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	02/27/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 25115 Based on observation, interview, and record review, the facility failed to ensure residents were free from abuse for 4 of 14 residents (Resident #2, #3, #4 and #5) reviewed for abuse, neglect, and exploitation. The facility failed to ensure Resident #2, #3, #4, and #5 were free of abuse from Resident #1. -On 07/10/24 Res #1 hit Res #3's head. -On 07/21/24 Res #1 hit Res #2 in the TV room. -On 07/22/24 Res #1 pushed Res #2 in the TV room. Res #2 sustained a head injury and was sent out to the ER for treatment. -On 09/02/24 Res #4 alleged Res #1 hit her. -On 11/24/24 Res #1 punched Res #3 in the forehead and chest. -On 12/28/24, Res #1 hit Res #5 in the face in the dining room The facility did not review, update, or implement interventions to include adequate supervision and continued to leave Resident #1 alone and unsupervised with other residents. An Immediate Jeopardy (IJ) was identified on 02/26/25 at 2:00 p.m. The IJ template was provided to the facility on [DATE] at 2:15 p.m. While the IJ was removed on 02/27/25, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. This failure could place residents at risk of physical abuse from other residents. Findings included: (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 02/27/2025
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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 - Immediate jeopardy to resident health or safety Residents Affected - Some	1. Record review of Resident #1's face sheet dated 02/20/25 indicated she was a [AGE] year old female, admitted on [DATE], and her diagnoses included schizophrenia (chronic mental disorder), diabetes (a chronic disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin), convulsions (sudden, violent, irregular movement of a limb or of the body), latent syphilis (a stage of syphilis infection where the bacteria (Treponema pallidum) remains in the body without causing any noticeable symptoms), and OCD (unwanted thoughts and fears, or obsessions). Record review of Resident #1's annual MDS assessment dated [DATE] indicated she was admitted to the facility with a serious mental illness, she was able to make herself understood and understood others, and she had mild cognitive impairment (BIMS-9). Record review of Resident #1's care plan dated 04/09/24 indicated she sometimes displayed verbally aggressive behavior. Interventions included social services to evaluate and visit with me, activity staff to visit with me, provide diversional activities, and remove me from public area when behavior is disruptive and unacceptable. Interventions included discuss behavior, monitor behavior episodes, and attempt to determine underlying causes. The interventions did not include resident specific interventions or supervision to prevent resident physical aggression towards others. Record review of Resident #1's care plan dated 06/12/23 indicated Resident #1 had potential to be physically aggressive by resident to resident altercations related to history of harm to others. Interventions included administer medications as ordered, labs as ordered by physician, monitor, document, and report PRN any sign or symptom of resident posing danger to self and others, and nursing staff to notify abuse coordinator, police, Ombudsman, MD, RP and psych, and psychiatric/psychogeriatric consult as indicated. Interventions included discuss behavior, monitor behavior episodes, and attempt to determine underlying causes. The interventions did not include resident specific interventions or supervision to prevent resident physical aggression towards others. Record review of Resident #1's care plan dated 04/20/24 indicated Resident #1 had a behavior problem related to schizophrenia and OCD. Interventions included discuss behavior, monitor behavior episodes, and attempt to determine underlying causes. The interventions did not include resident specific interventions or supervision to prevent resident physical aggression towards others. Record review of progress note dated 07/10/24 at 10:00 a.m., completed by LVN B indicated she was sitting at the desk charting and heard a loud noise. LVN B heard HSK Z say Resident #1 hit Resident #3 in the back. Resident #1 and Resident #3 were standing at the double doors of the secure unit. Resident #3 was crying and there was some redness to her upper back. MD A, Administrator, Ombudsman, NP K, (named police department), and DON notified. LVN B did not indicate Resident #1's level of supervision implemented to protect other residents from further aggressive and physical behaviors. Record review of IDT progress note dated 07/16/24 completed by the DON for Physical Aggression that occurred on 07/10/24 indicated Resident #1 was still showing signs of aggression and was sent out to behavior hospital on 07/12/24. The IDT note did not indicate Resident #1's level of supervision implemented to protect other residents from further aggressive and physical behaviors. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of facility investigation dated 07/17/24 indicated Resident #1 was discharged to behavioral hospital on 07/12/24. The facility confirmed Resident #1 hit Resident #3. Psych notification ordered 15 minute monitoring and labs. Resident #1 remained on 15 minute monitoring and continued to show signs of aggression until discharged to behavior hospital. Staff were trained on abuse/neglect/exploitation on 07/10/24. Monitoring sheets dated 07/10/24-through 07/12/24 indicated Resident #1 was on 15 minute monitoring. The investigation did not indicate Resident #1's level of supervision implemented to protect other residents from further aggressive and physical behaviors. Record review of Resident #1's progress note dated 07/18/24 at 1:45 p.m., completed by LVN A indicated Resident #1 returned to the facility from the behavior hospital. LVN A did not indicate Resident #1's level of supervision implemented to protect other residents from further aggressive and physical behaviors. Record review of Resident #1's progress note date 07/19/24 at 12:48 p.m., completed by LVN B indicated Resident #1 refused to let her roommate use the bathroom in their shared room. Resident #1 told the CNA to fuck off when she told Resident #1 her food was in the room. Record review of Resident #1's progress note dated 07/21/24 at 9:12 a.m., completed by LVN B indicated at 6:15 a.m. LVN B was at the medication cart. Resident #1's roommate stated Resident #1 hit another resident in the chest. There was no redness or complaint of pain from the other resident. Resident #1 was separated from the other resident. Critical monitoring started. Message left for NP/MD. Administrator and DON notified. (named police department) notified. NP K and RP notified. LVN B did not indicate Resident #1's level of supervision implemented to protect other residents from further aggressive and physical behaviors. Record review of Resident #1's progress note dated 07/22/24 at 08:32 a.m., completed by LVN A indicated Resident #1 pushed another resident down in the TV room. Administrator, DON, (named police department), and Ombudsman notified. Resident #1 on 1-1 at this time. (named police department) arrived at 7:20 to talk to Resident #1. Resident refused to tell (named police department) what happened or why it happened. RP notified. Record review of Resident #1's IDT Behavior Health Review dated 07/23/24 indicated Resident #1 was sent to behavioral hospital on 7/10/24 and returned back to the facility on [DATE]. Resident #1 came back with no new orders. Labs drawn and received critical ammonia level. New orders for Lactulose 15 ml tid x 5 days. Educated staff on recognizing agitation and de-escalate behaviors. Interventions care planned for all events. Emergency care plan set up with family related to behaviors and possible discharge from the generation unit. Psych NP involved and received no medication change. 07/21/24 Resident #1 was placed on q 15 min behavioral monitoring due to behavioral and MD and psych notified. Psych stated they would see the resident on visit. 07/22/24- Resident #1 placed one to one and sent out to the behavioral related to physical aggression. There was no resident specific intervention implemented to prevent and protect other residents from Resident #1's aggression towards others. The note did not indicate Resident #1's level of supervision implemented to protect other residents from further aggressive and physical behaviors upon her return to the facility. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the facility investigation dated 07/24/24 indicated Resident #1's roommate came to LVN B and said Resident #1 hit another resident in the chest. There was no redness or open areas noted to the other resident's chest and no complaint of pain. Residents were separated immediately. Psych was notified and Resident #1 was place on q 15 minute behavioral monitoring. Staff was inserviced on abuse and neglect and improving resident behavior. Behavior monitoring to continue for 72 hours post allegation with Q 15 min for first 24 hours. There were no specific interventions noted to prevent Resident #1's aggression toward others. The investigation did not indicate Resident #1's level of supervision implemented to protect other residents from further aggressive and physical behaviors. Record review of facility investigation dated 07/29/24 indicated Resident #1 was noted sitting in the television room on 07/22/24 when another