STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675755	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capstone Healthcare of Daingerfield	507 E W M Watson Blvd Daingerfield, TX 75638

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	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** 30527 Based on interviews and record review, the facility failed to ensure the right of the residents to be free from abuse for 2 of 4 residents (Resident #2, Resident #3) reviewed for abuse. The facility failed to protect other residents from being kicked by Resident #1, when Resident #1 kicked Resident #3's feet when he walked by him on 1/12/25 at 5:20 am. The facility failed to recognize and put measures in place for Resident #1's increased behaviors from 01/09/2025 through 01/12/2025, which resulted in Resident #1 choking Resident #2. An Immediate Jeopardy (IJ) was identified on 02/27/2025 at 1:40 PM. The IJ template was provided to the facility on [DATE] at 1:06 p.m. While the IJ was removed on 02/28/2025, the facility remained out of compliance at no actual harm with potential for more than minimal harm that is not immediate jeopardy with a scope identified as isolated due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. These failures could place residents at risk of abuse, physical harm, mental anguish, and emotional distress. Findings included: Record review of a face sheet dated 02/27/2025 indicated Resident #1 was a [AGE] year-old male, admitted to the facility on [DATE], with diagnoses including depression, hypercholesterolemia (high blood cholesterol that limits blood flow), hypertension (high blood pressure), delusional disorders (mental illness that causes people to have false beliefs), and dementia (degenerative brain disease - loss of memory, language). Record review of the comprehensive MDS dated [DATE] indicated Resident #1 had a BIMS score of 0 and was severely cognitively impaired. Resident #1's MDS indicated wandering behavior was exhibited, and physical and verbal behaviors towards others. Resident #1 was not assessed due to medical condition or safety concerns for eating, toileting, showering, dressing and personal hygiene, ambulation, or transfers. (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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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the consolidated physician orders dated 02/27/2025 indicated Resident #1 had an order for behavior monitoring for Diazepam,(medication used to treat anxiety, muscle spasms, and seizures) Seroquel (medication used to treat schizophrenia (disorder that affects a person's ability to think clearly), bipolar disorder (mood swings) and depression), Trazodone (medication used to treat depression) , and Wellbutrin (medication used to treat depression). Document number of times the resident has exhibited the above behavior during shift. Document the intervention and document the outcome with a start date of 09/25/2024. Record review of the care plan with a revision date of 01/15/2024 indicated Resident #1 had the potential to be physically aggressive related to dementia with the following interventions Administer medications as ordered after attempting non-medical approaches, analyze times of day, places, circumstances, triggers and what de-escalates behavior, anticipate needs such as food, water, toileting, if behavior is threat to self or others immediately call for assistance. If signs of agitation shown - intervene before it escalates: remain calm, stand out of reach, listen and respond with empathy, engage in conversation. If response is aggressive, team member to calmly walk away, ask others to leave, ensure everyone is safe, immediately report this to nurse. Record review of the facilities Incident and Accidents Report dated 10/01/2024 - 01/26/2025 indicated no reported incidents involving Resident #1 and Resident #3. Record review of a progress note dated 01/09/2025 at 2:07 PM by LVN A, indicated Resident #1 had behaviors with 2 other residents without physical contact. Record review of a progress noted dated 01/09/2025 at 08:38 PM by LVN B, indicated Resident #1 snatched a cover off another resident in the commons area of the secured unit. Resident #1 swung at staff when approached. Record review of progress noted dated 01/09/2025 at 08:40 PM by LVN B, indicated Resident #1 was going into other resident's rooms. Resident #1 raised his hand to the nurse and then walked out of the room. Record review of progress note dated 01/09/2025 at 09:09 PM by LVN B, indicated Resident #1 was bent down and kneeled on the floor then laid down on the floor. Resident #1 was given a pillow and covered with a blanket. Record review of progress note dated 01/09/2025 at 09:19 PM by LVN B, indicated Resident #1 was bent down and kneeled on the floor then laid down on the floor then got up and started pacing from door to door, shaking the doors. The ADON and the DON were notified of the behaviors. Record review of progress noted dated 01/12/2025 at 01:42 AM by LVN F, indicated Resident #1 was exit seeking, restless, and in and out of other resident's rooms. Resident #1 removed his pants in the commons area in the secured unit. Record review of progress note dated 01/12/2025 at 05:20 AM by LVN F, indicated Resident #1 (as he walked by) kicked Resident #3's feet while he was sitting in his wheelchair. Resident #1 was going in other resident rooms and pacing the secured unit. (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of progress noted dated 01/12/2025 at 07:00 AM by LVN C, indicated Resident #1 was up and pacing. Resident #1 was grabbing other resident's wheelchairs and attempting to move them. Resident #1 was crawling in hallway. Resident #1 continued to disturb other residents. Record review of progress noted dated 01/12/2025 at 08:40 AM by LVN C, indicated Resident #1 was entering rooms, busting in doors, combative with staff, required assistance by two staff members to remove from room. Resident #1 continued to push and pulled on other resident's wheelchairs. Resident was unable to be redirected. The MA reported Resident #1 continued to refuse his medications with multiple approaches. Resident #1 shoved LVN C in the chest then knocked the medication cup from LVN C. LVN C notified the Administrator, the DON, and the ADON of unable to control/redirect Resident #1, and the escalating behaviors. LVN C then notified Resident #1's family. Record review of progress note dated 01/12/2025 at 08:50 AM by LVN C indicated CNA D summoned for nurse and reported Resident #1 had entered Resident #2's room and physically attacked Resident #2. CNA D reported she observed Resident #2 lying in her bed with Resident #1 leaned over Resident 2 with his hands wrapped around her neck attempting to choke Resident #2. CNA D stated she had to physically pry Resident #1's hands/fingers off Resident #2's neck and restrain him to the floor. When LVN C entered Resident #2's room, Resident #1 was restrained by CNA D. Immediate notification made for 911 services. The family was notified of escalating behaviors and transfer and agreed to the transfer. Record review of a face sheet dated 02/27/2025 indicated Resident #2 was a 75 -year-old female, admitted to the facility on [DATE], with diagnoses including neuralgia (pain associated with nerves), weakness, age related physical debility, dementia (degenerative brain disease - loss of memory, language), and anxiety (intense, excessive worry). Record review of the comprehensive MDS dated [DATE] indicated Resident #2 had a BIMS score of 3 and was severely cognitively impaired. Resident #2's MDS indicated she required set up assistance with eating, partial assistance with personal hygiene, and substantial assistance with toileting, dressing, and showering. Resident #2's MDS indicated she was independent with ambulation. Record review of the consolidated physician orders dated 02/27/2025 indicated Resident 2 had an order to monitor for pain every shift. During an interview with the DON on 2/27/2025 at 10:10 AM , a copy of the Resident's #2 care plan was requested and not received prior to exiting the facility. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of progress note dated 01/12/2025 at 08:50 AM by LVN A indicated CNA D summoned for nurse and reported Resident #1 had entered Resident #2's room and physically attacked Resident #2. CNA D reported she observed Resident #2 lying in her bed with Resident #1 leaned over Resident 2 with his hands wrapped around her neck attempting to choke Resident #2. CNA D stated she had to physically pry Resident #1's hands/fingers off Resident #2's neck and restrain him to the floor. When LVN C entered Resident #2's room, Resident #1 was restrained by CNA D. CNA E was summoned to Resident #2's room and escorted Resident #2 from the room. Resident #2 was taken to a chair in the commons area of the memory care unit. Resident #2 was upset and crying. Assessment completed with vital signs within normal limits, oxygen saturation at 97%, no redness or bruising noted, and no petechia observed to bilateral eyes. Police officer and EMT arrived at the facility. The EMT completed a full assessment of Resident #2 until Resident #2 stopped the EMT and stated' I am fine. Resident #2 assured the EMT she was safe and could return to her room. Resident #2's family member arrived at the facility and took Resident #2 via private care to the hospital emergency room for evaluation. The Administrator and the DON were made aware of reportable to state. Record review of hospital discharge paperwork dated 01/12/2025 indicated