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	06/25/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to consult with the resident's physician when there was a need to alter treatment for 2 of 5 residents reviewed for physician notification. (Residents #46 and #317) 1. The facility failed to notify the physician of Resident #317 when an ordered UTI Panel specimen was not obtained. 2. The facility failed to notify the physician of Resident #46 when he missed 2 doses of Depakote a new medication prescribed for behaviors. These failures could place residents at risk of not receiving appropriate medical treatments, which could result in a decline in health. Findings included: 1. Record review of a face sheet dated indicated Resident #317 was a [AGE] year-old female admitted on [DATE]. Her diagnoses included pyelonephritis (a type of urinary tract infection that usually moves from your bladder to your kidneys), injuries of the head, and quadriplegia (a loss of motor function in all four limbs). Record review of physician order for May 2025 indicated Resident #317 dated 05/05/25 and start date of 05/29/25 for UTI Panel one time only. Record review of the Progress Notes for Resident #317 with an entry dated 5/5/2025 at 07:38 p.m. indicated the physician made rounds with new orders for Ambien (hypnotic) 10mg at bedtime, Macrodantin (antibiotic) 100mg four times a day for 10 days before kidney surgery, and obtain urine culture before the start of antibiotic. Record review of the May MAR indicated Resident #317 had a urine sample for a UTI Panel to be obtained dated 05/29/25. There was no documentation of the sample being collected on 05/29/25 or 05/30/25. She also had Macrodantin 100mg four times a day for 10 days with a start date of 05/30/25. The medication was initiated on 05/30/25. Record review of the Progress Notes for Resident #317 indicated there was no documentation on 05/29/25 or 05/30/25 of the urine specimen being obtained or the physician being notified it was not obtained. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/24/25 at 02:00 p.m. LVN F said she initiated Resident #317's ABT. She said she did not notice if the UTI specimen was obtained prior to initiating the ABT. She said the physician should have been notified if the specimen was not obtained. During an interview on 06/25/25 09:37 a.m. ADON L said the UTI Panel was not done prior to the initiation of the ABT. He said the physician was not notified until after the initiation of the medication. 06/25/25 12:45 PM the DON said the CN should have obtained the specimen as ordered on Resident #317 or the physician should have been notified at the time. 2. Record review of a face sheet dated 06/11/25 indicated Resident #46 was a [AGE] year-old male admitted on [DATE]. His diagnoses included traumatic brain injury (an injury to the brain caused by an outside force), bipolar disorder (mental disorder associated with episodes of mood swings ranging from depressive lows to manic highs), anxiety disorder (persistent and excessive worry that interferes with daily activities), major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and behavioral syndromes (consistent pattern of behaviors that are correlated and often observed across different situations). Record review of the Psychiatric Hospital discharge orders dated 06/24/25 indicated Resident #46 had a new order for Depakote 250mg twice daily for mood. Record review of the physician orders for June 2025 indicated Resident #46 had an order dated 06/24/25 with start date of 06/25/24 for Depakote Oral Tablet Delayed Release 250 MG (Divalproex Sodium) Give 250 mg by mouth two times a day for mood with Pending Confirmation. Record review of the Progress Notes with an entry dated 06/24/25 at 05:13 p.m. indicated LVN G documented Resident #46's provider was notified of return to facility and new order for Depakote. During an interview on 06/25/25 at 11:14 a.m. LVN H said she did not give the morning dose of Depakote since there was no area to document the medication on the MAR and she had not notified the physician of the missed dose. During an interview on 06/25/25 at 11:18 a.m. ADON L reviewed Resident #46's June 2025 Orders and Progress Notes since readmitted from the psychiatric hospital. He said the resident had an order for Depakote twice daily with Pending Confirmation on it. He said he did not understand why a start date of 06/25/25 when the resident would have been at the facility to receive his evening dose. He said there was no documentation of the physician being notified of the missed doses. During a phone interview on 06/25/25 at 11:21 a.m. LVN G indicated she had notified the physician's NP and conducted the medication reconciliation. She said she did not give the evening dose Depakote and did not notify the physician of the missed dose. During an interview on 06/25/25 at 02:15 p.m. the DON said she expected staff to notify the physician if they were unable to carry out an order. She said the negative outcome could be a delay in receiving care.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review, the facility failed to provide a safe, clean, comfortable and homelike environment for residents, staff, and the public, for 2 of 4 shower rooms (Hall 300 and Hall 400) reviewed for physical environment. Hall 300's shower room had two shower chairs soiled with brownish/black substance under seats and on frames. Hall 400's shower room had a shower bed and under the cushion with a thick black substance. This failure could lead to residents experiencing a diminished quality of life. Findings included: 1. During an observation and interview on 06/23/2025 at 10:45 a.m., two shower chairs were soiled with brown and black substances on the seat, under the seats and on frame. The wall in shower on the right side has area (approximately four 12 x 12 tile squares and approximately 4 x 6 baseboard) were soiled with black substance. LVN C said shower chairs should be cleaned before and after each use. She said the staff who provide the showers were responsible for cleaning between uses. During an observation and interview on 06/23/2025 at 11:00 a.m., the housekeeping supervisor and two housekeepers were in the shower room scrubbing soiled areas. The housekeeping supervisor said they clean the shower chairs when they are soiled, and the aides are to clean daily and before and after each use. During an interview on 06/23/2025 at 12:45 p.m., CNA D said the shower chairs were to be cleaned before and after each use. She said facility has cleaning disinfectant provided to use for cleaning. The chairs are to be cleaned top and bottom of seat as well as the frame. She said the cleaning solution was kept secured in locked storage in shower room and out of reach of residents. During an interview on 06/24/2025 at 2:20 p.m., the DON said her expectations were to clean shower chairs before and after each use. She said the aides were responsible for task. Management was responsible for following behind to ensure cleanliness of equipment. Housekeeping was responsible for cleaning shower stalls. During an interview on 06/25/2025 at 1:30 p.m., the administrator said the aides were expected to clean shower room and shower chairs after each resident was bathed. She said they are supplied with a cleaner as well as a disinfectant to use when scrubbing the shower chairs. The administrator said each shower room on the halls contained their own cleaning supplies which were stored under lock and key. 2. During an observation on 06/23/2025 at 1:40 p.m., Hall 400's shower room had a shower bed that had a cushion, and underneath was a thick black substance coated the full length of the white plastic stretcher part of the shower bed. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 06/23/2025 at 1:50 p.m., LVN F looked at the shower bed in the shower on Hall 400 and looked under the cushion and said that needs to be cleaned. During an interview on 06/23/2025 at 2:00 p.m., CNA K said she might have used the shower bed last and said that was a couple of weeks ago. She said she cleaned the shower bed with soap and water, however, did not remove the cushion and did not clean the plastic under the cushion. Record review of the Cleaning and Disinfection of Resident-Care Items and Equipment Policy Statement dated September 2022 indicated Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA Bloodborne Pathogens Standard. 5. Reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment). a. Single resident-use items are cleaned/disinfected between uses by a single resident and disposed of afterwards (e.g., bedpans, urinals). 6. Reusable resident care equipment is decontaminated and/or sterilized between residents according to manufacturers' instructions. 9. Durable medical equipment (DME) is cleaned and disinfected before reuse by another resident.

