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	06/04/2025

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 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** Based on interviews and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported, immediately but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or bodily injury, to the administrator of the facility and to other officials, including the State Survey Agency in accordance with State law through established procedures for 1 of 10 residents (Resident #4) reviewed for reporting allegations of abuse. The admission Coordinator failed to ensure allegations of abuse were reported to the Abuse Coordinator immediately. Resident #4 reported allegations to the admission Coordinator on 05/26/25 that an un-named CNA was verbally aggressive, physically aggressive and he feared for his safety. This failure could place residents at risk of abuse, neglect, and exploitation. Findings included: Record review of Resident #4's face sheet dated 06/04/25 indicated he was a [AGE] year old male, admitted on [DATE] and his diagnoses included schizophrenia (mental health condition that affects how people think, feel, and behave), anxiety (excessive feelings of worry, fear, and apprehension, schizoaffective disorder (mental health condition that combines symptoms of schizophrenia such as hallucinations and delusion with mood disorder symptoms including depression and mania [abnormally elevated and extreme changes in mood or emotions]), cannabis (marijuana) use, and cocaine abuse. Record review of Resident #4's admission MDS dated [DATE] indicated he was admitted from hospital, he was able to make himself understood and understood others, and he was cognitively intact (BIMS-15). He had verbal behavior directed at others. Record review of Resident #4's care plan dated 05/19/25 (revised 05/28/25) indicated Resident #4 had a behavior problem related to schizoaffective disorder. Interventions included discuss behavior if reasonable and intervene as necessary to protect the rights and safety of others. (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:	(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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #4's care plan dated 06/02/25 indicated he had the potential to be verbally aggressive and make false accusations against staff members related to mental and emotional illness. Interventions included administer medications as ordered, assess coping skills and support system, assess understanding of the situation and allow time to express self and feeling, care in pairs when providing ADL care, monitor behavior and document attempted interventions, and psychiatric consult as indicated. Record review of Resident #4's progress note dated 05/26/25 at 1:05 a.m., completed by LVN T, indicated Resident #4 wanted a cigarette and was informed the smoke breaks were over. Resident #4 threw something against his door. There was a water pitcher, water, and ice on the floor. LVN T asked what was going on. Resident #4 said Get out of my room fat bitch and then CNA S entered the room, CNA S asked Resident #4 why he threw he water pitcher at the nurse. Resident #4 said he was angry about not getting a cigarette. Resident #4 called LVN T a fat bitch and CNA S asked him to stop. Resident #4 called CNA S a black motherfucker and took a lighter and lit a glove on fire and threw it at CNA S and said, I will light your ass up. LVN T attempted to retrieve the lighter and Resident #4 refused to give the nurse his lighter. Called and spoke to the DON and Administrator. Record review of Resident #4's progress note dated 05/26/25 at 12:10 p.m., competed by the DON indicated This nurse, accompanied by a witness, entered the resident's room to follow up regarding the earlier reported incident. The resident was questioned about the alleged behaviors. The resident denied possession of a lighter and denied throwing a lit glove at an employee or throwing two water pitchers. He stated that the water was already on the floor prior to the incident and alleged that staff attempted to take his cell phone to prevent him from contacting the police. (Named Police Department) was contacted and arrived on-site at approximately 10:15 AM in response to the incident. Case number: [number]. Officers reviewed the witness statement and spoke with the resident, who again denied the incident. Police advised that if staff wished to press charges, they would need to appear in person to provide a formal statement. Resident was educated that possession of a lighter is strictly prohibited in resident rooms per facility safety policies. The potential fire hazard and risk to self and others were explained. Resident verbalized understanding. Additionally, this nurse discussed with the resident the importance of maintaining respectful and appropriate behavior toward staff. The resident was reminded of the facility's expectations regarding respectful communication and interactions. Resident was encouraged to express concerns appropriately and informed that threatening or aggressive behavior will not be tolerated. Record review of a Grievance/Complaint Report dated 05/26/25 (there was no time noted), completed by the admission Coordinator, indicated Resident #4 alleged an unidentified CNA came into his room, was yelling and being aggressive, would not let him call the police, and yanked the phone out of his hand and he was worried about his safety. The Administrator and DON were designated to investigate on 05/27/25 at 9:30 a. m. Resident #4's care plan was reviewed and updated to reflect interventions. Record review of TULIP indicated the facility reported the allegation of abuse on 05/27/25 at 11:15 a.m. Record review of the facility investigation dated 06/04/25 indicated the incident occurred on 05/26/25 at 12:10 a.m. The allegation was reported to the admission Coordinator the morning of 05/26/25. The allegation of abuse was unconfirmed. Resident #4 refused to identify staff who was abusive or who attempted to take his phone. (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 LVN T's statement dated 05/26/25 at 1:05 a.m. indicated Resident #4 wanted a cigarette and was informed the smoke breaks were over. Resident #4 threw something against his door. There was a water pitcher, water, and ice on the floor. Resident #4 LVN T asked what was going on. Resident #4 said Get out of my room fat bitch and then CNA S entered the room CNA S asked Resident #4 why he threw he water pitcher at the nurse. Resident #4 said he was angry about not getting a cigarette. Resident #4 called LVN T a fat bitch and CNA S asked him to stop. Resident #4 called CNA S a black motherfucker and took a lighter and lit a glove on fire and threw it at CNA s and said, I will light your ass up. LVN T attempted to retrieve the lighter and Resident #4 refused to give the nurse his lighter. Called and spoke to the DON and Administrator. During an interview on 06/04/25 at 9:40 a.m., the Administrator said Resident #4 made the allegation of abuse on 05/26/25 to the admission Coordinator. She said she did not know what time the allegation was made. She said she was made aware of the grievance on 05/27/25 and realized it was a reportable allegation and reported within two hours of being informed of the allegations. She said there was no staff identified because Resident #4 would only say it was a CNA and would not give a description. She said the risk of not reporting as required place residents at risk of further abuse. During an interview on 06/04/25 at 9:45 a.m., the admission Coordinator said she did not recall the time she received the allegation of verbal abuse from Resident #4. She said Resident #4 was involved with the police due to his behaviors and thought the grievance was in relation to his behaviors. She said Resident #4 would not identify or name the staff he accused. She was trained on abuse and reporting. She said all allegations were reportable to the Administrator immediately. During an interview on 06/04/25 at 10:00, Resident #4 said a CNA who was a young black male in his 30's took his phone. He said the CNA grabbed his wrist and would not let him call the police. He said he had dropped some water on the floor and the CNA took a blanket and wiped up the water. During an interview on 06/04/25 at 10:50 a.m., the DON said Resident #4 said they took his cell phone but Resident #4 did not have a cell phone. She said staff found the facility phone under his bed. She said Resident #4 would not identify or name any staff in his allegations. During an interview on 06/04/25 at 11:35 a.m., CNA S said he was completing care on another resident in another room and heard yelling. He said LVN T said Resident #4 had thrown his water pitcher and there was water and ice on the floor. He said he cleaned up the water with towels and blankets from the laundry cart. He said he had brought the facility phone for Resident #4 to use earlier in the shift. He said he did not grab Resident #4's wrist. He said Resident #4 called LVN T a fat bitch and CNA S a motherfucker. He said Resident #4 said he would fuck him up. CNA S denied yelling at or grabbing Resident #4. The surveyor called LVN T on 06/04/25 at 12:03 p.m. and left a voicemail message with contact information. LVN T did not respond during the investigation. Record review of the facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program dated 2001 (revised April 2012) indicated . 9. Investigate and report any allegations within timeframes required by federal requirements. (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 the facility's Abuse, Exploitation or Misappropriation-Reporting and Investigating dated 2001 (revised September 2022) indicated 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. Policy Interpretation and Implementation Reporting Allegations to the Administrator and Authorities If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 10 residents (Resident #1) reviewed for accidents and supervision. The facility failed to ensure adequate supervision for Resident #1 with two staff members for bed mobility during incontinent care to prevent a fall with injury on 9/19/2024 which resulted in Resident #1 having complaint of pain to the right knee. An x-ray was conducted on 09/19/2024 with the results of evidence of acute fracture of the right distal femur (bone in the upper leg) requiring hospitalization for surgical intervention. The non-compliance was identified as past non-compliance. The Immediate Jeopardy began on 09/19/2024 and ended on 09/24/2024. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk for injury and harm due to the lack of supervision provided by the facility. Findings included: Record review of the face sheet for Resident #1 indicated she was initially admitted on [DATE], was [AGE] years old female with diagnoses of high blood pressure, Chronic Obstructive Pulmonary Disease, muscle weakness, muscle wasting, cerebral infarction (lack of adequate blood supply to brain cells deprives them of oxygen and vital nutrients which can cause parts of the brain to die off), dementia (loss of cognitive functioning), and morbid obesity. Record review of the MDS state optional assessment dated [DATE] indicated Resident #1 required 2 staff members for bed mobility. Her BIMS indicated she was cognitively intact with a score of 14. Record review of the quarterly MDS assessment dated [DATE] indicated Resident #1 was able to understand and make her needs known. She required substantial/maximal assistance with the helper doing more than half the effort. Her BIMS indicated she was cognitively intact with a score of 14. Record review of the care plan dated 12/28/2024 indicated Resident #1 had an ADL self-care performance deficit. Resident #1 required 2 staff for assistance with bed mobility, with start date of 08/16/2024. Record review of the physician's orders September 2024 for Resident #1 indicated she had an order for Acetaminophen Tablet 650 mg, give 1 tablet by mouth every 4 hours as needed for general discomfort related to right knee pain with start date of 08/24/2024. Record review of the Kardex (electronic care task utilized by care staff) dated 09/19/2024 indicated Resident #1 required 2 staff for bed mobility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the nurse progress notes for Resident #1 authored by LVN D indicated on 09/19/2024 at 07:45 a.m., CNA A had reported to LVN D that while getting things ready to change the resident and while waiting on help to change the resident, Resident #1 slid off the bed feet first, so she guided the resident to floor and informed nurse of the incident. The CN performed a head-to-toe assessment and the resident denied pain or hitting her head. Resident #1 was able to move all extremities. The CN provided care to a skin tear to the left toe and Resident #1 was assisted back to bed using a mechanical lift and 3 staff members. Record review of the MAR for September 2024 indicated Resident #1 received 3 doses of Tylenol 650 mg 1 tablets on 09/19/2024 at 8:14 a.m., 4:24 p.m., and 8:29 p.m. for pain and it was effective. Record review of the nurse progress note authored by LVN H for Resident #1 indicated on 09/19/2024 at 4:40 p.m. the resident had an x-ray of her right hip for pain. Record review of the nurse progress note authored by LVN X for Resident #1 indicated on 09/20/2024 at 11:19 a.m. the resident was admitted to local hospital for a closed distal right femur fracture (lower leg bone fracture that occurs without leaving any open wound in the skin) and surgery was scheduled for later that evening. Record review of an x-ray report dated 09/19/2024 indicated Resident #1 had evidence of an acute fracture of the right distal femur (bone in the upper leg) and diffuse osteopenia (a condition of lower-than-normal bone mineral density that may lead to a condition in which bones become weak and brittle) is present. Record review of the nurse progress note authored by LVN D for Resident #1 indicated on 09/20/2024 at 12:02 a.m. the facility received x-ray report which reflected an acute fracture (a break in a bone that occurs due to sudden, one-time injury, typically from direct impact or fall) of the distal femur (bone in the upper leg). Notified the on-call physician of the x-ray report and was ordered to send Resident #1 to the local ER for evaluation. Resident #1 transferred to local hospital via ambulance. Record review of the hospital records dated 09/20/2024 indicated Resident #1 had a distal femur fracture that required surgical intervention. On 09/24/2024 a right femur fluoroscopic (is a medical imaging procedure that uses several pulses (brief bursts) of an X-ray beam to show internal organs and tissues moving in real time on a computer screen) indicated a previous exam showed a fracture of the distal right femur extending into the right knee joint. There had been placement of a plate along the medial aspect (toward the middle or center) with multiple screws and alignment was normal. Impression revealed: Open reduction internal fixature (a surgical procedure used to repair severe bone fractures by realigning and stabilizing the broken bones with hardware such as plates and screws) of right femur fracture. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's investigation report dated 09/26/2024 indicated on 09/19/2024 Resident #1 had a fall from bed requiring head to toe assessment. Resident #1 assisted back to bed using Hoyer lift and 3 staff members. Resident #1 began to complain of hip and knee pain and mobile x-ray ordered. Resident #1's x-ray results showed an acute fracture of the distal femur (upper bone of leg). Resident #1 was transported via ambulance via stretcher to the local hospital related to acute fracture of the distal femur with surgical intervention scheduled for 09/20/2024. The investigation interviews led to CNA A admitting on 09/19/2024 she provided incontinent care alone to a Resident #1 which required 2 persons assistance for incontinent care resulting in Resident #1 falling and having a significant injury. CNA A was suspended and terminated related to this incident. Facility staff in-serviced on following Kardex for required assistance with each resident and on identifying abuse and neglect. Record review of the nurse progress notes authored by LVN X for Resident #1 indicated on 10/01/2024 at 1:19 p.m., the resident was back in facility after she was hospitalized at the local hospital for a right femur fracture with surgical intervention. Resident #1 had a surgical incision to right knee with 14 staples intact. Assist x 2 staff with all ADL's and transfers. Record review of the physician's orders October 2024 for Resident #1 indicated she had an order for Acetaminophen Tablet 650 mg, give 1 tablet by mouth every 4 hours as needed for general discomfort related to pain with start date of 08/24/2024 and Tramadol 50 mg, give 1 tablet every 8 hours as needed for pain with start date of 10/04/2024. Record review of the MAR for October 2024 indicated Resident #1 received 1 dose of Tylenol 650 mg 1 tablet on 10/01/2024, 10/02/2024, 10/03/2024, 10/04/2024, 10/05/2024, 10/06/2024, 10/10/2024, 10/15/2024, 10/18/2024, and 10/20/2024 for pain and it was effective, and she received 1 dose of Tramadol 50mg 1 tablet on 10/05/2024, 10/06/2024, 10/07/2024, 10/11/2024, 10/14/2024, 10/16/2024, 10/22/2024 and 10/27/2024 for pain and it was effective. Record review of the Kardex dated 10/01/2024 indicated Resident #1 required 2 staff for bed mobility. Record review of CNA A's personnel file indicated that she was terminated on 09/19/2024 for failing to follow safety protocols and notation showed the employee did not follow the facility's safety protocol with a two-person assistance to turn and reposition a resident in bed and the failure resulted in the resident having a significant injury. Record review of an in-service dated 09/20/2024 indicated nursing staff were retrained on the use of the Kardex system and the Kardex must be followed at all times. If the Kardex indicated that a resident required 2 people for transfer, bed mobility, etc., then staff must have 2 people assisting. Mechanical transfers must always be completed with 2 staff members, no exceptions. During an interview on 06/03/2025 at 9:30 a.m., Resident #1 said she did not remember much about the day she fell. She said she recalled having to go to the hospital and have surgery from a broken leg after the fall. During an interview on 06/03/2025 at 1:05 p.m., LVN H said Resident #1 had always been 2 staff with turning her and for her care. She said Resident #1 required a mechanical lift with 2 staff for transfers. LVN H said the Kardex, and care plan identified care needs and assistance required. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 06/03/2025 at 1:15 p.m., LVN C said when staff reposition Resident #1 they must use 2 staff. LVN C said the Kardex, and care plan identified care needs and assistance required. During an interview on 06/03/2025 at 1:30 p.m., CNA G said she knew to use 2 staff with Resident #1. She said when giving incontinent care or bed mobility and use a mechanical lift with 2 staff members for transfer out of bed. CNA G was able to correctly identify residents requiring 2 persons assist on her assigned hall and Kardex system to identify if resident required 1 or 2 persons assist. CNA G said if a resident requires a 2 persons assistance always find another staff member to help with care. During an interview on 06/03/2025 at 1:40 p.m., CNA F said she knew to use 2 staff with Resident #1. She said when giving incontinent care or bed mobility and use a mechanical lift with 2 staff members for transfer out of bed. CNA F was able to correctly identify residents requiring 2 persons assist on her assigned hall. CNA F said the Kardex identified care required and assistance needed. CNA F said if a resident requires a 2 persons assistance always find another staff member to help with care. During an observation on 06/03/2025 at 2:00 p.m., revealed CNA G and CNA F provided incontinent care to Resident #1 on her back and pulled her up in the bed and repositioned. Both staff were present the entire time care was provided, and supplies required were obtained prior to the start of care, and adequate assistance/supervision was provided from start to finish. During an interview on 06/03/2025 at 2:45 p.m., CNA A said she had been oriented about the Kardex system. CNA A said on 09/19/2024 she was making her