Resident #2 was discharged with unremarkable findings. Record review of a face sheet dated 02/27/2025 indicated Resident #3 was an [AGE] year-old male, admitted to the facility on [DATE], with diagnoses including hypoglycemia (low blood sugar), type 2 diabetes mellitus (chronic disease when the body does not make insulin properly) mixed hyperlipidemia (causes high levels of cholesterol in the blood), hypertension (high blood pressure), and Alzheimer's disease (a progressive disease that destroys memory and other mental functions). Record review of the discharge MDS dated [DATE] indicated Resident #3 had a BIMS score of 0 and was severely cognitively impaired. Resident #3's MDS indicated wandering behavior was exhibited, physical and verbal behaviors towards others. The MDS indicated Resident #3 required set up assistance for eating. The MDS indicated Resident #3 required partial/moderate assistance for oral and toileting hygiene, partial assistance for shower, dressing, personal hygiene, ambulation, and transfers. Record review of the consolidated physician orders dated 02/27/2025 indicated Resident #3 had an order for behavior monitoring for Seroquel (medication used to treat schizophrenia (disorder that affects a person's ability to think clearly) Document number of times resident has exhibited the above behavior during shift. Document the intervention and document the outcome with a start date of 01/06/2025. During an interview with the DON on 2/27/25 at 10:10 AM, a copy of the Resident #3's care plan was requested and not received prior to exiting the facility. Record Review of Resident #3's progress notes dated 01/12/2025 indicated no incidents or assessments completed. Attempted interview on 02/25/2025 at 11:32 AM with Resident #2, she was not interview able. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 02/26/2025 at 09:30 AM, LVN C stated she had worked at the facility for approximately 2 years. LVN C stated Resident #1 was an elopement risk from another facility and required the secured unit. LVN C stated on 01/12/25 at 08:50 AM she received a telephone call from CNA E, to come to the secured unit to Resident #2's room. LVN C stated upon arrival CNA D had restrained Resident #1 on the floor. CNA E had removed Resident #2 to the commons area of the secured unit. LVN C stated she notified 911 for assistance. LVN C stated upon arrival of the police and the EMT, Resident #1 was transferred out of the facility. LVN C stated she completed an assessment on Resident #2. LVN C stated Resident #2 was upset and crying but then stated she was fine and declined any further care. LVN C stated Resident #2's family arrived and transported her to the emergency room via a private car. LVN C stated Resident #1's behaviors had escalated from the start of her shift at 06:00 AM. LVN C stated Resident #1 disturbed other residents by pulling on wheelchairs, walked with a rapid pace, crawled on the floors. LVN C stated she had not notified the physician of the increase of behaviors. LVN C stated she had contacted Resident #1's family at 08:40 AM. LVN C stated she contacted the ADON and the DON regarding Resident #1's escalated behaviors at 08:40 AM. LVN C stated, I guessed the ADON and DON were working to have the resident transferred out. LVN C stated she was not sure who was making the transfer arrangements at that time. LVN C stated she had reached out to the ADON and the DON via text message and neither were in the facility at that time. LVN C stated she could not recall what exactly she had been told by the ADON and the DON other than redirect Resident #1, but she would have charted the instructions received if she had received any. LVN C stated everything was happening very quickly and she had not delegated any 1 to 1 intervention because the facility did not have the staff. LVN C stated Resident #1 should have been transferred out to a behavioral unit due to escalating behaviors. LVN C stated 1 to 1 intervention could have prevented the choking incident between Resident #1 and Resident #2 but there was not enough staff. LVN C stated Resident #1 was not adequately monitored during the escalated behaviors that resulted in Resident #2 being choked while she was asleep in her bed. During an interview on 02/26/2025 at 10:21 AM, CNA E said Resident #1 had escalated behaviors on 1/12/2025 and was more difficult to redirect and was disturbing the other residents. CNA E said she had reported to LVN C several behaviors since the start of her shift at 6:00 AM. CNA E said Resident #1 was sitting at the table with her and CNA D and appeared settled at that moment. CNA E said she left the secured unit to retrieve the breakfast trays while CNA D was providing care with another resident. Upon returning to the secured unit, she heard CNA D hollering to get help. CNA E said upon entering resident #2's room, CNA D was attempting to restrain Resident #1 from going at Resident #2. CNA E said she removed Resident #2 to the commons area at the front of the secured unit. CNA E said she alerted LVN C by the phone located in the commons area of the secured unit to come and assist CNA D. CNA E said they continued to keep Resident #1 from other residents until the EMT arrived to transport Resident #1. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 02/26/2025 at 01:15 PM, CNA D said during her shift on 1/12/2025. she noticed Resident #1 was not in the commons area or his room after she finished providing care to another resident. CNA D stated while she looked for Resident #1, she faintly heard Resident #2 call for help. CNA D said when she entered Resident #2's room, Resident #1 was leaning over Resident #2 with both hands around her neck. CNA D said she had to pry Resident #1's hands and fingers from Resident #1's neck. CNA D said she got him down in a sitting position on the floor and placed his hands behind his back as Resident #1 continued to try to go at Resident #2. CNA D stated CNA E arrived back on the secured unit, and she yelled for her. CNA E removed Resident #2 from the room and notified LVN C by the phone located in the commons area of the secured unit. CNA D stated she continued to restrain Resident #1 until the police arrived. LVN C entered the room and then contacted 911. CNA D said the EMTs, and police assisted to transport Resident #1 out of the building to the hospital. During an interview on 02/26/2025 at 03:41 PM, the social worker stated she had not worked on a transfer for Resident #1 until 01/15/2025 after Resident #1 had transferred from the facility. The social worker stated she could not recall any conversation or text messages regarding Resident #1 until after he had left from the facility. The social worker stated escalated behaviors were addressed by putting the care plan interventions in place. When those interventions failed, the facility would transfer the resident with escalating behaviors out of the facility to a behavior unit. The social worker defined escalated behaviors as a change from the resident's baseline behavior such as increased agitation, crawling on floors, no longer able to distract the resident. The social worker said these failures could resulted in harm to residents such as death. During an interview on 02/26/2025 at 07:11 PM, LVN F said Resident #1's behavior had changed. LVN F stated Resident #1 could usually be redirected. LVN F stated that she reported to the ADON and the DON on 01/11/2025 that Resident #1 was more difficult to redirect. LVN F stated she was instructed to continue to redirect the resident and give medications as ordered. LVN F stated Resident #1 took off his pants in the commons area which he had never done anything like that before. LVN F stated the CNA reported to her that Resident #1 kicked Resident #3. LVN F stated she failed to complete the incident report and report the incident to the ADON, the DON, or the Administrator. LVN F stated the incident should have been investigated due to being a resident-to-resident altercation. LVN F stated it was at change of shift and although she had reported the incident to the oncoming shift, an incident report should have been completed by her at the time the incident had occurred. LVN F stated the physician should have been notified as well as the families of the residents involved. LVN F stated reporting should be completed for investigation and to protect the residents from abuse. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 02/26/2025 at 07:59 PM, LVN G stated Resident #1 experienced escalated behaviors on 01/09/2025. LVN G reported to the ADON and the DON that Resident #1 was crawling around and laying on the floor with his eyes closed. LVN G stated she was instructed by the ADON to give a pillow and blanket and ensure Resident #1 was warm and leave on the floor to sleep. LVN G stated she did not contact the physician for a change of condition related to increased behaviors. LVN G stated Resident #1 was pacing more often and faster. Resident #1 was blocking the doors and shaking the door handles to the secured unit which made it difficult for staff to get through. LVN G recalled Resident #1 took a swing at one of the CNAs. Resident #1 was entering in another resident's rooms and the staff had to coax Resident #1 out and attempted to detour him from going into another resident's rooms. LVN G stated Resident #1 raised his hand at her when she attempted to redirect Resident #1 from another resident's rooms. LVN G stated the CNA reported Resident #1 had jerked covers off of another resident in the commons area of the secured unit. LVN G said when the previous interventions were not effective, she should have also contacted the physician for orders. LVN G said as the charge nurse she was responsible for reporting the change of condition. LVN G said the residents were in harms way such as the choking or death. During an interview on 02/27/2025 at 10:10 AM, the DON identified escalating behaviors as increased agitation, loudness/screaming, and showing signs of aggression. The DON stated Resident #1 was at his baseline and was not showing signs of escalating behaviors. The DON did not respond to the state surveyor when asked if the charted behaviors reported to her through 01/09/2025 - 01/12/2025 describe the definitions as she had identified above as escalated behaviors of Resident #1. The DON said the behaviors exhibited by Resident #1 were typical behaviors of a resident with dementia. The DON said when the staff notified her of the incident with Resident #1 choking Resident #2, she told the staff (CNA E and LVN C) via text message that Resident #1 needed to be sent out because the facility did not provide 1 to 1 care. The DON stated the physician was notified as well as the families after the incident occurred. The DON said there was no way to know the choking incident was going to happen prior to the incident taking place. The DON said the incident with Resident #1 kicking Resident #3 could have been an accident while Resident #1 walked by Resident #3. The DON stated, we don't care what the residents do to the staff - residents hit staff all the time and it did not mean the behaviors were escalated. The DON said they educated the staff on better resident approaching strategies to prevent residents hitting staff. The DON later said when Resident #1 kicked Resident #3 feet, it was considered a resident-to-resident altercation and should have been reported as an incident and investigated to rule out abuse. During an interview on 02/27/2025 at 10:30 AM, the ADON stated Resident #1 exhibited behaviors of a dementia patient and she had not considered the behaviors to be escalated between the dates of 01/09/2025 - 01/12/2025. The ADON described an escalated behavior as something different from their typical baseline behavior and that varied between each individual resident. The ADON stated staff had reported Resident #1 jerking the blanket off another Resident but Resident #1 could have thought that was his blanket. The ADON stated she had told the staff to give Resident #1 the pillow and blanket and ensure resident was warm because he was sleeping and settled/safe on the floor. The ADON said it had not been reported except during the time of 01/09/2025 - 01/12/2025 of Resident #1 pulling/jerking covers from other residents or crawling/laying/sleeping in the floors. The ADON said it was not unusual for dementia residents to wander in and out of room rooms. The ADON stated that was why Resident #1 was in the secured unit due to wandering. The ADON said the incident when Resident #1 hit Resident #3 should have been reported as an incident and the physician, family, the abuse coordinator should have been notified for further investigation. The ADON said abuse allegations should be investigated to protect all residents from abuse. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 02/27/2025 at 10:50 AM, the Administrator stated behaviors were often unpredictable and predictable to a point. The Administrator said the facility and staff do their best to minimize behaviors and keep all residents safe. The Administrator said, it was not the best ideal to take eyes off of Resident #1 during the 10-minute time frame that the incident occurred within. The Administrator stated he expected staff to report incidents of suspected abuse including suspected resident to resident altercations so that the incident was then followed up on by him with a thorough investigation. The Administrator stated all staff were responsible for ensuring that no resident was subject to any type of abuse. The Administrator said the choking incident and failure of reporting incidents appropriately placed residents at a potential risk of abuse by physical or emotional trauma. The facility policy titled Abuse, Neglect Exploitation, & Misappropriation Policy dated 09/2024 indicated: .The resident has the right to be free of abuse, neglect, exploitation, and misappropriation of resident property and other reportable incidents that affect the Health and Safety of the resident .Physical Abuse includes slapping, biting .5. Abuse toward a resident can occur as: a. resident to resident abuse; . The Administrator was notified on 02/27/2025 at 01:04 PM that an Immediate Jeopardy situation was identified due to the above failure. The Administrator was provided the Immediate Jeopardy template on 02/27/2025 at 1:06 PM. The facility's Plan of Removal was accepted on 02/27/2025 at 06:30 PM. and included: Tag F-600: Systemic Approach 1. Resident 1 was transferred to The Local Hospital's Emergency Department where he was admitted to the Behavioral Health Hospital on 1/12/2025. As indicated on SRI #556297, the resident is not to return to the facility to eliminate the risk of behavior happening again. 2. The Medical Director was immediately notified by the Director of Nurses on 2/27/2025 at 2:11pm and the Chief Operating Officer at 1:07pm of the Immediate Jeopardy. 3. Administrator review of the following facility policy on 2.27.2025: a. Abuse, Neglect, Exploitation, & Misappropriation Policy b. Resident to Resident Altercations 4. An immediate in-service to be provided by Regional Nurse Consultant to Administrator, DON and staff at facility with the subject of Recognizing Escalating Behaviors and Effective Measures to Put in Place to Protect Residents on 2/27/2025 at 2:20pm. a. Main takeaways from training include: the use of interventions which include 1:1 monitoring, redirecting, social services department visits and using calming music. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5. An Immediate in-service of the facility's Abuse policy to be conducted for all staff. Employees not present at building will be called via phone and provided in-service information. Inservice of staff will be completed by 2/28/2025 by 5:00pm. Other staff will be in-serviced before their next shift. A questionnaire will be created from the abuse policy. Questionnaires will be provided at random to employees to ensure retention of policy. Employees answering wrongly on questionnaires will receive more training. Admin/DON/ADON are responsible for conducting the training. 6. An immediate QAPI meeting to be held by IDT on 2.27.2025 a. Review of incident b. Establish areas of improvement c. Create plan to monitor and manage areas of improvement 7. Safe Surveys were conducted at the time of the incident. Results from the survey can be found with supportive documents provided to State surveyor and in SRI folder administrator keeps on hand. Safe survey results indicated no other residents were in need of additional supervision. 8. Monitoring: a. Admin or DON will conduct weekly random questionnaires of the abuse policy for a period of 4 weeks to ensure staff retain knowledge from the Abuse Policy. 9. Root Cause Analysis was conducted on 2/27/2024 identifying issues related to incidents on 1/12/2025. It was established that employees need more education of the abuse policy and aware of effective ways to de-escalate resident behaviors. This education was immediately provided on 2/27/2025. 10. Quality Assurance a. An ad hoc Quality Assurance Meeting will be conducted with IDT, including medical director via phone call on 2/27/2025. b. The IJs for F689 and F600 were noted and steps for removal were discussed. c. Incidents have been reviewed with plans to improve. i. Improvement plans include Notifying physician immediately, placing interventions in place immediately such as 1:1 monitoring, redirecting, separating residents, and removing residents from environment. Deescalating behaviors and recognizing signs of escalating behaviors. d. Plan on Removal being conducted. e. The Medical Director made no relevant comments at the time of meeting. He agreed that discussions related to the incident during the meeting are thorough and will be effective. O2/28/2025, the state surveyor confirmed the facility implemented their plan of removal sufficiently to remove the immediate jeopardy by: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capstone Healthcare of Daingerfield	507 E W M Watson Blvd Daingerfield, TX 75638

