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	04/24/2025

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

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on observations, interviews, and record review, the facility failed to ensure residents had the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility for 1 of 21 residents (Resident #3) reviewed for resident rights. The facility failed ensure Resident #3's foley catheter drainage bag had a privacy cover on 04/21/25 and 04/22/25. This deficient practice could place residents at risk for loss of dignity. Findings included: Record review of Resident #3's face sheet dated 04/23/25 indicated an [AGE] year-old female who admitted to the facility on [DATE]. Resident #3 had diagnoses of diabetes (a group of diseases that result in too much sugar in the blood), dementia (a group of thinking and social symptoms that interferes with daily functioning), protein calorie malnutrition (inadequate intake of food), and urine retention. Record review of Resident #3's quarterly MDS assessment dated [DATE], indicated she was usually understood and usually understood others. Resident #3 had a BIMS score of 3, which indicated her cognition was severely impaired. The MDS assessment indicated Resident #3 had an indwelling catheter. Record review of Resident #3's comprehensive care plan revised on 04/04/25, indicated Resident #3 had an indwelling catheter related to neurogenic bladder (lack of bladder control due to brain, spinal cord, or nerve problems). The care plan interventions included to secure catheter tubing to leg to minimize trauma to the insertion site, make sure tubing was free of kinks and urine was present in the tube. Record review of Resident #3's order summary report dated 04/23/25, indicated the following order: o Privacy bag for drainage bag at all times while in bed, while walking or in wheelchair making sure tubing is not on the floor at any time with a start date of 09/25/24. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of Resident #3's nursing MAR dated 04/01/25-04/30/25 did not reveal an order to ensure Resident #3's catheter bag always had a privacy bag. During an observation on 04/21/25 at 1:33 PM, Resident #3 was in her bed. Resident #3 had her catheter drainage bag uncovered hanging on the left side of her bed and could be seen by her roommate and staff. Dark yellow urine was observed in the drainage bag. During an observation and interview on 04/22/25 at 2:21 PM Resident #3 was in her bed. Her catheter bag was uncovered, was hanging on the left side of her bed, and was facing toward the door. There was clear yellow urine noted in the catheter bag. Resident #3's door was open, and her catheter bag could be seen from her door. Resident #3 was unable to answer appropriately if having the catheter bag uncovered bothered her. During an interview on 04/22/25 at 2:28 PM, CNA E said Resident #3's catheter bag should be covered for Resident #3's privacy and dignity. CNA E said failure to have the catheter bag covered placed Resident #3 at risk for her urine to be seen. CNA E said it was the nurse's responsibility to ensure the catheter bag had a privacy cover over it. During an interview on 04/22/25 at 2:58 PM, LVN C said not having Resident #3's catheter bag covered was a privacy and dignity issue. LVN C said the aides and nurses were responsible for ensuring the catheter bags had privacy covers. LVN C said if the aide noticed the privacy bag was not in place, then they should be reporting it to the nurse. During an interview on 04/24/25 at 9:03 AM, the DON said most of the catheter bags utilized in the facility had a privacy protective cover already attached. The DON said by not having the catheter bag covered could cause a dignity issue. The DON said the nurses were responsible of ensuring they were covered during their daily rounds. During an interview on 04/24/25 at 9:58 AM, the Administrator said he expected the catheter bags to have a privacy covering on them. The Administrator said they tried to notice those things during their daily operation, but things happen. The Administrator said by not having the catheter bag covered, depending on the resident, it could cause embarrassment to the resident. The Administrator said the members of the nursing team were responsible for ensuring the catheter bags had privacy covers. Record review of the facility's policy Catheter Care, Urinary revised August 2022, indicated . The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections 4. Ensure that the catheter remains secure with a securement device to reduce friction and movement at the insertion site. The policy did not address the privacy of catheter drainage bag. Record review of the facility's policy Dignity revised February 2021, indicated . Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. 1. Residents are treated with dignity and respect at all times . 12. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents; for example: a. helping the resident to keep urinary catheter bags covered .

