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	05/15/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 32217 Based on observations, interviews, and record review, the facility failed to consult with the resident's physician when there was a need to alter treatment for 2 of 24 residents (Residents #68 and #71) reviewed for notification of changes. The facility failed to ensure the physician was notified of a change in condition when Resident #68's blood pressure was SBP>160, and DBP>90. (Systolic blood pressure refers to the amount of pressure experienced by the arteries while the heart is beating. Diastolic blood pressure refers to the amount of pressure in the arteries while the heart is resting in between heartbeats) The facility failed to ensure the physician was consulted regarding holding Resident #71's medication when vital signs were outside the prescribed parameters. This failure could place residents at risk of not receiving appropriate medical treatments, which could result in severe illness or hospitalization . Findings included: 1. Record review of face sheet dated 05/15/24 indicated Resident #68 was a [AGE] year-old female admitted on [DATE] with diagnoses of stroke, schizoaffective disorder (combination mental health condition), and seizures. Record review of Resident #68's physician orders dated 05/15/24 included orders for: -clonidine tablet 0.1 mg (clonidine HCl) give 1 tablet by mouth every 4 hours as needed for blood pressure (systolic/diastolic - SBP/DBP) SBP>160 DBP>90; Record review of the quarterly MDS assessment dated [DATE] indicated Resident #68 with a BIMS score of 10 (moderate cognition impairment) and required moderate assistance from staff with toileting hygiene and showering. Record review of the care plan dated 04/20/24 indicated Resident #68 had hypertension and interventions included to give anti-hypertensive medications as ordered and to monitor for side effects such as orthostatic hypotension and increased heart rate (tachycardia) and effectiveness. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #68's MAR dated May 2024 indicated she was administered clonidine 0.1 mg for blood pressure results outside of the parameters. There was no mention of the physician being notified of the resident's BP being outside of the parameters on the following days listed: 05/01/24 BP was 125/94; 05/02/24 BP was 140/100; 05/04/24 BP was 156/110; 05/05/24 BP was 159/101; 05/08/24 BP was 138/99; 05/09/24 BP was 161/114; 05/13/24 BP was 173/114; 05/14/24 BP was 143/114; and 05/15/24 BP was 159/100. Record review of Resident #68's nurse's notes indicated no physician notification from May 1 to May 15. During an interview on 05/15/24 at 11:45 a.m., LVN N said Resident #68's physician was not notified of the resident's BPs being outside of the parameters on the days the resident was given clonidine in May. She said over the last 3 days, Resident #68 blood pressure was elevated every morning. She said she was responsible for calling the physician when a change happened and normally it would be placed on the 24-hour report. LVN N said she had not placed it on the 24-hour report for Resident #68. She said when the BP was being elevated for 3 days in a row the physician should have been notified in case, he wanted to change medication or doses. During an interview on 05/15/24 at 11:50 a.m., the DON said her expectation was for the nurse to notify the resident's physician when there was a change of condition or when the vital signs were not within normal limits. 2. Record review of physician orders dated May 2024 indicated Resident #71, admitted [DATE], was a [AGE] year-old female with a diagnosis including essential hypertension (high blood pressure). Resident #71 was prescribed metoprolol tartrate - give 12.5 mg by mouth twice daily for hypertension. Hold for SBP below 100 or DBP below 60 or pulse below 60. (Systolic blood pressure refers to the amount of pressure experienced by the arteries while the heart is beating. Diastolic blood pressure refers to the amount of pressure in the arteries while the heart is resting in between heartbeats) Record review of the quarterly MDS assessment dated [DATE] indicated Resident #71 had a BIMS score of 15 which indicated cognition was intact. She had a diagnosis of hypertension and heart failure. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #71's care plan revised on 04/24/24 indicated the resident had diagnosis of hypertension. The interventions included give antihypertensive medication as ordered by physician and to monitor/document for side effects and effectiveness. Review of the May 2024 MAR indicated on the following dates and times, Resident #71's metoprolol tartrate 12.5 mg was held when the pulse was less than the prescribed parameters: 05/11/24 at 8:00 a.m., pulse was 48; 05/11/24 at 5:00 p.m., pulse was 46; 05/12/24 at 8:00 a.m., pulse was 52; 05/13/24 at 5:00 p.m., pulse was 50; and 05/14/24 at 8:00 a.m., pulse was 51. Review of Nurse Progress notes (05/02/24 - 05/15/24) gave no indication the physician had been consulted regarding Resident #71's metoprolol being held. During an interview on 05/15/24 at 11:45 a.m., LVN N said Resident #71's physician was not notified of the Metoprolol being held when the HR was outside of the parameters. She said nurses were responsible for calling the physician when a change happened and normally it would be placed on the 24-hour report . During an interview on 05/15/24 at 11:50 a.m., the DON said her expectation was for the nurse to notify the resident's physician when there was a change of condition or when the vital signs were not within normal limits. During an interview and record review on 05/15/24 at 1:15 p.m., ADON A reviewed Resident #71's May 2024 MAR and Nurse Progress notes with this surveyor. ADON A said the nurses documented the metoprolol on the electronic MAR as not administered on the above dates and times. He said his expectations were for the nurses to consult physicians when medications were held for 2 consecutive occasions. Review of Nurse Progress notes (05/02/24 - 05/15/24) gave no indication the physician had been consulted regarding Resident #71's metoprolol being held. This failure could place residents at risk of not receiving appropriate medical treatments, which could result in severe illness or hospitalization . The undated policy Medication Therapy indicated . The Physician will identify situations where medications should be tapered, discontinued, or changed to another medication, for example: . A). When a medication is being given in excessive doses, for excessive periods of time, without adequate monitoring, or in the absence of a valid clinical rationale. B) When the results of ongoing assessment, or the presence of clinically significant adverse consequences monitoring, suggest that a medication should be reduced or discontinued entirely 33460

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32217 Based on observation, interview and record review, the facility failed to ensure the rights of residents to be free from abuse or neglect for 2 of 18 residents reviewed for abuse or neglect. (Residents #s 16 and 28) The facility failed to ensure Resident #16 was free from verbal abuse by a staff member. The facility failed to ensure Resident #28 was free from physical abuse when his roommate grabbed his arm causing redness. The failure could place residents at risk for abuse/neglect, humiliation, intimidation, fear, shame, agitation, and decreased quality of life. Findings included: 1. Record review of a face sheet dated 05/13/24 indicated Resident #16 was a [AGE] year-old female, admitted [DATE]. Her diagnosis included schizoaffective disorder. (A mental health disorder that is marked by a combination of schizophrenia symptoms such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania) Review of a quarterly MDS assessment dated [DATE] indicated Resident #16 had a BIMS of 15 indicating cognition was intact. No behaviors were noted which affected others. Resident #16 was independent with dressing and personal hygiene. Record review of care plan dated 04/20/24 indicated Resident #16 was at risk for a behavior problem related to schizoaffective disorder. Interventions included caregivers to provide opportunity for positive interaction and attention and to stop and talk with her when passing by. Record review of Resident #16's Nurse Progress Notes indicated LVN Q documented incident 05/08/24 at 7:09 p.m. upon being notified by CNA C. During an interview on 05/14/24 at 2:00 p.m., Resident #16 said CNA D had cursed her and called her fat and stinky. She said she was trying to use the facility phone to call her family when CNA D unplugged the facility phone and would not let her use it and told her that she did not need to be calling anyone. Resident #16 said the aide was rude to her. She denied being afraid of staff or other residents in the facility. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 05/15/24 at 11:00 a.m., CNA C said she was in a resident's room when she heard loud voices. She looked out the door and CNA D was yelling at Resident #16 and telling her You're not going to use this damn phone to call nobody - do that shit in the daytime. Resident #16 told CNA D she could use the phone anytime and this was her home. CNA D said, you need to shower, you stinky bitch. She said she told CNA D that she could not talk to the resident like that, and asked her would she want someone talking to her mother like that? She said CNA D then said f . it and walked away. She said CNA D had disconnected the facility phone from the wall and would not let Resident #16 use the phone. CNA C said she then reconnected the facility phone and Resident #16 then called her family member. CNA C said she immediately reported the incident to the LVN Q. CNA C said the facility provided in-services following the incident with topics including abuse/neglect and reporting to abuse coordinator. During a phone interview on 05/15/24 at 12:00 p.m., CNA D said Resident #16 was holding a food pamphlet in her hand and wanted to use the facility phone. She said she told the resident it was too late to place a food order. She said Resident #16 then told her Don't worry about me or what I'm doing. CNA D said the resident started cursing her and said she was going to call 911. She said Resident #16 dialed 911 and yelled help me, help me and CNA D then hung up the phone and disconnected it from the wall so resident would not call 911. CNA D said she was suspended pending an investigation. State surveyor asked CNA D if the 911 operator returned a call after the hangup and she stated, well I'm not sure if she dialed 911 but I did see her dial a 9 and a 1 and she started yelling for help. During an interview on 05/15/24 at 11:25 a.m., the DON said she expected staff to contact the Abuse Coordinator or herself immediately for any suspected or actual abuse or neglect. She said any allegations of abuse/neglect were profoundly serious and were not to be taken lightly. The DON said she did not know why CNA D did not just let the resident use the phone in the first place. The DON suspended CNA D pending an investigation and then terminated the CNA on 05/10/24. She said the facility could not take a chance on the probability of a repeat incident such as this and felt best to terminate CNA D. During an interview on 05/15/24 at 1:30 p.m., the Administrator said her expectations were for the residents to be free of abuse of any kind in their home. The Administrator said following an investigation, the allegation of Abuse was confirmed. CNA D was terminated the following day. The Administrator said she had made a referral regarding CNA D's certificate. Record review of CNA D's personnel file indicated she was a rehire to the facility on [DATE]. Documentation included on-hire orientation training including abuse and neglect. Disciplinary action included suspension following this incident which CAN D declined to sign. During a phone interview on 5/16/24 at 2:00 p.m., LVN Q said CNA C informed him of verbal conflict between Resident #16 and CNA D on 05/08/24 at 9:50 p.m. He said he spoke with CNA D and Resident #16 immediately after CNA C told him of the incident. Resident #16 told him CNA D was mean to her and would not let her use the facility phone. Resident #16 said CNA D told her she was fat and stinky. LVN Q said Resident #16 was always nice and calm with no behaviors. CNA D was allowed to continue to work. LVN Q said CNA C was also on the secure unit with CNA D. He said CNA C attended Resident #16 throughout the shift while CNA D attended to other residents. He said he had training on abuse, neglect, and reporting timely. He said he wrote out a statement of the incident and stated,it totally slipped my mind to report to Abuse Coordinator until end of shift. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of a face sheet dated 4/22/2024 indicated Resident #28 was an 85-years-old male, admitted to the facility on [DATE]. His diagnoses included Alzheimer's, dementia, and anxiety. Record review of an annual MDS assessment dated [DATE] indicated Resident #28 had a BIMS of 04 (severely impaired cognition) and no behaviors were noted which affected others. Resident #28 required substantial/maximal assistance with 1 staff member for transfer and grooming. Record review of the care plan for Resident #28 dated 05/02/24 indicated He received physical aggression-r/t his roommate having increased agitation. The goal indicated the bruise to his right arm would resolve over the next 90 days. The care plan interventions for Resident #28 included: * Abuse and Neglect In-services in place for Staff; o Complete head to toe assessment-initiated post incident; o Monitor/document/report PRN any s/sx of Pain; o Psychiatric consult as indicated; and o RP and Hospice notified. Record review of Resident #28's progress note dated 05/02/24 at 6:30 pm indicated LVN M charted that the SN heard Resident #28 call out, What are you doing? She entered the resident's room and observed Resident #28 lying in his bed and his roommate standing over him with his hands gripping this resident's right forearm. Staff x2 separated Resident #28 from the roommate without difficulty. Resident #28 was assessed and there was noted redness to his right forearm. During an observation and interview on 05/13/24 at 11:00 a.m., Resident # 28 's right arm had no visible injuries and he said he had never had problems with anyone here. Record review of a face sheet dated 05/14/24 indicated Resident #72 was a [AGE] year-old male, admitted to the facility on [DATE]. His diagnoses included Alzheimer's (progressive disease that destroys memory), dementia (loss of memory) and altered mental status (change in brain function). Record review of an annual MDS assessment dated [DATE] indicated Resident #72 had a BIMS of 03 (severely impaired cognition), no behaviors were noted which affected others. Resident #72 required substantial/maximal assist with 1 staff for transfer and grooming. Record review care plan dated 05/02/24 indicated Resident #72 had limited physical mobility r/t weakness. Resident #72 was at times physically aggressive by being combative with staff, being non-compliant when re-directed, agitated, and grabbing his roommate's right forearm and leaning himself into the other resident's arm r/t dementia. Record review of a progress note dated 05/02/24 at 6:30 p.m., indicated Resident #72 was standing by his roommate's bed and had grabbed roommate's right arm and was leaning over roommate's right arm. The staff had to remove the hands of Resident #72 from gripping the roommate's right forearm and separated the residents. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the resident roster dated 05/13/24 indicated Resident #72 was at a behavior hospital . During an interview on 05/14/24 at 9:43 a.m., the CNA L said Resident #72 was standing beside Resident #28's bed and tightly and aggressively holding Resident #28's forearm. She said we had to remove him from holding Resident #28's right forearm. During an interview on 05/14/24 at 9:45 a.m., LVN M said she and nurse aide separated the residents after Resident had called out what are you doing. She said Resident #72 had both of his hands on Resident #28's forearm. Resident #72 was leaning down on Resident #28's arm. LVN M said there was some redness to Resident #28's forearm near the wrist. She said I reported it to the ADON, and he monitored Resident 72 while she did the paperwork for transfer. During an interview on 5/15/24 at 10:15 a.m., ADON A said he monitored Resident #72 one on one and moved him to another room until he was sent to the local hospital. ADON A said when Resident #72 returned from the hospital orders were noted to place Resident #72 in private room without one-on-one monitoring. ADON A said the next day Resident #72 was sent to the behavioral hospital and he was still at the behavioral hospital being treated. He said there were indentations on Resident #28's forearm and redness but skin was intact. He said he instructed the nurse to report the incident to the abuse prevention coordinator. During an interview on 5/15/24 at 10:25 a.m., the DON said any allegation of abuse should be reported within 2 hours. She said the policy indicated resident abuse would need to be reported by the abuse coordinator. The DON said she felt this incident was an allegation of abuse and needed to be reported . Record review of the Abuse, Neglect, Exploitation and Misappropriation Prevention Program dated April 2021 indicated Policy Statement Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to facility staff; other residents; consultants; volunteers; staff from other agencies; family members; legal representatives; friends; visitors; and/or any other individual. Develop and implement policies and protocols to prevent and identify abuse or mistreatment of residents; neglect of residents; and/or theft, exploitation or misappropriation of resident property. Record review of the facility's Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating dated September 2022 indicated Policy Statement All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/ misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulation) and investigated thoroughly investigated by facility management. Findings of all investigations are documented and reported. 3. Immediately is defined as: a. within two hours of an allegation involving abuse or results in serious bodily injury or within 24 hours that does not involve abuse or results in serious bodily injury. 33460