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F 0600 Level of Harm - Minimal harm or potential for actual harm 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** Based on observation, interview, and record review, the facility failed to protect the residents' right to be free from verbal and physical abuse for 4 of 7 residents reviewed for abuse. (Residents #3, #9, #37, and #55) 1. The facility failed to ensure Resident #3 was free from physical abuse when Resident #61 rolled up in her wheelchair and slapped Resident #3 on the face on 05/28/25. 2. The facility failed to ensure Resident #9 was free from verbal abuse when Resident #46 cursed her and told her it was her fault her daughter died on [DATE]. 3. The facility failed to ensure Resident #37 was free from physical abuse when Resident #46 walked up to her, grabbed her by the wrists, and shook her on 06/11/25. 4. The facility failed to ensure Resident #55 was free from physical abuse when Resident #45 hit her on the arm when she backed into him with her wheelchair on 06/14/25. This failure could place residents at risk for emotional distress, fear, decreased quality of life and further abuse. Findings included: Resident #3 Record review of a face sheet dated 06/25/25 indicated Resident #3 was a [AGE] year-old female admitted on [DATE]. Her diagnoses included dementia (loss of cognitive functioning), intellectual disabilities (a condition that affects a person's ability to learn and function at an expected level), visual loss (partial or complete loss of the ability to see), and cognitive communication deficit (problem with communication that results from impaired cognition, as opposed to a problem affecting language and/or speech). Record review of the MDS dated [DATE] indicated Resident #3 had severely impaired cognition with a BIMS of 3 out of 15 and had no behaviors. Record review of the care plan reviewed on 06/23/25 indicated Resident #3 had impaired thought processes related to cognitive impairment AEB by her history or perceived physical aggression. The goal was she will remain free from actual harm of injury and verbalize feeling safe in her environment daily. Interventions included assess and document the resident's specific claims of physical aggression, conduct a head-to-toe assessment after each claim to rule out actual injury, consult psych services, and separate resident from other resident to ensure safety. Resident #61 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a face sheet dated 06/25/25 indicated Resident #61 was a [AGE] year-old female admitted on [DATE]. Her diagnoses included schizophrenia (a mental disorder characterized variously by hallucinations (typically, hearing voices), delusions, disorganized thinking and behavior, and flat or inappropriate affect), cocaine abuse, hypertension (a condition in which the force of the blood against the artery walls is too high), 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), and vascular dementia (a type of loss of cognitive functioning caused by conditions that damage blood vessels and block blood flow to your brain). Record review of the MDS dated [DATE] indicated Resident #61 had severely impaired cognition with a BIMS of 2 out of 15 and had no behaviors. Record review of the care plan last reviewed on 05/05/25 indicated Resident #61 had a behavior problem related schizophrenia. The goal was she would have no evidence of behavior related to schizophrenia through the next 90 days. Interventions included administer medications as ordered, intervene as necessary to protect the rights and safety of others, remove from situation and take to alternate location as needed, monitor behavior episodes and attempt to determine underlying cause, and refer to psychiatric services for evaluation and treatment. 1. Record review of a Provider Investigation Report dated 06/04/25 indicated an incident categorized as Abuse occurred on 05/28/25. The incident involved Resident #3 and Resident #61. Resident #61 was ambulating around the nurse station in her wheelchair, rolled up to Resident #3, and slapped her in the face. An assessment was conducted on Resident #3 indicated she had no pain and there was no bruising or injuries to her face. Resident #61 was placed on 15-minute checks for 72 hours and was seen by the psychiatric services. Record review of Nurse Notes for Resident #3 indicated the following: * on 5/28/2025 at 08:52 p.m. at Resident #3 was sitting up in wheelchair. She had no signs or symptoms of acute distress. She had no signs or symptoms of facial discoloration, edema, warmth or open areas. * on 05/29/2025 at 11:33 a.m. Resident #3 was up in her wheelchair. She had no signs or symptoms of pain or discomfort, and no injuries were noted to her face. * on 05/30/2025 at 05:00 p.m. Resident #3 was up propelling herself around facility throughout shift. She had no signs or symptoms of distress. She denied pain or discomfort to face with no redness or swelling noted to her face. She was in a friendly mood. * on 05/31/2025 at10:20 a.m. Resident #3 was up in her wheelchair rolling around facility. She was cheerful and voiced no discomfort. * on 05/31/2025 at 04:36 p.m. Resident #3 was up propelling herself around facility throughout shift. She had no signs or symptoms of distress. She had a calm friendly mood. There was no redness or swelling noted to right cheek and she denied pain or discomfort. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 06/23/25 at 09:45 a.m., Resident #3 was in bed. She indicated she was doing good. She indicated she had no issues. She was confused when asked about the incident involving Resident #61. She had no redness or bruising on her face. During an observation and interview on 06/23/25 at 10:25 a.m. Resident #61 was in bed. She was calm. She indicated she was doing fine. She indicated she could not recall the incident. During an interview on 06/23/25 at 01:15 p.m. LVN G said Resident #61 was fairly new and was adjusting. She said she had no issues of Resident #61 hitting anyone before or after the incident with Resident #3. She said residents were put on 15-minute checks and referred to psychiatric services if they had behaviors towards other residents. During an interview on 06/23/25 at 01:20 p.m. LVN C said Resident #3 would roam around the facility. She said she had not had any issues with the resident provoking any other resident. Resident #46 Record review of a face sheet dated 06/11/25 indicated Resident #46 was a [AGE] year-old male admitted on [DATE]. His diagnoses included traumatic brain injury (an injury to the brain caused by an outside force), bipolar disorder (mental disorder associated with episodes of mood swings ranging from depressive lows to manic highs), anxiety disorder (persistent and excessive worry that interferes with daily activities), major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and behavioral syndromes (consistent pattern of behaviors that are correlated and often observed across different situations). Record review of the MDS dated [DATE] indicated Resident #46 had intact cognition with a BIMS of 15 out of 15 and had verbal behavioral symptoms directed toward others occurred 1 to 3 days. Record review of the care plan last reviewed 03/26/25 indicated Resident #46 had potential to be verbally and physically aggressive to staff and other residents. The goal was he would demonstrate effective coping skills and not harm himself or another resident. Interventions included monitor/document/report as needed any signs or symptoms of resident posing danger to self and others, separate resident from other residents due to behaviors, and refer to behavior hospital for admission due to escalating behaviors. Resident #9 Record review of a face sheet dated 06/25/25 indicated Resident #9 was an [AGE] year-old female admitted on [DATE]. Her diagnoses included anxiety disorder (persistent and excessive worry that interferes with daily activities), depression (mental illness that negatively affects how you feel, the way you think and how you act), and diastolic congestive heart failure (a condition in which the heart's main pumping chamber (left ventricle) becomes stiff and unable to fill properly). Record review of physician orders for June 2025 indicated Resident #9 had no new orders for any medications. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the MDS dated [DATE] indicated Resident #9 had intact cognition with a BIMS of 14 out of 15 and had no behaviors. Record review of the care plan last reviewed 05/28/25 indicated Resident #9 had no behaviors. 2. Record review of a Provider Investigation Report dated 06/23/25 indicated an incident categorized as Abuse occurred on 06/16/25. The incident involved Resident #9 and Resident #46. Resident #46 stood in front of Resident #9's walker in the smoke area and cursed her out. Resident #46 was placed on 15-minute checks for 72 hours and was sent to a psychiatric hospital for treatment of his escalation in behaviors. Record review of Nurse Notes for Resident #9 indicated an entry on 06/16/25 at 04:55 p.m. Resident #9 stated that she feels safe now, that she was just afraid when it happened. Record review of Social Services Notes for Resident #9 indicated an entry on 06/17/25 at 03:48 p.m. Resident #9 stated she was okay, and that the other resident did apologize to her the after the incident and they shook hands. She stated the incident did scare her, but she was okay and felt safe. During an observation and interview on 06/23/25 at 09:35 a.m. Resident #9 was sitting in bed working a word find puzzle. She said she was doing fine at this time. She said she did have an incident involving Resident #46. She said she was giving out candy and offered him a piece. She said she told him if he had a top denture, he would have to take it out because the candy would stick. She said he got up quickly and came to where she was sitting and started cursing at her. She said he also made the comment that the reason her daughter died was because of her. She started crying and said she had not seen him in a few days, but she was afraid of him at the time. She said she was sad about her daughter's death but was okay about the incident because he did apologize to her. Resident #37 Record review of a face sheet dated 06/25/25 indicated Resident #37 was a [AGE] year-old female admitted on [DATE]. Her diagnoses included bipolar disorder (mental disorder associated with episodes of mood swings ranging from depressive lows to manic highs). Record review of the MDS dated [DATE] indicated Resident #37 had moderately impaired cognition with a BIMS of 10 out of 15. She had behaviors of verbal behavioral symptoms occur 1 to 3 days and wandering occurred 1 to 3 days. Record review of the care plan last reviewed 05/05/25 indicated Resident #37 had behavior problem related to bipolar disorder. The goal was she would have no evidence of behavior problems through the next 90 days. Interventions included administer medications as ordered, explain/reinforce why behavior is inappropriate and/or unacceptable to the resident, and monitor behavior episodes and attempt to determine underlying cause. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a face sheet dated 06/11/25 indicated Resident #46 was a [AGE] year-old male admitted on [DATE]. His diagnoses included traumatic brain injury (an injury to the brain caused by an outside force), bipolar disorder (mental disorder associated with episodes of mood swings ranging from depressive lows to manic highs), anxiety disorder (persistent and excessive worry that interferes with daily activities), major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and behavioral syndromes (consistent pattern of behaviors that are correlated and often observed across different situations). Record review of the MDS dated [DATE] indicated Resident #46 had intact cognition with a BIMS of 15 out of 15 and had verbal behavioral symptoms directed toward others occurred 1 to 3 days. Record review of the care plan last reviewed 03/26/25 indicated Resident #46 had potential to be verbally and physically aggressive to staff and other residents. The goal was he would demonstrate effective coping skills and not harm himself or another resident. Interventions included monitor/document/report as needed any signs or symptoms of resident posing danger to self and others, separate resident from other residents due to behaviors, and refer to behavior hospital for admission due to escalating behaviors. 3. Record review of a Provider Investigation Report dated 06/18/25 indicated an incident categorized as Abuse occurred on 06/11/25. The incident involved Resident #37 and Resident #46. Security camera footage showed Resident #46 was walking down the hall and saw Resident #37 standing in his doorway. He was hollering and using inappropriate language as he approached her. Staff were positioned between the residents but Resident #46 bypassed staff and forcefully grabbled Resident #37 by the wrists and appeared to shake her. Resident #37 was assessed, and she had no scratches or bruising noted and she had no pain. Resident #46 was placed on 15-minute checks for 72 hours and was seen by the psychiatric services. Record review of Nurse Notes for Resident #37 indicated: * on 06/12/25 at 05:40 p.m. Resident #37 was ambulating in hallway with no complaints of pain or discomfort. * on 06/13/25 at 01:42 p.m. Resident #37 was in her room watching TV. She had no distress and no complaints of pain. During an observation and interview on 06/23/25 at 10:30 a.m. Resident #37 was ambulating independently in the facility. She had no bruising to her wrists. She said she was fine and had an issue with one resident, but she had no further issues with him. During an observation and interview on 06/25/25 at 10:22 a.m. Resident #46 was sitting in his room in his recliner. He was calm. He said he was doing fine. He said he had a problem with his attitude and went to the hospital for a little while but was doing better now. He said he did not want to talk about the incidents. During an interview on 06/23/25 at 01:15 p.m. LVN G said Resident #37 was known for wandering into other resident rooms and Resident #46 kept groceries in his room that were visibly seen from the open door. She said he was always accusing others of trying to take his food he had in his room. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #55 Record review of a face sheet dated 06/25/25 indicated Resident #55 was a [AGE] year-old female admitted on [DATE]. Her diagnoses included hypertension (a condition in which the force of the blood against the artery walls is too high) and 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). Record review of the MDS dated [DATE] indicated Resident #55 had intact cognition with a BIMS of 15 out of 15 and she had verbal behavioral symptoms directed toward others 1 to 3 days. Record review of the care plan last reviewed 03/26/25 indicated Resident #55 rolled backward in her wheelchair and had a history of running into another resident accidentally. The goal was she would not roll into another resident while wheeling through the hall. The interventions included consult with DOR related to therapy/restorative evaluation to assist resident with moving forward in wheelchair for safety and educated resident that rolling backward in hallway can be a safety hazard and potentially injure self and/or other residents. Resident #45 Record review of a face sheet dated 06/25/25 indicated Resident #45 was a [AGE] year-old male admitted on [DATE]. His diagnoses included hypertension (a condition in which the force of the blood against the artery walls is too high) and 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). Record review of the MDS dated [DATE] indicated Resident #45 had intact cognition with a BIMS of 15 out of 15 and he had no behaviors. Record review of the care plan last reviewed 05/05/25 indicated Resident #45 had no behaviors. 4. Record review of a Provider Investigation Report dated 06/20/25 indicated an incident categorized as Abuse occurred on 06/14/25. The incident involved Resident #45 and Resident #55. Resident #55 while rolling backwards in her wheelchair down the hallway accidentally made contact with the right arm of Resident #45 that was hanging on the side of his wheelchair. Resident #45 struck Resident #55 on the back of her arm. Resident #55 denied any pain or injury. There was no bruising or visible injury noted upon assessment. Resident #45 was placed on 15-minute checks for 72 hours and was seen by the psychiatric services. Record review of Nurse Notes for Resident #55 indicated on 06/15/25 at 05:57 p.m. Resident #55 had no signs of redness, warmth, or swelling. She denied pain or discomfort. During an observation and interview on 06/23/25 at 09:55 a.m. Resident #45 propelling self in hallway. Interactions with other residents were appropriate at this time. He said he had an incident with Resident #55. He said she back into him and did not even try to apologize to him so he hit her. He said it was the second time she backed into him with the wheelchair so he hit her, punched her right in the arm. (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 - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 06/23/25 at 09:58 a.m. Resident #55 said she was able to propel herself backwards better than forwards. She had no bruising to her right upper arm. She said she accidently bumped into Resident #45 and before she even had the chance to apologize to him he hauled off and punched her in the arm. She said she knows they had a talk with him and she thought her husband spoke with him too. She said her husband was not happy about him hitting her. During an interview on 06/23/25 at 01:10 p.m. LVN F said Resident #45 was seen by psychiatric services shortly after the incident. She said she had had no other issue with Resident #45 before or after the incident. During an interview on 06/23/25 at 01:22 p.m. LVN C said Resident #55 always rolled herself backwards with the wheelchair. She said she knew therapy was trying to work with her on propelling forward. She said the resident was not known for deliberately rolling into other residents. During an interview on 06/25/25 at 02:15 p.m. the DON said she expected staff to prevent residents from being abused. She said they could not control a resident's unexpected behaviors or reactions to other residents' actions. She said the resident with behaviors would be placed on 15-minute checks and a psychiatric review would be done. She said if it was needed the resident would be sent to the psychiatric hospital for treatment. During an interview on 06/25/25 at 02:20 p.m. the Administrator said they tried to do everything to prevent residents from being abused but they could not determine when a resident would have a behavior or reaction to another resident. She said the resident with behaviors would be placed on 15-minute checks and a psychiatric review would be done. She said if it was needed the resident would be sent to the psychiatric hospital for treatment. Record review of the Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy revised April 2021 indicated the following: Policy Statement 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. Policy Interpretation and Implementation 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; (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. consultants; d. volunteers; e. staff from other agencies; f. family members; g. legal representatives; h. friends; i. visitors; and/or j. any other individual

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received an accurate assessment, reflective of the resident's status for 1 of 23 residents reviewed for accuracy of assessments. (Resident #s 14) The facility did not accurately complete the MDS assessment to indicate Resident #14 did not have a restraint/ side rail. This failure could place the residents at risk of not receiving the appropriate care and services to maintain their highest level of well-being. Findings included: Record review of a face sheet dated 06/23/25 indicated Resident #14 was a [AGE] year-old female readmitted on [DATE]. Her diagnoses included dementia (group of thinking and social symptoms that interfere with daily function) and bipolar disorder (disorder associated with episodes of mood swings ranging from depressive lows to manic highs). Record review of the most recent quarterly MDS assessment dated [DATE] indicated Resident #14 was severely impaired of cognition and needed supervision for sit to lying, lying to sitting on the side of bed, sit to stand, and chair/ bed-to chair transfer. The assessment indicated Resident #14 had restraints and alarms of bed rails used less than daily during the last 7 days marked. Record review of Resident #14's care plans with a target date of 08/26/25 did not include a care plan for side rails. Record review of the physician's orders dated 06/23/25 indicated Resident #14 was not prescribed side rails or restraints. Record review of Resident #14's June 2025 MAR printed 06/23/25 indicated no side rails prescribed or received in June 2025. During an observation and interview on 06/24/25 at 10:47 a.m., Resident #14 was lying on her bed with no restraints and no side rails on her bed. She was confused but said yes to was she was treated well. During an interview on 06/24/25 at 2:16 p.m., LVN E said she was providing care for Resident #14 today. She said Resident #14 was not restrained and did not have side rails on her bed. LVN E said Resident #14 never had side rails on her bed. She said Resident #14 was on the secure unit of the facility and monitored 24 hours a day 7 days a week. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/25/25 at 9:34 a.m., the MDS Nurse said she was responsible for all MDSs completed in the facility. She said her back up was the Senior Director of Clinical Reimbursement. The MDS Nurse said she was educated on completion of MDS and accuracy. She said Resident #14 did not have a restraint or side rails on her bed. The MDS Nurse said it was an error on her part, she checked the box on the MDS by accident for side rails. The MDS nurse said there was no resident risk of Resident #14's MDS marked for side rails less than weekly, just an inaccurate MDS and not following regulations. During an interview on 06/25/25 10:48 a.m., the DON said the MDS Nurse was responsible for all MDSs completed in the facility, and she was educated on completion of MDSs. The DON said the backup was the Senior Director of Clinical Reimbursement. She said Resident #14 did not have side rails on her bed nor a restraint. The DON said the MDS should not have been marked for side rails. She said it was an oversight. The DON said there was no resident risk, it was just an inaccurate assessment. The DON said her expectation was all MDSs completed accurately and timely. During an interview on 06/25/25 at 10:57 a.m., the Administrator said the MDS nurse was responsible for all MDSs completed in the facility and she was educated on completion of MDSs. She said the Senior Director of Clinical Reimbursement was the back up. The Administrator said Resident #14's MDS marked for side rails was a typo and no risk to the resident. The Administrator said her expectation was for all MDSs completed accurately and timely. During an interview on 06/25/25 at 12:30 p.m., the DON said the facility did not have an MDS policy they followed the RAI. During an interview on 06/25/25 at 12:54 p.m., the Senior Director of Clinical Reimbursement said the MDS Nurse was responsible for all MDSs completed in the facility. She said she completed OIG audits (a systematic examination of government programs, operations or financial record to assess for compliance with laws and regulations) and completed quarterly audits of a randomly selected group of resident's MDSs to review and audit the MDS coding. She said she educated MDS nurses weekly about rotating MDS coding topics along with any trends identified in the audits. She said there was no resident risk since it was only the MDS that was incorrect, not the care plan or Kardex (a nursing documentation system that organized and summarizes key patient information to guide nursing care plans), and therefore did not impact the care provided to the resident. Record review of Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual dated October 2023 indicated, . P0100: Physical Restraints Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restrict freedom of movement or normal access to one's body Coding: 1. Not used 2. Used less than daily 2. Used daily . Used in Bed . A. Bed rails . Bed rails include any combination of partial or full rails.

