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	04/16/2024

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47879 Based on observation, interview and record review, the facility failed to provide behavioral health services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for 1 of 6 residents (Resident #2) reviewed for behavioral health services. The facility failed to ensure Resident #2 received behavioral health services after returning to facility following an inpatient stay at behavioral health hospital for a resident-to-resident altercation with behavioral symptoms occurred. This failure could place residents at risk for not receiving behavioral health services and a decline in Quality of life. Findings Included: 1. Record review of Resident #2's face sheet dated 04/14/2024 indicated he was [AGE] years old, initially admitted on [DATE] and readmitted [DATE] after an admission to behavioral hospital following a resident-to-resident altercation. Resident #2 with newly onset (02/22/2024) diagnoses including Major Depressive Disorder (mental illness that negatively affects how you feel, the way you think and how you act), Impulse Disorder (a group of mental health disorders that involve problems with self-control), and Anxiety Disorder (persistent and excessive worry that interferes with daily activities). Record review of Resident #2's Quarterly MDS assessment dated [DATE] indicated he was cognitively intact, required moderate assistance for most ADLs, was occasionally incontinent of bowel and bladder, and had a right above the knee amputation and uses wheelchair for mobility. There were no behaviors, signs of delusions or rejection of care noted on the assessment. (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: 675541	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2024
NAME OF PROVIDER OR SUPPLIER Cascades at Senior Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 8825 Lamplighter LN Port Arthur, TX 77642	

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's care plan dated 06/30/2023 and revised on 07/26/2023 indicated he had impaired cognitive function/dementia or impaired thought process related to cognitive communication deficit. Interventions included: Administer medications as ordered. Monitor/document for side effects and effectiveness: Cue, reorient and supervise as needed; engage the resident in simple, structured activities that avoid overly demanding tasks; Keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. Monitor/document/report PRN any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status; present just one thought, idea, question or command at a time; and provide the resident with a homelike environment. No care plan indicating Resident #2's potential risk for aggression/behaviors. 2. Record review of Resident #3's face sheet dated 04/14/2024 indicated he was [AGE] years old, initially admitted on [DATE] with diagnoses including hemiplegia affecting left nondominant side (paralysis on left side), diabetes (chronic condition that affects the way the body processes blood sugar) and hypertension (condition in which the force of the blood against the artery walls is too high). Record review of Resident #3's Annual MDS assessment dated [DATE] indicated he was moderately impaired cognitively, required maximum assistance for most ADLs, was always incontinent of bowel and bladder, and uses wheelchair for mobility. There were no behaviors, signs of delusions or rejection of care noted on the assessment. Record review of resident #3's care plan dated 02/14/2024 indicated he had potential to be verbally aggressive, accused other resident of having his pajamas, curse words were exchanged between the two residents. Interventions included: analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document; assess resident's understanding of the situation, allow time for the resident to express self and feelings towards the situation; may order labs to rule out urinary tract infection or any abnormal lab level; residents separated from one another; and when the resident becomes agitated: intervene before agitation escalates; guide away from source of distress; engage calmly in conversation; if response is aggressive, staff to walk calmly away, and approach later. Record review of Resident #2's physician order dated 04/16/2024 indicated resident was taking Melatonin 5mg by mouth once a day for insomnia started on 02/27/2024 and Trazadone 100 mg 1 tablet by mouth one time a day for major depressive disorder started on 03/05/2024. No orders for behavioral monitoring were noted. Record review of Resident #2's progress note dated 02/14/2024 indicated that Resident #2 had a disagreement with Resident #3 about clothing that he had in his room. Resident #3 claimed the clothes belonged to him. Both Resident #2 and Resident #3 exchanged curse words in dining area. Maintenance staff came and separated the two residents. Resident #2 turned around and rolled toward Resident #3 with a fork in his hand. Again, maintenance separated the two residents and took fork from Resident #2. MD and RP notified of incident. ADON called Administrator and was advised to send out Resident #2 for behavior evaluation. Behavior monitoring has been initiated and both residents are in their rooms. (continued on next page)