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32217 Based on interview and record review the facility failed to implement their written policies and procedures to prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property for 3 of 18 residents (Resident #s 16, 28 and 72) reviewed for abuse. The facility failed to ensure Resident #16 was free from verbal abuse from CNA A. The facility failed to ensure Resident #28 was free from physical agression. The facility failed to ensure Resident #72 was free from physical aggression from Resident #72 who grabbed his arm while standing over him resulting in redness to his forearm. This failure could place residents at risk of abuse, physical harm, mental anguish, and emotional distress. Findings included: Record review of the Abuse, Neglect, Exploitation and Misappropriation Prevention Program dated April 2021 indicated Policy Statement Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to facility staff; other residents; consultants; volunteers; staff from other agencies; family members; legal representatives; friends; visitors; and/or any other individual. Develop and implement policies and protocols to prevent and identify abuse or mistreatment of residents; neglect of residents; and/or theft, exploitation or misappropriation of resident property. Record review of the facility's Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating dated September 2022 indicated Policy Statement All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/ misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulation) and investigated thoroughly investigated by facility management. Findings of all investigations are documented and reported. 3. Immediately is defined as: a. within two hours of an allegation involving abuse or results in serious bodily injury or within 24 hours that does not involve abuse or results in serious bodily injury. 1. Record review of a face sheet dated 05/13/24 indicated Resident #16 was a [AGE] year-old female, admitted [DATE]. Her diagnosis included schizoaffective disorder. (A mental health disorder that is marked by a combination of schizophrenia symptoms such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania) Review of a quarterly MDS assessment dated [DATE] indicated Resident #16 had a BIMS of 15 and cognition was intact. No behaviors were noted which affected others. Resident #16 was independent with dressing and personal hygiene. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of care plan dated 04/20/24 indicated Resident #16 was at risk for a behavior problem related to schizoaffective disorder. Interventions included caregivers to provide opportunity for positive interaction and attention. Stop and talk with her when passing by. Record review of Resident #16's Nurse Progress Notes indicated LVN Q documented incident 05/09/24 at 9:09 p.m. upon being notified by CNA C. During an interview on 05/14/24 at 2:00 p.m., Resident #16 said CNA D had cursed her and called her fat and stinky. She said she was trying to use the facility phone to call her family and CNA D unplugged the facility phone and would not let her use it and told her that she did not need to be calling anyone. Resident #16 said the aide was rude to her. She denied being afraid of staff or other residents in the facility. During a phone interview on 05/15/24 at 11:00 a.m., CNA C said she was in a resident's room when she heard loud voices. She looked out the door and CNA D was yelling at Resident #16 and telling her You're not going to use this damn phone to call nobody - do that shit in the daytime. Resident #16 told CNA D she could use the phone anytime and this was her home. CNA D said, you need to shower, you stinky bitch. She said she told CNA D that she could not talk to the resident like that, and asked her would she want someone talking to her mother like that? She said CNA D then said f . it and walked away. She said CNA D had disconnected the facility phone from the wall and would not let Resident #16 use the phone. CNA C said she then reconnected the facility phone and Resident #16 then called her family member. CNA C said she immediately reported the incident to the LVN Q. CNA C said the facility provided in-services following the incident with topics including abuse/neglect and reporting to abuse coordinator. CNA C said the facility provided in-services following the incident with topics including abuse/neglect and reporting to abuse coordinator. During an interview on 05/15/24 at 11:25 a.m., the DON said she expected staff to contact the Abuse Coordinator or herself immediately for any suspected or actual abuse or neglect. She said any allegations of abuse/neglect were profoundly serious and were not to be taken lightly. The DON said she did not know why the aide did not just let the resident use the phone in the first place. The DON suspended CNA D pending an investigation and then was terminated. She said the facility could not take a chance on the probability of a repeat incident such as this and felt best to terminate CNA D. During a phone interview on 05/15/24 at 12:00 p.m., CNA D said Resident #16 was holding a food pamphlet in her hand and wanted to use the facility phone. She said she told the resident it was too late to place a food order. She said Resident #16 then told her Don't worry about me or what I'm doing. CNA D said the resident started cursing her and said she was going to call 911. She said Resident #16 dialed 911 and yelled help me, help me and CNA D then hung up the phone and disconnected it from the wall so resident would not call 911. CNA D said she was suspended pending an investigation. State surveyor asked CNA D if the 911 operator returned a call after the hangup and she stated, well I'm not sure if she dialed 911 but I did see her dial a 9 and a 1 and she started yelling for help. During an interview on 05/15/24 at 1:30 p.m., the Administrator said she was not notified by staff until the morning after the incident on 05/09/24 involving Resident #16 and CNA D. Her expectations were for staff to report any suspicion or actual allegations of abuse or neglect to her within 2 hours. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 5/16/24 at 2:00 p.m., LVN Q said CNA C informed him of verbal conflict between Resident #16 and CNA D. He said he spoke with CNA D and Resident #16 immediately after CNA C told him of the incident. Resident #16 told him CNA D was mean to her and would not let her use the facility phone. Resident #16 said CNA D told her she was fat and stinky. LVN Q said Resident #16 was always nice and calm with no behaviors. CNA D was allowed to continue to work. LVN Q said CNA C was also on the secure unit with CNA D. He said CNA C attended Resident #16 throughout the shift while CNA D attended to other residents. He said he had training on abuse, neglect, and reporting timely. He said he wrote out a statement of the incident and stated, it totally slipped my mind to report to Abuse Coordinator until end of shift. LVN Q said they were expected to report allegations of Abuse or Neglect within two hours of an incident. 2. Record review of a face sheet dated 4/22/2024 indicated Resident #28 was an 85-years-old male, admitted to the facility on [DATE]. His diagnoses included Alzheimer's (progressive disease that destroys memory), dementia (loss of memory), and anxiety (nervousness). Record review of an annual MDS assessment dated [DATE] indicated Resident #28 had a BIMS of 04 (severely impaired cognition) and no behaviors were noted which affected others. Resident #28 required substantial/maximal assistance with 1 staff member for transfer and grooming. Record review of the care plan for Resident #28 dated 05/02/24 indicated He received physical aggression-r/t his roommate having increased agitation. The goal indicated the bruise to his right arm would resolve over the next 90 days. The care plan interventions for Resident #28 included: * Abuse and Neglect In-services in place for Staff; o Complete head to toe assessment-initiated post incident; o Monitor/document/report as needed any signs /symptoms of Pain; o Psychiatric consult as indicated; and o Responsible Party and Hospice notified. Record review of Resident #28's progress note dated 05/2/24 at 6:30 pm LVN M charted SN heard Resident #28 call out What are you doing? She entered the resident's room and observed Resident #28 lying in his bed and his roommate from bed B standing over him with his hands gripping this resident's R forearm. Staff x2 separated resident from roommate in bed B without difficulty. Resident #28 was assessed and noted redness to R forearm. During an observation and interview on 05/13/24 at 11:00 a.m., Resident # 28 's right arm had no visible injuries and he said he had never had problems with anyone here. 3. Record review of a face sheet dated 05/14/24 indicated Resident #72 was a [AGE] year-old male, admitted to the facility on [DATE]. His diagnoses included Alzheimer's (progressive disease that destroys memory), dementia (loss of memory) and altered mental status (change in brain function). (continued on next page)

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	675541	A. Building B. Wing	05/15/2024

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an annual MDS assessment dated [DATE] indicated Resident #72 had a BIMS of 03 (severely impaired cognition), no behaviors were noted which affected others. Resident #72 required substantial/maximal assistance of 1 staff for transfer and grooming. Record review care plan dated 05/02/24 indicated Resident#72 had limited physical mobility r/t weakness. Resident #72 was noted to be physically aggressive by being combative with staff, being non-compliant when re-directed, agitated, and by grabbing his roommate's right forearm and leaning himself into the other resident's arm r/t dementia. Record review of the progress note dated 05/02/24 at 6:30 p.m., indicated Resident #72 was standing by his roommate's bed and he was grabbing the roommate's right arm and leaning over Resident #28's right arm with both hands. The staff had to remove Resident #72's hands from Resident #28's right forearm. Record review of the resident roster dated 05/13/24 indicated Resident #72 was discharge from the facility and transfer to the behavior hospital on 05/03/24. During an interview on 05/13/24 at 2:00 p.m., the Administrator said when she got to work on 5/3/24, IDT discussed the incident r/t Resident #28 and Resident #72 and said the IDT felt it was not an allegation of abuse because both residents were not willful. She said the incident was reported on 05/03/24 at 9:44 a.m. The Administrator Administer said she was responsible for notifying the state of any allegations of abuse within 2 hrs. and she said she did not feel this was abuse. She said the decision to report or not report would need to be made before the two hours. During an interview on 5/15/24 at 10:25 a.m., the DON said any allegation of abuse should have been reported within 2 hours. She said the policy indicated resident abuse would need to be reported by the abuse coordinator. The DON said she felt this incident was an allegation of abuse and needed to be reported 33460

