01/15/24 included: 2-person assist and how to check the Kardex. The noncompliance was identified as PNC. The Immediate Jeopardy began on 01/13/24 and ended on 01/15/24. The facility had corrected the noncompliance before the survey began.