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

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's progress note dated 02/14/2024 indicated that during incident/altercation Resident #2 made verbal statement that he would get Resident #3 later. During 1:1 monitoring, Resident #2 was discovered to have a pair of scissors in his possession, and they were removed. Record review of Resident #2's progress note dated 02/14/2024 at 8:51 p.m. indicated that Resident #2 was transported to behavioral health facility for evaluation. Record review of Resident #2's behavioral health hospital records discharge paperwork indicated the discharge date of [DATE] and follow up appointments included psychiatry services through nursing facility. Record review of Resident #2's progress note dated 02/23/2024 at 1:28 p.m. indicated that Resident #2 arrived back to facility from behavioral health facility. Resident #2 noted to be calm in his demeanor. Record review of Resident #2's electronic medical record did not reflect a psychiatric assessment or progress notes from 02/23/2024 to 04/16/2024 since his return to facility from behavior health hospital admission for aggressive behaviors. Record review of Resident #2's Task monitoring does not indicate that the facility has initiated behavior or mood monitoring since the resident-to-resident altercation on 02/14/2024 and/or since his return to facility on 02/23/2024. Record review of Resident #2's Social Workers psychosocial review dated 03/04/2024 indicated Assessment/ Observation - Mood: Pleasant and calm; Psychosocial Well-being: Resident was recently sent out to the behavior hospital due to an altercation with another resident. Resident is on facility psych services. Pt is a full code. Behavioral Concerns: Resident was admitted to behavioral hospital due to behaviors. During an observation on 04/10/2024 at 9:25 a.m., Resident #2 was sitting up in wheelchair in his room, listening to music and watching TV. No complaints at that time. During an interview on 04/10/2024 at 1:00 p.m., MNT B said that Resident #2 and Resident #3 were in the dining area on 02/14/2024 after lunch, and when he was passing by he heard the two residents having a verbal altercation and separated the two residents. He said when he turned around he noticed that Resident #2 had a fork in his hand and was rolling towards Resident #3 in an aggressive behavior., He said he removed the fork from Resident #2 before any physical contact was made and by that time several staff were present and Resident #2 and Resident #3 were taken to their rooms by staff and were monitored 1:1. MNT B said they were arguing over some pajama pants. Resident #3 thought that Resident #2 had his pajama pants. MNT B said he reported the incident to the CN, ADON, and Administrator immediately. MNT B said that during his time of employment at the facility he had not seen either Resident #2 or Resident #3 in an altercation or behave in that manner. MNT B said Resident #2 lost his cool because Resident #3 kept asking him and accusing him of stealing his pants. MNT B said that Resident #2 is usually very calm and quiet. (continued on next page)

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

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/15/2024 at 2:00 p.m., with MDS Coordinator, she said that she was aware of the altercation between Resident #2 and Resident #3. She said she was notified during a morning meeting or an IDT meeting. MDS Coordinator said Resident #2 should have been evaluated by psych services upon his return to the facility from behavioral health hospital and best practice would be for resident to be evaluated by psych services following altercation and return to facility. During an interview on 04/15/2024 at 2:15 p.m., with LVN C, she said that she was CN for Hall 400 and Hall 500 and was familiar with Resident #2 and Resident #3. She said she did not witness the altercation on 02/14/2024 because she was on break but it was reported to her and she was surprised that these two residents were involved especially Resident #2 because she had not witnessed him have any aggression or behavior during his stay at the facility. LVN C said she was assigned to provide 1:1 monitoring of Resident #2. She said that staff did find a pair of scissors on resident after the altercation, but he was very calm, ashamed, and appeared remorseful during the monitoring phase prior to transfer to behavioral health hospital. LVN C said he was calm and did not having any additional behaviors or aggression during monitoring. LVN C said that Resident #2 has not exhibited any aggression or behaviors during her shifts since he has returned from the behavioral hospital. During an interview on 04/10/2024 at 9:15 a.m., with Resident #3, he said that the altercation between him and Resident #2 was all a big mistake. He accused Resident #2 of having his pajamas and later found out that they were not his pajamas. Resident #3 said everything is good between him and Resident #2. He said they participate in activities together now. During an interview on 04/16/2024 at 10:00 a.m., with Resident #2, he said that he recalls the altercation between him and Resident #3. He said that he became irritated, agitated, and upset with Resident #3 because he kept accusing him of stealing his pajamas and he threatened to harm him. Resident #2 said that the treatment he received at the behavioral hospital helped him. He said he was remorseful for what he had done and that him and Resident #3 are now friends and participate in activities together. Resident #2 said that he gets upset and down at times because he lost his wife of [AGE] years last year. He said she lived at the facility also, but he is doing better now that he is getting rest and change in his medications. Resident #2 said he is pleased with the care provided by the facility and has no complaints. During an interview on 04/16/2024 at 1:00 p.m., the DON said Resident #2 had returned from behavior facility and has not had any aggression or behaviors but does acknowledge that Resident #2 should have received behavioral health services assessment with his readmission due to recent altered behavior. DON said that Resident #2 will be evaluated by behavioral health staff this week. DON said the resident not receiving a behavioral health assessment could potentially put resident at risk for having another altered behavior or put the resident's psychosocial well-being at risk. During an interview on 04/16/2024 at 11:15 a.m., the corporate nurse said Resident #2 returned to facility at his baseline behavior and behavioral hospital did not order resident to have psych services. Corporate nurse does acknowledge that best practice and for safety of other residents that Resident #2 should be assessed by behavioral health services for interventions if applicable. (continued on next page)

