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	07/01/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm 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** Based on observation, interview, and record review the facility failed to ensure each resident's environment remained free of accidents and hazards for 1 of 7 residents (Resident #1) reviewed for accident hazards. 1. The facility failed to ensure CNA B performed a safe transfer for Resident #1 on 6/24/2026. 2. The facility failed to ensure CNA B, LVN A and CMA C performed a safe transfer on Resident #1 while assisting her from the floor to the bed and assisting her from the bed to the wheelchair on 6/24/2026. These failures could place residents at risk of injury.Findings included: Record review of Resident #1's face sheet dated 6/30/26 indicated she was a [AGE] year old female, admitted to the facility on [DATE]. Resident #1 had diagnoses which included unspecified dementia (forgetfulness), metabolic encephalopathy (a general term for brain dysfunction caused by an underlying chemical imbalance in the body), Alzheimer's disease (a progressive brain disorder that accounts for 60% to 80% of dementia cases), Parkinson's disease (a progressive nervous system disorder that affects movement), major depressive disorder (a serious mental health condition), and anxiety disorder. Record review of Resident #1's comprehensive MDS dated [DATE] indicated Resident #1 had a BIMS of 9 which indicated she had moderate cognitive impairment. The MDS indicated Resident #1 required substantial/maximal assistance from staff with chair/bed-to-chair transfers. Record review of Resident #1's care plan dated 6/30/26 indicated she had an ADL self-care performance deficit related to cognitive impairment, fatigue and limited mobility. Intervention indicated transfer: Requires assistance with transfer with 1-2 care team members for assistance with transfers. Provide directions by using short, simple instructions. Provide step-by-step guidance during transfer process, encouraging their participation as much as possible. During a record review of a video on 6/30/26 at 11:36 AM, CNA B was attempting to transfer Resident #1 from the bed to the wheelchair. The transfer started after CNA B applied Resident #1's pants to her lower legs then proceeded to set her up on the side of the bed. CNA B attempted to place Resident #1's hands on the wheelchair arm rest to assist her with standing while transferring, but Resident #1 was not able to grasp on to the arm rest. CNA B tried to get Resident #1 to stand while she tried to guide her to the wheelchair, but while trying to stand Resident #1's knees buckled and CNA B attempted to grab her by the brief, then grabbed her in the torso (human truck) area and under her arms, then assisted her to the floor. During a second attempt to assist Resident #1 to the wheelchair from the floor CNA B wrapped her arms around Resident #1's torso (human trunk) area and under her arms to lift her off the floor to the wheelchair, but Resident #1 was too heavy for CNA B to lift. CNA B assisted Resident #1 back to the floor and secured her torso (human trunk) up against the bed to in an upright sitting position. CNA B went to get help and returned with LVN A and MA B to Resident #1's room to assist with getting her off the floor. The staff removed Resident #1 from the floor by grabbing under her arms and pulling on her brief and placed her on the bed. Then the staff transferred Resident #1 from the bed to the wheelchair; during the transfer CNA B grabbed her under the left arm and MA C grabbed her under the right arm while pulling her pants up, then sat her in the wheelchair. During an interview on 6/30/26 at 1:32 PM, CNA D stated Resident #1 was a one-person assist and a gait belt transfer if (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff felt safe, but if staff did not feel comfortable, they could use 2 people. She stated Resident #1 did not assist with transferring as she did in the past, but she should not be transferred with a Hoyer lift (a medical device designed to safely transfer patients with limited mobility) yet. She stated a risk for not using a gait belt was the resident could fall and get injured. During an interview on 6/30/26 at 2:11 PM, CNA B stated Resident #1 was a 1-person assist. She stated she has been a CNA for over 40 plus years and she knew she was supposed to apply a gait belt when transferring a resident, but she did not apply one that day, because Resident #1 usually stood up on her own, but that day she just quit standing. She stated Resident #1 usually grabbed the wheelchair and stood up, and she would just help her get into the chair, but that day she did not stand. CNA B stated LVN A and CMA C assisted her with getting Resident #1 off the floor and putting her in the wheelchair. CNA B stated she knew they were supposed to use a gait belt when getting the resident off the floor to the bed, but she had not been using it because Resident #1 usually could stand. CNA B stated Resident #1 did not sustain any injuries from the incident. She stated a negative effect of not using the gait belt when staff transferred a resident could fall. She stated a gait belt helped the residents keep their balance without staff having to pull on body parts or clothing. During an interview on 6/30/26 at 2:22 PM, LVN A stated Resident #1 was able to do more when she first arrived at the facility. She stated the incident when Resident #1 was lowered to the floor was the first time, she had seen her not able to stand. LVN A stated Resident #1 was not even trying to stand. She stated the facility changed Resident #1 to a 2-person assist with a gait belt since the incident. She stated anytime a staff member was assisting a resident to transfer from the bed to the wheelchair they were supposed to use a gait belt. She stated that when she herself and the other 2 staff members were transferring Resident #1 from the floor to the bed, they should have used gait belt. She stated Resident #1 did not sustain any injuries during the incident. She stated CNA B assisted Resident #1 down to the floor while trying to transfer her and she was on a fall mat when she was assisted to the floor. She stated when staff transfer a resident manually, they should use a gait belt. She stated a risk of not using a gait belt during a manual transfer was the resident could fall. She also stated the gait belt helped the residents to keep their balance while the staff have a handle on them. During an observation and interview on 6/30/26 at 2:36 PM, Resident #1 was lying in bed. Resident #1 stated she remembered the incident when CNA B was trying to put her in the wheelchair; she stated she did not get hurt and she did not want to talk about it. During an interview on 6/30/26 at 3:26 PM, CMA C stated she had been a CNA since 2018. She stated she helped assist CNA B and LVN A with getting Resident #1 off of the floor and into the wheelchair. She stated every time she helped Resident #1, she was a 1-person assist. She stated that was the first time she had seen her buckle to the floor. She stated when transferring a resident staff should use a gait belt, but with Resident #1 she had good leg strength, so they used the back of her pants to help assist her to transferring. She stated the staff had been in-serviced on using a gait belt while transferring a resident. She stated the risk of not using a gait belt with a resident during a transfer; was pulling under their arms could hurt them. During an interview on 6/30/26 at 3:35 PM, the DON stated Resident #1 was a standby assist. She stated during the incident when CNA B was getting Resident #1 to hold on to the wheelchair, because that was how she usually transferred, bearing her own weight. She stated Resident #1 required little to no weight bearing assistance, then her knees buckled during that transfer. She stated she had therapy to evaluate Resident #1, and she was a 1-person transfer assist. She stated after the incident she had Resident #1 re-evaluated by therapy and they said she was a 1-person assist with a gait belt. She stated if a resident could bear their own weight, then a gait belt would not be required. She stated the facility did not encourage staff to use the gait belt until it was necessary, because that was a dignity issue; by using something the resident does not need. She stated before that incident Resident #1 did not have any weight bearing issues. She stated that she did not see a risk for not using the gait belt. During an interview on 7/1/26 at 9:34 AM, OTA F stated he does not recall working with Resident #1. He stated that anytime a resident needs substantial to maximal assistance a gait belt should be used. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	He stated if a resident needed substantial to maximal assistance, they should be wearing a gait belt during a transfer. He stated that anytime a resident needed more than moderate assistance; a gait belt should be worn. He stated he was not sure what the risk was of not wearing a gait belt, but the staff want to keep the floor out of the equation as much as possible. During an interview on 7/1/26 at 9:47 AM, the ADON stated Resident #1 assistance changed and it depends on the day with her. She stated that sometimes if Resident #1 does not want to get up she does not try to stand. She stated normally we used a gait belt while assisting a resident with standing or doing anything that required weight bearing. She stated in the video Resident #1 was standing up and holding on to the wheelchair while CNA B tried to pull her pants up and her knees buckled. She stated CNA B should not have used a gait belt while attempting to transfer Resident #1, but staff should have used a gait belt when they were getting Resident #1 up off the floor. She stated herself and the DON were responsible for ensuring that the staff use the appropriate transferring techniques. She stated the risk with an improper transfer was that the resident could fall and possibly get hurt; that was with any resident in the facility. She stated she felt like the residents would not have gotten hurt if they were assisted to the floor. During an interview on 7/1/2026 at 9:59 AM, LVN E stated Resident #1 had always been a 1-person transfer. She stated she would expect the staff to use a gait belt on a 1-person transfer with a resident. She stated Resident #1 could bear weight when she first admitted to the facility, but she could not bear weight on her own now. She stated the risk was the resident falling or an injury. During an interview on 7/1/26 at 10:40 AM, PTA G stated she had seen Resident #1 transferred once and when therapy transferred her, they used a gait belt. She stated if a resident needs assistance with a transfer, she would expect staff to use a gait belt, because it was the safest way. She stated the risk for the resident would be a fall, skin tears, or injury. She stated the risk for staff would be they could hurt their back or have nothing to grab the residents by if resident was to fall. During an interview on 7/1/26 at 11:02 AM, the Administrator stated his expectations were that the staff do everything they could to make sure they did a safe transfer with the information they knew, with the knowledge they had. He stated the facility was responsible for ensuring the staff were transferring the residents appropriately. He stated from his perspective that the video captured a change of condition. He stated the knowledge that the facility had prior to the incident he felt like the gait belt would not been required. He stated what he saw in the video was a staff member attempting to transfer Resident #1 and her knees buckled. He stated that the information he had Resident #1 was a 1-person assist with transferring, but no gait belt was required. He stated from the information he had; he does not think the staff were doing anything outside of what they had documented. He stated he thought CNA B did a very good job in protecting the residents. He stated there was no harm, pain or bruising noted to Resident #1 after the incident. He stated he had no idea the video existed until surveyor walked into the building. He stated he thought the CNA did the best she could with what she had and the facility did everything they could after the incident. Record review of the facility's policy Use of Gait Belt dated 3/1/26, indicated .It is the policy of this facility to use gait belts with residents whenever appropriate to assist with resident transfers, mobility assistance or ambulation. 1. All employees will receive education on the proper use of gait belts. 2. It will be the responsibility of each employee to ensure they have it available for use at all times when at work. 5. Clinical staff may determine that a gait belt is not appropriate based on: a. Therapy recommendations. b. Physician orders. c. Resident refusal. d. Clinical assessment or contraindications . Record review of the facility policy Safe Resident Handling/ Transfers dated 3/1/26 indicated It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines. All residents require safe handling when transferred to prevent or minimize the risk for injury to themselves and employees that assist them. While manual lifting techniques may be utilized dependent upon the resident's condition and mobility, the use. The interdisciplinary team or designee will evaluate and assess each resident's mobility (continued on next page)

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