resident reported to LVN A that Resident #1 had pushed Resident #2 to the floor. Residents were separated immediately. Resident #2 sustained a 1 inch laceration to the back of her head. Psych stated to do an q 15 min behavioral monitoring. Resident #1 placed on one on one and sent to behavioral hospital. Resident #2 sent out to medical center for evaluation and treatment Upon Resident #2 returned with 6 staples noted to the back of her head. In-services provided on abuse and neglect and notifying abuse coordinator/administrator with any allegation of abuse, neglect or misappropriation. In-service completed on behavior monitoring and interventions to use to dissuade physical altercation behaviors. Emergency care plan held with family. Behavior monitoring to continue for 72 hours post allegation with Q 15 min for the first 24 hours. There were no specific interventions noted to prevent Resident #1's aggression toward others. Record review of IDT Event Review dated 09/03/24 for Physical Aggression initiated on 09/02/24 indicated Resident #4 reported to the nurse that Resident #1 hit her on the back of the head while she was coming out of their shared room. There was no injury. Residents were immediately separated and place on behavior monitoring q-15 minute monitoring for 72 hours. Orders received to send Resident #1 to hospital for psych evaluation. Resident #1 transferred to another room. Psych NP visited on 09/03/24 and received order to send Resident #1 out to behavioral hospital. Resident returned from hospital and was transferred to behavior hospital. The note did not indicate Resident #1's level of supervision implemented to protect other residents from further aggressive and physical behaviors. Record review of Resident #1's progress note dated 11/24/24 at 11:25 a.m., completed by LVN B indicated LVN B was standing at the medication cart with her back turned away from the residents and heard a CNA shout no. CNA reported Resident #1 hit Resident #3 forehead and chest. The residents were separated. There were no injuries. Administrator, psych NP, family, RP, ombudsman, named police department and physician notified. Record review of facility investigation dated 11/29/24 indicated psych ordered 15 minute behavioral monitoring for 72 hours. The facility confirmed Resident #1 abused Resident #3. Record review of Resident #1's progress note dated 12/28/24 at 8:00 a.m., completed by LVN A indicated CNA was standing in the doorway monitoring residents in the dining room when she witnessed Resident #1 getting up from a table and went to another table and struck Resident #5 in the face. Staff separated residents. Resident #1 was on 1-1 monitoring. Administrator, DON, ADON, were notified immediately. (named police department) was called. Ombudsman was notified. On call was notified and gave new orders to send Resident #1 out for evaluation. Psych was called. Resident was transported to ER for evaluation. (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 0600

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Some

Record review of Resident #1's progress note dated 12/29/24 at 2:55 a.m., completed by LVN AA indicated Resident #1 returned to the facility. Resident RP and MD notified of Resident #1's return. Will continue to monitor resident for behaviors and all other concerns. LVN AA did not indicate Resident #1's level of supervision implemented to protect other residents from further aggressive and physical behaviors.

Record review of IDT Event Review dated 01/03/25 for physical aggression initiated on 12/28/24 indicated Resident #1 was unable to say what happened or why. Resident #1 was sent to ER for evaluation. She returned with no new orders. Psych indicated discontinue 1-1 and begin 15-minute monitoring for 72 hours. Psych would see resident next facility visit. The note did not indicate Resident #1's level of supervision implemented to protect other residents from further aggressive and physical behaviors upon her return to the facility.

Record review of the facility investigation dated 01/03/25 indicated Resident #1 and Resident #5 were in the dining room on 12/28/24 at 7:57 a.m. Resident #1 walked over to Resident #5 and struck him in the face. Residents were separated. Residents were assessed. There were no injuries. Resident #5 asked why Resident #1 hit him. Resident #1 was place on 15 minute monitoring and transferred to the ER for evaluation and treatment. Resident #5 did not provoke Resident #1. Staff were in-serviced on abuse and neglect. Staff were in-serviced on improving resident behaviors (resident-to resident altercations)-redirect any resident that is causing agitation towards another resident. Separate residents immediately before/after an altercation and monitor each resident.