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Cascades at Senior Rehab	8825 Lamplighter LN Port Arthur, TX 77642

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy titled, Behavioral Assessment, Intervention and monitoring, dated revised March 2019, reflected, Policy Statement: The facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care . Behavioral health services will be provided by qualified staff who have the competencies and skills necessary to provide appropriate services to the residents .

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47879 Based on observation, interview, and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 4 of 12 residents (Resident #1, Resident #4, Resident #5, and Resident #6) reviewed for accuracy of medical records. The facility failed to document weekly wound assessment to Resident #1's inner left ankle trauma wound the week of [DATE]. The facility failed to document ordered wound care to Resident'#1's inner left ankle trauma wound on [DATE], [DATE], [DATE], [DATE] and [DATE]. The facility failed to document Resident #4, and Resident #5 wounds were assessed weekly, and care was performed as ordered. The facility failed to document weekly skin assessments to Resident #1, Resident #5, and Resident #6. This deficient practice could place residents at risk of having incomplete or inaccurate records and inadequate care. Findings included: 1. Record review of Resident #1's face sheet dated [DATE] indicated he was [AGE] years old, initially admitted on [DATE] and readmitted [DATE], with diagnoses including diabetes mellitus (chronic condition that affects the way the body processes blood sugar), cerebral infarction (lack of adequate blood supply to brain cells deprives them of oxygen and vital nutrients which can cause parts of the brain to die off), severe protein-calorie malnutrition (a nutritional status in which reduced availability of nutrients leads to change in body composition and function), atherosclerotic heart disease (condition where the blood vessels become narrowed and hardened due to buildup of fats in the blood vessel wall), hypertension (condition in which the force of the blood against the artery walls is too high), anemia (condition that develops when your blood produces lower than normal amount of healthy red blood cells), and local infection of the skin and subcutaneous tissue. Record review of Resident #1's Quarterly MDS assessment dated [DATE] indicated he was cognitively intact, required supervision for showering/bathing and was independent with other ADLs, was continent of bowel and bladder, and had a trauma wound to left inner ankle. The skin and ulcer/injury treatments section indicated Resident #1 was not on turning/repositioning program and did not have nutrition or hydration interventions to manage skin problems. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's care plan dated [DATE] and revised on [DATE] indicated he had potential for actual impairment to skin related to diabetes mellitus type 2. Resident #1 had an actual impairment to skin integrity related to trauma wound to left medial (inner) ankle. Interventions included: Avoid scratching and keep hands and body parts from excessive moisture, keep fingernails short, educate resident/family/caregivers of causative factors and measures to prevent skin injury, encourage good nutrition and hydration in order to promote healthier skin, enhanced barrier precautions - providers and staff must: put on gown & gloves before room entry and providing high-contact care activities such as: changing bed linens, changing briefs, and performing wound care. Identify/document potential causative factors and eliminate/resolve where possible. The care plan did not address assessment, care, and treatment to Resident'#1's left ankle trauma wound. Record review of Resident #1's physician order dated [DATE] indicated wound to left inner ankle: cleanse with normal saline, pat dry, paint with betadine and cover with dry dressing one time a day for wound management starting [DATE]. Record review of Resident #1's physician order dated [DATE] indicated wound care: left inner ankle:, cleanse with normal saline, pat dry, apply triple antibiotic ointment, Calcium Alginate, and cover with dry dressing, one time a day for wound management starting [DATE]. Record review of Resident #1's physician order dated [DATE] indicated wound: left inner ankle: cleanse with NS pat dry apply triple antibiotic ointment and cover with dry dressing one time a day every Tue, Thu, Sat for wound management starting [DATE]. Record review of Resident #1's TAR for [DATE] indicated the treatment order for left inner ankle dated [DATE] was to begin on [DATE] and continue daily. Staff did not e-sign the TAR to indicate the treatment to left inner ankle was completed on [DATE]. Record review of Resident #1's TAR for February 2024 indicated the treatment order for left inner ankle dated [DATE] was to begin on [DATE] and continue daily. Staff did not e-sign the TAR to indicate the treatment to left inner ankle was completed on [DATE] and [DATE]. Record review of Resident #1's TAR for [DATE] indicated the treatment order for left inner ankle dated [DATE] was to begin on [DATE] and continue daily. Staff did not e-sign the TAR to indicate the treatment to left inner ankle was completed on [DATE] and [DATE]. Record review of Resident #1's Nursing Weekly Wound Observation Tool dated [DATE] indicated he had a trauma wound to his left medial malleolus (inner ankle), which was acquired during facility stay, was 1.6 cm x 1.0 cm x 0 cm with 100% scab, overall impression indicated worsening, draining small amount of serosanguinous (yellowish with small parts of blood) drainage with no odor. The surrounding skin was intact with erythema (redness), blanchable (goes away by pressing) to touch. Indicated no infection or inflammation present. Record review of Resident #1's Nursing Weekly Wound Observation Tool indicated no weekly wound observation had been completed for week of [DATE]. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's Nursing Weekly Skin Review/assessment dated [DATE] indicated he had no new skin integrity problems. Skin condition: Skin warm and dry to touch. Scab to left medial ankle remains unchanged, surrounding skin remains intact, no drainage noted at this time. There are no signs of any skin tears or skin lesions at this time. Skin is fair in color. Record review of Resident #1's Nursing Weekly Skin Review/Assessment indicated no nursing weekly skin reviews/assessments were completed for the month of [DATE]. Record review of Resident #1's Nursing Weekly Skin Review/Assessment indicated he had no nursing weekly skin review/assessment for the week of [DATE]. Record review of Resident #1's Nursing Weekly Skin Review/Assessment indicated he had no nursing weekly skin review/assessment for the week of [DATE]. During an observation and interview on [DATE] at 1:45 p.m., Resident #1 was lying in bed. LVN A washed and sanitized hands, prepared wound care supplies on tray outside of room, cup of normal saline, cup with triple antibiotic ointment, gauze sponges, q-tips, and dressing. LVN A entered room with prepared tray, cleansed bedside table with wipe, placed barrier, and sat down tray. LVN A entered resident's restroom and washed and dried hands, applied gloves and gown for enhanced barrier precautions, explained procedure to resident, removed a dressing off the resident's left inner ankle, with moderate amount of serosanguinous drainage on old dressing, placed old dressing in small red bag. There was an opening the size of a dime on the inner ankle boney area, with slough (dead/shedding) tissue covering 90% of the wound, pink tissue noted to bottom of open wound area, slight redness noted to peri (around) wound. LVN A cleansed wound with normal saline soaked gauze, and dried with clean dry gauze, disposed of soiled bandage in small red bag, and removed gloves and washed hands and donned new gloves, and applied triple antibiotic ointment to wound site with q-tip, covered wound with dated and initialed dry dressing. The resident winced when care was provided. LVN A disposed of used supplies in red bag, removed gloves and gown and disposed in trash and removed trash bag from room upon departure. LVN A washed and sanitized hands. LVN A said Resident #1's wound had been cultured and he had received a round of antibiotics due to culture results. LVN A said that the wound care doctor visits with Resident #1 weekly for wound evaluation and treatment orders. LVN A said he provided wound care to Resident #1's trauma wound to left ankle Monday -Friday when scheduled and in his absence. LVN A said CN performs wound care or if the dressing comes off. LVN A said either may provide care. LVN A said Resident #1 has had the wound to his ankle since [DATE], when he hit his ankle on the bedside table. LVN A said staff have been providing care to wound, resident has diabetes, and was slower to heal. During an interview on [DATE] at 2:15 p.m., Resident #1 said that the staff was providing care to his wound on his left ankle daily he thinks but it changed recently to three times a week. Resident #1 said they have missed caring for his wound a few times, but it could have been because of him being out of his room or out of the facility. Resident #1 said he recently took antibiotics for his ankle wound, which was slow to heal because of his diabetes. Resident #1 said he recalls visiting with the wound doctor but does not think he visits weekly. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #4's face sheet dated [DATE] indicated he was 81years old, initially admitted on [DATE] with diagnoses including diabetes mellitus (chronic condition that affects the way the body processes blood sugar), hypertension (condition in which the force of the blood against the artery walls is too high), history of TIAs (short period of symptoms similar to those of a stroke), lack of coordination, muscle weakness, peripheral vascular disease (a blood circulation disorder that causes the blood vessels outside of the heart and brain to narrow, block, or spasm), adult failure to thrive, malnutrition (lack of proper nutrition, caused by not having enough to eat, not eating enough of the right things, or being unable to use the food that one does eat), and violent behaviors. Resident expired at the facility and was pronounced by hospice staff on [DATE]. Record review of Resident #4's Significant Change in status MDS assessment dated [DATE] indicated he was unable to complete the interview for BIMS, was able to make self-understood and understand others, required moderate to maximum assistance for