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record Review of in-service dated 02/27/2025 provided by the Regional Nurse to the Administrator, the DON, and the ADON with the following topics: A. Abuse, Neglect, Exploitation, & Misappropriation Policy B. Resident to Resident Altercations Record Review of the in-service dated 02/27/2025 at 2:20 PM provided by the Regional Nurse Consult to the Administrator, the DON, and the staff at the facility with the subject topic of: Recognizing Escalating Behaviors and effective measure to put in place to protect the residents such as intervention of 1:1 monitoring, redirecting, social services departments visit, and using calming music. Record review of in-service dated 02/27/2025 of the facility's Abuse policy conducted for all staff. (Employees not present at the building will be called via phone and provided in-service information. In-service of staff will be completed by 2/28/2025 by 5:00pm. Other staff will be in-serviced before their next shift.) Record review of a questionnaire created from the abuse policy with 25 employee/staff correctly completed on 02/28/2025. (Questionnaires will be provided at random to employees to ensure retention of policy. Employees answering wrongly on questionnaires will receive more training. Admin/DON/ADON were responsible for conducting the training) Record review of signed QAPI Committee Meeting completed on 2/27/2025 at 2:20 PM addressed the following: a. An ad hoc Quality Assurance Meeting will be conducted with IDT, including medical director via phone call on 2/27/2025. b. The IJs for F689 and F600 were noted and steps for removal were discussed. c. Incidents have been reviewed with plans to improve. i. Improvement plans include Notifying physician immediately, placing interventions in place immediately such as 1:1 monitoring, redirecting, separating residents, and removing residents from environment. Deescalating behaviors and recognizing signs of escalating behaviors. d. Plan on Removal being conducted. e. The Medical Director made no relevant comments at the time of meeting. He agreed that discussions related to the incident during the meeting are thorough and will be effective. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interviews of nursing staff on 2/28/2025 from 09:49 AM - 11:55 AM (6 AM - 6 PM Shift) DON, ADON, MDS Nurse, LVN C, CNA D, CNA E, CNA L, MA P, LVN Q, LVN W, LVN A, CNA AA, (6PM - 6AM) MA X, LVN Y, LVN Z, CNA BB, CNA CC, CNA DD, CNA EE, Administrator, Dietary Manager, Assistant Dietary Manager, Housekeeping Supervisor, Social Worker, Maintenance Supervisor, Director Business Development, Medical Records, Dietary Aide H, Housekeeper K, Housekeeper M, Housekeeper N, Director of Rehabilitation, PTA U, OT V, Activities Assistant. During these interviews staff were able to correctly identify types of abuse such as physical, sexual, verbal and resident to resident altercations; who to notify if abuse was suspected - such as the abuse coordinator, physician, families; proper documentation in resident charts, incident reports and care plans; recognizing escalated behaviors such as increased screaming and agitation and notifying the physician immediately of escalating behaviors; ways to de-escalate behaviors 1 to 1 monitoring, redirecting, separating residents, removing residents from the environment, calming music, and social services. On 02/28/2025 at 12:00 PM, the Administrator was informed the IJ was removed; however, the facility remained out of compliance at no actual harm with potential for more than minimal harm that is not immediate jeopardy with a scope identified as isolated due to the facilities need to complete in-service training and evaluate the effectiveness of the corrective systems.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30527 Based on interviews and record review, the facility failed to ensure all alleged violations involving abuse are reported immediately, but not later than 2 hours after the allegation is made, to the administrator of the facility and toother officials for 1 of 4 residents (Resident #3) reviewed for abuse. The facility failed to report an allegation of abuse to the administrator and HHSC when Resident #1 kicked Resident #3's feet when he walked by him on 1/12/25 at 5:20 am. These failures could place residents at risk of abuse, physical harm, mental anguish, and emotional distress. Findings included: Record review of a face sheet dated 02/27/2025 indicated Resident #1 was a [AGE] year-old male, admitted to the facility on [DATE], with diagnoses including depression, hypercholesterolemia (high blood cholesterol that limits blood flow), hypertension (high blood pressure), delusional disorders (mental illness that causes people to have false beliefs), and dementia (degenerative brain disease - loss of memory, language). Record review of the comprehensive MDS dated [DATE] indicated Resident #1 had a BIMS score of 0 and was severely cognitively impaired. Resident #1's MDS indicated wandering behavior was exhibited, and physical and verbal behaviors towards others. Resident #1 was not assessed due to medical condition or safety concerns for eating, toileting, showering, dressing and personal hygiene, ambulation, or transfers. Record review of the consolidated physician orders dated 02/27/2025 indicated Resident #1 had an order for behavior monitoring for Diazepam,(medication used to treat anxiety, muscle spasms, and seizures) Seroquel (medication used to treat schizophrenia (disorder that affects a person's ability to think clearly), bipolar disorder (mood swings) and depression), Trazodone (medication used to treat depression) , and Wellbutrin (medication used to treat depression). Document number of times the resident has exhibited the above behavior during shift. Document the intervention and document the outcome with a start date of 09/25/2024. Record review of the care plan with a revision date of 01/15/2024 indicated Resident #1 had the potential to be physically aggressive related to dementia with the following interventions Administer medications as ordered after attempting non-medical approaches, analyze times of day, places, circumstances, triggers and what de-escalates behavior, anticipate needs such as food, water, toileting, if behavior is threat to self or others immediately call for assistance. If signs of agitation shown - intervene before it escalates: remain calm, stand out of reach, listen and respond with empathy, engage in conversation. If response is aggressive, team member to calmly walk away, ask others to leave, ensure everyone is safe, immediately report this to nurse. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facilities Incident and Accidents Report dated 10/01/2024 - 01/26/2025 indicated no reported incidents involving Resident #1 and Resident #3. Record review of a progress note dated 01/09/2025 at 2:07 PM by LVN A, indicated Resident #1 had behaviors with 2 other residents without physical contact. Record review of a progress noted dated 01/09/2025 at 08:38 PM by LVN B, indicated Resident #1 snatched a cover off another resident in the commons area of the secured unit. Resident #1 swung at staff when approached. Record review of progress noted dated 01/09/2025 at 08:40 PM by LVN B, indicated Resident #1 was going into other resident's rooms. Resident #1 raised his hand to the nurse and then walked out of the room. Record review of progress note dated 01/09/2025 at 09:09 PM by LVN B, indicated Resident #1 was bent down and kneeled on the floor then laid down on the floor. Resident #1 was given a pillow and covered with a blanket. Record review of progress note dated 01/09/2025 at 09:19 PM by LVN B, indicated Resident #1 was bent down and kneeled on the floor then laid down on the floor then got up and started pacing from door to door, shaking the doors. The ADON and the DON were notified of the behaviors. Record review of progress noted dated 01/12/2025 at 01:42 AM by LVN F, indicated Resident #1 was exit seeking, restless, and in and out of other resident's rooms. Resident #1 removed his pants in the commons area in the secured unit. Record review of progress note dated 01/12/2025 at 05:20 AM by LVN F, indicated Resident #1 (as he walked by) kicked Resident #3's feet while he was sitting in his wheelchair. Resident #1 was going in other resident rooms and pacing the secured unit. Record review of a face sheet dated 02/27/2025 indicated Resident #3 was an [AGE] year-old male, admitted to the facility on [DATE], with diagnoses including hypoglycemia (low blood sugar), type 2 diabetes mellitus (chronic disease when the body does not make insulin properly) mixed hyperlipidemia (causes high levels of cholesterol in the blood), hypertension (high blood pressure), and Alzheimer's disease (a progressive disease that destroys memory and other mental functions). Record review of the discharge MDS dated [DATE] indicated Resident #3 had a BIMS score of 0 and was severely cognitively impaired. Resident #3's MDS indicated wandering behavior was exhibited, physical and verbal behaviors towards others. The MDS indicated Resident #3 required set up assistance for eating. The MDS indicated Resident #3 required partial/moderate assistance for oral and toileting hygiene, partial assistance for shower, dressing, personal hygiene, ambulation, and transfers. Record review of the consolidated physician orders dated 02/27/2025 indicated Resident #3 had an order for behavior monitoring for Seroquel (medication used to treat schizophrenia (disorder that affects a person's ability to think clearly) Document number of times resident has exhibited the above behavior during shift. Document the intervention and document the outcome with a start date of 01/06/2025. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON on 2/27/25 at 10:10 AM, a copy of the Resident #3's care plan was requested and not received prior to exiting the facility. Record Review of Resident #3's progress notes dated 01/12/2025 indicated no incidents or assessments completed. During an interview on 02/26/2025 at 07:11 PM, LVN F said Resident #1's behavior had changed. LVN F stated Resident #1 could usually be redirected. LVN F stated that she reported to the ADON and the DON on 01/11/2025 that Resident #1 was more difficult to redirect. LVN F stated she was instructed to continue to redirect the resident and give medications as ordered. LVN F stated Resident #1 took off his pants in the commons area which he had never done anything like that before. LVN F stated the CNA reported to her that Resident #1 kicked Resident #3. LVN F stated she failed to complete the incident report and report the incident to the ADON, the DON, or the Administrator. LVN F stated the incident should have been investigated due to being a resident-to-resident altercation. LVN F stated it was at change of shift and although she had reported the incident to the oncoming shift, an incident report should have been completed by her at the time the incident had occurred. LVN F stated the physician should have been notified as well as the families of the residents involved. LVN F stated reporting should be completed for investigation and to protect the residents from abuse. During an interview on 02/26/2025 at 07:59 PM, LVN G stated Resident #1 experienced escalated behaviors on 01/09/2025. LVN G reported to the ADON and the DON that Resident #1 was crawling around and laying on the floor with his eyes closed. LVN G stated she was instructed by the ADON to give a pillow and blanket and ensure Resident #1 was warm and leave on the floor to sleep. LVN G stated she did not contact the physician for a change of condition related to increased behaviors. LVN G stated Resident #1 was pacing more often and faster. Resident #1 was blocking the doors and shaking the door handles to the secured unit which made it difficult for staff to get through. LVN G recalled Resident #1 took a swing at one of the CNAs. Resident #1 was entering in another resident's rooms and the staff had to coax Resident #1 out and attempted to detour him from going into another resident's rooms. LVN G stated Resident #1 raised his hand at her when she attempted to redirect Resident #1 from another resident's rooms. LVN G stated the CNA reported Resident #1 had jerked covers off of another resident in the commons area of the secured unit. LVN G said when the previous interventions were not effective, she should have also contacted the physician for orders. LVN G said as the charge nurse she was responsible for reporting the change of condition. LVN G said the residents were in harms way such as the choking or death. During an interview on 02/27/2025 at 10:10 AM, the DON identified escalating behaviors as increased agitation, loudness/screaming, and showing signs of aggression. The DON stated Resident #1 was at his baseline and was not showing signs of escalating behaviors. The DON did not respond to the state surveyor when asked if the charted behaviors reported to her through 01/09/2025 - 01/12/2025 describe the definitions as she had identified above as escalated behaviors of Resident #1. The DON said the behaviors exhibited by Resident #1 were typical behaviors of a resident with dementia. The DON said the incident with Resident #1 kicking Resident #3 could have been an accident while Resident #1 walked by Resident #3. The DON stated, we don't care what the residents do to the staff - residents hit staff all the time and it did not mean the behaviors were escalated. The DON said they educated the staff on better resident approaching strategies to prevent residents hitting staff. The DON later said when Resident #1 kicked Resident #3 feet, it was considered a resident-to-resident altercation and should have been reported as an incident and investigated to rule out abuse. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/27/2025 at 10:30 AM, the ADON stated Resident #1 exhibited behaviors of a dementia patient and she had not considered the behaviors to be escalated between the dates of 01/09/2025 - 01/12/2025. The ADON described an escalated behavior as something different from their typical baseline behavior and that varied between each individual resident. The ADON stated staff had reported Resident #1 jerking the blanket off another resident but Resident #1 could have thought that was his blanket. The ADON stated she had told the staff to give Resident #1 the pillow and blanket and ensure resident was warm because he was sleeping and settled/safe on the floor. The ADON said it had not been reported except during the time of 01/09/2025 - 01/12/2025 of Resident #1 pulling/jerking covers from other residents or crawling/laying/sleeping in the floors. The ADON said it was not unusual for dementia residents to wander in and out of room rooms. The ADON stated that was why Resident #1 was in the secured unit due to wandering. The ADON said the incident when Resident #1 hit Resident #3 should have been reported as an incident and the physician, family, the abuse coordinator should have been notified for further investigation. The ADON said abuse allegations should be investigated to protect all residents from abuse. During an interview on 02/27/2025 at 10:50 AM, the Administrator stated behaviors were often unpredictable and predictable to a point. The Administrator said the facility and staff do their best to minimize behaviors and keep all residents safe. The Administrator stated he expected staff to report incidents of suspected abuse including suspected resident to resident altercations so that the incident was then followed up on by him with a thorough investigation. The Administrator stated all staff were responsible for ensuring that no resident was subject to any type of abuse. The Administrator said failure of reporting incidents appropriately placed residents at a potential risk of abuse by physical or emotional trauma. Record review of the facility's resident-to-resident altercations policy dated September 2022 indicated .all altercations, including those that may represent resident-to-resident abuse, are investigated and reported to the nursing supervisor, the director of nursing services and to the administrator .The administrator will report the incident in accordance with the criteria established under Abuse, Neglect, Exploitation or Misappropriation -Reporting and Investigating . The facility policy titled Abuse, Neglect Exploitation, & Misappropriation Policy dated 09/2024 indicated: .The resident has the right to be free of abuse, neglect, exploitation, and misappropriation of resident property and other reportable incidents that affect the Health and Safety of the resident .Physical Abuse includes slapping, biting .5. Abuse toward a resident can occur as: a. resident to resident abuse; .If resident abuse .is suspected, the suspicion must be reported immediately to the administrator and other officials according to state law .Immediately is defined as: within two hours of an allegation involving abuse or result in bodily injury .

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30527 Based on observations, interviews, and record review the facility failed to ensure adequate supervision was provided to prevent accidents for 2 of 3 residents (Resident #2 and Resident #3) reviewed for accidents and supervision. The facility failed to increase supervision and implement interventions when Resident #1 displayed increased behaviors beginning on 1/9/25 to prevent resident to resident altercations. The facility failed to ensure Resident #1 received adequate supervision to prevent escalating behaviors towards other residents. The facility failed to ensure Resident #1 received adequate supervision after displaying increased behaviors beginning on 1/9/25 which resulted in Resident #1 choking Resident #2. This failure resulted in an identification of an Immediate Jeopardy (IJ) at 1:40 PM on 02/27/2025. While the IJ was removed on 02/28/2025, the facility remained out of compliance at no actual harm with potential for more than minimal harm that is not immediate jeopardy with a scope identified as isolated due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. These failures could place residents at risk of accidents, injury, or death. Findings included: Record review of a face sheet dated 02/27/2025 indicated Resident #1 was a [AGE] year-old male, admitted to the facility on [DATE], with diagnoses including depression, hypercholesterolemia (high blood cholesterol that limits blood flow), hypertension (high blood pressure), delusional disorders (mental illness that causes people to have false beliefs), and dementia (degenerative brain disease - loss of memory, language). Record review of the comprehensive MDS dated [DATE] indicated Resident #1 had a BIMS score of 0 and was severely cognitively impaired. Resident #1's MDS indicated wandering behavior was exhibited, and physical and verbal behaviors towards others. Resident #1 was not assessed due to medical condition or safety concerns for eating, toileting, showering, dressing and personal hygiene, ambulation, or transfers. Record review of the consolidated physician orders dated 02/27/2025 indicated Resident #1 had an order for behavior monitoring for Diazepam,(medication used to treat anxiety, muscle spasms, and seizures) Seroquel (medication used to treat schizophrenia (disorder that affects a person's ability to think clearly), bipolar disorder (mood swings) and depression), Trazodone (medication used to treat depression) , and Wellbutrin (medication used to treat depression). Document number of times the resident has exhibited the above behavior during shift. Document the intervention and document the outcome with a start date of 09/25/2024. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the care plan with a revision date of 01/15/2024 indicated Resident #1 had the potential to be physically aggressive related to dementia with the following interventions Administer medications as ordered after attempting non-medical approaches, analyze times of day, places, circumstances, triggers and what de-escalates behavior, anticipate needs such as food, water, toileting, if behavior is threat to self or others immediately call for assistance. If signs of agitation shown - intervene before it escalates: remain calm, stand out of reach, listen and respond with empathy, engage in conversation. If response is aggressive, team member to calmly walk away, ask others to leave, ensure everyone is safe, immediately report this to nurse. Record review of the facilities Incident and Accidents Report dated 10/01/2024 - 01/26/2025 indicated no reported incidents involving Resident #1 and Resident #3. Record review of a progress note dated 01/09/2025 at 2:07 PM by LVN A, indicated Resident #1 had behaviors with 2 other residents without physical contact. Record review of a progress noted dated 01/09/2025 at 08:38 PM by LVN B, indicated Resident #1 snatched a cover off another resident in the commons area of the secured unit. Resident #1 swung at staff when approached. Record review of progress noted dated 01/09/2025 at 08:40 PM by LVN B, indicated Resident #1 was going into other resident's rooms. Resident #1 raised his hand to the nurse and then walked out of the room. Record review of progress note dated 01/09/2025 at 09:09 PM by LVN B, indicated Resident #1 was bent down and kneeled on the floor then laid down on the floor. Resident #1 was given a pillow and covered with a blanket. Record review of progress note dated 01/09/2025 at 09:19 PM by LVN B, indicated Resident #1 was bent down and kneeled on the floor then laid down on the floor then got up and started pacing from door to door, shaking the doors. The ADON and the DON were notified of the behaviors. Record review of progress noted dated 01/12/2025 at 01:42 AM by LVN F, indicated Resident #1 was exit seeking, restless, and in and out of other resident's rooms. Resident #1 removed his pants in the commons area in the secured unit. Record review of progress note dated 01/12/2025 at 05:20 AM by LVN F, indicated Resident #1 (as he walked by) kicked Resident #3's feet while he was sitting in his wheelchair. Resident #1 was going in other resident rooms and pacing the secured unit. Record review of progress noted dated 01/12/2025 at 07:00 AM by LVN C, indicated Resident #1 was up and pacing. Resident #1 was grabbing other resident's wheelchairs and attempting to move them. Resident #1 was crawling in hallway. Resident #1 continued to disturb other residents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of progress noted dated 01/12/2025 at 08:40 AM by LVN C, indicated Resident #1 was entering rooms, busting in doors, combative with staff, required assistance by two staff members to remove from room. Resident #1 continued to push and pulled on other resident's wheelchairs. Resident was unable to be redirected. The MA reported Resident #1 continued to refuse his medications with multiple approaches. Resident #1 shoved LVN C in the chest then knocked the medication cup from LVN C. LVN C notified the Administrator, the DON, and the ADON of unable to control/redirect Resident #1, and the escalating behaviors. LVN C then notified Resident #1's family. Record review of progress note dated 01/12/2025 at 08:50 AM by LVN C indicated CNA D summoned for nurse and reported Resident #1 had entered Resident #2's room and physically attacked Resident #2. CNA D reported she observed Resident #2 lying in her bed with Resident #1 leaned over Resident 2 with his hands wrapped around her neck attempting to choke Resident #2. CNA D stated she had to physically pry Resident #1's hands/fingers off Resident #2's neck and restrain him to the floor. When LVN C entered Resident #2's room, Resident #1 was restrained by CNA D. Immediate notification made for 911 services. The family was notified of escalating behaviors and transfer and agreed to the transfer. Record review of a face sheet dated 02/27/2025 indicated Resident #2 was a 75 -year-old female, admitted to the facility on [DATE], with diagnoses including neuralgia (pain associated with nerves), weakness, age related physical debility, dementia (degenerative brain disease - loss of memory, language), and anxiety (intense, excessive worry). Record review of the comprehensive MDS dated [DATE] indicated Resident #2 had a BIMS score of 3 and was severely cognitively impaired. Resident #2's MDS indicated she required set up assistance with eating, partial assistance with personal hygiene, and substantial assistance with toileting, dressing, and showering. Resident #2's MDS indicated she was independent with ambulation. Record review of the consolidated physician orders dated 02/27/2025 indicated Resident 2 had an order to monitor for pain every shift. During an interview with the DON on 2/27/2025 at 10:10 AM , a copy of the Resident's #2 care plan was requested and not received prior to exiting the facility. Record review of progress note dated 01/12/2025 at 08:50 AM by LVN A indicated CNA D summoned for nurse and reported Resident #1 had entered Resident #2's room and physically attacked Resident #2. CNA D reported she observed Resident #2 lying in her bed with Resident #1 leaned over Resident 2 with his hands wrapped around her neck attempting to choke Resident #2. CNA D stated she had to physically pry Resident #1's hands/fingers off Resident #2's neck and restrain him to the floor. When LVN C entered Resident #2's room, Resident #1 was restrained by CNA D. CNA E was summoned to Resident #2's room and escorted Resident #2 from the room. Resident #2 was taken to a chair in the commons area of the memory care unit. Resident #2 was upset and crying. Assessment completed with vital signs within normal limits, oxygen saturation at 97%, no redness or bruising noted, and no petechia observed to bilateral eyes. Police officer and EMT arrived at the facility. The EMT completed a full assessment of Resident #2 until Resident #2 stopped the EMT and stated' I am fine. Resident #2 assured the EMT she was safe and could return to her room. Resident #2's family member arrived at the facility and took Resident #2 via private care to the hospital emergency room for evaluation. The Administrator and the DON were made aware of reportable to state. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capstone Healthcare of Daingerfield	507 E W M Watson Blvd Daingerfield, TX 75638

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of hospital discharge paperwork dated 01/12/2025 indicated Resident #2 was discharged with unremarkable findings. Record review of a face sheet dated 02/27/2025 indicated Resident #3 was an [AGE] year-old male, admitted to the facility on [DATE], with diagnoses including hypoglycemia (low blood sugar), type 2 diabetes mellitus (chronic disease when the body does not make insulin properly) mixed hyperlipidemia (causes high levels of cholesterol in the blood), hypertension (high blood pressure), and Alzheimer's disease (a progressive disease that destroys memory and other mental functions). Record review of the discharge MDS dated [DATE] indicated Resident #3 had a BIMS score of 0 and was severely cognitively impaired. Resident #3's MDS indicated wandering behavior was exhibited, physical and verbal behaviors towards others. The MDS indicated Resident #3 required set up assistance for eating. The MDS indicated Resident #3 required partial/moderate assistance for oral and toileting hygiene, partial assistance for shower, dressing, personal hygiene, ambulation, and transfers. Record review of the consolidated physician orders dated 02/27/2025 indicated Resident #3 had an order for behavior monitoring for Seroquel (medication used to treat schizophrenia (disorder that affects a person's ability to think clearly) . Document number of times resident has exhibited the above behavior during shift. Document the intervention and document the outcome with a start date of 01/06/2025. During an interview with the DON at 2/27/25 at 10:10 AM, a copy of the Resident #3's care plan was requested and not received prior to exiting the facility. Record Review of Resident #3's progress notes dated 01/12/2025 indicated no incidents or assessments completed. Attempted interview on 02/25/2025 at 11:32 AM with Resident #2, she was not interview able. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 02/26/2025 at 09:30 AM, LVN C stated she had worked at the facility for approximately 2 years. LVN C stated Resident #1 was an elopement risk from another facility and required the secured unit. LVN C stated on 01/12/25 at 08:50 AM she received a telephone call from CNA E, to come to the secured unit to Resident #2's room. LVN C stated upon arrival CNA D had restrained Resident #1 on the floor. CNA E had removed Resident #2 to the commons area of the secured unit. LVN C stated she notified 911 for assistance. LVN C stated upon arrival of the police and the EMT, Resident #1 was transferred out of the facility. LVN C stated she completed an assessment on Resident #2. LVN C stated Resident #2 was upset and crying but then stated she was fine and declined any further care. LVN C stated Resident #2's family arrived and transported her to the emergency room via a private car. LVN C stated Resident #1's behaviors had escalated from the start of her shift at 06:00 AM. LVN C stated Resident #1 disturbed other residents by pulling on wheelchairs, walked with a rapid paced crawled on the floors. LVN C stated she had not notified the physician of the increase of behaviors. LVN C stated she had contacted Resident #1's family at 08:40 AM. LVN C stated she contacted the ADON and the DON regarding Resident #1's escalated behaviors at 08:40 AM. LVN C stated, I guessed the ADON and the DON were working to have the resident transferred out. LVN C stated she was not sure who was making the transfer arrangements at that time. LVN C stated she had reached out