last rounds around 4:30 - 5:00 a.m. alone and was going to provide incontinent care. She said while she was changing Resident #1's brief, she turned her over towards her and the resident rolled off the bed, landed on her feet but her knees buckled because she can't walk/hold her weight and she guided/assisted Resident #1 to the floor. She said Resident #1 was a 2 person assist with task but because the facility was always short staffed, she had to provide the care by herself. She said Resident #1 was a large lady and she should have had someone assist her while providing care. She said that the Kardex provided if the resident required 1 or 2 persons to assist with care and Resident #1 was a 2 person assist and she should have requested help or waited on help. She said, If care would not have been provided would have got in trouble and now got terminated for the incident. Record review of staffing schedule for nursing on 09/18/2024 indicated the 6:00 p.m. to 6:00 a.m. shift had 3 LVNs and 6 CNAs scheduled. An attempted telephone interview on 06/03/2025 at 3:45 p.m. with LVN D, was unsuccessful. During an interview on 06/03/2025 at 6:10 p.m., CNA Q said Resident #1 required 2 staff members for bed mobility and mechanical lift with 2 staff members for transfers. He said he looked at the Kardex and provided care as directed on the Kardex. During an interview on 06/03/2025 at 6:10 p.m., CNA R said Resident #1 required 2 staff members for bed mobility and mechanical lift with 2 staff members for transfers. She said she looked at the Kardex and provide care as directed on Kardex. CNA R was able to correctly identify residents requiring 2 persons assist on her assigned hall. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 06/03/2025 at 6:35 p.m., the ADON/LVN B said CNA A was terminated on 09/20/2024 due to failing to follow facility safety protocol. The ADON said all the nursing staff were retrained on the Kardex system to ensure all staff knew about the residents who needed 2 staff for bed mobility. The ADON said his expectation was for the staff to get help in turning the residents who required 2 staff members per Kardex or care plan. During interviews on 06/03/2025 at 8:00 a.m. to 7:00 p.m. and 06/04/2025 at 7:00 a.m. to 3:00 p.m., 14 CNAs (CNA F, CNA G, CNA K, CNA L, CNA M, CNA N, CNA O, CNA P, CNA Q, CNA R, CNA S, CNA U, CNA V and CNA Y), and 8 LVNs (ADON/LVN B, LVN C, LVN D, LVN E, LVN H, LVN J, LVN T and LVN W) revealed all the staff were retrained on the Kardex system and said the program indicated how many staff was required for eating, transfer, bed mobility and ambulation. During an interview on 06/04/2025 at 9:00 a.m., the Administrator said she expected the staff to use the Kardex system and get help when help was needed or required. The facility policy revised July 2017 titled Safe Lifting and movement of Residents indicated the Policy Statement In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents.1. Resident safety, dignity, comfort, and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents. 2. Manual lifting of residents shall be eliminated when feasible. 3. Nursing staff, in conjunction with the rehabilitation staff, shall assess individual residents' needs for transfer assistance on an ongoing basis. Staff will document resident transferring and lifting needs in the care plan. Such assessment shall include Resident's preferences for assistance; Resident's mobility (degree of dependency); Resident's size; Weight-bearing ability; Cognitive status; Whether the resident is usually cooperative with staff; and the resident's goals for rehabilitation, including restoring or maintaining functional abilities. 4. Staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts, lateral boards) and mechanical lifting devices. 5. Mechanical lifting devices shall be used for heavy lifting, including lifting, and moving residents when necessary. 6. Only staff with documented training on the safe use and care of the machines and equipment used in this facility will be allowed to lift or move residents. 7. Staff will be observed for competency in using mechanical lifts and observed periodically for adherence to policies and procedures regarding use of equipment and safe lifting techniques. 8. Mechanical lifts shall be made readily available and accessible to staff 24 hours a day. Back-up battery packs on remote chargers shall be provided as needed so that lifts can be used 24 hours a day while batteries are being recharged . On 06/04/2025 at 10:28 a.m., the Administrator was informed of the Immediate Jeopardy. The non-compliance was identified as past non-compliance. The Immediate Jeopardy began on 09/19/2024 and ended on 09/24/2024. The facility had corrected the noncompliance before survey began.