ADLs and mobility, was always incontinent of bowel and bladder, and had a trauma wound to left inner ankle. The skin and ulcer/injury treatments section indicated Resident #4 was not on turning/repositioning program. Record review of Resident #4's care plan dated [DATE] indicated Resident #4 had multiple pressure injuries. Interventions included implement wound care protocol, weekly visits with facility wound care provider, weekly skin checks, turn/reposition, low air loss mattress. Record review of Resident #4's physician order dated [DATE] indicated wound treatment: apply betadine to discolored area to right hip daily, leave open to air one time a day for wound management starting date [DATE] and ending date [DATE]. Record review of Resident #4's physician order dated [DATE] indicated wound treatment: apply betadine to reddened area to left lateral (outer) heel daily, leave open to air one time a day for preventative starting date [DATE] and ending date [DATE]. Record review of Resident #4's physician order dated [DATE] indicated wound treatment: cleanse DTI (Deep Tissue Injury) to right heel with normal saline or wound cleanser, pat dry, apply betadine daily, leave open to air one time a day for wound management starting date [DATE] and ending date [DATE]. Record review of Resident #4's physician order dated [DATE] indicated wound treatment: sacrum (bony structure located at base of the lower back) cleanse with normal saline, pat dry, apply zinc cover with dry dressing daily and prn as needed for wound management and one time a day for Wound Management starting date [DATE] and ending date [DATE]. Record review of Resident #4's physician order dated [DATE] indicated wound treatment: left inner ankle cleanse with normal saline or wound cleanser pat dry, paint with betadine, leave open to air as needed for soiled or dislodged and one time a day for wound management starting date [DATE] and ending date [DATE]. Record review of Resident #4's physician order dated [DATE] indicated wound treatment: sacrum cleanse soap and water, apply barrier cream daily as needed for wound management and one time a day for wound management starting date [DATE] and no ending date identified. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #4's physician order dated [DATE] indicated wound treatment: L Heel Cleanse with normal saline or wound cleanser, pat dry, paint with betadine leave open to air, one time a day for wound management starting date [DATE] and no ending date identified. Record review of Resident #4's physician order dated [DATE] indicated wound treatment: R Heel Cleanse with normal saline or wound cleanser, pat dry, paint with betadine cover with pad, apply rolled gauze and secure as needed for Soiled or dislodged and one time a day every Tue, Thu, Sat for wound management starting date [DATE] and no ending date identified. Record review of Resident #4's electronical medical records indicated no nursing weekly wound observation tool was completed for the week of [DATE]. Record review of Resident #4's TAR for [DATE] indicated the treatment order for right hip dated [DATE] and continue daily until [DATE]. Staff did not e-sign the TAR to indicate the treatment was completed on [DATE] and [DATE] to right hip. Treatment order for left lateral heel dated [DATE] and continue daily until [DATE]. Staff did not e-sign the TAR to indicate the treatment was completed on [DATE] and [DATE] to left lateral heel. Treatment order for right heel dated [DATE] and continue daily until [DATE]. Staff did not e-sign the TAR to indicate the treatment was completed on [DATE] and [DATE] to right heel. Record review of Resident #4's TAR for [DATE] indicated the treatment order for sacrum dated [DATE] was to begin on [DATE] and continue daily until [DATE]. Staff did not e-sign the TAR to indicate the treatment was completed on [DATE] and [DATE] to sacrum. Record review of Resident #4's TAR for February 2024 indicated the treatment order for left inner ankle dated [DATE] was to begin on [DATE] and continue daily until [DATE]. Staff did not e-sign the TAR to indicate the treatment was completed on [DATE], [DATE]. [DATE], [DATE], [DATE] and [DATE] to left inner ankle. Record review of Resident #4's TAR for [DATE] indicated the treatment order for left inner ankle dated [DATE] was to begin on [DATE] and continue daily until [DATE]. Staff did not e-sign the TAR to indicate the treatment was completed on [DATE], [DATE], [DATE], [DATE], and [DATE] to left inner ankle. Treatment order for sacrum dated [DATE] and continue daily. Staff did not e-sign the TAR to indicate the treatment was completed on [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE] to sacrum. Treatment order for left heel dated [DATE] and continue daily. Staff did not e-sign the TAR to indicate the treatment was completed on [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE] to left heel. Treatment order for right heel dated [DATE] and continue every Tues, Thurs, and Sat. Staff did not e-sign the TAR to indicate the treatment was completed on [DATE] and [DATE] to right heel. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675541	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2024
NAME OF PROVIDER OR SUPPLIER Cascades at Senior Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 8825 Lamplighter LN Port Arthur, TX 77642	