2. Record review of Resident #2's face sheet dated 02/25/25 indicated she was a [AGE] year old female, admitted on [DATE], and her diagnosis included IDD (intellectual or developmental disorder), anxiety (a feeling of fear, dread, and uneasiness), diabetes (a chronic disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin), depression (mental health condition), and delirium due to known physiological condition (state of acute mental confusion and disorientation caused by an underlying medical condition).

Record review of Resident #2's annual MDS dated [DATE] indicated was usually able to make herself understood and understood others, had severe cognitive impairment (BIMS-5), had verbal behavioral symptoms directed at others that put her at risk for physical illness or injury and significantly interfered with the resident's participation in activities or social interactions. She had wandering behaviors that significantly intruded on privacy or activities of others.

Record review of Resident #2's care plan dated 12/14/23 indicated she was an elopement risk/wanderer related to a history of wandering. Interventions included admit to secure unit, identify pattern of wandering, and intervene as appropriate.

Record review of an incident report dated 07/22/24 completed by LVN A indicated an un-named resident notified LVN A Resident #2 was pushed down by another resident. Resident #2 was crying and lying on the floor of the activity room. Resident #2 had bleeding and a 1 inch laceration to the back of her head. Resident #2 was sent to the ER for evaluation and treatment.

Record review of Resident #2's hospital records dated 07/22/24 indicated she was admitted due to a fall caused by being pushed by another resident. She had a laceration to the back of her head. It was repaired with 6 staples.

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3. Record review of Resident #3's face sheet dated 02/26/25 indicated she was a [AGE] year old female admitted on [DATE] and her diagnoses included schizoaffective disorder-bipolar type (a chronic mental health condition characterized primarily by symptoms of schizophrenia, such as hallucinations or delusions, and symptoms of a mood disorder, such as mania and depression), anxiety (a feeling of fear, dread, and uneasiness), cognitive communication deficit (problems with communication), and dementia (loss of cognitive functioning). Record review of Resident #3's annual MDS assessment dated [DATE] indicated she was sometimes able to make herself understood and usually understood others, and she had severe cognitive impairment (BIMS-00). Record review of Resident #3's care plan dated 07/30/21 indicated Resident #3 had cognitive impairment and required cues and redirecting. Interventions included repeating information, allowing time for response, and assist as needed with tasks. Record review of Resident #3's care plan indicated she had a history of inappropriate/disruptive behavior. Interventions included activities, administer medications, and monitor and document behavior. Record review of Resident #3's care plan dated 04/28/22 indicated she wandered aimlessly and significantly intruded on privacy and activities. Interventions included offering diversions, activities, food, conversation, television or books. Record review of progress note dated 07/10/24 at 4:15 p.m., completed by LVN B indicated she was charting at the desk in the hall and heard a loud noise. LVN B heard HSK Z say Resident #1 hit Resident #3 in the back. Both residents were standing at the secure unit double doors. There was some redness noted to Resident #3's upper back. Residents were separated for safety. 4. Record review of Resident #4's face sheet dated 02/26/24 indicated she was a [AGE] year old female admitted on [DATE] and her diagnoses included schizophrenia (mental health disorder), major depressive disorder (mood disorder), mild cognitive impairment (stage between normal aging and dementia), anxiety (a feeling of fear, dread, and uneasiness), and dementia (loss of cognitive functioning). Record review of Resident #4's quarterly MDS assessment dated [DATE] indicated she was able to make herself understood and understood others, and she had severe cognitive impairment (BIMS 6). Record review of Resident #4's care plan dated 09/20/24 indicated she had the potential for physical aggression. Interventions included critical behavior monitoring, separate resident from other resident, and intervene before agitation escalates. Record review of IDT Event Review dated 09/03/24-Physical Aggression Received on 09/02/24 indicated Resident #4 reported Resident #1 hit her on the back of the head. Residents were separated and assessed with no injuries or pain. Resident #4 stated she was o.k. and no distress was noted. Resident #4 was transferred to another room. 5. Record review of Resident #5's face sheet dated 02/26/25 indicated he was an [AGE] year old male, admitted on [DATE], and his diagnoses included dementia (loss of cognitive functioning and cognitive communication deficit (problems with communication). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #5's quarterly MDS assessment indicated he was able to make himself understood and understood others and had severe cognitive impairment (BIMS-3). Record review of Resident #5's care plan dated 07/19/23 indicated he had impaired cognition related to dementia. Interventions included cue, reorient and supervise as needed. During an observation on the secure unit on 02/20/25 at 11:00 a.m., Resident #1 was asleep in her room with the door closed. There were other residents observed walking in the hall, in their rooms, or in the TV room and dining room. There was no staff observed near Resident #1 or her room. During an interview on 02/20/24 at 11:30 a.m., CNA G said on 12/28/24, Resident #1 was leaving the dining room and then she turned around and hit Resident #5 in the face. She said she redirected Resident #1 to her room and called for the nurse. She said there was nothing happening at the time of the incident. She said there was no warning before Resident #1 hit Resident #5. She said there was no specific interventions to prevent Resident #1's aggression towards others. She said staff could only watch and intervene and separate before and after the aggression. During an interview on 02/20/25 at 1:12 p.m., CNA G said she was working on 07/22/24 when Resident #1 pushed Resident #2 to the floor in the TV room. She said she was not working the day before when Resident #1 hit Resident #2 and was not aware of the incident. She said she was not aware Resident #1 was being monitored. She said Resident #1 was no on 1-1 monitoring for behavior. She said she was busy with other resident care and LVN A was at the medication cart in the hallway. During an interview on 02/20/25 at 1:20 p.m., CNA H said she was assisting other residents in the shower and did not observe Resident #1 push or hit Resident #2 on 07/22/24. She said she was not aware Resident #1 was on 15 minute monitoring. She said after Resident #1 pushed Resident #2 the residents were separated. She said Resident #1 was in her own room after the incident. During an interview on 02/20/25 at 1:23 p.m., LVN A said the aides were taking care of the residents and as they got each resident ready for the day, each resident was brought to the TV room. She said Resident #1 was already in the TV room. She said she was busy passing medications and heard a bump and then Resident #4 said Resident #1 pushed Resident #2 to the floor. She said she went to the TV room and and separated the residents. She said Resident #1 refused to say what happened and refused to leave the TV room. She said one aide stayed with Resident #1 while they moved the other residents. She said Resident #2 had a 1 inch laceration to the back of her head and was sent out to the hospital. She said Resident #1 was on 15 minute monitoring that started from 07/21/24. She said Resident #1 eventually went to her room and and stayed in in her room until a referral and transfer to to a behavioral hospital on 07/22/24. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 02/21/25 at 9:30 a.m., the DON said the facility had attempted to discharge Resident #1 to another facility but no facility would accept her due to her aggressive behaviors. She said Resident #1 resided on the secure unit. She said there was 1 nurse on shift (6a-6p and 6p-6a 7 days/week), 2 aides (6a-2p,2p-10p, and 10p-6a 7 days/week) and 1 activity staff/CNA (8a-5p Monday through Friday). She said said staff was increased to protect the residents from aggressive behavior. She said Resident #1 was assessed for any medical issues, removed and separated from other residents, and had psychiatric interventions after each behavior. She said Resident #1 was sent to the ER and then, if necessary, referrals were obtained to send her to a behavioral hospital. She said Resident #1 may have been on 1-1 prior to being sent out to the behavior hospital. She said if there was no additional signs of aggression or behaviors the monitoring was reduced. During an interview on 02/21/25 at 12:22 p.m., SW J said she was employed with the facility since December 2024 and had not attempted to find alternative placement for Resident #1. She said she was aware the previous SW had attempted to find alternative placement for Resident #1 