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32217 33460 Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse of residents were reported immediately to the administrator and to HHSC within the 2-hour period for 3 of 18 residents (Resident #16, #28, and #72) reviewed for abuse. The facility failed to ensure allegations of resident-to-resident altercations and resident and staff altercations were reported immediately to the administrator and to the State Agency no later than 2 hours after the incident occurred or was suspected. The facility failed to report an allegation of verbal abuse to the administrator and to the State Agency within 2 hours when Resident #16 was involved in verbal altercation with CNA. The facility failed to report an allegation of physical abuse within 2 hours to the State Agency when Resident #72 grabbed Resident #28. This failure could place residents at risk of abuse, physical harm, mental anguish, and emotional distress. Findings included: 1. Record review of a face sheet dated 05/13/24 indicated Resident #16 was a [AGE] year-old female, admitted [DATE]. Her diagnosis included schizoaffective disorder. (A mental health disorder that is marked by a combination of schizophrenia symptoms such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania) Review of a quarterly MDS assessment dated [DATE] indicated Resident #16 had a BIMS of 15 and cognition was intact. No behaviors were noted which affected others. Resident #16 was independent with dressing and personal hygiene. Record review of care plan dated 04/20/24 indicated Resident #16 was at risk for a behavior problem related to schizoaffective disorder. Interventions included caregivers to provide opportunity for positive interaction and attention. Stop and talk with her when passing by. During an interview on 05/14/24 at 2:00 p.m., Resident #16 said CNA D had cursed her and called her fat and stinky. She said she was trying to use the facility phone to call her family and CNA D unplugged the facility phone and would not let her use it and told her that she did not need to be calling anyone. Resident #16 said the aide was rude to her. She denied being afraid of staff or other residents in the facility. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 05/15/24 at 11:00 a.m., CNA C said she was in a resident's room when she heard loud voices. She looked out the door and CNA D was yelling at Resident #16 and telling her You're not going to use this damn phone to call nobody - do that shit in the daytime. Resident #16 told CNA D she could use the phone anytime and this was her home. CNA D said, you need to shower, you stinky bitch. She said she told CNA D that she could not talk to the resident like that, and asked her would she want someone talking to her mother like that? She said CNA D then said f . it and walked away. She said CNA D had disconnected the facility phone from the wall and would not let Resident #16 use the phone. CNA C said she then reconnected the facility phone and Resident #16 then called her family member. CNA C said she immediately reported to LVN Q following the incident. CNA C said the facility provided in-services following the incident with topics including abuse/neglect and reporting to abuse coordinator. During an interview on 05/15/24 at 11:25 a.m., the DON said she expected staff to contact the Abuse Coordinator or herself immediately for any suspected or actual abuse or neglect. She said any allegations of abuse/neglect were profoundly serious and were not to be taken lightly. The DON said she did not know why the aide did not just let the resident use the phone in the first place. The DON suspended CNA D pending an investigation and was then terminated on 05/10/24. She said the facility could not take a chance on the probability of a repeat incident such as this and felt best to terminate CNA D. During a phone interview on 05/15/24 at 12:00 p.m., CNA D said Resident #16 was holding a food pamphlet in her hand and wanted to use the facility phone. She said she told the resident it was too late to place a food order. She said Resident #16 then told her Don't worry about me or what I'm doing. CNA D said the resident started cursing her and said she was going to call 911. She said Resident #16 dialed 911 and yelled help me, help me and CNA D then hung up the phone and disconnected it from the wall so resident would not call 911. CNA D said she was suspended pending an investigation. State surveyor asked CNA D if the 911 operator returned a call after the hangup and she stated, well I'm not sure if she dialed 911 but I did see her dial a 9 and a 1 and she started yelling for help. During an interview on 05/15/24 at 1:30 p.m., the Administrator said her expectations were for the residents to be free of abuse of any kind in their home. She said she was not notified by staff until the morning after the incident. Her expectations were for staff to report any suspicion or actual allegations of abuse or neglect to her within 2 hours. The administrator said she promptly reported the incident to the State Office. During a phone interview on 05/16/24 at 2:00 p.m., LVN Q said on 05/09/24 at approximately 9:50 p.m., CNA C informed him of verbal conflict between Resident #16 and CNA D. He said he spoke with CNA D and Resident #16. Resident #16 told him CNA D was mean to her and would not let her use the facility phone. Resident #16 said CNA D told her she was fat and stinky. He said he wrote out a statement of the incident and stated, it totally slipped my mind to report to Abuse Coordinator until end of my shift the next morning. He said he had training on abuse, neglect, and reporting timely. CNA D was allowed to continue to work. LVN Q said CNA C was also on the secure unit with CNA D. He said CNA C attended Resident #16 throughout the shift while CNA D attended to other residents. 2. Record review of a face sheet dated 04/22/2024 indicated Resident #28 was an 85-years-old male, admitted to the facility on [DATE]. His diagnoses included Alzheimer's (progressive disease that destroys memory), dementia (loss of memory), and anxiety (nervousness). (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an annual MDS assessment dated [DATE] indicated Resident #28 had a BIMS of 04 (severely impaired cognition), no behaviors were noted which affected others. Resident #28 required substantial/maximal assistance with 1 staff for transfer and grooming. Record review of the care plan for Resident #28 dated 05/02/24 indicated He received physical aggression-r/t his roommate having increased agitation. The goal indicated the bruise to his right arm would resolve over the next 90 days. The care plan interventions for Resident #28 included: * Abuse and Neglect In-services in place for Staff; o Complete head to toe assessment-initiated post incident; o Monitor/document/report as needed any signs/symptoms of Pain; o Psychiatric consult as indicated; and o RP and Hospice notified. Record review of Resident #28's progress note dated 05/2/24 at 6:30 pm LVN M charted nurse heard Resident #28 call out What are you doing? She entered the resident's room and observed Resident #28 lying in his bed and his roommate from bed B standing over him with his hands gripping this resident's R forearm. Staff x2 separated resident from roommate in bed B without difficulty. Resident #28 was assessed and noted redness to R forearm. Record review of a face sheet dated 05/14/24 indicated Resident #72 was a [AGE] year-old male, admitted to the facility on [DATE]. His diagnoses included Alzheimer's (progressive disease that destroys memory), dementia (loss of memory) and altered mental status (change in brain function). Record review of an annual MDS assessment dated [DATE] indicated Resident #72 had a BIMS of 03 (severely impaired cognition), no behaviors were noted which affected others. Resident #72 required substantial/maximal assist with 1 staff for transfer and grooming. Record review care plan dated 05/02/24 indicated Resident #72 had limited physical mobility r/t weakness. Resident #72 was physically aggressive by being combative with staff, being non-compliant when re-directed, agitated, and grabbing his roommate's right forearm and leaning himself into the other resident's arm r/t dementia. Record review of a progress note dated 05/02/24 indicated Resident #72 was standing by his roommate's bed and had grabbed roommate's right arm and was leaning over Resident's arm. Record review of the resident roster dated 05/13/24 indicated Resident #72 was at a behavior hospital. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/13/24 at 2:00 p.m., the Administrator said when she got to work on 5/3/24, IDT discussed the incident r/t Resident #28 and Resident #72 and said the IDT felt it was not an allegation of abuse because both residents were not willful. She said the incident was reported on 05/03/24 at 9:44 a.m. as soon as she knew about it . The Administrator Administer said she was responsible for notifying the state of any allegations of abuse within 2 hrs. and she said she did not feel this was abuse. She said the decision to report or not report would need to be made before the two hours. During an interview on 05/14/24 at 9:43 a.m., the CNA L said Resident #72 was standing beside Resident #28's bed and tightly and aggressively holding Resident #28's forearm. She said we had to remove him from holding Resident #28's right forearm. During an interview on 05/14/24 at 9:45 a.m., LVN M said she and CNA L separated the residents after Resident had called out what are you doing. She said Resident #72 had both of his hands on Resident #28's forearm. Resident #72 was leaning down on Resident #28's arm. LVN M said there was some redness to Resident #28's forearm near the wrist. She said I reported it to the ADON, and he monitored Resident 72 while she did the paperwork for transfer. During an interview on 5/15/24 at 10:15 a.m., ADON A said he monitored Resident #72 one on one and moved him to another room until he was sent to the local hospital . ADON A said when Resident #72 returned from the hospital orders were noted to place Resident #72 in private room without one-on-one monitoring. ADON A said the next day Resident #72 was sent to the behavioral hospital and he was still at the behavioral hospital being treated. He said there were indentations on Resident #28's forearm and redness but skin was intact. He said he instructed the nurse to report the incident to the abuse prevention coordinator (the Administrator). He said this was an allegation of abuse and should have been reporting in 2 hours. During an interview on 5/15/24 at 10:25 a.m., the DON said any allegation of abuse should be reported within 2 hours. She said the policy indicated resident abuse would need to be reported by the abuse coordinator. The DON said she felt this incident was an allegation of abuse and needed to be reported. Record review of the Abuse, Neglect, Exploitation and Misappropriation Prevention Program dated April 2021 indicated Policy Statement Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to facility staff; other residents; consultants; volunteers; staff from other agencies; family members; legal representatives; friends; visitors; and/or any other individual. Develop and implement policies and protocols to prevent and identify abuse or mistreatment of residents; neglect of residents; and/or theft, exploitation or misappropriation of resident property. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating dated September 2022 indicated Policy Statement All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/ misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulation) and investigated thoroughly investigated by facility management. Findings of all investigations are documented and reported. 3. Immediately is defined as: a. within two hours of an allegation involving abuse or results in serious bodily injury or within 24 hours that does not involve abuse or results in serious bodily injury.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41057 Based on observation, interview, and record review, the facility failed to ensure assessments accurately reflected the status for 2 of 18 residents reviewed for assessments. (Residents #21 and #40). The facility failed to complete an accurate resident assessment for Resident #21. Resident #21's resident assessment did not indicate she received special treatments, procedures, and programs of tracheostomy care. The facility failed to complete an accurate resident assessment for Resident #40. Resident #40's resident assessment did not indicate he received special treatments, procedures, and programs of dialysis. This failure could place residents at risk of not having individual needs met and a decreased quality of life. Findings included: 1. Record review of a face sheet dated 05/14/24 indicated Resident #21 was a [AGE] year-old female readmitted on [DATE]. Her diagnoses included quadriplegia (a symptom of paralysis that affects all a person's limb and body from the neck down) and tracheotomy status (has a hole in your windpipe that a doctor makes to help you breathe that a tube is inserted into to keep it open to help you breathe). Record review of physician orders for May 2024 indicated Resident #21 had an order for tracheostomy (trach) care every shift per tracheotomy status two times a day with a start date of 07/25/23. Record review of a quarterly MDS dated [DATE] indicated Resident #21 usually understood but was rarely understood and had a diagnosis of tracheotomy status. The MDS was not marked for special treatment, procedures, and programs of tracheostomy care. Record review of a MAR dated March 2024 indicated Resident #21 received tracheotomy care twice a day from 03/01/24 to 03/31/24. Record review of a care plan revised 05/02/24 indicated Resident #21 has a tracheostomy with an intervention including provide trach care per order. Record review of a MAR dated 05/15/24 indicated Resident #21 received tracheostomy care twice a day from 05/01/24 to 05/14/24. During an observation on 05/13/24 at 9:53 a.m., Resident #21 was lying in bed with a tracheostomy and trach collar attached. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/15/24 at 9:35 a.m., the MDS nurse said she was responsible for all MDSs in the facility. She said she was educated on completing MDS for accuracy and re-educated a couple months ago on new changes on the MDS around March. She said Resident #21 had a trach and received trach care. She said it should have been captured on the MDS, but it was not. She said she missed it. She said she has no back up to double check her MDS. The MDS nurse said the risk of dialysis not documented on the MDS was it was not properly claimed on state and facility records but no risk to the resident. 2. Record review of a face sheet dated 05/13/24 indicated Resident #40 was a [AGE] year-old male readmitted on [DATE] with diagnoses including chronic kidney disease stage 4 (your kidneys are damaged severely and not working as well as they should to filer waste from your blood) and dependence on renal dialysis (the process of removing excess water and toxins from the blood in people whose kidneys can no longer perform naturally). Record review of a quarterly MDS assessment dated [DATE] indicated Resident #40 had a BIMS score of 5 indicating severely impaired of cognition and diagnosis of renal failure. The MDS was not marked for special treatment, procedures, and programs of dialysis. Record review of a care plan revised 05/06/24 indicated Resident #40 needed dialysis Tuesday, Thursday, and Saturday for renal failure. During an interview on 05/13/24 at 12:30 p.m., Resident #40 said he went to dialysis 3 days a week on Tuesday, Thursday, and Saturday. Resident #40 said he had no problems with dialysis. During an interview on 05/15/24 at 09:40 a.m., the Regional Reimbursement Coordinator said she signed the MDS to verify they were completed in time but not for accuracy. During an interview on 05/15/24 at 10:08 a.m., the DON said Resident #21 had a tracheostomy and received trach care every shift. She said the tracheostomy should have been documented on the MDS. The DON said Resident #40 received dialysis 3 days a week and it should have been documented on his MDS. She said the MDS nurse was responsible for all the facilities MDSs. The DON said the Regional Reimbursement Coordinator was responsible for being her back up. The DON said the documentation was overlooked. She said the MDS nurse was educated on completing MDSs accurately. The DON said the risk of the tracheostomy care and dialysis not documented on the MDS was not following facility policy and not accurately portraying the resident's status. She said her expectation was all MDS be completed correctly and timely. During an interview on 05/15/24 at 10:30 a.m., the Administrator said the MDS nurse was responsible for completing all MDS accurately in the facility. She said Resident #21's tracheostomy care and Resident #40's dialysis should have been captured on the MDS. The Administrator said the Regional Reimbursement Coordinator was responsible for being her back up. The Administrator said her expectation was accuracy for all MDS and the MDS nurse to coordinate with the nurses and CNAs and assess the resident before completing the MDS. The Administrator said the risk of not documenting tracheostomy care and dialysis was the facility missing out on revenue. During an interview on 05/15/24 at 3;30 p.m., the Regional Nurse Consultant said the facility followed the RAI (Resident Assessment Instrument) for a facility policy related to MDS. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the, Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated, October 2023, indicated, . Section O: Special treatments, procedures, and programs Intent: The intent of the items in this section is to identify any special treatments, procedures, and programs that the resident received or perform during the specified time periods. E1. Tracheostomy care . J. Dialysis . Health-related Quality of Life - The treatments, procedures, and programs listed in Item O01I0. Special Treatments, Procedures, and Programs, can have a profound effect on an individual's health status, self-image, dignity, and quality of life.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25779 Based on observation, interview and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain grooming, and personal and oral hygiene for 1 of 18 residents reviewed for ADLs. (Resident #20) The facility failed to ensure Resident #20's fingernails were trimmed. The resident had contractures to the left upper fingers and thumb. This failure could place the residents at risk of not receiving the care and services to maintain their highest level of physical, mental and psycho-social well-being. Findings included: Record review of physician orders dated May 2024 indicated Resident #20, admitted [DATE], was [AGE] years old with diagnoses of hemiplegia/hemiparesis (a condition that causes paralysis or weakness on one side of the body) and a stroke. Record review of the most recent quarterly MDS dated [DATE] indicated Resident #20 had a BIMs of 5 (severe cognitive impairment), had a decrease in ROM to one side of his upper extremities and required partial/moderate assistance with upper body dressing and personal hygiene. The MDS assessment did not indicate the resident had behaviors or resisted care. Record review of a care plan revised 04/11/24 indicated Resident #20 had the potential for impaired skin integrity due to hemiplegia/hemiparesis and bowel/bladder incontinence. The interventions indicated to maintain or develop clean and intact skin, avoid scratching, and keep fingernails short. A care plan revised 04/11/24 indicated Resident #20 had ADL self-care performance deficits related to physical limitations. The interventions indicated the resident required limited assistance of one staff for personal hygiene and for staff to check nail length and trim and clean on bath day and as necessary. The care plans did not indicate the resident had behaviors or resisted care. During observation and interview on 05/13/24 at 9:22 a.m., Resident #20 was sitting in the wheelchair in his room. The resident's fingers to the left hand were contracted upward towards the bottom of the palm of his hand. The thumb was contracted inward and rested under the contracted fingers and between the third and fourth fingers of the left hand. The resident's fingernails were approximately 1/4 inch past the tips of the fingers and thumbs on both hands. Resident #20 said he wanted his fingernails cut. He said the staff cut his fingernails ever so often but had not cut them for a while. During observations Resident #20's fingernails were approximately 1/4 inch past the tips of the fingers and thumbs on both hands: *05/13/24 at 01:10 p.m. *05/14/24 at 9:12 a.m., *05/14/24 at 11:40 a.m.; and (continued on next page)