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 02:40 p.m., LVN A said he was the facility treatment nurse. He said he was responsible for the wound care/treatment for all pressure ulcer, trauma wounds and surgical wounds Monday thru Friday and the charge nurses were responsible for wound care on the weekends. LVN A states that the CN provides simple wound care (skin tears, abrasions). LVN A said he currently performs all the skin assessments weekly on scheduled days. LVN A said that the charge nurses are responsible to provide wound care and skin assessments during his absence. LVN A said the wound care doctor visits the facility weekly and assesses residents assigned to his schedule. LVN A said he was usually the nurse that makes rounds with the wound care doctor during his facility visits. LVN A said that he remembers Resident #4, and he recalls providing wound care and skin assessments to Resident #4's multiple wounds. He said that Resident #4 had been a resident of the facility for years. He said at the end of last year Resident #4 stopped eating and drinking and seemed to have given up. LVN A said the facility, facility wound care doctor and attending MD/NP tried to intervene and provide needed care, but family decided to place Resident #4 on hospice services due to his declining status. LVN A said his wound deteriorated due to his decrease in nutritional intake and systems failing. LVN A said he provided wound care and skin assessments to Resident #4 as ordered when he was working. He said maybe he forgot to sign in the electronic medical record that treatment was provided and complete skin assessments. 3. Record review of Resident #5's face sheet dated [DATE] indicated he was [AGE] years old, initially admitted on [DATE], with diagnoses including pressure ulcer of buttock stage 3 (wound caused from pressure involving full thickness tissue loss), morbid (severe) obesity due to excess calories (severely overweight), cognitive communication deficit (trouble reasoning and making decisions while communicating), contracture of muscle, dysphagia (difficulty swallowing), hemiplegia (paralysis of one side of body) and hemiparesis (weakness of one side of the body) following stoke. Record review of Resident #5's Quarterly MDS assessment dated [DATE] indicated he was cognitively intact, required maximum assistance with ADLs and mobility, and was always incontinent of bowel and bladder. The skin and ulcer/injury treatments section indicated Resident #5 was not on turning/repositioning program. Record review of Resident #5's care plan dated [DATE] and revised on [DATE] indicated he had actual impairment to skin integrity of the left buttocks, stage 3, Interventions included: Administer supplements as ordered, avoid scratching and keep hands and body parts from excessive moisture, keep fingernails short, cleanse pressure and dress pressure wound per order, educate resident/family/caregivers of causative factors and measures to prevent skin injury, encourage good nutrition and hydration in order to promote healthier skin, enhanced barrier precautions - providers and staff must: put on gown & gloves before room entry and providing high-contact care activities such as: changing bed linens, changing briefs, and performing wound care, identify/document potential causative factors and eliminate/resolve where possible, ensure air mattress is at appropriate settings, monitor/document location, size and treatment of skin injury, report abnormalities, failure to heal, sign and symptoms of infection, maceration (softening and breaking down of skin resulting from prolonged exposure to moisture), etc to MD, resident will have weekly visits with the wound care physician and weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate (drainage) and any other notable changes or observations. (continued on next page)