but was not successful due to her behaviors. During an interview on 02/24/25 at 12:30 p.m., LVN C said the IDT discussed interventions for the incident that occurred on 07/22/24 when Resident #1 pushed Resident #2. She said there were no new specific interventions to protect other residents from Resident #1's aggression added to the care plan. She said she did not know why interventions were not added. She said she was responsible for adding the interventions to the care plan. She said the monitoring intervention was already in place. During an interview on 02/25/25 at 1:34 p.m., LVN B said there were no residents who were said they were afraid or acted as if they were afraid of Resident #1. She said staff have to watch and be on the look out for Resident #1 was she is walking past or by other residents because her aggression and behaviors were unpredictable. During an interview on 02/25/25 at 1:40 p.m., Activity Staff C said she was not aware of any residents or staff who were afraid of Resident #1. She said staff would attempt to keep Resident #1 separate from other residents to avoid aggressions. During an interview on 02/25/25 at 1:45 p.m., Resident #5 said he was not afraid of anyone. He said he did not get hit by anyone or remember anyone hitting him. During an interview on 02/25/24 at 3:48 p.m., NP F said it was her first psych visit with Resident #1 was on 12/23/24. And she was in the process of reviewing her medications for possible adjustments. She said it would be her expectations the facility would implement 1-1 after resident to resident aggression until the resident was calm then go to 15 minute monitoring. She said moods were not predicable and behaviors would happen. She said she did not know what interventions were available to prevent the behaviors. She said the resident may need a referral to a behavior hospital if the behavior was not caused by a medical issue. During an interview on 02/25/25 at 4:30 p.m. LVN B said staff knew to be aware of Resident #2 wandering around Resident #1 and to keep them separate. She said she was usually in the hall monitoring to keep residents away from resident #1. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 02/25/25 at 4:34 p.m., CNA I said Resident #1's behaviors were unpredictable. She said staff were aware of her behaviors and monitored other residents to keep them away from Resident #1. She said she was not aware of any specific interventions to prevent Resident #1's behaviors. She said she was standing in the hall on 11/24/24 and she saw Resident #1 used her right hand/fist and hit Resident #3 on her forehead and her chest. She said she told the charge nurse and the residents were separated. During an interview on 02/25/25 at 5:40 p.m., the DON said Resident #1 was not monitored every 15 minutes for behaviors upon her return from the behavior hospital. She said Resident #1 was monitored for 72 hours just as every new admission was monitored. She said there was no policy related to resident behavior monitoring. During an interview on 02/26/25 at 8:30 a.m., Resident #4 said she saw Resident #1 push Resident #2 in the TV room. She said Resident #2 fell and hit her head. She said Resident #2's head was bleeding. She said Resident #2 was not doing anything to Resident #1. She said there was no staff in the TV room. She said LVN A was in the hall with the medication cart. She said she told LVN A that Resident #1 pushed Resident #2 and the staff came running fast to take care of Resident #2. She said she did not know if any other residents were afraid of Resident #1 except Resident #2. She said Resident #2 would come and sit by her (Resident #4) if Resident #1 would be in the same room. During an observation on the secure unit on 02/26/25 at 9:00 a.m., Resident #1 was in her room, dressed and sitting on her bed. She said she was fine and had no complaints. There was no signs of distress or agitation. There were other residents observed walking in the hall, in their rooms, or in the TV room and dining room. There was no staff observed near Resident #1 or her room. During an interview on 02/26/25 at 9:10 a.m., LVN A said Resident #1 was in the TV room. She said Resident #2 walked into the TV room. She said she heard a loud noise from the TV room and then Resident #4 came and told her (LVN A) that Resident #1 had pushed Resident #2 to the floor. She said Resident #1's behaviors were unpredictable. She said at the time of the incident on 07/22/24, Resident #1 was on 15 minute monitoring from 07/21/24. During an interview on 02/26/25 at 10:00 a.m., the Administrator said Resident #1 was constantly redirected due to her behaviors. She said staff were aware they had to