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	05/15/2024

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*05/15/24 09:22 a.m. During an observation and interview on 05/15/24 at 12:32 p.m., Resident #20 was in the dining room eating. The resident's nails were approximately 1/4 inch past the tips of each finger and thumb. CNA O said she worked on Hall 500, where the resident resided, but she was not assigned to him. She said the resident's nails were too long and needed to be trimmed. During an observation and interview on 05/15/24 at 12:36 p.m., Resident #20 was in the dining room eating. The resident's nails were approximately 1/4 inch past the tips of each finger and thumb. CNA P said Resident #20's nails were too long and needed to be cut. She said she was responsible to make sure the resident's nails were trimmed. She said the possible negative outcome would be his nails could possibly cut his skin. During an interview on 05/15/24 at 12:58 p.m., the DON said her expectations were for the staff to keep the resident's nails trimmed. She said the possible negative outcome would be Resident #20 could scratch himself or get a skin tear. Record review of an Activities of Daily Living (ADLs), Supporting policy revised March 2018 indicated: . Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. .

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25779 Based on observation, interview and record review, the facility failed to ensure residents with limited range of motion received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion for 1 of 18 residents reviewed for range of motion. (Resident #20) The facility did not ensure Resident #20 had a splint to the left contracted hand as ordered. This failure could place the residents at risk of not receiving the appropriate care and services to maintain their highest level of well-being. Findings included: Record review of physician orders dated May 2024 indicated Resident #20, admitted [DATE], was [AGE] years old with diagnoses of hemiplegia/hemiparesis (a condition that causes paralysis or weakness on one side of the body) and stroke. The orders indicated the resident was to receive a resting hand splint for left and wrist to treat and correct contracture dated 03/12/24. The orders indicated the resident was ordered physical therapy on 9/8/23 and occupational therapy on 1/31/24. Record review of the most recent quarterly MDS dated [DATE] indicated Resident #20 had a BIMs of 5 (severe cognitive impairment) and had a decrease in ROM to one side of his upper extremities. The MDS assessment did not indicate the resident had behaviors or resisted care. Record review of a care plan revised 04/11/24 indicated Resident #20 had hemiplegia/hemiparesis following cerebral infarction affecting left non-dominant side. The goal indicated The resident will maintain optimal status and quality of life within limitations imposed by Hemiplegia/Hemiparesis through review date. There were no interventions to indicate the resident had splints. The care plans did not indicate Resident #20 had behaviors or resisted care. Record review of Resident #20's TARs dated April 2024 and May 2024 did not indicate the resident received a splint as treatment. The April 2024 and May 2024 TARs were blank and had no interventions in place for the resident. Record review of the electronic clinical record titled Therapy dated 5/15/24 indicated Resident #20 had no upcoming therapy appointments, did not have treatment diagnoses and had no therapy projections. (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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 05/13/24 at 9:22 a.m., Resident #20 was sitting in the wheelchair in his room. The resident's fingers to the left hand were contracted upward towards the bottom of the palm of his hand. The thumb was contracted inward and rested under the contracted fingers and between the third and fourth fingers of the left hand. The resident's fingernails were approximately 1/4 inch past the tips of the fingers on both hands. Resident #20 said he wanted his fingernails cut. He said they cut his fingernails ever so often but had not cut them for a while . He said he had a splint they put in his hand sometimes, but they had not placed the splint in his hand today. He said his fingernails could cut into the resident's skin of the contracted hand. During the following observations, Resident #20 did not have a splint in his contracted left hand: *05/13/24 at 01:10 p.m. *05/14/24 at 9:12 a.m., *05/14/24 at 11:40 a.m.; and *05/15/24 09:22 a.m During observations, interview and record review on 05/15/24 at 12:12 p.m., Resident #20 was in the dining room eating. There was not a splint in the resident's left contracted hand. RA J said she performed ROM on 8 residents daily each month. She said the director of therapy would give her an assignment of 8 residents she needed to do ROM on each month. She said therapy did all the assessments and would then notify her of who needed to be seen. RA J said she had a restorative sheet for Resident #20 that OT had given her, but since they only saw 8 residents a month, he had not been seen for ROM yet. She then provided the Nursing Restorative Care Program form dated 3/29/24 for Resident #20. The form indicated . Perform left upper extremity splint care for 2 to 4 hours daily and PRN . During observation and interview on 05/15/24 at 12:22 p.m., Resident #20 was sitting at the dining table eating. There was not a splint in the resident's left contracted hand. The OTA K said he was responsible for ensuring the residents with contractures had the splints placed in their hands. He said he saw Resident #20 for restorative for his fingers in March 2024, when the order was written. He said Resident #20 received splint care for the left hand to wear at intervals during the day, for an hour or two hours at a time, to stretch out the contracted fingers. When asked if he knew how the order for the splint read, he said he did not. He said he would see the residents when they were placed on his schedule and would clean their contracted hands. He said unfortunately, he had to keep the splints in his office to prevent them from being taken. He said Resident #20 did not have a splint in his left hand and it was not in his room. He said the splint was in the therapy office. He said the possible negative outcome of Resident #20 not having the splint in his hand would be a decrease in his ROM to the contracted hand. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 05/15/24 at 12:40 p.m., Resident #20 was sitting at the dining table eating. There was not a splint in the resident's left contracted hand. The PTA/director of therapy said the orders were usually written that the resting hand splint may be in place, not that the splint would be in place at all times. The surveyor read the orders out loud to the director of therapy and she said she was not aware the order said the splint was to be on Resident # 20 period. She said she thought the orders said the resident may have the splint applied. She said the possible negative outcome of not having the splint in place could be an increase in contractures. She said Resident #20 did not have the splint on and should have the splint in place as ordered. During an interview on 05/15/24 at 12:58 p.m., the DON said her expectations were for the staff to follow the physician orders. She said the possible negative outcome would be Resident #20 could get further contractures and a decrease in ROM. Record review of a Range of Motion-General policy revised 10/16 indicated . A resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25779 Based on observation, interview and record review, the facility failed to ensure that a resident who needed respiratory care, including tracheostomy care and tracheal suctioning, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences for 1 of 18 residents reviewed for oxygen administration. (Resident #15) The facility failed to administer Resident #15's oxygen at 2 liters as ordered. This failure could place the residents at risk of not receiving the care and services to maintain their highest level of well-being. Findings included: Record review of physician orders dated May 2024 indicated Resident #15, readmitted [DATE], was [AGE] years old with diagnoses of atrial fibrillation (an irregular, often rapid heartbeat that commonly caused poor blood flow), morbid obesity and tobacco use. The order indicated the resident received oxygen at 2 liters nasal cannula continuously for shortness of breath active date 05/01/24. Record review of the most recent quarterly MDS assessment dated [DATE] indicated Resident #15 had a BIMs of 15 (cognitively intact), was dependent and/or maximum assist for ADL care, required a Hoyer