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review , the facility failed to accurately submit a PL1 (PASRR Level 1 Screening) screening when a resident admitted with a diagnosis of Mental Illness, Intellectual Disability or Developmental Disability for 1 of 5 residents reviewed for PASRR screenings. (Resident # 29) The facility failed to submit a new PL1 screening when Resident #29 was readmitted from mental health hospital on [DATE] . This failure could place residents at risk of not receiving specialized services. Findings included: Record review of Resident #29's face sheet dated 06/25/25 was a [AGE] year-old-female admitted on [DATE] and readmitted on [DATE] . She had diagnoses of convulsions (uncontrolled jerking, loss of consciousness and other symptoms caused by abnormal electrical activity in the brain), and stroke. Record review of Resident #29's annual MDS dated [DATE] indicated she was not PASRR positive and had a BIMS score of 00 indicated severely impaired with cognition. The assessment indicated she had diagnoses of anxiety (feelings of worry and nervousness), schizophrenia (disorder that affects the thinking ability) and depression (persistent feelings of sadness). The assessment indicated Resident #29 received an antianxiety during last 7 days. Record review of Resident #29's quarterly MDS dated [DATE] indicated she had a BIMS score of 00; indicatinged severely impaired with cognition. Record review of Resident #29's care plan created on 05/28/24 indicated Resident #29 had a history of seizures and psychotropic medication for depression and anxiety with a goal to monitor for effectiveness of psychotropic medication. Record review of Resident #29's PL1 form dated 05/28/24, indicated she was positive for mental illness. There was no PASRR Level II Screening or Form 1012 (Mental Illness/Dementia Resident Review) found in the clinical record from the resident's readmission on [DATE] to 06/25/25. Record review of Resident #29's annual MDS dated [DATE] indicated she was not PASRR positive and had a BIMS score of 00 indicated severely impaired with cognition. The assessment indicated she had diagnoses of anxiety (feelings of worry and nervousness), schizophrenia (disorder that affects the thinking ability) and depression (persistent feelings of sadness). The assessment indicated Resident #29 received an antianxiety during last 7 days. During an interview on 06/25/25 at 11:15 a.m., the MDS nurse said she was responsible for all PASRR forms in the facility. She said Resident #29's PL1 was positive for mental illness, and she overlooked transmitting the PL 1 to the local mental health authority. The MDS nurse said Resident #29 would need a PASRR evaluation to be completed by the local mental health authority. The MDS nurse said the risk of a PL1 form being missed the resident could miss out on needed services. She said she had been trained and it was an oversight when Resident #29 was readmitted from the mental health hospital. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/25/25 at 11:25 a.m., the DON said the MDS nurse was responsible for all PASRR forms in the facility and was educated on completing PASRR forms correctly and timely. She said Resident #29 's PL1 form was overlooked. The DON said the risk of PASRR forms completed incorrectly or not transmitted was a resident could miss out on services if deemed PASRR positive. The DON said her expectation was all PASRR forms completed correctly and timely. She said the facility followed the RAI for their PASRR policy. Record review of the October 2023 Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual titled, A1500: Preadmission Screening and Resident Review (PASRR) Item Rationale Health-related Quality of Life indicated . o Individuals who have or are suspected to have MI or ID/DD or related conditions may not be admitted to a Medicaid-certified nursing facility unless approved through Level II PASRR determination. Those residents covered by Level II PASRR process may require certain care and services provided by the nursing home, and/or specialized services provided by the State.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the services provided or arranged by the facility, as outlined by the comprehensive care plan, meet professional standards of quality for 2 of 7 residents reviewed for following physician orders. (Residents #46 and #317) 1. The facility did not administer a new medication Depakote prescribed to Resident #46 for behaviors as ordered. 2. The facility did not obtain a urine specimen on Resident #317 for a UTI Panel prior to ABT administration as ordered. These failures could place the residents at risk of not having their individual needs met and of not receiving adequate care and medical interventions to maintain their health and prevent worsening health conditions. Findings included: 1. Record review of a face sheet dated 06/11/25 indicated Resident #46 was a [AGE] year-old male admitted on [DATE]. His diagnoses included traumatic brain injury (an injury to the brain caused by an outside force), bipolar disorder (mental disorder associated with episodes of mood swings ranging from depressive lows to manic highs), anxiety disorder (persistent and excessive worry that interferes with daily activities), major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and behavioral syndromes (consistent pattern of behaviors that are correlated and often observed across different situations). Record review of the Psychiatric Hospital discharge orders dated 06/24/25 indicated Resident #46 had a new order for Depakote 250mg twice daily for mood. Record review of the physician orders for June 2025 indicated Resident #46 had an order dated 06/24/25 with start date of 06/25/25 for Depakote Oral Tablet Delayed Release 250 mg (Divalproex Sodium) Give 250 mg by mouth two times a day for mood with Pending Confirmation. Record review of the Progress Notes with an entry dated 06/24/25 at 05:13 p.m. indicated LVN G documented Resident #46's provider was notified of return to facility and new order for Depakote. Record review of the June 2025 MAR indicated Resident #46 did not receive the evening dose of Depakote on 06/24/25 or the morning dose of Depakote on 06/25/25. During an interview on 06/25/25 at 11:14 a.m. LVN H said she did not give Resident #46 the morning dose of Depakote since there was no area to document the medication on the MAR. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/25/25 at 11:18 a.m. the ADON reviewed Resident #46's June 2025 Orders since readmitted from the psychiatric hospital and he said he had an order for Depakote twice daily with Pending Confirmation on it. He said he did not understand why a start date of 06/25/25 when the resident would have been at the facility to receive his evening dose. He said the resident should have received an evening dose on 06/24/25. He said the Depakote was available in the emergency medication supply. During a phone interview on 06/25/25 at 11:21 a.m. LVN G indicated she had notified the physician's NP and conducted the medication reconciliation. She said she did not give the evening dose Depakote on 06/24/25 and did not notify the physician of the missed dose. During an interview on 06/25/25 at 11:36 a.m. LVN H said Resident #46 did not have any Depakote on the cart this morning, so she ordered it from the pharmacy. She said the pharmacy said they had not received a request to fill the medication previously. During an interview on 06/25/25 at 02:15 p.m. the DON said she expected staff to follow the physician orders. She said the negative outcome could be a delay in receiving care. She said she expected staff to notify the physician if they were unable to carry out an order. She said the negative outcome could be a delay in receiving care. 2. Record review of a face sheet dated indicated Resident #317 was a [AGE] year-old female admitted on [DATE]. Her diagnoses included pyelonephritis (a type of urinary tract infection that usually moves from your bladder to your kidneys), injuries of the head, and quadriplegia (a loss of motor function in all four limbs). Record review of the physician orders for May 2025 indicated Resident #317 dated 05/05/25 and start date of 05/29/25 for UTI Panel one time only. Record review of the Progress Notes for Resident #317 with an entry dated 05/05/2025 at 07:38 p.m. indicated the physician made rounds with new orders for Ambien (hypnotic) 10mg at bedtime, Macrodantin (antibiotic) 100mg four times a day for 10 days before kidney surgery, and obtain urine culture before the start of antibiotic. Record review of the May MAR indicated Resident #317 had a UTI Panel to be obtained dated 05/29/25. There was no documentation of the sample being collected on 05/29/25 or 05/30/25. She also had Macrodantin 100 mg four times a day for 10 days with a start date of 05/30/25. The medication was initiated on 05/30/25. Record review of the Progress Notes for Resident #317 indicated there was no documentation on 05/29/25 or 05/30/25 of the UTI specimen being obtained. Record review of the EMR from 05/29/25 through 05/30/25 indicated there was no UTI Panel results under the Results tab and none scanned in under the Miscellaneous tab. During an interview on 06/24/25 at 02:00 p.m. LVN [NAME] said she initiated Resident #317's ABT. She said she did not notice if the UTI specimen was obtained prior to initiating the ABT. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/25/25 09:37 a.m. ADON L said the UTI Panel was not done prior to the initiation of the ABT and the physician was notified. Record review of a laboratory report dated 06/06/25 provided by ADON L indicated a UTI Panel specimen was obtained and processed on 06/06/25. During an interview on 06/25/25 at 12:45 p.m. the DON said the CN should have obtained the specimen as ordered by the physician on Resident #317. Record review of a Medication and Treatment Orders policy revised July 2016 and provided was not pertinent to the information needed.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences for 1 of 1 resident reviewed for tracheostomy care. (Resident #317) LVN A did not change Resident #317's outer tracheostomy cannula on 05/11/25 as listed on the May 2025 MAR. This failure could place residents with a tracheostomy at risk for infections to the tracheostomy site. Findings included: Record review of a face sheet dated indicated Resident #317 was a [AGE] year-old female admitted on [DATE]. Her diagnoses included injuries of the head, quadriplegia (a loss of motor function in all four limbs), and tracheostomy status (an opening in the neck in order to place a tube into a person's windpipe so they can breath). Record review of physician orders for May 2025 indicated Resident #317 had an order dated 04/11/2025 to change tracheostomy outer cannula every month one time a day the 11th every month. Record review of the May 2025 MAR indicated Resident #317 did not receive her tracheostomy outer cannula change on the day ordered or anytime during the month. During an interview on 06/24/25 02:10 p.m. ADON L said Resident #317's May 2025 MAR was blank on the day the tracheostomy outer cannula was to be changed and it was not documented on any other day of the month. He said he did not see where it was changed out on another day of the month. He said if it was not documented as being done then it was not done. During an interview on 06/25/25 at 12:45 p.m. the DON reviewed Resident #317's May 2025 MAR and said the tracheostomy outer cannula was blank on the 11th when it was to be changed. She said if it was not documented then it was not done. During an interview on 06/25/25 at 12:50 p.m. LVN A reviewed Resident #317's May 2025 MAR and said she was on duty on 05/11/25. She said she had been trained on tracheostomy care. She said she just may have forgotten to document on the MAR. She said if it was not documented as being done then it was not done. Record review of a Tracheostomy Care Policy and Procedure revised August 2013 indicated Purpose: The purpose of this procedure is to guide tracheostomy care and the cleaning of reusable tracheostomy cannulas General Guidelines: 4. Tracheostomy tubes should be changed as ordered and as needed (at least monthly) . (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/25/25 at 02:15 p.m. the DON said she expected staff to provide the required tracheostomy care. She said the negative outcome could be infection. She said all nurses were trained on tracheostomy care upon hire and reviewed annually.