be attentive to Resident #1 due to her history of aggressive behaviors and her risk of aggressive behavior. She said the facility was doing everything possible to prevent behaviors including activities and medications changes. She said she was not aware Resident #1 was left alone in the TV room on 07/22/24. She said she was not going to say whether or not Resident #1 should have been left alone with other residents. During an interview on 02/26/25 at 10:15 a.m., LVN C said behavior interventions should be on Resident #1's care plan. She said the interventions should have included educating staff, redirection, and activities. She said resident specific interventions should be on the Kardex and available for all staff. (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 02/27/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 02/26/25 at 10:20 p.m., the DON said Resident #1's was compulsive and her behaviors could not be anticipated. She said the facility had previously attempted to find alternate placement but was not successful due to her aggressive behavior. During an interview on 02/26/25 at 11:00 a.m., CNA G said she was not aware Resident #1 was being monitored for behaviors or that anyone should have been watching her on 07/22/24. She said other residents were at risk of Resident #1's aggressive behaviors because the behaviors were unpredictable. She said staff had to watch Resident #1 and keep her separate from other residents or keep other residents away from being too close to Resident #1. During an interview on 02/26/25 at 11:00 a.m. CNA H said she was not aware Resident #1 was being monitored for behaviors or that anyone should have been watching her on 07/22/24. She said Resident #1 had unpredictable aggressive behaviors. She said all residents had to be keep away from Resident #1 for their protection. During an interview on 02/26/25 at 11:00 a.m., LVN A said she was aware of Resident #1 being on 15 minute monitoring but was not aware of the reason for the monitoring. She said she would look to see where Resident #1 was and what she was doing and document on the sheet. She said on 07/22/24 after the incident, Resident #1 refused to say anything. She said Resident #2 said Sorry mama help. She said Resident #1's behaviors were unpredictable and all other residents on the secure unit were at risk from her aggressive behaviors. During an interview on 02/26/25 at 2:47 p.m., NP K (previous psychiatric provider) said Resident #1's behaviors were unpredictable and she was a danger to others. She said it was her opinion Resident #1 was not appropriately placed in the facility. She said she was aware the facility had attempted to find alternate facility placement and was not successful. She said Resident #1 really needed placement in a state facility. She said Resident #1's medications never really worked and were always being adjusted but nothing ever worked to prevent the unpredictable behaviors. Review of the facility's Abuse and Neglect Policy dated 04/2021 indicated Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to 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. The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: 1. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to: a. facility staff; b. other residents; . 2. Develop and implement policies and protocols to prevent and identify: a. abuse or mistreatment of residents; b. neglect of residents; and/or c. theft, exploitation or misappropriation of resident property. 10. Protect residents from any fur [TRUNCATED]

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 02/27/2025
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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25115 Based on interview and record review, the facility failed to investigate and report the findings of the investigation to the State Survey Agency within 5 working days of the incident for 2 of 7 residents (Residents #6 and #7) reviewed for abuse. The facility failed to investigate and submit the results of their investigation within 5 days after Resident #6 slapped Resident #7 on 05/20/24. These failures could place residents at risk of abuse, physical harm, mental anguish and emotional distress. Findings included: 1. Record review of Resident #6's face sheet dated 02/20/25 indicated she was a [AGE] year old female admitted on [DATE] and her diagnoses included cerebral infarction (stroke), hemiplegia (paralysis of one side of the body) and hemiparesis (one-sided muscle weakness) affecting right dominant side, aphasia (a language disorder that prevents effective communication), anxiety (fear, dread and other symptoms that are out of proportion to the situation), and