lift to transfer, and was morbidly obese. The MDS was prior to the resident's order for oxygen and did not indicate the resident received oxygen. Record review of a care plan dated 05/03/24 indicated Resident #20 was short of breath related to CHF. A care plan dated 05/03/24 indicated the resident had oxygen due to sleep apnea. The interventions indicated to administer medications as ordered by the physician and administer oxygen as ordered. Record review of a MAR dated May 2024 indicated Resident #15 received oxygen at 2 liters nasal cannula continuously. During observation and interview on 05/13/24 at 10:14 a.m., Resident #15 was in the bed with oxygen in progress at 3 liters nasal cannula. The resident was morbidly obese. He said he was bedfast and was only able to get out of the bed by Hoyer lift and could not change the oxygen dosage. He said he was sent out to the hospital a few weeks ago for shortness of breath and returned to the facility on oxygen. During the following observations, Resident #15 had oxygen in progress at 3 liters nasal cannula: *05/13/24 at 1:32 p.m., *05/14/24 at 10:52 p.m., *05/14/24 at 1:50 p.m.; and (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*05/15/24 at 9:01 a.m. During observation, interview and record review on 05/15/24 at 9:12 a.m., During record review of Resident #15's electronic record, LVN S said the resident was ordered oxygen at 2 liters nasal cannula continuously. Upon entering the room, Resident #15 was lying in bed with oxygen in progress at 3 liters nasal cannula. LVN S said the oxygen was set at 3 liters and should be set at 2 liters nasal cannula. She said she was responsible for checking the oxygen to make sure the dosage was correct. She said the possible negative outcome of the oxygen not being set at the correct dose would be it could damage the resident's lungs . During observations and interview on 05/15/24 at 9:17 a.m., Resident #15 had oxygen in progress at 3 liters nasal cannula. ADON A said his expectations were for the nurses to check the orders with the dose the resident was receiving and ensure the resident was receiving the correct dose. He said the possible negative outcome could be the incorrect dose could affect the resident's breathing and cause carbon dioxide build up in the resident's lungs. He said Resident #15's oxygen should be set at 2 liters nasal cannula as ordered. During an interview on 05/15/24 at 9:25 a.m., the DON said her expectations were for the nurses to follow the orders and make sure Resident #15's oxygen was set on 2 liters as ordered. She said the possible negative outcome would be the resident could receive too much oxygen. Record review of the Oxygen Administration policy revised October 2010 indicated: The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation: 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41057 Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident to ensure the accurate administration of medications for 1 of 18 residents reviewed for medication administration. (Resident #40) The facility did not document blood pressure (BP) or heart rate (HR) for Resident #40 on the MAR, before administering medications with orders that included instructions to hold for prescribed parameters. This failure could place residents with prescribed medication parameters at risk of not receiving the desired therapeutic effects of their medications. Findings included: Record review of a face sheet dated 05/13/24 indicated Resident #40 was a [AGE] year-old male readmitted on [DATE] with diagnosis including hypertension (high blood pressure). Record review of an, Employee In-Service Record,dated 03/04/24 indicated The DON inserviced the nurses on, . Administering Medication .Make sure all medicaion monitoring tools are in place ex {example} (BS {blood sugar}, anticoagulant, BP monitoring) . Record review of a quarterly MDS assessment dated [DATE] indicated Resident #40 had a BIMS score of 5 indicating severely impaired of cognition and a diagnosis of hypertension. Record review of a care plan revised 04/10/24 indicated Resident #40 had hypertension and received antihypertension medication with interventions including to give antihypertensive medication as ordered, record use and side effects, and report to the physician as needed. Record review of physician orders dated 05/13/24 indicated Resident #40 was prescribed metoprolol tartrate 25 mg two times a day for hypertension, with parameters of hold for a SBP < 110, DBP < 60 or HR (heart rate) < 60 with a start date of 11/09/23. Record review of nurses notes dated 05/02/24 to 05/13/24 indicated Resident #40 did not have BP or HR documented with administration of metoprolol tartrate. During an interview on 05/13/24 at 12:30 p.m., Resident #40 said he was given BP medication, and the staff checked his BP before they gave it every time. Record review of the MAR dated May 1 - 14, 2024 indicated on the following dates at 9:00 a.m., and 2:00 p. m., Resident #40's metoprolol tartrate was given with no indication in the clinical record of BP or HR being obtained prior to administration of medications : *05/01/24, (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*05/02/24, *05/03/24, *05/04/24, *05/05/24, *05/06/24, *05/07/24, *05/08/24, *05/09/24, *05/10/24, *05/11/24, *05/12/24, *05/13/24; and *05/14/24 Record review of the MAR indicated LVN R administered Resident #40's metoprolol at 9:00 a.m., on: *05/01/24, *05/02/24, *05/06/24, *05/07/24, *05/10/24, (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on 05/15/24 at 9:56 a.m., LVN R said she was providing care for Resident #40 today. She said she checked Resident #40's BP and HR before she gave his metoprolol at 9:00 a.m. today. She said there were prescribed parameters to hold the medication. She said after she reviewed Resident #40's clinical record there was no place to document the BP and HR. LVN R said she always checked a resident's BP and HR with all BP medication even if there were no prescribed parameters. LVN R said the BP and HR should have been documented with every medication administration of the metoprolol. She said it was overlooked. She said she would document the BP and HR in her nurses note and add the trigger for the system for BP and HR documentation for the metoprolol after surveyor intervention. She said it was the facility policy and all the nurses' responsibility to document BP and HR if orders had parameters for a medication they administer. LVN R said she was educated in medication administration and documentation of BP and HR for medications with prescribed parameters. LVN R said the risk of a blood pressure medication being given without the resident's BP and HR not documented was a nurse, being unaware of the resident's BP and HR, could give the medication and lower the resident's blood pressure. During an interview on 05/15/24 at 10:22 a.m., the DON, said Resident #40's BP and HR should have been documented with every administration of the metoprolol prescribed with parameters. She said the nurses were responsible for documentation of BP and HR with medication administration. The DON said ADON A was responsible for auditing charts and ensuring the BP and HR were triggered for documentation with medication administration. She said it was overlooked. She said when the staffing coordinator put the order in it was not triggered on the order for BP and HR documentashetion. The DON said she in-serviced the staff on 03/04/24 on medication administration including documentation of BP and HR for BP medication with parameters. The DON said the risk was a resident's BP lowered or side effects. The DON said her expectation was medication administration according to physician orders. She said she expected the nurses to put the orders in the computer system correctly with BP and HR triggered for medication with parameters and read the orders before medication administration. During an interview on 05/15/24 at 10:40 a.m., ADON A said Resident #40's metoprolol should have had BP and HR documentation with administration but was overlooked. He said the nurses were responsible for triggering the system for documentation of BP and HR with medication administration and he was responsible for auditing the charts to ensure it was triggered in the computer system. ADON A said he did not see it when he was auditing charts. He said the physician order was put in the system incorrectly. ADON A said the risk of not documenting the BP and HR with BP medication given when it should have been held was a risk a resident's BP could be lowered. During an interview on 05/15/24 at 10:43 a.m., the Staffing Coordinator said he only adjusted the times for medication administration and did not recheck the orders for accuracy. He said Resident #40's metoprolol with no documentation of BP and HR being triggered in the system was overlooked. He said ADON A was responsible for auditing the charts. He said he was educated on completing orders and triggering BP and HR for medications with parameters. He said the risk of not documenting BP and HR with blood pressure medication with prescribed parameters was a resident could have low blood pressure or dizziness. During an interview on 05/15/24 at 10:45 a.m., the Administrator said Resident #40's BP medication with parameters administration should have had the BP and HR documented with all medication administration. The Administrator said the risk of administration of a BP medication administered without documented BP and HR was adverse side effects and if the medication was not working and needed adjusting, staff would be unaware. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy Administrating Medication revised April 2019 indicated . Medications are administered in a safe and timely manner, and as prescribed. 11. The following information is checked/verified for each resident prior to administering medications: . b. Vital signs, if necessary .