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

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #5's physician order dated [DATE] indicated wound: Cleanse Stage 3 pressure wound to left buttock with wound cleanser, pat dry, cut calcium alginate into a strip and apply triple antibiotic ointment to calcium alginate and apply into wound tunneling at 6 o'clock and the remainder of calcium alginate onto wound bed, cover with dressing, change daily and PRN. one time a day for wound management starting date [DATE] and ending date [DATE]. Record review of Resident #5's TAR for [DATE] indicated the treatment order for stage 3 left buttock pressure ulcer dated [DATE] and continue daily until [DATE]. Staff did not e-sign the TAR to indicate the treatment was completed on [DATE] to left buttock. Record review of Resident #5's TAR for February 2024 indicated the treatment order for stage 3 left buttock pressure ulcer dated [DATE] and continue daily until [DATE]. Staff did not e-sign the TAR to indicate the treatment was completed on [DATE] and [DATE] to left buttock. Record review of Resident #5's TAR for [DATE] indicated the treatment order for stage 3 left buttock pressure ulcer dated [DATE] and continue daily until [DATE]. Staff did not e-sign the TAR to indicate the treatment was completed on [DATE] and [DATE] to left buttock. Record review of Resident #5's electronical medical records indicated no nursing weekly wound observation tool was completed for the week of [DATE]. Record review of Resident #5's electronical medical records indicated no nursing weekly skin reviews/assessments was completed for the month of [DATE]. Record review of Resident #5's electronical medical records indicated no nursing weekly skin reviews/assessments was completed week of [DATE]. Record review of Resident #5's electronical medical records indicated no nursing weekly skin reviews/assessments was completed week of [DATE]. Record review of Resident #5's electronical medical records indicated no nursing weekly skin reviews/assessments was completed week of [DATE]. Unable to observe Resident #5's pressure ulcer due to resident would not consent for the surveyor to observe wound care and wounds, provided a flexible schedule for observation and resident continued to deny allowing surveyor to observe. During an interview on [DATE] at 2:15 p.m., Resident #5 said that the staff was providing care to his wound on his buttocks daily prior to getting him out of bed. Resident #5 says he guesses the staff assessed his wound before he applied dressing but was not sure, he said that staff does inform him of the progression of the wound. Resident #5 said he recalls visiting with the wound doctor but does not think he visits weekly. (continued on next page)

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a group interview on [DATE] at 9:00 a.m., CNAs (CNA E, CNA F, CNA G, CNA H) providing care to Resident #5, said that treatment nurse or charge nurse provides care to Resident #5's wound to buttock prior to him getting out of bed, up to wheelchair. CNAs said that they know to notify the treatment nurse or charge nurse before getting him up each morning so wound care can be done because he does not like to be put back to bed after getting up for the day. CNAs said that wound care is provided daily, none recall days that wound care was missed or not performed by nurse. 4. Record review of Resident #6's face sheet dated [DATE] indicated she was [AGE] years old, initially admitted on [DATE] and readmitted on [DATE], with diagnoses including neurocognitive disorder with lewy bodies (condition affecting the brain region involved in thinking, memory and movement), hypertension (condition in which the force of the blood against the artery walls is too high), protein-calorie malnutrition (a nutritional status in which reduced availability of nutrients leads to change in body composition and function), neuromuscular dysfunction of bladder (when a person lacks bladder control due to brain, spinal cord or nerve problems), Alzheimer's disease (progressive disease that destroys memory and other important mental functions), chronic diastolic heart failure (a condition in which the heart's main pumping chamber (left ventricle) becomes stiff and unable to fill properly) and history of falls. Record review of Resident #6's Quarterly MDS assessment dated [DATE] indicated she was severely impaired cognitively, required maximum to moderate assistance with ADLs and mobility, was frequently incontinent of bowel and resident had a catheter. The skin and ulcer/injury treatments section indicated Resident #6 was not on turning/repositioning program and did not have nutrition or hydration interventions to manage skin problems. Record review of Resident #6's care plan dated [DATE] indicated she had potential for skin integrity related to intermittent incontinence, thin/fragile skin. Interventions included: Assist with transfers to prevent hitting extremities on surroundings, follow facility policies/protocols for the prevention/treatment of skin breakdown, and monitor nutritional status. Serve diet as ordered, monitor intake and record. Record review of Resident #6's electronical medical records indicated no nursing weekly skin reviews/assessments was completed for the month of [DATE]. Record review of Resident #6's electronical medical records indicated no nursing weekly skin reviews/assessments was completed week of [DATE]. Record review of Resident #6's electronical medical records indicated no nursing weekly skin reviews/assessments was completed week of [DATE]. Record review of Resident #6's electronical medical records indicated no nursing weekly skin reviews/assessments was completed week of [DATE]. (continued on next page)

