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	01/08/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to review and revise resident's comprehensive care plans by the interdisciplinary team after each assessment to reflect the current condition for 1 of 18 (Resident #1) residents reviewed for comprehensive care plans. The facility failed to ensure Resident #1's care plan was updated to indicate Resident #1 had a resident-to-resident incident on 07/18/2025 and 08/16/2025. This deficient practice could place residents at risk of not receiving appropriate interventions to meet their current needs.The findings included: Resident #1Record review of Resident #1's admission Record dated 01/06/2026 indicated she was a [AGE] year-old female who was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included schizoaffective disorder (mental health condition with a combination of symptoms of schizophrenia and mood disorder), 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), aphasia (a disorder that results from damage (usually from a stroke or traumatic brain injury) to areas of the brain that are responsible for language) and dysphagia (difficulty swallowing) following cerebral infarction, anxiety disorder (persistent and excessive worry that interferes with daily activities), and seizures.Record review of Resident #1's quarterly MDS assessment, dated 06/22/2025, indicated she had a BIMS score of 00 which indicated she had severely impaired cognition, and was sometimes able to make herself understood and usually understood others. She had no behaviors indicated during the 7-day look back period prior to completing the MDS assessment. The functional abilities self-care indicated she required maximum assistance with oral care, toileting hygiene, personal hygiene, lower body dressing, putting on/taking of footwear, and required moderate assistance with shower/bathing and upper body dressing. Her functional abilities mobility indicated she required moderate assistance with all tasks except rolling left to right, sitting to lying, and lying to sitting on side of bed which required supervision or touching assistance. She uses a manual wheelchair with supervision or touching assistance at times.Record review of Resident #1's care plan, revision dated 11/03/2025, indicated she had history of being physically aggressive with staff and other residents. Interventions included administering medications as needed, assessment and anticipating resident's needs: food, thirst, toileting needs, comfort level, body positioning, and/or pain, communication techniques, effective strategies, behavior monitoring, labs, psychiatric/psychogeriatric consult as indicated, and proper authorities notified (Abuse Coordinator, Ombudsmen, DON, ADON, police dept, and RP). The care plan did not indicate Resident #1 had an updated or revised care plan for resident-to-resident incident on 07/18/2025 and 08/16/2025. Further review of care plan indicated no interventions added since 06/17/2024.Record review of Resident #1's progress notes/incident report, authored by LVN A, indicated on 07/18/2025 at 3:55 p.m., [Resident #1] was in wheelchair in the hallway. While walking out the shower room, [CNA B] witnessed resident grabbed another resident by the hands (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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and slapped her on the left side of face. [CNA B] immediately separated the residents. Nurse notified. [Resident #1] was nonverbal and unable to provide a statement. Monitoring initiated. Head to toe assessment completed. No skin issues noted. Pain assessment completed. No pain or discomfort indicated at the time of the incident. Vitals taken. Will continue to monitor. Administrator, DON, Ombudsman, local police department, NP with Psych, NP with MD, and RP notified of incident.Record review of the provider investigation report dated 07/22/2025 for the Resident-to-Resident incident revealed Resident #1 hit another resident on the left side of face/neck on 07/18/2025. An assessment of both residents revealed no injuries. Resident #1 was placed on behavioral monitoring for 72 hours with no adverse events.Record review of Resident #1's progress notes/incident report, authored by LVN C, indicated on 08/16/2025 at 9:45 am, [CNA B] reported to [LVN C], [Resident #1] hit her roommate twice in the chest. Roommates immediately separated for safety. Assessed for injuries and pain. No injuries noted to hands. Shakes head no to pain. Administrator, DON, Ombudsman, local police department, NP with Psych, NP with MD, and RP notified of incident. Orders for labs and urine to be collected on Monday 8-18-25. Behavior monitoring started. Local police department interviewed involved residents.Record review of the provider investigation report dated 08/16/2025 for the Resident-to-Resident incident revealed Resident #1 hit another resident on the chest on 08/16/2025. An assessment of both residents with no injuries. Resident #1 was placed on behavioral monitoring for 72 hours with no adverse events.Unsuccessful attempts to interview CNA B on 01/06/2026 at 11:40 a.m., 01/07/2026 at 11:35 a.m., and 01/08/2026 at 11:41 a.m. were made, with no returned call to voice mail or text message.During an interview on 01/08/2026 at 1:03 p.m., LVN A said she was the nurse on duty 7/18/2025 when CNA B reported she witnessed Resident #1 hit another resident. She said that Resident #1 was non-verbal and tended to hit other residents to get their attention because she did not speak. She said that facility staff had been trained to report all physical contact to charge nurses and administrator for alleged physical abuse. She said that she assessed both residents after the incident, and no injuries were identified. She said she followed the facility's protocol separated involved residents for residents' safety, initiated monitoring for 72 