schizoaffective disorder (mental health condition). Record review of Resident #6's annual assessment dated [DATE] indicated she was rarely/never understood, sometimes understood others, had severe cognitive impairment (BIMS-00), and utilized a wheelchair for mobility. Record review of Resident #6's care plan dated 05/20/24 indicated Resident #4 was physically aggressive by hitting another resident in the dining room. Interventions included notify abuse coordinator, administer medications as ordered, assess and anticipate Resident #4's needs, and provide physical and verbal cues to alleviate anxiety. The care plan was resolved on 08/22/24. Record review of Resident #6's progress note dated 05/20/24 at 8:22 a.m., competed by LVN X indicated ST Y reported Resident #6 hit another resident on the arm in the dining room. Resident #6 unable to voice what happened. Residents separated and safe. Administrator W (previous administrator), RP, and DON informed. Physician notified and order obtained for CBC, CMP, and UA. Record review of Resident #6's progress note dated 05/20/24 at 10:02 a.m., completed by LVN X indicated Resident #6 was placed on 1-1 monitoring. Record review of Resident #6's progress note dated 05/20/24 at 4:36 p.m., completed by ADON M indicated Resident #6 was transferred to a behavioral hospital. 2. Record review of Resident #7's face sheet dated 02/20/25 indicated she was a [AGE] year old female admitted on [DATE] and her diagnoses included cerebral infarction (stroke) and depression (mental health condition). (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #7's quarterly MDS assessment dated [DATE] indicated she was able to make herself understood and understood others, she was cognitively intact (BIMS-15), and she utilized a wheelchair for mobility. Record review of Resident #7's progress note dated 05/20/24 at 9:28 a.m., completed by LVN E, indicated she was informed Resident #7 was hit on the arm while in the dining room. LVN E noted left arm with active bleeding. Pressure was applied and sterile dressing applied. Administrator W (previous Administrator) was notified. MD notified and no new orders. Resident #7 reported she was hit by another resident because she thought she was blocking her wheelchair. Record review of ST Y's statement dated 05/20/25 indicated she was in the dining room on 05/20/24. She witnessed Resident #7 back away from her table and into a chair. Resident #6 and Resident #7 began having an exchange. Resident #7 and Resident #6 began yelling at one another and Resident #6 slapped and grabbed Resident #7's left arm. ST Y was on the way to separate the residents when the hitting happened. ST Y separated the residents and informed the nurse. Record review of the facility's investigation file indicated there was no completed investigation report available for review. Record review of TULIP on 02/20/25 indicated there was no completed investigation report available for review. During an interview on 02/2/25 at 11:30 a.m., Resident #6 said she was fine. When asked if she was afraid of any residents she smiled and shook her head no. During an interview on 02/21/25 at 11:45 a.m., Resident #7 said Resident #6 hit her arm and caused a scratch. She said it happened in the dining room. She said Resident #6 was upset she had bumped into her (wheelchair). She said it was an accident. She said she was not afraid of Resident #6. During an interview on 02/24/25 at 5:00 p.m., the Administrator said she was not able to locate the facility investigation report for intake #505773. She said there was no copy in the facility's hard file. The Administrator said Administrator W's (previous Administrator) provider investigation report should have been sent to HHSC no later than 5 working days after the incident or initial report. The Administrator said not investigating alleged abuse could place residents at risk for further abuse. Record review of the facility's Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating dated 09/2022 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 regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Follow-Up Report . 1. Within five (5) business days of the incident, the administrator will provide a follow-up investigation report. 2. The follow-up investigation report will provide sufficient information to describe the results of the investigation, and indicate any corrective actions taken if the allegation was verified. 3. The follow-up investigation report will provide as much information as possible at the time of submission of the report. 4. The resident and/or representative are notified of the outcome immediately upon conclusion of the investigation.