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

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 02:40 p.m., LVN A said he was the facility treatment nurse. He said he was responsible for the wound care/treatment for all pressure ulcer, trauma wounds and surgical wounds Monday thru Friday and the charge nurses was responsible for wound care on the weekends. LVN A states that the CN provides simple wound care (skin tears, abrasions). LVN A said he currently performs all the skin assessments weekly on scheduled days. LVN A said that the charge nurses are responsible to provide wound care and skin assessments during his absence. LVN A said wound care doctor visits facility weekly and assesses residents assigned to his schedule. LVN A said that he has provided wound care to Resident #1, #4, #5 as ordered when he was the treatment nurse. LVN A said he does Resident #5's wound care prior to him getting up in his wheelchair each day. LVN A said CNAs and/ or CN helps him due to resident's size. LVN A said he must have forgot to sign that treatment was provided in the electronic medical record. LVN A said he performed the wound assessments on Resident # 1, #4, and #5 and skin assessments on Resident #1, #4, #5 and #6 but failed to document them in the electronic medical records. During an interview on [DATE] at 2:15 p.m. LVN C said that the treatment nurse provides wound care to pressure ulcers, surgical wounds, trauma wounds, usually all the wounds that are assessed by the facility wound care doctor, during the week. LVN C says that she provides the wound care when she works the weekends or if the treatment nurse was not there. LVN C says she reviews orders, collects supplies, uses enhanced barrier precautions now, and provide ordered care. She said the dressing should be dated and initialed, and the treatment should be signed off on the TAR. LVN C said if wound care was not signed off on the TAR it could not be proved the wound care was performed as ordered. LVN C said that the treatment nurse performed the weekly skin assessments for Resident #1, #4, #5, and #6. During an interview on [DATE] at 3:15 p.m. LVN D said that the treatment nurse performed the weekly skin assessments, and he provides wound care during the week. LVN D says that she provides the wound care when she works the weekends or if the treatment nurse not here. LVN D says she reviews orders, and provides wound care as ordered and the treatment should be signed off on the TAR. LVN D said that the treatment nurse performed the weekly skin assessments for Resident #1, #4, #5, and #6. During an interview on [DATE] at 1:00 p.m., the DON said that during a quality monitoring survey in February 2024, a system failure had been identified that treatment nurse (LVN A) and other staff were not completing the wound and skin assessments weekly per facility policy. She said she began monitoring the skin and wound assessments daily to assure they were completed in the electronic medical record. She said that the electronic medical records system identifies all uncompleted tasks in red, and she was reviewing these daily. She said she has now identified during current survey that some of the skin and wound assessments assigned to treatment nurse (LVN A) had been deactivated and were not showing up on the uncompleted task report that she was reviewing. DON said that she had removed the access to deactivate tasks in the electronic medical record from all staff members except herself, corporate regional nurse and one back up management person. DON said that she will begin training staff and will be changing the weekly skin assessment task to the CN and assigning them on a shower/bath day so that CN can perform assessment during those times when applicable and will have assistance from CNA if needed. DON said that the weekly wound assessment will be assigned to the treatment nurse. DON said that skin assessments and wound care assessments should be completed weekly, and wound care should be provided as ordered and documented by facility staff on the TAR when completed. DON said these assessment and care not being provided could cause new development or worsening of existing wounds, pain, and infection. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy Prevention of Pressure Injuries indicated Assess the resident on admission (within eight hours) for existing pressure injury risk factors. Repeat the risk assessment weekly and upon any changes in condition. In addition, each resident's skin should be assessed during direct care procedures for changes in skin integrity. Review of the facility policy Wound Care indicated The following information should be recorded in the resident's medical record: the type of wound care given; date and time the wound care was given; position in which the resident was placed; name and title of the individual performing the wound care; any change in the resident's condition; all assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound; how the resident tolerated the procedure; any problems or complaints made by the resident related to the procedure; if the resident refused the treatment and the reason(s) why; and the signature and title of the person recording the data.