hours, assessments, notified administrator/AC, DON, MD/NP, RP, local police, ombudsman, and followed any new orders received. She said Resident #1 did make physical contact to get staff or other residents' attention, but not to cause harm or injury. She said during the assessment, following the incident, Resident #1 did not show any aggressive behavior. She said Resident #1 may have patted face or hit arm or chest to get attention or direct eye contact. She said that Resident #1 had been provided with a communication board to attempt to communicate and staff monitor her and redirect if anticipated incidents. She said she worked until 6:00 p.m. the day of the incident and continued to monitor both residents with no further incidents or negative effects identified and reported the incident to the oncoming staff. She said when residents had incidents or changes in condition, the care plans were revised or updated by the MDS Coordinator or DON.During an interview on 01/08/2025 at 11:58 a.m., LVN C said she was the nurse on duty on 08/16/2025 when CNA B reported she witnessed Resident #1 hit another resident. LVN C said that Resident #1 was non-verbal and patted/hit to get others attention because she did not speak. LVN C said that facility staff have been trained to report all physical contact to the nurse and administrator for alleged physical abuse. LVN C said CNA B reported while she was changing linens and making the roommate's bed, Resident #1 was touching and putting her feet on the bed. LVN C said the roommate and CNA instructed Resident #1 to stop and she did. LVN C said the roommate exited the room and Resident #1 remained in the room, then the roommate returned to the room and Resident #1 went up to her roommate and hit/patted her on the chest. LVN C said she assessed both residents after the incident and no (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	injuries were identified. LVN C said she followed the facility' protocol after the incident was reported, separate or verified separation for residents' safety, initiated monitoring for 72 hours, head-to-toe assessments, notified proper authorities, followed any new orders received. LVN C said Resident #1 was found to have a UTI and received treatment. LVN C said since the residents involved were roommates, Resident #1 was moved to another room to prevent further interactions. LVN C said Resident #1 is non-verbal and did pat/hit to get staff or other residents' attention, but not to cause harm or injury. LVN C said that she did not feel that Resident #1 hit her roommate in the chest to causes harm or injury. LVN C said that she worked until 6:00 pm the day of the incident and monitored Resident #1 with no further incidents. LVN C said when residents have incidents or changes in condition that the care plans or revised or updated by the MDS Coordinator.During an interview on 01/08/2025 at 3:00 p.m., MDS Coordinator said she participated in morning meetings and incident reports, and allegations were discussed during the morning meeting, if residents' care plans require updating and/or the IDT care plan meeting scheduling required it to be completed, if applicable. She said she recalls discussing the incidents with Resident #1 on 07/18/2025 and 8/16/2025 and thought the care plan was updated to reflect the incidents and the interventions updated. She said the care plan should have been updated to reflect the current residents' needs and interventions. She said that monitoring interventions for 72 hours was completed, authority notification and communication techniques were discussed, and the care plan should have reflected those interventions. She said she had forgotten to update the care plans with the revised interventions. She said she was responsible for updating or revising care plans and the DON reviews the care plans for completion. She said that the facility did not have a policy for care plan updating or revision, they followed the Resident Assessment Instrument (RAI) Manual. During an interview on 01/08/2026 at 3:30 p.m., the DON said that all incidents and allegations were discussed during morning meetings (including herself, Assistant DONs, administrator, department heads, MDS Coordinator, and Regional Nurse per phone if needed) and the MDS Coordinator is notified of any incidents requiring care plan revisions, and she was responsible for updating the care plans. She stated new interventions should be added to the care plan regarding recurrent resident-to-resident altercations. She stated she did not know why the care plans and interventions for Residents #1 had not been updated and/or revised after the alleged incidents. She said the MDS Coordinator is responsible for updating and revising the care plan as indicated. She said she was responsible for monitoring and ensuring that the care plans were completed and updated by the MDS Coordinator. She said if care plans were not updated or revised, the care plan would not reflect the current residents' needs. She said that the facility did not have a policy for care plan updating or revision, they followed the Resident Assessment Instrument (RAI) Manual. During an interview on 01/08/2026 at 4:00 p.m., the Administrator said the MDS Coordinator, and the DON were responsible for ensuring all care plans were updated/revised as needed. He said the possible negative outcome of care plans not being revised or updated could be residents not receiving the care they needed.Requested a policy for care plan updating and revision, the DON and MDS Coordinator said they did not have a care plan policy for updating or revising care plans. They followed the Resident Assessment Instrument (RAI) Manual. Record review of the mds-3.0-rai-manual-v1.20.1_October_2025 indicated A significant change is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered self-limiting; 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan.