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	05/26/2026

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

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	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 ensure residents were free from sexual abuse from a visitor for 1 of 3 residents (Resident #1) reviewed for abuse. The facility failed to ensure Resident #1 was free from sexual abuse on 05/17/26 when Visitor A was found with his hand down Resident #1's pants. The noncompliance was identified as PNC. The immediate jeopardy (IJ) began on 05/17/26 and ended on 05/17/26. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk of serious adverse psychosocial outcome such as fear, anxiety, shame or guilt, depression, withdrawal from activities, helplessness, low self-worth, and post-traumatic responses such as flashbacks, nightmares, or increased startle responses.The findings included: Record review of the face sheet, dated 05/26/26, reflected Resident #1 was an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of vascular dementia (decline in thinking and reasoning skills caused by conditions that block or reduce blood flow to the brain, depriving it of oxygen and nutrients) and generalized anxiety disorder (a mental health condition characterized by persistent, excessive, and uncontrollable worry about everyday issues). Record review of the quarterly MDS assessment, dated 04/16/26, reflected Resident #1 had clear speech, was understood by others, and was able to understand others. Resident #1 had a BIMS score of 6, which indicated severe cognitive impairment. Resident #1 required setup assistance with eating, oral and toileting hygiene, and bed mobility. She required supervision or touching assistance with bathing, dressing, personal hygiene, and transfers. Record review of the comprehensive care plan, dated 01/21/25, reflected Resident #1 had impaired cognitive functioning and impaired thought processes related to dementia. The interventions included: cue, reorient, and supervise as needed and keep routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. Record review of Resident #1's nursing progress note electronically signed by LVN E on 05/17/26 at 11:30 a.m., reflected [CNA B] called [LVN E] reports a male visitor that was visiting another resident was sitting on the couch and throw blanket was covering [Resident #1] and [Visitor A]. [CNA B] reports she then pulled throw blanket off of [Resident #1] and [Visitor A] was observed with his hand placed inside [Resident #1's] brief. [CNA B] immediately removed [Resident #1] from couch and away from [Visitor A]. [CNA B] confronted white male on his actions. [Visitor A] then left memory care unit and [CNA B] alerted [LVN E], [Visitor A] proceeded to walk past [LVN E] at [nurses' station]. [LVN E] attempted to stop and question [Visitor A] he [continued] to leave the building. [RN F] made aware of incident. [RN F] and [LVN E] proceeded to follow [Visitor A] as he [continued] fleeing to parking lot and left facility. DON, [Administrator], [Medical Director] notified of incident. [Resident #1's responsible party] notified of incident involving [Resident #1] and police being notified and [Resident #1's responsible party] verbalized she is in agreement with this plan of care. [Local police department] notified. Head to toe assessment completed on [Resident #1] no trauma or injury noted to vaginal opening. No bleeding or redness is observed. Trauma assessment completed at this time on [Resident #1]. [Resident #1] questioned with no recall of [Visitor A]. No emotional distress or trauma observed from [Resident #1] at this time. [Vital signs] - 97.8 (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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Meantime me and another CNA was busy cleaning up another resident, when finished the other CNA went over to get [Resident #1] up because she felt uneasy about [Visitor A], she discovered that the visitor had pulled the blanket that the resident had over his lap also. When CNA pulled the blanket off, we saw that the visitor had his hand in her brief. [sic] Record review of RN F's witness statement, dated 05/17/26, reflected Tall, white older male with dark hair walked toward nurses' station, leaving facility. He greeted us and proceeded down hallway toward front door. We received a phone call from the cove (memory care unit) answered by [LVN E], advising this visitor was caught with his hand down the front of a resident's pants. Nurse asked visitor to wait but was told he needed to get his medicine from his truck. This nurse and [LVN E] followed visitor to parking lot, where the visitor proceeded to get into his truck and leave the parking lot. This nurse took a pictures of his license plate and video of his truck. Record review of LVN E's witness statement, dated 05/17/26, reflected [NAME] male approached [nurses' station] asked to see [Resident #2] a resident that resides in memory care unit. This nurse instructed [white male] to head down hall 200 to memory care unit code provided. This nurse was called to [memory care unit] to render aide to another resident. [NAME] male was observed on the couch next to [Resident #1]. This nurse then exited [memory care unit] back to [nurses' station]. Call received from [CNA B] in [memory care unit] reports that [white male] had his hand in [Resident #1's] brief when she pulled the throw blanket off [Resident #1's] lap. [White male] passing [nurses' station] this nurse immediately followed [white male] asked him to stop that I had questions for him. [White male continued] to exit building with urgency. This