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	02/21/2026

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 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. **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 and restore continence to the extent possible for 1 of 2 residents (Resident #1) reviewed for treatment and services related to indwelling suprapubic catheters. 1. The facility failed to ensure Resident #1's indwelling suprapubic catheter was secured on [DATE]. 2. The facility failed to ensure Resident #1's indwelling suprapubic catheter was a 16 FR (catheter with size of 5.3 mm) instead of an 18 FR (catheter with size of 6 mm diameter). These failures could place residents at risk for urinary tract infections, dislodgment, potential complications and a decreased quality of life. Findings include: Record review of Resident #1's face sheet, dated [DATE], indicated a [AGE] year-old female who was initially admitted to the facility on [DATE] and re-admitted on [DATE]. Resident #1 had diagnoses which 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), aphasia (a disorder that affects how someone communicates), quadriplegia (paralyzed in both arms and both legs),tracheostomy (a surgical procedure that creates an opening in the neck to facilitate breathing when the usual airway is obstructed or compromised), injuries of the head, sequela (closed head injury). Record review of Resident #1's care plan, dated [DATE], with a target date of [DATE], indicated she had an indwelling 18 FR suprapubic catheter with a goal that she will be/remain free from catheter-related trauma through the next 90 days. The care plan listed an intervention Ensure statlock is in place to secure foley tubing to prevent injury. Record review of Resident #1's quarterly MDS, dated [DATE], indicated she had a BIMS score of 0, which indicated she had severe cognitive impairment. Resident #2 had an indwelling catheter. Record review of Resident #1's order summary, dated [DATE], indicated: to exchange the suprapubic catheter 16 FR/ 30ml every 4 weeks and as needed if clogged and unable to flush. Please secure SPT (suprapubic catheter with statlock. After surveyor's intervention, ADON C obtained an order for the 18 FR suprapubic catheter on [DATE]. Record review of Resident #1's MAR, dated February 2025, indicated on [DATE] at 2:20 a.m. Resident #1's suprapubic catheter was changed by LVN B. The MAR indicated the suprapubic catheter size was 16 FR/30 ml. During an observation on [DATE] at 10:15 a.m. indicated Resident #1 was lying in his bed with the head of his bed elevated. Resident #1's suprapubic catheter was unsecured, there was no statlock (leg securement device) in place on her leg securing her suprapubic catheter. Resident #1's suprapubic catheter had 18 FR/30 ml on it. During an observation on [DATE] at 5:10 p.m. the facility had 16 FR and 18 FR catheters in stock at the facility inside the supply room. During an attempted interview with Resident #1 on [DATE] at 10:20 a.m. indicated the resident was unable to respond verbally or physically to surveyors questions. During an interview with LVN A on [DATE] at 10:20 a.m., she said Resident #1 had an order for a 16 FR suprapubic catheter since [DATE]. She said (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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 currently had an 18 FR suprapubic catheter. LVN A said she was unaware Resident #1 had no securement device in place and did not know for how long Resident #1 had not had a statlock (leg securement device). LVN A said nurses were responsible for ensuring and verifying indwelling catheters were secured and had the correct catheter size in place. LVN A said she should have verified the indwelling suprapubic catheter size and compare it to the order at the beginning of her shift. She said it was important to ensure all catheters were secured to prevent the catheter being dislodged out of the bladder, causing trauma or injuries. During an interview with ADON C on [DATE] at 12:20 p.m., he said the nurses were responsible for making sure the statlock/ leg securement device was in place securing the suprapubic catheter. ADON C said it was important for the catheter to be secured so it did not become dislodged or cause urinary tract infection. The ADON C said Resident #1 had an order for a 16 FR suprapubic catheter since [DATE]. He said Resident #1 had an 18 FR suprapubic catheter placed in by LVN B since [DATE] according to the MAR. He said he was not aware Resident #1 had the wrong catheter size in place. He said the facility had 16 FR suprapubic catheters in stock at the facility. He said the suprapubic catheter that should have been used was 16 FR/30 ml. He said the associated potential risk related to the wrong size catheter used would be a deceased quality in care. During an interview with the DON on [DATE] at 12:30 p.m., she said she was not aware Resident #1's suprapubic catheter was unsecured nor that she had not had a statlock (leg securement device) in place. She said she educated staff on making sure residents had statlocks (leg securement device) if they had a catheter. The DON said she was not aware Resident #1 had an 18 FR catheter instead of the ordered 16 FR catheter. She said Resident #1 should have had the 16 FR placed. The DON said the nurses were responsible for verifying physician orders and implanting the orders correctly. She said it was her expectation for the nurses to insert the correct size catheter and then secure the catheter to prevent the potential of dislodgement. 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 catheter securement. An interview with the Administrator was not obtained. The Administrator was out of town, the DON was the designee at the time. Record review of the facility's policy, revised [DATE], 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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 2 residents (Resident #2) reviewed for infection prevention. 1. The facility failed to ensure CNA D used PPE when she provided care to Resident #2 who was on Enhanced Barrier Precautions (EBP) for his suprapubic catheter. 2. The facility failed to ensure CNA D did not place and leave Resident #2's suprapubic catheter bag on the floor. 