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to provide pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for one (Resident #117) of seven residents and one of five medication carts(Hall 400 cart) reviewed for pharmacy services. The facility failed to ensure all of Resident #117's medications was administered as ordered by the physician resulting in the incorrect dose of Vitamin C administration. The facility failed to ensure three insulin pens of aspart insulin were removed from use. Aspart insulin (rapid acting insulin used to lower blood sugar), with open date of 04/25/25, had been expired for 31 days, open date of 05/19/25, had been expired for 9 days, and open date of 05/23/25, had been expired for 5 days. This failure could place residents at risk of not receiving medications as ordered by their physicians and exacerbations of their medical conditions. Findings included: Record review of Resident #117's face sheet dated 06/25/25 indicated a [AGE] year-old male admitted to the facility on [DATE] and initially admitted on [DATE]. His diagnoses included protein-calorie malnutrition (insufficient intake of protein and caloric-energy), abnormal findings in urine, allergic rhinitis (watery eyes sneezing associated with immune reaction to irritants), diabetes and cerebrovascular disease (decreased blood flow to brain). Record review of Resident #117's quarterly MDS dated [DATE] indicated he had a BIMS of 9 out of 15 indicating he had moderately impaired cognitive skills for daily decision making. Record review of Resident #117's active orders as of 05/08/25 included a physician order for asorbic acid tablet 500 mg give 2 tablet equal 1 gram by mouth one time a day for UTI. Date started was 06/28/24. Record review of Resident #117's June 2025 MAR/TAR revealed LVN C documented administration of asorbic acid tablet 500 mg tablet, 2 tablets on 06/24/25 in the morning at 9:00 a.m. Record review of Resident #117's undated care plan included: Focus - Resident #117 was at risk for iron deficiency anemia and Interventions - encourage intake of food high in iron, vitamin c and to give medications as ordered. Focus- Resident #117 has multiple complications and at risk for vitamin deficiency and Interventions - administer my vitamins per MD orders and monitor for effectiveness. (continued on next page)

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	675541	A. Building B. Wing	06/25/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/23/25 at 2:00 PM, the DON stated Resident #117 received the vitamin c 500mg for preventative reasons for UTI. She said a pharmacy consultant comes in monthly and reviews medication administration, reports any errors and also provides training to the staff. The DON said she expects the staff to follow the orders as written and the order for Resident #117's vitamin c should have been 2 tablets to equal the full dose of 1 gram. The DON said Resident #117 was given the wrong dosage of medication. The DON said she expected her nurses to pass medications and do basic medication functions like following the 5 Rights of Medication Administration and notify the Physician for anything out of the ordinary. The DON said the risk to residents would be not receiving the correct therapeutic dosages of medications. During an observation on 06/24/25 at 8:45 a.m., LVN G prepared medications for Resident #117. LVN G sanitized her hands and placed the following medications into a medication cup: Amlodipine 10mg one tablet, buspirone 15 mg one tablet, metformin one tablet, sotalol 80mg one tablet, alfuzosin 10mg one tablet, vitamin c 500mg one tablet, cranberry 450mg 1 tablet, iron 324mg 1 tablet sertraline 50mg one tablet and hydrocodone 10/325mg two tablets. LVN G administered the medications to Resident #117 and he swallowed them without incident. During a phone interview on 06/25/25 at 1:43 p.m., LVN G said Resident #117 received vitamin c 500mg one tablet for supplementation. LVN G said the order was for vitamin c 500mg x 2 tablets. LVN G said she gave one tablet instead of two and stated it was her mistake, and just missed it. She said she checks the medication cart drawers for each medication to ensure she has everything needed. She said then she takes each medication container and dispenses the drug into cups while checking the order again before finally administering. LVN G did not see there would be any severe risk to Resident #117 when he did not receive the full dose and she thought she was following the orders at the time. She said it was a medication error and would report it to the DON right away and next time she will slow down and re-check what she is doing. During an observation and interview on 06/25/25 at 2:00 p.m., inventory of the Hall 400 Nurse Cart with LVN F indicated in the top draw, 3 insulin pens in use beyond the recommended time frame of use after opened. Observation on the medication cart insulin pens included: - one with open date of 04/25/25, had been expired for 31 days, - one open date of 05/19/25, had been expired for 9 days, - one open date of 05/23/25, had been expired for 5 days LVN F said nursing staff were expected to check their medication carts daily for expired medication and inappropriately labeled medication. LVN F said the insulin pens should have been removed from the medication cart 28 days from the opening date, but they were overlooked. She said she was providing care for residents on the 400 hall today, and had not given any insulin. LVN F said she was educated on medication storage and removal of insulin in use beyond the recommended time frame of use after opened. LVN F said the resident risk of insulin, in use beyond the recommended time frame of use after opened, was the medication may not be as effective. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/25/25 at 3:44 p.m., the DON said the nurses were responsible for the removal of insulin on the nurses' medication cart, 28 days after the open date. She said the pharmacy consultant checked random carts monthly for expired medication. She said the nurses were educated on removing expired medication off the nurse's medication cart during orientation, annually and on an as needed basis. The DON said insulin pens on 400 hall, in use beyond the recommended time frame of use after opened, were overlooked and should have been removed. She said the resident risk of insulin in use beyond the recommended time frame of use after opened was the medication may not be as potent as it should be. The DON said her expectation was all insulin removed, at the beyond use date, off the nurse's medication cart. Record Review of facility policy titled, Administering Medication revised dated April 2019 read in part: . Policy Statement: Medications are administered in a safe and timely manner, and as prescribed . 4. Medications are administered in accordance with prescriber orders, including any required time frame . 10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication . Record review of a facility policy titled, Medication Labeling and Storage revised February 2023 indicated, 3. If the facility has discontinued, outdated, or deteriorated medication or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items .

