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	11/21/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (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
	675541	A. Building B. Wing	11/21/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for 1 of 2 residents (Resident #1) reviewed for treatment and services related to indwelling catheters. The facility failed to ensure Resident #1's Foley catheter (an indwelling catheter) was secured on 11/04/2025. This failure could place residents at risk for urinary tract infections, dislodgment, potential complications and a decreased quality of life. Findings included: Record review of face sheet dated 11/04/2025 indicated Resident #1 was a [AGE] year-old male initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included neuromuscular dysfunction of the bladder (problem due to disease or injury of the central nervous system or nerves involved in the control of urination). Record review of Resident #1's care plan dated 11/03/2025 with a target date of 08/17/2025 indicated he had an indwelling catheter with a goal that he will be/remain free from catheter-related trauma through the next 90 days. Record review of the Comprehensive MDS assessment dated [DATE] indicated Resident #1 was able to make himself understood and was usually understood by others. The MDS assessment indicated Resident #1 had a BIMS score of an 1, which indicated Resident #1 was severely cognitively impaired. The MDS assessment indicated Resident #1 required touching assistance from staff for all ADLs. The MDS assessment indicated Resident #1 had an indwelling catheter. Record review of Resident #1's Order Summary Report dated 10/01/2025 indicated: Monitor to ensure leg strap placement to secure Foley catheter drainage tubing. two times a day related to neuromuscular dysfunction of bladder, unspecified., with a start of 10/31/2022. During an observation on 11/04/2025 at 9:05 a.m. indicated Resident #1 was lying in his bed with the head of his bed elevated. Resident #1's Foley catheter was not secured to his leg. There was no securement device observed. During an interview on 11/04/2025 at 2:00 p.m. LVN B said nurses were responsible for ensuring Foley catheters were secured. LVN B said she should have checked it at the beginning of her shift. LVN B said she was unaware Resident #1 had no securement device in place. LVN B said she was nervous and had forgotten to check to see if Resident #1's Foley catheter was secured. LVN B said it was important to ensure Foley catheters were secured to prevent the catheter being dislodged out of the bladder, causing trauma or injuries. During an interview on 11/05/2025 at 10:35 a.m., ADON C said the nurse was responsible for making sure the catheter device was in place to secure the catheter. ADON C said it was important for the catheter to be secured so it doesn't become dislodged or cause urinary tract infection. During an interview on 11/05/2025 at 11:05 a.m., the DON said the nurses were supposed to make sure the Foley catheters are secured. The DON said it was important for the catheters to be secured because if they were not, it could potentially pull out and hurt the residents. The DON said she expected the nurses to follow policy and procedures regarding Foley catheter securement. During an interview on 11/05/2025 at 12:00 a.m., the Administrator said he expected the Foley catheter to be secured and maintained correctly by facility policy and acceptable standards CDC guidelines. He said a urine infection can be introduced to the residents if the Foley catheter is not secured and physician orders not followed. Record review of the facility's policy revised August 2022, titled, Catheter Care, Urinary, indicated: Purpose-The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections.General Guidelines:4. Ensure that the catheter remains secured with a securement device to reduce friction and movement at the insertion site.

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	11/21/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure in accordance with state and federal laws, all drugs and biologicals were stored in locked compartments and permitted only authorized personnel to have access to medication carts for 1 of 4 Nurse medication carts (Hall 300 Nurse Cart) reviewed for medication storage. LVN A failed to ensure the Hall 300 Nurse medication cart was kept locked and under direct observation where residents and unauthorized staff could not access it when left at the main nurse's station for five minutes on 11/04/2025 at 9:23 a.m. This failure could place residents at risk of unauthorized persons, as well as residents, at risk of gaining access to unlocked medications that were not prescribed to them.Findings included: During an observation on 11/04/2025 from 9:23 a.m. to 9:28 a.m., indicated the Hall 300 Nurse medication cart was noted to be unsecured and unsupervised on hall 300. The Hall 300 Nurse medication cart was front facing with the drawers facing the hallway with the lock mechanism out (indicating it was unlocked). At 9:28 a.m. the state surveyor notified LVN A, who was coming out of a residents room that was two rooms down, approximately 100 feet away from the unlocked 100 hall nurse medication cart. Further observation of 300 hall nurse cart with LVN A, indicated inside the medication cart Drawer #1 were glucometers, OTC (over the counter) aspirin, vitamins, minerals and eye drops. Drawer #2 had a locked compartment with several controlled substances, and multiple resident's individual medication bubble-blister packets. During an interview and observation on 11/04/2025 at 9:28 a.m. LVN A said she was in charge of the cart. LVN A walked to the cart and locked it and said I know I should have locked my cart, I have been trained on locking my cart and she was the person responsible for administering medications on the 300 hall and used the cart. LVN A said she was two rooms down talking with a resident with the medication cart was out of her site. LVN A said she forgot to lock the cart before she stepped away from it. LVN A said the cart should not be unlocked and unattended because anyone walking by could get into the medications and risk medication theft or diversion. LVN A said she was in-serviced this year to keep the medication cart locked when not in use. During an interview on 11/04/2025 at 12:15 p.m., the DON said she expected the nurses to follow the facility policy and procedure related to locking the medication cart. She said the medication carts should always be locked if staff walked away from it or turned their back to it. The DON stated she was responsible for making sure the nurses locked the carts because of risk for misappropriation of property. She said she and both ADON's had in-serviced nursing staff to keep the medication cart locked when not in use. During an interview on 11/05/2025 at 2:45 p.m., the Administrator said his expectation was for nurses to have their medication carts in their line of site and keep the medication cart locked if it's not in use. He said all nursing staff were responsible for securing medications when not in use. He said the potential risk of unsecured medication cart was medication safety. Record review of the facility's Security of Medication Cart policy and procedure, dated April 2007, indicated: Policy Statement: The medication cart shall be secured during medication passes. Policy Interpretation and Implementation:1. The nurse must secure the medication cart during the medication pass to prevent unauthorized entry.2. The medication cart should be parked in the doorway of the resident's room during the medication pass.The cart doors and drawers should be facing the resident's room.3. When it is not possible to park the medication cart in the doorway, the cart should be parked in thehallway against the wall with doors and drawers facing the wall. The cart must be locked before the nurseenters the resident's room.4. Medication carts must be securely locked at all times when out of the nurse's view.5. When the medication cart is not being used, it must be locked and parked at the nurses' station or insidethe medication room.