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	06/04/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 2 out of 3 (Resident #2 and Resident #3) residents reviewed for enhanced barrier precautions (EBP) and the wound care process for infection control practices. LVN B failed to follow enhanced barrier precautions while providing wound care for Resident #3. The facility failed to ensure LVN C followed appropriate infection control during wound care treatment for Resident #2. The failures could place residents at risk for cross contamination and the spread of infection. The findings included: Record review of Resident #3's admission Record, dated 06/04/25, indicated she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses including migraine, essential hypertension, and local infection of the skin. Record review of Resident #3's Quarterly MDS Assessment, dated 05/12/25 indicated her BIMS score was 00, meaning she had severe cognitive impairment. Further review indicated under the section skin conditions; she was at risk of developing pressure ulcers/injuries but did not have one. It also indicated under the skin and ulcer/injury treatments section; pressure reducing device for bed, turning/repositioning program; nutrition, or hydration intervention to manage skin problems; applications of ointments/medications other than to feet; and application of dressings to feet. Record review of Resident #3's Care Plan, dated 05/05/2025, indicated: Resident #3 had a pressure injury: DTI (deep tissue injury) to right lateral (the side) ankle, revision 01/17/25. Resident #3 required enhanced barrier precautions due to DTI on right lateral ankle, revision 02/18/25. Record review of Resident #3's Order Summary Report, dated 06/04/25, indicated to clean the right lateral foot with wound cleanser or normal saline, pat dry, apply betadine-soaked gauze, and wrap with Kerlix. Change daily and as needed if dislodged, saturated, or soiled, one time a day, an active order with a start date of 03/23/25. Enhanced Barrier Precautions: Providers and staff must: Put on gown and gloves before room entry and providing high-contact care activities such as: bathing/showering, transferring residents, providing hygiene, changing bed linens, changing briefs, or assisting with toileting, caring for or using an indwelling medical, or performing wound care, two times a day, an active order with a start date of 01/14/25. During an observation on 06/03/25 at 6:30 p.m. of the LVN B providing wound care for Resident #3 indicated LVN B completed hand hygiene and cleansed table surfaces prior to wound care treatment. LVN B applied gloves, but no gown. The dressings were removed and were dated 06/02/25. LVN B cleansed the right lateral heel and the right lateral foot with wound cleanser, patted dry with gauze, applied betadine-soaked gauze, and wrapped the right foot with kerlix. LVN B cleansed table surfaces after wound care treatment and completed hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's admission Record, dated 06/04/25, indicated he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including pressure ulcer of the left ankle, muscle spasm, and pain. Record review of Resident #2's Quarterly MDS Assessment, dated 05/12/25, indicated his BIMS score was 15, indicating he was cognitively intact. Further review indicated under the section skin conditions, the resident had one or more unhealed pressure ulcers/injuries. Record review of Resident #2's Care Plan, dated 05/28/25, indicated: Resident #2 had an actual impairment to skin integrity related to stage 3 pressure ulcer (full thickness skin loss) to the left lateral ankle, initiated 01/14/25. The resident had actual impairment to skin integrity of bilateral (both sides) heels related to prolonged moisture and pressure resulting in MASD (moisture associated skin damage). Record review of Resident #2's Order Summary Report, dated 06/04/25, indicated to cleanse the MASD to the left heel with normal saline or wound cleanser, pat dry, apply calcium alginate sheet to wound surface, and cover with a dry dressing. Change daily and PRN. One time a day, an active order with a start date of 06/04/25. Cleanse the MASD to the right heel with normal saline or wound cleanser, pat dry, apply calcium alginate sheet to wound surface, and cover with dry dressing. Change daily and PRN. One time a day, an active order with a start date of 06/04/25. During an observation on 06/04/25 at 1:30 p.m. of Resident #2's door revealed a sign for enhanced barrier precautions. LVN C placed on a gown and entered the room. She propped both of Resident #2's feet on top of one wound care boot. She then completed hand hygiene. She pulled gloves out of her scrub pockets and placed them on both of her hands. The wound care supplies were already on Resident #2's bedside table on top of wax paper. Both dressings on the heels were labeled 06/03/25 and initialed. LVN C removed both dressings and discarded and removed her gloves. No hand hygiene was completed. She reached into her scrub pockets, under her gown, and retrieved gloves, scissors, a marker, and a bottle of hand sanitizer. LVN C labeled both bandages using the marker and then completed hand hygiene. LVN C replaced her gloves and placed both new dressings on the resident. The wound cleanser was moved from the bed to the bedside table. LVN C proceeded to clean up the wound care supplies and to remove them and the trash. The wound cleanser was placed into the treatment cart drawer without cleaning it. LVN C removed her gown outside of the room. No hand hygiene was completed before leaving the room or immediately after leaving the room. During an interview with LVN B on 06/04/25 at 11:17 a.m., he stated he did not wear a gown during wound care on 06/03/25. LVN B stated he should have worn a gown during wound care with Resident #3. He stated not wearing a gown could harbor bacteria. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LVN C on 06/04/35 at 1:48 p.m., she stated PPE for enhanced barrier precautions were to be worn when a resident had an opening, such as a suprapubic catheter, colostomy (an opening that allows stool to leave the body), g-tube (tube inserted into the stomach), or an IV. LVN C stated anyone that completed patient care on a resident with any of the listed openings, should wear a gown and gloves. She stated that included nurses and CNAs. She stated staff knew when residents were on EBP due to signs on the door and bins with PPE outside of the room. She stated not wearing a gown or gloves could transmit infection. LVN C was interviewed regarding infection control and the wound care treatment process. LVN C stated she probably should have had scissors, gloves, and hand sanitizer on the table instead of pulling them out of her pockets from under the gown. She also should have cleaned the wound cleanser bottle before placing it directly into the treatment cart drawer. During an interview with LVN B on 06/04/25 at 2:03 p.m., he stated LVN C did not use correct technique. He stated all supplies to be used should be displayed on wax paper on the bedside table, after cleaning the table and completing hand hygiene. He stated, next gloves should be put on. Dressing #1 should be removed, hand hygiene completed, dressing #2 should be removed, and hand hygiene completed again. He stated, supplies should not be pulled from staff pockets, under the gown, with dirty hands. He stated the entire process needs to stay clean. He stated not following the correct process could cause harboring of bacteria. During an interview with LVN E on 06/04/25 at 2:15 p.m., she stated she was the Infection Preventionist and an ADON. LVN E stated, residents that were on EBP would have signs on the door and bins that consisted of gloves, gowns, and biohazard bags. She stated anyone that encountered the patient for transferring, changing the patient, and direct care should wear a gown and gloves. She stated EBP should be worn when wound care treatments were being administered. She stated all staff were responsible to wear EBP. She stated EBP was worn to prevent the spread of infection to and from staff and patients. LVN E stated when providing wound care, all supplies should be laid out on wax paper on top of the table after the table has been cleaned and hand hygiene had been completed. She stated gloves should be worn, one dressing should be removed, gloves removed, hand hygiene completed, gloves replaced, second dressing removed, gloves removed, and hand hygiene completed again. She stated, staff should not reach under the gown with dirty hands. She stated, it defeats the point of the gown. She stated she would not place the wound cleanser on the bed, it would be placed on the table. Her gloves would be replaced again, and the new dressings would be placed. She would remove all the supplies and trash. She would have cleaned the wound cleanser since it was placed on the bed. She would complete hand hygiene once again. She stated following infection control protocol, prevents spread of infection to and from staff and patients. Infection control in-services and infection control policy specific to EBP were requested on 06/04/25 and were not received prior to exit. Review of the facility's policy and procedure on Infection Prevention and Control Program, dated December 2023, indicated: Policy Statement: An infection prevention and control program (IPCP) are established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.7. Prevention of Infection a. Important facets of infection prevention include: (1) identifying possible infections or potential complications of existing infections. (2) instituting measures to avoid complications or dissemination. (3) educating staff and ensuring that they adhere to proper techniques and procedures. (4) communicating the importance of standard precautions and respiratory hygiene to visitors and family members. (5) screening for possible significant pathogens. (6) immunizing residents and staff to try to prevent illness. (7) implementing appropriate enhanced barrier and transmission-based precautions when necessary; and (8) following established general and disease-specific guidelines such as those of the Centers for Disease Control (CDC) . Review of the CDC website, https:// www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html, Titled Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes | LTCFs | CDC, dated 06/28/24, indicated: .Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected .Enhanced Barrier Precautions require the use of gown and gloves only for high-contact resident care activities .