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident's drug regimen was free of unnecessary medication for 1 of 23 residents reviewed for unnecessary medication. (Resident #22) The facility failed to hold two of Resident #22's blood pressure medications when the blood pressure and/or heart rate was outside the prescribed parameters. This failure could place the residents at risk for adverse consequences and decline in health. Findings included: Record review of Resident #22's face sheet reflected a [AGE] year-old female admitted on [DATE] with diagnosis of hypertension (high blood pressure). Record review of Resident #22's quarterly MDS assessment, dated 03/21/25, indicated a BIMS score of 13 indicating Resident #22 was cognitively intact. Hypertension was included as one of Resident #22's diagnoses. Record review of Resident #22's care plan dated 03/06/2025 indicated a diagnosis of hypertension. Interventions included Give anti-hypertensive medications as ordered. Record review of Resident #22's June 2025's physician orders indicated the following: 1. Metoprolol tartrate 25 mg. Give 1 tablet by mouth twice daily for hypertension. Hold if SBP below 100 or DBP below 60 or HR below 60; and 2. Hydralazine HCL 25 mg - give one tablet three times daily for hypertension. Hold if SBP below 110 or DBP below 60. Record review of Resident #22's June 2025 MAR indicated the following: 1. Metoprolol 25 mg BID - hold if SBP below 110 or DBP below 60 or HR below 60 On the following dates and times, Resident #22 received Metoprolol 25 mg when the vital signs were outside the prescribed parameters: - On 06/03/2025 at 8:00 p.m., the BP was 94/60; (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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 06/08/2025 at 08:00 a.m., the BP was 98/64 and HR was 59; and - On 06/20/2025 at 08:00 a.m., the BP was 106/68. 2. Hydralazine 25 mg TID - hold if SBP below 110 or DBP below 60 On the following dates and times, Resident #22 received Hydralazine 25 mg when the vital signs were outside the prescribed parameters: On 06/03/2025 at 8:00 p.m., the BP was 94/60; On 06/08/2025 at 8:00 a.m., the BP was 98/64; and On 06/20/2025 at 2:00 p.m., the BP was 99/72. During an interview on 06/24/2025 at 2:00 p.m., the DON said her expectations was for all medications to be administered per physician orders including according to parameters. She added this failure could result in resident's blood pressure becoming lower, possibly cause fainting and injury, or resulting in fall with major injuries. During an interview on 06/24/2025 at 1:30 p.m., the administrator said her expectations were for all nursing staff and ADONs to monitor for accuracy of physician orders and any changes on their assigned units. During an interview on 06/24/2025 at 1:50 p.m., LVN A said it was an oversight administering the B/P medications to Resident #22. She said she should have held the medications as prescribed by the physician. She said if it was documented on the MAR, then it was given and should not have been. LVN A said it was a bad reflection on her nursing abilities as she had been educated and re-educated on administering medications with parameters. She said she needed to slow down more and focus on task at hand. A facility policy titled Administering Medications dated April 2019 indicated the following. Medications are administered in accordance with prescriber orders.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 under proper temperature controls, and permitted only authorized personnel to have access to the keys for 1 of 5 medication carts(400 Hall cart) and 1 of 1 treatment carts (Station 2 Nurse Cart) reviewed for medication storage. - The facility failed to ensure the medication treatment cart was locked when left unsecured and unsupervised at the main nurse station. - The facility failed to ensure Hall 400 Nurse Cart did not contain loose pills. - The facility failed to ensure an insulin pen of basaglar insulin (long acting insulin used to lower blood sugar) had a date as to when it was opened. These failures could place residents at risk of adverse reactions to medications, misappropriation of medications and not receiving therapeutic effects of medication. Findings include: During an observation and interview on 06/23/2025 at 09:00 a.m., the medication treatment cart was noted to be unsecured and unsupervised at the main nurse station. Located inside the unlocked medication treatment cart was the following items labeled as keep out of reach of children: -Mupirocin 2% ointment - treats bacterial skin infections. -Iodosorb Cadexomer Iodine Gel 10gm/0.35 oz - a gel applied to the skin to treat wet ulcers and wounds. This medication can kill bacteria, absorb exudate (pus), and clean out your wound so it can heal faster. Can be bought over-the-counter. -Zinc Oxide Ointment - used to treat and prevent diaper rash. Also used to protect skin from being irritated and wet. Iodine 10% swabs - used as a first aid antiseptic to prevent infection in minor cuts, scrapes and burns. -Hydrophilic Wound dressing pansement hydrophile - for the local management of pressure and venous stasis ulcers, superficial wounds, scrapes, burns, and partial-and-full thickness wounds. -16 oz bottle hydrogen peroxide - used as an oxidizer, bleaching agent, and antiseptic. -bottle of Dakin solution full strength - a dilute antiseptic solution containing bleach and other ingredients, traditionally used for cleaning wounds and preventing infection. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 8 oz bottle povidine-iodine 10% solution - an over-the-counter antiseptic solution used to treat and prevent skin infections. Antifungal powder - treats fungal or yeast infections in your skin. ADON B approached the medication treatment cart and reviewed the unsecured items with surveyor. She said the treatment cart should never be unlocked and unsupervised. She said anyone could pass by and take anything out at any time. ADON B said all the nursing staff were responsible for providing treatments to their assigned residents and whomever was last to use the cart should always lock when finished. She said the key to unlock treatment cart was kept in medication room. During an interview on 06/24/2025 at 2:00 p.m., the DON said licensed nursing staff perform the treatments to the residents they oversee. She said the keys to the treatment cart was kept in the medication room behind locked door. She said medication and treatment cart should be kept locked and always secured when not in use for safety purposes. She said the treatment carts should be always kept clean. The DON said the risk of treatment cart being left unlocked and unsupervised would be that any resident, staff, or visitors could open the drawers while passing by and retrieve harmful items including scissors or any treatment medications. During an observation and interview on 06/25/2025 at 7:45 a.m., the medication treatment cart was noted to be unsecured and unsupervised at the main nurse station and containing the same items as previously noted. ADON B approached surveyor as before and said the medication treatment cart was left unsupervised and unsecured and should not have been. She said she did not know who had used the treatment cart last, and whomever should have secured after use. During an observation and interview on 06/25/25 at 2:00 p.m., indicated inventory of the Hall 400 Nurse Cart with LVN F indicated had 4 loose pills and one basaglar insulin pin was used, did not have a date as to when it was opened. LVN F said nursing staff were expected to check their carts daily for inappropriately labeled medication or lose pills. She said all medications are were expected to be packaged in the original pharmacy packaging containing all the required pharmacy labels or in the OTC stock bottles to ensure patient safety. She said if mistakenly administered, unlabeled insulin usage or loose pills could place residents at risk of disastrous side effects since their identification was unknown; so they must be crushed and discarded in the sharp's container and the insulin had to be reordered. LVN F said she was educated on medication storage and keeping the medication cart clean of loose pills. During an interview on 06/25/25 at 3:44 p.m., the DON said the nurses were responsible for keeping medication carts clean, free of loose pills and label medication with date of when first opened. She said the pharmacy consultant checked random carts monthly for loose pills and medication labeling. She said the nurses were educated on keeping the medication carts clean and labeling insulins with first opened. The DON said having loose pills and usig insulin that was not labeled can lead to adverse reactions, infection from contamination or uncontrolled health conditions. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a facility policy titled, Medication Labeling and Storage revised February 2023 indicated, 1. Medications and biologicals are stored in the packaging, containers or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers. 2. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner . 4. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others .