nurse and [RN F] followed [white male] out of building. [White male] proceeded to get in truck and leave, this nurse stood in driveway with hand up gesturing to stop, [white male continued] to drive off, this nurse moved out of driveway (to avoid being hit). [RN F] was able to video license plate [number]. Record review of the skin check, dated 05/17/26, reflected Resident #1's skin was warm and dry, skin color was within normal limits, and turgor was normal. No new skin issues were identified. Record review of the trauma informed care assessment, dated 05/17/26, reflected Resident #1 indicated she had not experienced an event that was unusually or especially frightening, horrible, or traumatic. Record review Resident #1's orders report, dated 05/17/26, reflected a new order was started for the following:1. Monitor every shift for signs or symptoms of emotional distress for three days.2. Refer to social services one time only for three days. Record review of the Abuse/Neglect Policy in-service training report, dated 05/17/26, reflected all staff were provided education on the abuse and neglect policy to include the following: abuse occurring by anyone including visitors, types of abuse, and reporting abuse or suspected abuse to the Abuse Coordinator (Administrator) immediately. There were 58 staff signatures. Record review of the The Cove - Door Code Instructions in-service training report, dated 05/17/26, reflected all staff were provided education on the secured unit door code being changed. The in-service informed staff the code was not to be given out to visitors. The visitors were to be escorted in and out of the secured unit by a staff member. There were 42 staff signatures. Record review of the Sexual Abuse in-service training report, dated 05/17/26, reflected all staff were provided education on the types of sexual abuse, to include unwanted touching and signs and symptoms of sexual abuse to include emotional and physical trauma. There were 58 staff signatures. Record review of the Visitor A - Not allowed on property in-service training report, dated 05/17/26, reflected all staff were provided education and description of Visitor A not being allowed on the property and to notify the police (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	department and Administrator immediately if seen. There were 44 staff signatures. Record review of the Visitor Sign In - Kiosk in-service training report, dated 05/17/26, reflected all staff were provided education on making sure visitors check in on the kiosk located in the front lobby. The visitors were to wear the sticker at all times while visiting. The staff were instructed if a visitor did not have a sticker, to escort them to the front and assist them with signing in. There were 57 staff signatures. Record review of the Resident #1's progress note electronically signed and dated by the Social Worker on 05/18/26 at 8:33 a.m., reflected Emotional distress assessment completed following report. [Resident #1] reported she was ?fine' emotionally and denied feelings of sadness, anxiety, loneliness, anger, or being overwhelmed. [Resident #1] denied any current emotional distress, suicidal ideation, or homicidal ideation. [Resident #1] stated she feels safe at this time and declined need for social services, family involvement, or additional supportive services. [Resident #1] unable to recall details related to prior incident. During assessment, [Resident #1] appeared calm, pleasant, well-groomed, and cooperative with conversation. No acute signs of emotional distress or behavioral concerns noted. [Resident #1] rated emotional distress [0 out of 10]. [Resident #1] reported difficulty with sleep, stating she is unable to fall asleep until approximately 2 - 3 a.m., and expressed interest in medication to assist with sleep. For safety and potential psychosocial impact, referral will be placed to [counseling services] for further in-depth psychosocial evaluation and risk assessment. Record review of Resident #1's orders report, dated 05/18/26, reflected a new order was started for counseling services to evaluate and treat as indicated one time only for psychiatric services. Record review of resident safe surveys, dated 05/18/26, reflected Resident's #2, #3, #4, #5, #6, #7, #8, #9, #10, and #11 were interviewed. The residents denied anyone being abusive, knowing about any abuse, and all verbalized they felt safe in the facility. Record review of the Quality Assurance Committee Meeting Agenda form, dated 05/18/26, reflected the Administrator, DON, ADON, MDS Coordinator, Social Worker, Business Office Manager, Dietary Manager, Director of Rehabilitation, Housekeeping Supervisor, Transportation Aide, Maintenance Director, Activity Director, and Medical Director met to discuss Resident #1 being subjected to sexual abuse. Record review of Resident #1's counseling diagnostic assessment, dated 05/19/26, reflected Resident #1 was re-admitted for services following a confirmed incident of inappropriate touching by another resident's family member. This assessment was conducted through Telehealth (digital technology to access healthcare services using computer, smartphone, and the internet). Resident #1 had no recollection of any type of inappropriate touching and could not recall anything of any nature occurring that she found distressing. Resident #1 confirmed feeling safe and properly care for in this facility and stated that all of her needs were currently met. Resident #1's conversation reflected short-term and long-term memory loss over situational confusion. During an observation on 05/26/26 at 8:35 a.m., there was signage