to the ADON and the DON via text message and neither were in the facility at that time. LVN C stated she could not recall what exactly she had been told by the ADON and DON other than redirect Resident #1, but she would have charted the instructions received if she had received any. LVN C stated everything was happening very quickly and she had not delegated any 1 to 1 intervention because the facility did not have the staff. LVN C stated there was not enough staff to do 1 to 1 supervision with Resident #1. LVN C stated lack of staff for the 1 to 1 supervision of Resident #1 resulted in another resident being harmed. During an interview on 02/26/2025 at 10:21 AM, CNA E said Resident #1 had escalated behaviors on 1/12/2025 and was more difficult to redirect and was disturbing the other residents. CNA E said she had reported to LVN C several behaviors since the start of her shift at 6:00 AM. CNA E said Resident #1 was sitting at the table with her and CNA D and appeared settled at that moment. CNA E said she left the secured unit to retrieve the breakfast trays while CNA D was providing care with another resident. Upon returning to the secured unit, she heard CNA D hollering to get help. CNA E said upon entering resident #2's room, CNA D was attempting to restrain Resident #1 from going at Resident #2. CNA E said she removed Resident #2 to the commons area at the front of the secured unit. CNA E said she alerted LVN C by the phone located in the commons area of the secured unit to come and assist CNA D. CNA E said she should have stayed on the unit and prevented the incident, but she had left the unit to get the trays for the other residents because there was no other staff to do so at that time. CNE E said she had notified the charge nurse and she thought she had sent a text message to the DON and ADON about Resident #1 behaviors and was told to continue to monitor and distract Resident #1. CNA E said the lack of supervision during Resident #1's escalating behaviors resulted in Resident #2 being choked in her room. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 02/26/2025 at 01:15 PM, CNA D said during her shift on 1/12/2025. she noticed Resident #1 was not in the commons area or his room after she finished providing care to another resident. CNA D stated while she looked for Resident #1, she faintly heard Resident #2 call for help. CNA D said when she entered Resident #2's room, Resident #1 was leaning over Resident #2 with both hands around her neck. CNA D said she had to pry Resident #1's hands and fingers from Resident #1's neck. CNA D said she got him down in a sitting position on the floor and placed his hands behind his back as Resident #1 continued to try to go at Resident #2. CNA D stated CNA E arrived back on the secured unit, and she yelled for her. CNA E removed Resident #2 from the room and notified LVN C by the phone located in the commons area of the secured unit. CNA D stated she continued to restrain Resident #1 until the police arrived. LVN C entered the room and then contacted 911. CNA D said the EMTs, and police assisted to transport Resident #1 out of the building to the hospital. CNA D said Resident #1 should not have been left alone. CNA D said Resident #1 was out of control. CNA D said the charge nurse had been notified previously through out the morning. CNA D said lack of supervision resulted in Resident #2 being choked. During an interview on 02/26/2025 at 03:41 PM, the social worker stated she had not worked on a transfer for Resident #1 until 01/15/2025 after Resident #1 had transferred from the facility. The social worker stated she could not recall any conversation or text messages regarding resident #1 until after he had left from the facility. The social worker stated when the care plan interventions failed, Resident #1 should have been placed on 1 to 1 supervision for all resident safety including the safety of Resident #1 and transferred from the facility. The social worker stated the physician should have been notified by the clinical staff and new orders should have been received. During an interview on 02/26/2025 at 07:11 PM, LVN F said Resident #1's behavior had changed LVN F stated Resident #1 could usually be redirected. LVN F stated that she reported to the ADON andthe the DON on 01/11/2025 that Resident #1 was more difficult to redirect. LVN F stated she was instructed to continue to redirect the resident and give medications as ordered. LVN F stated Resident #1 took off his pants in the commons area which he had never done anything like that before. LVN F stated the CNA reported to her that Resident #1 kicked Resident #3. LVN F stated she failed to complete the incident report and report the incident to the ADON, the DON or the Administrator. LVN F stated the incident should have been investigated due to being a resident-to-resident altercation. LVN F stated it was at change of shift and although she had reported the incident to the oncoming shift, an incident report should have been completed by her at the time the incident had occurred. LVN F stated the physician should have been notified as well as the families of the residents involved. LVN F stated reporting should be completed for investigation and to protect the residents from abuse. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 02/26/2025 at 07:59 PM, LVN G stated Resident #1 experienced escalated behaviors on 01/09/2025. LVN G reported to the ADON and the DON that Resident #1 was crawling around and laying on the floor with his eyes closed. LVN G stated she was instructed by the ADON to give a pillow and blanket and ensure Resident #1 was warm and leave on the floor to sleep. LVN G stated she did not contact the physician for a change of condition related to increased behaviors. LVN G stated Resident #1 was pacing more often and faster. Resident #1 was blocking the doors and shaking the door handles to the secured unit which made it difficult for staff to get through. LVN G recalled Resident #1 took a swing at one of the CNAs. Resident #1 was entering in another resident's rooms and the staff had to coax Resident #1 out and attempted to detour him from going into another resident's rooms. LVN G stated Resident #1 raised his hand at her when she attempted to redirect Resident #1 from another resident's rooms. LVN G stated the CNA reported Resident #1 had jerked covers off of another resident in the commons area of the secured unit. LVN G stated she should have contacted the physician and received new orders regarding Resident #1's change in escalating behaviors to ensure the other residents were not placed in harm or danger of Resident #1. During an interview on 02/27/2025 at 10:10 AM, the DON identified escalating behaviors as increased agitation, loudness/screaming, and showing signs of aggression. The DON stated Resident #1 was at his baseline and was not showing signs of escalating behaviors. The DON did not respond to the state surveyor when asked if the charted behaviors reported to her through 01/09/2025 - 01/12/2025 describe the definitions as she had identified above as escalated behaviors of Resident #1. The DON said the behaviors exhibited by Resident #1 were typical behaviors of a resident with dementia. The DON said when the staff notified her of the incident with Resident #1 choking Resident #2, she told the staff (CNA E and LVN C) via text message that Resident #1 needed to be sent out because the facility did not provide 1 to 1 care. The DON stated the physician was notified as well as the families after the incident occurred. The DON said there was no way to know the choking incident was going to happen prior to the incident taking place. The DON said the incident with Resident #1 kicking Resident #3 could have been an accident while Resident #1 walked by Resident #3. The DON stated, we don't care what the residents do to the staff - residents hit staff all the time and it did not mean the behaviors were escalated. The DON said they educated the staff on better resident approaching strategies to prevent residents hitting staff. The DON later said when Resident #1 kicked Resident #3 feet, it was considered a resident-to-resident altercation and should have been reported as an incident and investigated to rule out abuse. The DON said there was no just no way to know that Resident #1 was going to harm another resident prior to the incident occurring. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 02/27/2025 at 10:30 AM, the ADON stated Resident #1 exhibited behaviors of a dementia patient and she had not considered the behaviors to be escalated between the dates of 01/09/2025 - 01/12/2025. The ADON described an escalated behavior as something different from their typical baseline behavior and that varied between each individual resident. The ADON stated staff had reported Resident #1 jerking the blanket off another Resident but Resident #1 could have thought that was his blanket. The ADON stated she had told the staff to give Resident #1 the pillow and blanket and ensure resident was warm because he was sleeping and settled/safe on the floor. The ADON said it had not been reported except during the time of 01/09/2025 - 01/12/2025 of Resident #1 pulling/jerking covers from other residents or crawling/laying/sleeping in the floors. The ADON said it was not unusual for dementia residents to wander in and out of room rooms. The ADON stated that was why Resident #1 was in the secured unit due to wandering. The ADON said the incident when Resident #1 hit Resident #3 should have been reported as an incident and the physician, family, the abuse coordinator should have been notified for further investigation. The ADON said abuse allegations should be investigated to protect all residents from abuse. The ADON said when escalated behavior begin, the charge nurse should notify the physician for new orders and interventions. If those intervention and new orders are not effective, the charge nurse should be communicated to the physician to transfer the resident out of the facility to protect other residents as well as the resident with the behavioral changes. During an interview on 02/27/2025 at 10:50 AM, the Administrator stated behaviors were often unpredictable and predictable to a point. The Administrator said the facility and staff do their best to minimize behaviors and keep all residents safe. The Administrator said, it was not the best ideal to take eyes off of Resident #1 during the 10-minute time frame that the incident occurred within. The Administrator stated he expected staff to report incidents of suspected abuse including suspected resident to resident altercations so that the incident was then followed up on by him with a thorough investigation. The Administrator stated all staff were responsible for ensuring that no resident was subject to any type of abuse. The Administrator said the choking incident and failure of reporting incidents appropriately placed residents at a potential risk of abuse by physical or emotional trauma. The Administrator said the clinical staff was responsible for reporting and notifying the physician for changes of condition such as escalating behaviors to protect all the residents from any type of potential harm. The facility policy titled Abuse, Neglect Exploitation, & Misappropriation Policy dated 09/2024 indicated: .The resident has the right to be free of abuse, neglect, exploitation and misappropriation of resident property and other reportable incidents that affect the Health and Safety of the resident .Physical Abuse includes slapping, biting .5. Abuse toward a resident can occur as: a. resident to resident abuse; . The Administrator was notified on 02/27/2025 at 01:04 PM that an Immediate Jeopardy situation was identified due to the above failure. The Administrator was provided the Immediate Jeopardy template on 02/27/2025 at 1:06 PM. The facility's Plan of Removal was accepted on 02/27/2025 at 06:30 PM. and included: Tag F-689: Systemic Approach (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Resident 1 was transferred to The Local Hospital's Emergency Department where he was admitted to the Behavioral Health Hospital on 1/12/2025. As indicated on SRI #556297, the resident is not to return to the facility to eliminate the risk of behavior happening again. 2. The Medical Director was immediately notified by the Director of Nurses on 2/27/2025 at 2:11pm and the Chief Operating Officer at 1:07pm of the Immediate Jeopardy. 3. Administrator review of the following facility policy on 2.27.2025: a. Abuse, Neglect, Exploitation, & Misappropriation Policy b. Resident to Resident Altercations 4. An immediate in-service to be provided by Regional Nurse Consultant to Administrator, DON and staff at facility with the subject of Recognizing Escalating Behaviors and Effective Measures to Put in Place to Protect Residents on 2/27/2025 at 2:20pm. a. Main takeaways from training include: the use of interventions which include 1:1 monitoring, redirecting, social services department visits and using calming music. 5. An Immediate in-service of the facility's Abuse policy to be conducted for all staff. Employees not present at building will be called via phone and provided in-service information. Inservice of staff will be completed by 2/28/2025 by 5:00pm. Other staff will be in-serviced before their next shift. A questionnaire will be created from the abuse policy. Questionnaires will be provided at random to employees to ensure retention of policy. Employees answering wrongly on questionnaires will receive more training. Admin/DON/ADON are responsible for conducting the training. 6. An immediate QAPI meeting to be held by IDT on 2.27.2025 a. Review of incident b. Establish areas of improvement c. Create plan to monitor and manage areas of improvement 7. Safe Surveys were conducted at the time of the incident. Results from the survey can be found with supportive documents provided to State surveyor and in SRI folder administrator keeps on hand. Safe survey results indicated no other residents were in need of additional supervision. 8. Monitoring: a. Admin or DON will conduct weekly random questionnaires of the abuse policy for a period of 4 weeks to ensure staff retain knowledge from the Abuse Policy. 9. Root Cause Analysis was conducted on 2/27/2024 identifying issues related to incidents on 1/12/2025. It was established that employees need more education of the abuse policy and aware of effective ways to de-escalate resident behaviors. This education was immediately provided on 2/27/2025. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	10. Quality Assurance a. An ad hoc Quality Assurance Meeting will be conducted with IDT, including medical director via phone call on 2/27/2025. b. The IJs for F689 and F600 were noted and steps for removal were discussed. c. Incidents have been reviewed with plans to improve. i. Improvement plans include Notifying physician immediately, placing interventions in place immediately such as 1:1 monitoring, redirecting, separating residents, and removing residents from environment. Deescalating behaviors and recognizing signs of escalating behaviors. d. Plan on Removal being conducted. e. The Medical Director made no relevant comments at the time of meeting. He agreed that discussions related to the incident during the meeting are thorough and will be effective. O2/28/2025, the state surveyor confirmed the facility implemented their plan of removal sufficiently to remove the immediate jeopard by: Record Review of in-service dated 02/27/2025 provided by the Regional Nurse to the Administrator, the DON and the ADON with the following topics: A. Abuse, Neglect, Exploitation, & Misappropriation Policy B. Resident to Resident Altercations Record Review of the in service dated 02/27/2025 at 2:20 PM provided by the Regional Nurse Consult to Administrator,the DON and the staff at the facility with the subject topic of: Recognizing Escalating Behaviors and effective measure to put in place to protect the residents such as intervention of 1:1 monitoring, redirecting, social services departments visit and using calming music. Record review of in-service dated 02/27/2025 of the facility's Abuse policy conducted for all staff. (Employees not present at the building will be called via phone and provided in-service information. Inservice of staff will be completed by 2/28/2025 by 5:00pm. Other staff will be in-serviced before their next shift.) Record review of a questionnaire created from the abuse policy with 25 employee/staff correctly completed on 02/28/2025. (Questionnaires will be provided at random to employees to ensure retention of policy. Employees answering wrongly on questionnaires will receive more training. Admin/DON/ADON were responsible for conducting the training) Record review of signed QAPI Committee Meeting completed on 2/27/2025 at 2:20 PM addressed the following: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. An ad hoc Quality Assurance Meeting will be conducted with IDT, including medical director via phone call on 2/27/2025. b. The IJs for F689 and F600 were noted and steps for removal were discussed. c. Incidents have been reviewed with plans to improve. i. Improvement plans include Notifying physician immediately, placing interventions in place immediately such as 1:1 monitoring, redirecting, separating residents, and removing residents from environment. Deescalating behaviors and recognizing signs of escalating behaviors. d. Plan on Removal being conducted. e. The Medical Director made no relevant comments at the time of meeting. He agreed that discussions related to the incident during the meeting are thorough and will be effective'. Interviews of nursing staff: on 2/28/2025 from 09:49 AM - 11:55 AM for(6 AM - 6 PM shift) - DON, ADON, MDS Nurse, LVN C, CNA D, CNA E, CNA L, MA P, LVN Q, LVN W, LVN A, CNA AA (6PM - 6AM shift) - MA X, LVN Y, LVN Z, CNA BB, CNA CC, CNA DD, CNA EE Administrator, Dietary Manager, Assistant Dietary Manager, Housekeeping Supervisor, Social Worker, Maintenance Supervisor, Director Business Development, Medical Records, Dietary Aide H, Housekeeper K, Housekeeper M, Housekeeper N, Director of Rehabilitation, PTA U, OT V, Activities Assistant During these interviews staff were able to correctly identify types of abuse such as physical, sexual, verbal and resident to resident altercations; who to notify if abuse was suspected - such as the abuse coordinator, physician, families; proper documentation in resident charts, incident reports and care plans; recognizing escalated behaviors such as increased screaming and agitation and notifying the physician immediately of escalating behaviors; ways to de-escalate behaviors 1 to 1 monitoring, redirecting, separating residents, removing residents from the environment, calming music, and social services. On 02/28/2025 at 12:00 PM, the Administrator was informed the IJ was removed; however, the facility remained out of compliance at no actual harm with potential for more than minimal harm that is not immediate jeopardy with a scope identified as isolated due to the facilities need to complete in-service training and evaluate the effectiveness of the corrective systems.