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32217 Based on interview and record review, the facility failed to ensure each resident's drug regimen was free from unnecessary drugs for 1 of 18 residents reviewed. (Resident #71) The facility did not hold Resident #71 metoprolol tartrate when the resident's heart rate was outside parameters set by the physician. This failure could place the residents at risk of adverse side effects from medications. Findings included: Record review of physician orders dated May 2024 indicated Resident #71, admitted [DATE], was a [AGE] year-old female with diagnosis including essential hypertension (high blood pressure). Resident #71 was prescribed Metoprolol Tartrate - give 12.5 mg by mouth twice daily for hypertension, hold for SBP below 100 or DBP below 60 or pulse below 60. Record review of the quarterly MDS assessment dated [DATE] indicated Resident #71 had a BIMS score of 15 which indicated cognition was intact. She had a diagnosis of hypertension and heart failure. Review of Resident #71's care plan revised on 04/24/24 indicated the resident had diagnosis of hypertension. The interventions included administer antihypertensive medication as ordered by physician and to monitor/document for side effects and effectiveness. Review of the May 2024 MAR indicated on the following dates at 8:00 a.m., Resident #71 was administered Metoprolol Tartrate 12.5 mg when the pulse was less than the prescribed parameters and should not have been: *05/3/24, pulse was 47; *05/9/24, pulse was 57; and *05/10/24, pulse was 52. During an interview and record review on 05/15/24 at 1:15 p.m., ADON A reviewed Resident #71's May 2024 MAR with surveyor. ADON A said the nurses charted the doses of metoprolol on the electronic MAR as administered and documented heart rates that were outside the prescribed parameters. He said his expectations were for the nurses to follow the physician's orders . He said administering antihypertensive medications when outside parameters could cause blood pressure and/or heart rate to become significantly lower. (continued on next page)

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	05/15/2024

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.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The undated policy Medication Therapy indicated . The Physician will identify situations where medications should be tapered, discontinued, or changed to another medication, for example: . A). When a medication is being given in excessive doses, for excessive periods of time, without adequate monitoring, or in the absence of a valid clinical rationale. B) When the results of ongoing assessment, or the presence of clinically significant adverse consequences monitoring, suggest that a medication should be reduced or discontinued entirely

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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 0850 Level of Harm - Potential for minimal harm Residents Affected - Many	Hire a qualified full-time social worker in a facility with more than 120 beds. 33460 Based on interview and record review, the facility with more than 120 beds failed to employ a qualified social worker on a full-time basis for 1 of 1 facility reviewed for social worker qualifications. The facility failed to employ a qualified social worker full-time for all residents residing there. The facility was without a full-time SW for approximately 6 months (from November 2023 - present date, May 2024). This failure could place residents at risk of social service and psychosocial needs not being met. Findings included: During an interview on 05/13/24 at 10:10 a.m., the HR staff said the SW was only as needed and worked some weekends. She said the facility was still searching for a full time SW. During an interview on 05/14/24 10:45 a.m., the SW said she worked at this facility on weekends when she could. During an interview and record review of staff training and licensure on 05/15/24 at 12:45 p.m., the HR indicated the SW currently employed, worked as needed and did not work full time. She said the last time the facility had a full time SW was 11/02/23. During an interview on 05/15/24 at 1:00 p.m., the Administrator said the facility had tried to employee a full-time SW and placed ads but were still searching for one. She said the part time SW was monitoring the social services and the facility required full time because > 120 beds. Record review of Facility Summary Report, undated, revealed the facility had a total licensed capacity of 199 beds.

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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 0944 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 33460 Based on interview and record review, the facility failed to ensure Quality Assurance and Performance Improvement (QAPI) training that outlines and informs staff of the elements and goals of the facility's QAPI program was provided for 8 of 23 staff (Dietary Supervisor, ADON W, LVN T, LVN U, Laundry Supervisor, CNA E, CNA X and CNA V) reviewed for training. The facility failed to ensure that Dietary Supervisor, ADON W, LVN T, LVN U, Laundry Supervisor, CNA E, CNA X and CNA V completed the QAPI training. This failure could place residents at risk for staff not being aware of the QAPI program injury or improper care due to a lack of training. The findings were: 1. Record review of the staff roster, undated, indicated Dietary Supervisor was hired on 09/14/22. Record review of the Dietary Supervisor's training record- undated, indicated no QAPI training from 09/14/22 to 05/15/24. 2. Record review of the staff roster, undated, indicated the ADON W was hired on 03/25/20. Record review of the ADON W's training record, undated, indicated no QAPI training from 03/25/20 to 05/15/24. 3. Record review of the staff roster, undated, indicated LVN T was hired on 09/22/17. Record review of LVN T's staff training record, undated, revealed no QAPI training from 09/22/17 to 05/15/24. 4. Record review of the staff roster, undated, indicated the LVN U was hired on 01/10/2017. Record review of LVN U 's training record, undated, indicated no QAPI training from 01/10/17 to 05/15/24. 5. Record review of the staff roster, undated, indicated Laundry Supervisor was hired on 04/25/15. Record review of Laundry Supervisor's training record, undated, indicated no QAPI training from 04/25/15 6. Record review of the staff roster, undated, indicated the CNA V was hired on 05/29/15. Record review of CNA V's training record, undated, indicated no QAPI training from 05/29/15 to 05/15/24. (continued on next page)

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F 0944 Level of Harm - Potential for minimal harm Residents Affected - Many	7. Record review of the staff roster, undated, indicated CNA E was hired on 01/04/89. Record review of CNA E's training record, undated, indicated no QAPI training from 01/04/89 to 05/15/24. 8. Record review of the staff roster, undated, indicated CNA X was hired on 09/22/22. Record review of CNA X's training record, undated, indicated no QAPI training from 09/22/22 to 05/15/24. During an interview on 05/15/24 at 11:45 a.m., HR said she had not been informed of the new requirement for QAPI training. During an interview on 05/15/24 at 2:10 p.m., the Administrator said her expectation for the QAPI training would have been included in their computerized training system. She said she completed an in-service during orientation - on QAPI with the new hires since she was hired and expected all staff to be trained on QAPI as required. She said QAPI was for quality assurance.