inside the front door indicating visitor sign-in was required on the kiosk. There was a small kiosk stand in the hallway with a stop sign that stated STOP: Visitors Must Sign-In During an interview on 05/26/26 at 9:00 a.m., the DON stated the code to the secured unit had changed. During an observation and interview on 05/26/26 at 9:15 a.m., Resident #1 was sitting on the couch in the secured unit, which was placed against the wall. The couch was visible from all areas of the dining room and living areas. Resident #1's hair was combed neatly and her face was clean. Resident #1 stated the staff treated her well and she had no issues with any of the male staff or male visitors. Resident #1 stated she felt safe at the facility. Resident #1 was unable to remember the incident with Visitor A. During an interview on 05/26/26 at 9:37 a.m., Resident #1's family member stated she was notified Visitor A had his hands down Resident #1's pants on 05/17/26. She stated the staff acted immediately and appropriately. She stated the police were involved. She said that Resident #1 had dementia and did not remember the incident. She stated if Resident #1 was in her right mind, she would have slugged the man and would have been mortified. She stated Resident #1 had no previous history of trauma in her life. During an interview on 05/26/26 at 10:16 a.m., CNA B stated she normally worked the 2-10 shift, but on 05/17/26 she had picked up a morning shift. She stated another resident had thrown up (continued on next page)

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She stated Resident #1 seemed sad and distressed immediately after the incident and stated, I didn't tell him to put his hands in my pants, he just did it. CNA B stated Resident #1 did not remember the incident later on. CNA B stated the police were notified and she had to write a statement about what happened. She stated the code to the secured unit was changed and the furniture was re-arranged. She stated Visitor A was no longer allowed on the property and if he tried to visit, they were instructed to notify the police and administration. During an interview on 05/26/26 at 10:34 a.m., MA C stated Visitor A had come to the facility to visit Resident #2. She stated another resident got sick during that time and started throwing up. She stated she was cleaning up the vomit, and Visitor A was standing behind her and kept saying You missed a spot. She stated Visitor A walked off toward the couch and she finished cleaning, then started caring for another resident in the dining room. She stated CNA B returned to the living area and noticed Visitor A was sitting by Resident #1 on the couch. She stated when CNA B lifted Resident #1's covers off her lap; Visitor A's hand was observed down her pants. MA C stated CNA B immediately moved Resident #1 off the couch and Visitor A quickly got up and left. She stated a housekeeper on the other side of the doors let Visitor A off the secured unit. She stated he was running down the hallway. MA C stated Resident #1 stated I don't know why he put his hands in my pants he just did. MA C stated she initially seemed distressed and nervous but then quickly forgot about the incident. She stated LVN E called the police and they arrived at the facility right away. She stated LVN E and RN F assessed Resident #1 and she had no injuries or evidence of trauma. During an interview on 05/26/26 at 11:03 a.m., LVN E stated Visitor A had come into the building as asked her about visiting Resident #2. She said she instructed him toward the memory care unit and gave him the code. She stated Visitor A had visited before with no issues. LVN E said not long after that encounter, she received a call from the secured unit about another resident who was sick. LVN E stated as they were assisting the other resident to be cleaned, Visitor A was observed sitting on couch next to Resident #1 and she did not think anything about it. LVN E stated she did not see Resident #1 and Visitor A under the blanket together or she would have said something. LVN E stated she walked back to the nurses' station to document. She stated CNA B called her not too long after that to report Visitor A was found with his hand down Resident #1's pants. CNA B had reported she had confronted Visitor A, who then got up to leave. She said a housekeeper had let him off the secured unit. LVN E stated she tried to stop Visitor A but he was walking briskly. She stated Visitor A kept saying he needed to go to truck for medication. LVN E stated she and RN F followed Visitor A outside. She stated that he started driving down the driveway and she stood in the road holding her hand up to try and stop him, but he kept driving. She stated RN F got the vehicle information and they notified the police department, DON, Administrator, family member, and Medical Director. There were no new orders given. She stated a head to toe assessment and trauma assessment were completed and negative for findings. She stated Resident #1 did not recall what happened by the time she was assessed. She stated the code to the secured unit was changed, the furniture was rearranged, and Visitor A was banned from the facility. She was instructed to notify police and administration immediately if he attempted to come back. During an interview on 05/26/26 at 11:18 a.m., RN F stated she was standing at the nurses' station, when Visitor A walked down the hallway. Visitor A stated Hope yall have a nice day. She stated about that time the phone rang, and LVN E was notified Visitor A was caught with hand down (continued on next page)

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