3. The facility failed to ensure CNA D performed hand hygiene before starting care, between glove changes and after completed care. These deficient practices could place residents at risk for infection.Findings include:Record review of Resident #2's face sheet, dated 02/23/2026, indicated a [AGE] year-old male, with an initial admission date of 01/01/2021 and a readmission date of 09/11/2025. Resident #2 had diagnoses which included: hemiplegia (severe or complete loss of strength leading to paralysis on one side of the body and is usually the result of brain damage) and hemiparesis (one-sided muscle weakness) affecting left non- dominant side, chronic obstructive pulmonary disease (a lung disease that blocks airflow making it difficult to breathe), urinary tract infection (an infection in the kidneys, ureters, bladder, or urethra), unspecified bulbous urethral stricture (is a narrowing of the bulbar urethra, often caused by trauma or injury, leading to urinary flow obstruction).Record review of Resident #2's Quarterly MDS assessment, dated 12/17/2025, indicated he had a BIMS score of 15, which indicated normal, intact cognition. Resident #2 had an indwelling catheter. Record review of Resident #2's Active Orders, dated 02/23/2026, indicated orders which included: Enhanced Barrier Precautions- providers and staff must: Put on gown & 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 device (for example, central venous catheter, urinary catheter, feeding tube care, tracheostomy/ventilator care), Performing wound care, two times a day listed under Special Instructions in the Orders tab.Record review of Resident #2's Care Plan, dated last reviewed 02/23/2026, indicated he was on enhanced barrier precautions related to his suprapubic catheter. The care plan listed enhanced barrier precautions interventions as Staff will wear gloves and gown (per protocol) to provide high-contact care activity to include: Dressing, Bathing/Showering, Transferring, Hygiene, Changing Linens, Changing Briefs, Assisting with Toileting, Device Care or Use (PICC/Central Line, Catheter, Feeding Tube, Trach-(- a surgical procedure that creates an opening in the neck to facilitate breathing when the usual airway is obstructed or compromised), Vent (refers to ventilator, a medical device used to provide mechanical ventilation by moving breathable air into and out of the lungs.), wound care.) initiated 02/18/2025. The care plan listed Resident #2 had an indwelling catheter related to obstructive uropathy (is a condition in which urine flow is blocked, causing urine to back up and potentially damage the kidneys) with an intervention of Enhanced Barrier Precautions (per protocol): Use gloves and gown to provide high contact care. Use face mask if there is a risk of splash or spray.During an observation on 02/21/2026 at 11:11 a.m. indicated CNA D entered Resident #2's room without gown or gloves. Resident #2's suprapubic catheter was on the floor near his bed. CNA D put on gloves without hand hygiene. CNA D picked Resident #2's catheter bag off the floor and emptied it (580 ml of urine) into a urinal. CNA D placed the catheter bag back onto the floor. CNA D discarded used gloves and applied a new pair without using hand hygiene. CNA D used the same gloves for Resident #2's incontinent care and to dress him. CNA D had picked Resident #2's catheter bag off the floor and placed it in on (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	his bed to dress him without sanitizing or changing his catheter bag (did not changed bed sheets.) CNA D did not perform hand hygiene after she completed Resident #2's care.During an interview with CNA D on 02/21/2026 at 11:20 p.m., she said she should have worn a gown while she attended to the needs of Resident #2. She said she did not put a gown on because she was nervous and rushing. She said she noticed his catheter bag on the floor but didn't think to put it on the bedframe. She said she knew the catheter bag should have been on a fixed structure below the bladder. CNA D said she should have used hand hygiene between gloves changes and should have sanitized his catheter bag before putting in into his bed to prevent the potential for cross contamination. During an interview with LVN E on 02/21/2026 at 11:29 a.m., she said she was the charge nurse for CNA D. LVN E said her expectations were for CNAs to wash or sanitize their hands before, between, and after glove changes. LVN E said CNA D should have sanitized Resident #2's catheter bag then made her aware so she could have gotten him a clean catheter bag. She said CNA D should have worn a gown while she was caring for Resident #2 to prevent the potential for cross contamination. During an interview with the DON on 02/21/2026 at 11:45 a.m., she said her expectations were for all staff to wash or sanitize their hands before, between, and after glove changes. She said the catheter bags should never be left on the floor but be placed on a fixed structure to prevent any pulling or potential trauma. The DON said all staff should wear gowns and gloves when carrying out tasks for residents on enhanced barrier precautions to ensure there was no cross contamination. She said hand hygiene should be done before and after resident care and gloves should be changed after incontinent care. She said she educated staff on enhanced barrier precautions, hand hygiene, and catheter care.An interview with the Administrator was not obtained. The Administrator was out of town, the DON was the designee at the time. 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.Infection Control1. Use aseptic technique when handling or manipulating the drainage system.2. Be sure the catheter tubing and drainage bag are kept off the floor.Changing Catheters2. Change catheters and drainage bags based on clinical indications such as infection, obstruction, or when the closed system is compromised.Cleaning and Disinfecting Drainage Bags1. Disconnect the drainage bag from the catheter; replace with a clean bag. Record review of the facility's policy, dated December 2023, titled Infection Prevention and Control Program, indicated: Policy StatementAn infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.7. Prevention of Infectiona. 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 forDisease Control (CDC).