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892 Based on observation, interview, and record review the facility failed to ensure each resident had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 1 of 21 residents (Resident #2) reviewed for reasonable accommodations. The facility failed to ensure Resident #2's call light was within reach while in bed on 04/21/2025. This failure could place residents at risk for a delay in assistance and a decreased quality of life. Findings include: Record review of a face sheet dated 04/23/2025 indicated Resident #2 was a [AGE] year-old female with diagnoses which included hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side (weakness and paralysis of left side of the body), type 2 diabetes mellitus with diabetic neuropathy (insulin resistance, with or without insulin deficiency that induces organ dysfunction) progressive death of nerve fibers, which leads to loss of nerves, increased sensitivity, and the development of foot ulcers), and anxiety disorder. Record review of Resident #2's Comprehensive MDS assessment dated [DATE] indicated she understood others and was understood. Resident #2's BIMS score was a 15, which indicated her cognition was intact. The MDS assessment indicated Resident #2 was dependent on staff for showering/bathing, toileting, dressing, and personal hygiene. The MDS assessment indicated Resident #2 had a functional limitation in range of motion of her upper and lower extremity on one side. Record review of Resident #2's care plan with a target date of 02/09/2025 indicated she had impaired physical mobility to assist resident in performing movements/tasks. During an observation and interview on 04/21/2025 starting at 9:20 AM, Resident #2 requested the state surveyor give her call light to her, so she could call for assistance with repositioning in the bed. Resident #2's call light was hung over the foot of the bed out of her reach. Resident #2 said she did not know who had placed it there, and it had been out of her reach for too long. During an interview on 04/22/2025 at 4:21 PM, LVN B said sometimes Resident #2 got mad and threw her call light at people. LVN B said she did not know why Resident #2's call light was not within reach. LVN B said any of the staff should be making sure the call light was within reach. LVN B said it was important for the residents' call lights to be within reach because if they needed something that is how they contacted the staff. During an interview on 04/23/2025 at 4:11 PM, CNA H said she did not know why Resident #2's call light was not within reach. CNA H said she did not place it over the foot of the bed, but she should have made sure Resident #2 had it within reach. CNA H said it was important for the call lights to be within reach because if something happened, they would not be able to call for staff. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 04/24/2025 at 10:31 AM, the DON said the staff were responsible for ensuring the call lights were within the resident's reach, and it should be monitored on rounds. The DON said the risk for Resident #2's call light not being in reach was that she would not be able to push the call light. During an interview on 04/24/2025 at 11:02 AM, the Administrator said he expected for the call lights to be within the resident's reach. The Administrator said the CNAs and anybody who went into the room should know that the call lights needed to be withing reach. The Administrator said if the call light was not within reach the resident would not have the ability to use the call light as a communication device to let them know they needed assistance. Record review of the facility's policy titled, Call System, Resident, dated September 2022, indicated, Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized work station. 1. Each resident is provided with a means to call staff directly for assistance from his/her bed .

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on interviews and record reviews, the facility failed to ensure each resident had the right to make choices about aspects of his or her life in the facility that were significant to the resident for 1 of 21 residents (Resident #11) reviewed for self-determination. The facility failed to ensure Resident #11 was provided showers instead of bed baths per her request. This failure could place residents at risk for being denied the opportunity to exercise his or her autonomy regarding things that were important in their life and decrease their quality of life. Findings included: Record review of Resident #11's face sheet dated 04/23/25, indicated a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included diabetes (a group of diseases that result in too much sugar in the blood), cerebral infarction (stroke), irritable bowel syndrome (an intestinal disorder causing pain in the belly, gas, diarrhea, and constipation), and need for assistance with personal care. Record review of Resident #11's quarterly MDS assessment dated [DATE], indicated she was able to make herself understood and understood others. Resident #11 had a BIMS score of 15, which indicated her cognition was intact. Resident #11 did not refuse care or had behaviors. Resident #11 required substantial/maximal assistance with showering/bathing and upper body dressing. Record review of Resident #11's comprehensive care plan 10/28/24, indicated Resident #11 was at risk for self-care deficit regarding bathing, dressing, and feeding. The care plan interventions indicated to maintain consistent schedule with daily routine and provide assistance with ADLs as needed. Record review of Resident #11's Skin Monitoring: Comprehensive CNA Shower Review for the following dates indicated: o On 03/06/25 it was handwritten on the shower sheet bed bath was given and was signed by CNA A. o On 04/03/25 it was handwritten on the shower sheet Dr. appt. CNAs had to bed bath her and was signed by CNA A. Record review of Resident #11's ADLs point of care report dated 04/09/25- 04/19/25, indicated no documentation was completed for Resident #11's showers. During an interview on 04/21/25 at 10:42 AM, Resident #11 said within the last 2 weeks she had missed 3 showers. She said when the shower aide was assigned to work as a CNA on the floor, she received a bed bath by her assigned aide. She said it made her feel not good when she did not receive a shower as preferred. Resident #11 said the facility staff knew she preferred to receive showers. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 04/22/25 at 2:05 PM, CNA E said if CNA A, the shower aide, was moved to the floor, she was responsible for providing the showers on her hall. CNA E said if there was only one aide assigned to the hall it was hard to provide all showers. CNA E said she had given Resident #11 bed baths on her shower days. CNA E said she was responsible for giving Resident #11 a shower if she wanted a shower. CNA E said Resident #11 had the right to receive a shower as per her preference. CNA E said Resident #11 did not refuse her showers. CNA E said it was Resident #11's right to have her requests met for a shower. During an interview on 04/24/25 at 09:03 AM, the DON said when the shower aide was pulled from giving showers, the aide assigned to the hall was responsible for providing their own showers. The DON said if Resident #11 wanted a shower she should have received one. The DON said it was Resident #11's right to receive a shower if that was what she preferred. The DON said it was Resident #11's right to have her requests met for a shower. During an interview on 04/24/25 at 09:58 AM, the Administrator said he expected the showers to be provided as per their shower schedule. The Administrator said if the shower aide was assigned to a hall, then the aide assigned to the hall was responsible for ensuring the showers were being provided. The Administrator stated if the resident requested to receive a shower instead of a bed bath and the staff was able to safely provide one, then they should provide the resident with a shower. The Administrator said it was Resident #11's right to have her request met for a shower. Record review of the facility's policy Resident Rights revised February 2021, indicated . Employees shall treat all residents with kindness, respect, and dignity. 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to . a. dignified existence; b. be treated with respect, kindness, and dignity . e. self-determination .

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on observations, interviews, and record review, the facility failed to ensure the residents' rights to formulate an advance directive for 1 of 21 residents reviewed for advanced directives. (Resident #41) The facility did not ensure Resident #41's code status was updated when the OOHDNR was signed by the physician on [DATE]. These failures placed the residents at risk of not having their end of life wishes honored. Findings included: Record review of Resident #41's face sheet dated [DATE], indicated a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included cerebral palsy (a congenital disorder of movement, muscle tone, or posture), epilepsy (seizures), hypertension (high blood pressure), and gastrostomy status (surgical opening in stomach to provide nutrition and medications). The face sheet indicated under the advance directive section **Code Status: FULL CODE**. Record review of Resident #41's comprehensive care plan dated [DATE], indicated Resident #41's guardian had requested and signed a DNR that was awaiting a doctor's signature. The care plan interventions included to complete and update the advance directives document. Record review of Resident #41's quarterly MDS assessment dated [DATE], indicated Resident #41 was usually understood and usually understood others. Resident #41 had a BIMS score of 2, which indicated her cognition was severely impaired. Record review of Resident #41's OOHDNR order was signed on [DATE] by Resident #41's POA. The OOHDNR was signed by Resident #41's attending physician on [DATE]. Record review of Resident #41's order summary report dated [DATE], indicated she had an order for full code status with an order date of [DATE]. During an interview on [DATE] at 11:02 AM, the Social Services Designee said she was responsible for getting the OOHDNRs signed. She said when she received a signed OOHDNR, she provided the nurses with a signed copy to let them know of the change in code status. She said she then uploaded the signed OOHDNR in the resident's EMR. She said Resident #41 had a signed OOHDNR. The Social Services Designee said the nurses were responsible for updating the resident's code status once the signed OOHDNR was received. She said Resident #41's code status should have been changed on [DATE] when it was signed by the physician. She said failure to update the resident's code status could place the resident at risk for receiving CPR. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview and observation on [DATE] at 11:07 AM, the ADON said the social services were responsible for the OOHDNRs. The ADON said Resident #41's signed OOHDNR was an order. The ADON reviewed Resident #41's orders and said Resident #41 had an order for full code. The ADON said in an emergency they would not just go by the physician's order. She said they would review all documents uploaded in the resident's EMR. The ADON said Resident #41's physician's orders should have been updated by the nurse who received the signed OOHDNR. The ADON said she could not speculate if there were any risks to Resident #41 because they would double and triple check on what they needed to do in an emergency. The ADON said Resident #41's name on her door would have a red heart, which indicated DNR, or a green heart, which indicated full code. The ADON walked to Resident #41's door and applied a red heart sticker over the green heart sticker that was currently next to Resident #41's name. During an interview on [DATE] at 2:17 PM, LVN D said in case of an emergency and because the resident had an order for full code, they would proceed with life saving measures. LVN D said she would look at the resident's dashboard because it was the quickest to see the resident's code status. LVN D said realistically she would not look at the resident's uploaded documents in a life-or-death situation. LVN D said whoever received the signed OOHDNR was responsible for ensuring the residents orders were updated . LVN D said providing life safe measures would be going against Resident #41's wishes. During an interview on [DATE] at 09:03 AM, the DON said she expected the residents code status to be updated immediately once the signed OOHDNR was received. The DON said the nurse or social services, whoever received the signed OOHDNR, was responsible for ensuring the resident's code status was updated. The DON said failure to update the resident's code status could lead to initiation of CPR in an emergency and going against the resident's wishes. The DON said Resident #41's code status should have been updated when the signed OOHDNR was uploaded in her EMR on [DATE]. The DON said the social services pulled a code list report weekly and unsure of how Resident #41's code status was missed. During an interview on [DATE] at 09:58 AM, the Administrator said he expected if an OOHDNR was in place then the documentation should reflect the same. The Administrator said failure to update the residents code status placed the resident at risk for acting against her wishes. The Administrator said nurse leadership and social services were responsible for ensuring they were compliant with the resident's code status. Record review of the facility's policy Advance Directives revised [DATE], indicated . The resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy . I. If the resident or the resident's representative has executed one or more advance directive(s), or executes one upon admission, copies of these documents are obtained and maintained in the same section of the resident's medical record and are readily retrievable by any facility staff. 2. The director of nursing services (DNS) or designee notifies the attending physician of advance directives (or changes in advance directives) so that appropriate orders can be documented in the resident's medical record and plan of care .

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47612 Based on observations, interviews and record review, the facility failed to ensure residents had a right to personal privacy and confidentiality of medical records for 4 of 21 residents (Resident #8, Resident #9, Resident #51, and Resident #11) reviewed for privacy and confidentiality. 1.LVN C failed to ensure she closed the EMR of Resident #8, Resident #9, and Resident #51 before entering residents' room to obtain a blood sugar check and administer medications on 04/21/2025. 2. The facility failed to ensure MA G closed Resident #11's EMR before entering her room to administer her pain medication on 04/21/25. These failures could place residents at risk for low self-esteem, loss of dignity, and decreased quality of life due to medication administration record being accessible to others. Findings included: 1.Record review of a face sheet dated 04/23/2025, revealed Resident # 8 was an [AGE] year-old female who admitted on [DATE] with the diagnoses of chronic obstructive pulmonary disease with acute exacerbation (sudden worsening of respiratory symptoms in individuals with COPD, typically involving increased shortness of breath, cough, and/or sputum production), type 2 diabetes mellitus with hyperglycemia (person diagnosed with type 2 diabetes has persistently high blood sugar levels), and chronic respiratory failure with hypoxia (a condition where the body's tissues don't receive enough oxygen due to a chronic inability of the lungs to adequately exchange oxygen and carbon dioxide), Record review of the quarterly MDS assessment dated [DATE], indicated Resident #8 understood and could make herself understood by others. Resident #8 had a BIMS score of 15 which indicated the resident was cognitively intact. The MDS indicated he received insulin injections 7 out of the 7 days of the look back period. 2. Record review of a face sheet dated 04/23/2025, revealed Resident # 9 was an [AGE] year-old female who admitted on [DATE] with the diagnoses of vascular dementia (a form of dementia caused by reduced blood flow to the brain, leading to cognitive decline), bipolar disorder (a mental illness characterized by extreme shifts in mood, energy, and activity levels, including both manic (elevated mood) and depressive (low mood) periods), and mild cognitive impairment of uncertain or unknown etiology(memory and thinking problems that are more pronounced than normal aging but don't meet the criteria for dementia). Record review of the quarterly MDS assessment dated [DATE] indicated Resident #9 understood and could make herself understood by others. Resident #9 had a BIMS score of 09 which indicated moderate cognitive impairment. The MDS indicated he received insulin injections 7 out of the 7 days of the look back period. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Record review of a face sheet dated 04/23/2025, revealed Resident # 51 was an [AGE] year-old female who admitted on [DATE] with the diagnoses of type 2 diabetes mellitus with hyperglycemia (a person diagnosed with type 2 diabetes has persistently high blood sugar levels), chronic respiratory failure with hypoxia (a condition where the body's tissues don't receive enough oxygen due to a chronic inability of the lungs to adequately exchange oxygen and carbon dioxide), and essential (primary) hypertension (the most common type of high blood pressure). Record review of the quarterly MDS assessment dated [DATE], indicated Resident #51 understood and could make herself understood by others. Resident #51 had a BIMS score of 15 which indicated the resident was cognitively intact. The MDS indicated he received insulin injections 7 out of the 7 days of the look back period. During an observation and interview on 04/21/2025 at 11:45 a.m., LVN C was observed going into Resident #51's room to check a blood sugar and left the EMR open with Resident #51, Resident #8, and Resident # 9's information visible. LVN C stated it was her responsibility to close the EMR before going into a room. LVN C stated it was important to ensure the residents medical information was confidential. LVN C stated the failure was a HIPPA violation. 46928 4. Record review of Resident #11's face sheet dated 04/23/25, indicated a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included diabetes (a group of diseases that result in too much sugar in the blood), cerebral infarction (stroke), irritable bowel syndrome (an intestinal disorder causing pain in the belly, gas, diarrhea, and constipation), and need for assistance with personal care. Record review of Resident #11's quarterly MDS assessment dated [DATE], indicated she was able to make herself understood and understood others. Resident #11 had a BIMS score of 15, which indicated her cognition was intact. Resident #11 was dependent on staff with toileting, lower body dressing, and putting on/taking off footwear. Resident #11 received scheduled pain medication. Record review of Resident #11's comprehensive care plan dated 10/28/24, indicated she had acute pain. The care plan interventions indicated to administer pain medications as ordered. Record review of Resident #11's order summary report dated 04/23/25, indicated she had an order for acetaminophen-codeine (narcotic pain medication) 300mg-60mg tablet give one tablet by mouth three times a day for pain with an order start date of 01/14/25. Record review of Resident #11's medication administration record dated 04/01/25-04/30/25, indicated she had received an acetaminophen-codeine 300mg-60mg tablet three times a day. During an observation and interview on 04/21/25 at 10:08 AM the 200-hall medication cart was on the 200 hall and had a laptop on top with the screen open to Resident #11's information. Staff and residents were noted to be walking next to the medication cart. MA G exited Resident #11's room and said she should not have left screen up because someone could come by and take all of Resident #11's information. MA G said she forgot to lock the screen because she was in a hurry to administer Resident #11 her medication. MA G said it was her responsibility in ensuring the screen was locked when leaving it unattended. (continued on next page)

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	675755	A. Building B. Wing	04/24/2025

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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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/24/25 at 09:03 AM, the DON said it was a HIPPA violation leaving the screen up with resident information. The DON said she expected the screen to be locked or pulled down when leaving it unattended. The DON said it was the responsibility of the person on the cart to ensure the resident's information was kept confidential. During an interview on 04/24/25 at 09:58 AM, the Administrator said he expected resident information to me kept confidential and not visible to unauthorized persons. He said there was a potential for the resident's information to be seen by leaving the screen up. The Administrator said it was the responsibility of the person on the cart to ensure the resident information was kept confidential. Record review of the facility's policy Resident Rights revised February 2021, indicated . Employees shall treat all residents with kindness, respect, and dignity. 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to . t. privacy and confidentiality . Record review of the facility's policy Confidentiality of Information and Personal Privacy revised October 2017, indicated . Our facility will protect and safeguard resident confidentiality and personal privacy. 1. The facility will safeguard the personal privacy and confidentiality of all resident personal and medical records .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892 Based on observation, interview, and record review, the facility failed to provide a safe, clean, and comfortable homelike environment for 1 of 3 resident rooms (Resident #2) reviewed for environment. The facility failed to ensure Resident #2's broken light cover was repaired. This failure could place residents at risk for an uncomfortable, unhomelike environment, and a diminished quality of life. Findings included: Record review of a face sheet dated 04/23/2025 indicated Resident #2 was a [AGE] year-old female with diagnoses which included hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side (blood flow to the brain affected with weakness and paralysis of left side of the body), type 2 diabetes mellitus with diabetic neuropathy (insulin resistance, with or without insulin deficiency that induces organ dysfunction) progressive death of nerve fibers, which leads to loss of nerves, increased sensitivity, and the development of foot ulcers), and anxiety disorder. Record review of Resident #2's Comprehensive MDS assessment dated [DATE] indicated she understood others and was understood. Resident #2's BIMS score was a 15, which indicated her cognition was intact. The MDS assessment indicated Resident #2 was dependent on staff for showering/bathing, toileting, dressing, and personal hygiene. Record review of Resident #2's care plan with a target date of 02/09/2025 indicated she had impaired coping and interventions included to reduce unnecessary external stimuli and for staff to provide care in a confident and assured manner. During an observation and interview on 04/21/2025 starting at 9:20 AM, the cover of the middle section of Resident #2's wall light was broken. The broken cover was jagged. When asked if staff were aware it was broken, Resident #2 said, They can see it. Resident #2 said she could not remember when it broke. During an interview on 04/22/2025 at 2:58 PM, the Maintenance Director said he was aware Resident #2's light cover was broken, and he had a replacement for it, but he had not gotten to it. The Maintenance Director said he did not remember exactly how long it had been since it was broken, but he thought it had been about 2-3 weeks ago. The Maintenance Director said it was important for things in the residents' rooms to be repaired for them to be better for the residents and their visitors. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 04/23/2025 at 4:00 PM, LVN L said she was aware Resident #2's light cover was broken, and she had reported it to the Maintenance Director. LVN L said she may have put it in the maintenance book when they had one, but it had been a while (she was unable to provide a date). LVN L said it was important for it to be fixed for quality of care, and because the residents should not have broken stuff and broken things could cause injuries. During an interview on 04/24/2025 at 10:32 AM, the DON said she was aware the light cover in Resident #2's room was broken, but she did not know how long it had been broken. The DON said the Maintenance Director was responsible for fixing it. The DON said with the light cover broken the resident would not be able to use their light and she could have a risk management because she could cut herself if she was able to reach it. During an interview on 04/24/2025 at 11:04 AM, the Administrator said he was aware Resident #2's light cover was broken. The Administrator said his expectations were for the residents' rooms to be in good repairs. The Administrator said he did not know how long it had been since it was broken, but it was long enough that he was upset with the Maintenance Director for not fixing it. The Administrator said the light cover was plastic and it was broken, and Resident #2 could reach up to it and touch it. Therefore, there was a potential for her to get scratched by it. Record review of the facility's Work Order Report dated 11/13/2024-04/22/2025, indicated a work order for Resident #2's overbed light dated 03/31/2025. Record review of the facility's policy titled, Resident Rights, revised February 2021, indicated, .Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence . The policy did not address homelike environment.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on observations, interviews, and record review, the facility failed to ensure prompt efforts were made to resolve grievances for 2 of 21 residents (Resident #'s 8 and #26) reviewed for grievances. 1. The facility did not ensure a grievance was filed for Resident #8's missing black pants and green shirt. 2. The facility did not ensure a grievance was filed for Resident #26's missing black pants. These failures could place residents at risk for grievances not being addressed or resolved promptly. Findings included: 1. Record review of Resident #8's face sheet dated 04/23/25, indicated an [AGE] year-old female who initially admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), diabetes (a group of diseases that result in too much sugar in the blood), and heart failure (a chronic condition in which the heart doesn't pump blood as well as it should). Record review of Resident #8's quarterly MDS assessment dated [DATE], indicated she was able to make herself understood and understood others. Resident #8 had a BIMS score of 15, which indicated her cognition was intact. Resident #8 required substantial/maximal assistance with toileting, showering, lower body dressing, and personal hygiene. Record review of Resident #8's comprehensive care plan dated 11/12/24, indicated Resident #8 was a risk for self-care deficit for bathing, dressing, and feeding. The care plan intervention included to provide assistance with ADLs as needed. During an interview on 04/22/25 at 11:25 AM Resident #8 said she had been missing a pair of black pants when she admitted to the facility and a green sleeveless V-neck shirt which had been missing for a few months. During an interview on 04/23/25 at 2:10 PM, Resident #8 said the missing clothes had not been found or replaced. Resident #8 said her clothes had been missing a couple of months and she had reported this to a staff member but was unsure who the staff members was. 2. Record review of Resident #26's face sheet dated 04/23/25, indicated an [AGE] year-old female who initially admitted to the facility on [DATE]. Resident #26 had diagnoses which included congestive heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), atrial fibrillation (irregular heartbeat), muscle weakness, and need for assistance with personal care. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of Resident #26's quarterly MDS assessment dated [DATE], indicated Resident #26 was understood and understood others. Resident #26 had a BIMS score of 15, which indicated her cognition was intact. Resident #26 did not have behaviors or reject care. Resident #26 required supervision or touching assistance with personal hygiene and showering/bathing. Record review of Resident #26's comprehensive care plan dated 11/12/24, indicated Resident #26 was a risk for self-care deficit related to bathing, dressing, and feeding. The care plan interventions indicated to maintain consistent schedule with daily routine and provide assistance with ADLs as needed. During an interview on 04/21/25 at 2:15 PM, Resident #26 said she had a pair of black pants that had been missing for a few months. Resident #26 said she brought it up in every resident council meeting and everyone knew about it. Resident #26 said her pants had not been replaced. During an interview on 04/23/25 at 2:05 PM, Resident #26 said it had made her feel bad having her pants missing but that her pants were found yesterday 04/22/25. Record review of the Resident Council Meeting from dated 01/30/25, indicated Resident #26 had reported she was missing black slacks. Record review of the Town Hall Meeting Notes dated 01/30/25 indicated Resident #26 had reported she was missing pants black slacks. Record review of the Resident Council Meeting from dated 03/07/25, indicated Resident #26 had reported she was missing black pants. Record review of the Resident Council Meeting Form dated 04/04/25, indicated Resident #8 had reported she was missing black pants and green sleeping shirt. Record review of the grievances from September 2024-April 2025 did not reveal any grievances filed for Resident #8's and Resident #26's missing clothing. During an interview on 04/23/25 at 10:51 AM, CNA A said Resident #26 had reported missing black pants a few months back. CNA A said she had reported it to laundry, and they had been looking for them. CNA A said Resident #8 had not reported any missing clothes to her. CNA A Resident #26 would have to purchase more clothing. During an interview on 04/23/25 at 1:58 PM, Laundry Aide Q said Resident #26 had reported she had been missing a pair of black pants. She said when a resident complained of missing clothes, she looked for them and if not found, she reported it to her supervisor. Laundry Aide Q said Resident #26's missing black pants were never found. Laundry Aide Q said Resident #8's clothes were always found. She said Resident #8's clothes would always be in the laundry and returned the next day. During an interview on 04/23/25 at 2:06 PM, CNA E said Resident #26 had reported missing a black pair of pants about two months ago. She said Resident #8 had not complained to her of any missing clothes. CNA E said when she received a complaint of missing clothes, she would check the laundry to see if she could locate them. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 04/23/24 at 2:33 PM, the Housekeeping/Laundry Supervisor said Resident #26's black pants were replaced a couple of weeks ago. She said she had no knowledge of Resident #26's missing clothes prior to that. She said Resident #8's missing a green shirt and black pants was brought to her attention on 04/22/24 and had no knowledge of them missing prior to yesterday. The Housekeeping/Laundry Supervisor said when she received a complaint of missing clothes, she instantly began to look for them. She said if the missing items could not be found she would then report it to the Administrator so the items could be replaced. She said it should not take months for clothing to be found or replaced. She said the resident could feel bad about their missing clothing. The Housekeeping/Laundry Supervisor said management staff was responsible for resolving the grievance. During an interview on 04/23/25 at 2:40 PM, the Social Services Designee said she was responsible for documenting the grievances. She said a grievance was written if it bothered the resident. She said residents complained of missing clothing and they liked the results, so the same complaint was brought up again. The Social Services Designee said a town hall meeting was led by staff and a resident council meeting was resident led. She said the complaints in those meetings were brought to her and she would go and speak to those residents. She said if residents told her it's not a bother a grievance was not filed. She said Resident #26's black pants have been replaced prior but was unable to provide documentation. She said Resident #8's missing green shirt and black pants came after Resident #26 received a new pair of pants. The Social Worker Designee said to her knowledge Resident #8's pants or green shirt have not been found or replaced. She said the Administrator had the final say for clothing to be replaced. During an interview on 04/24/25 at 09:03 AM, the DON said social services were responsible for handling the grievances. The DON said missing clothes was a grievance. The DON said she was not aware of Resident #8's missing clothes. The DON said Resident #26 had accused staff of wearing her clothes. She said a grievance should not take a long time for it to be resolved. She said if a grievance could not be resolved it should be taken to the Administrator. The DON said Resident #8 could incur more clothing costs. During an interview on 04/24/25 at 09:58 AM, the Administrator said missing clothes could be a grievance. He said if the resident formally reported missing clothes to a staff member, it needed to be documented and investigated by the leadership team. The Administrator said the grievance should be followed up on and clothes should be checked in all rooms and laundry. The Administrator said he followed up with housekeeping to see if missing clothes had been found and if they had not, he would replace them. The Administrator said he was responsible for ensuring grievances were ultimately resolved. Record review of the facility's policy Grievances/Complaints, Filing revised 2017, indicated . Residents and their representatives have the right to file grievances, either orally or in writing, to the facility staff or to the agency designated to hear grievances (e.g., the State Ombudsman). The administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident and/or representative . 3. All grievances, complaints or recommendations stemming from resident or family groups concerning issues of resident care in the facility will be considered. Actions on such issues will be responded to in writing, including a rationale for the response . 8. Upon receipt of a grievance and/or complaint, the grievance officer will review and investigate the allegations and submit a written report of such findings to the administrator within five (5) working days of receiving the grievance and/or complaint .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892 Based on observations, interviews, and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment for 3 of 21 (Resident #2, Resident #6, and Resident #9) residents reviewed for care plans. 1. The facility failed to develop a plan of care for Resident #2's smoking and use of a vape (an electronic cigarette). 2. The facility failed to develop a plan of care specific to Resident #6's use of clozapine (antipsychotic medication used to treat mental/mood disorders) The facility failed to develop a plan of care to indicate Resident #6 was considered by the PASRR process to have serious mental illness and an intellectual disability. 3. The facility failed to care plan Resident #9 was in the memory care unit. These failures could place the residents at increased risk of not having their individual needs met and a decreased quality of life. Findings included: 1. Record review of a face sheet dated 04/23/2025 indicated Resident #2 was a [AGE] year-old female with diagnoses which included hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side (blood flow to the brain affected with weakness and paralysis of left side of the body), type 2 diabetes mellitus with diabetic neuropathy (insulin resistance, with or without insulin deficiency that induces organ dysfunction) progressive death of nerve fibers, which leads to loss of nerves, increased sensitivity, and the development of foot ulcers), and anxiety disorder. Record review of Resident #2's Comprehensive MDS assessment dated [DATE] indicated she understood others and was understood. Resident #2's BIMS score was a 15, which indicated her cognition was intact. The MDS assessment indicated Resident #2 was dependent on staff for showering/bathing, toileting, dressing, and personal hygiene. The MDS assessment indicated Resident #2 used tobacco. Record review of Resident #2's care plan with a target date of 02/09/2025 did not indicate she used a vape or smoked. During an observation and interview on 04/21/2025 starting at 9:20 AM, Resident #2 had a vape on her over bed table. Resident #2 said she used the vape. During an interview on 04/22/2025 at 4:12 PM, LVN B said when Resident #2 got out of bed she went to smoke sometimes. LVN B said Resident #2 used a vape device. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/23/2025 at 1:20 PM, the MDS Coordinator said the care plans were completed by therapy, dietary activities, the DON, and social services. The MDS Coordinator said the care plan was initiated on admission. The MDS Coordinator said she was responsible for care planning Resident #2's use of a vape and that she smoked. The MDS Coordinator said she was aware Resident #2 smoked, and she used a vape. The MDS Coordinator said she did not know why it was not included in her care plan. The MDS Coordinator said it should have been care planned because Resident #2 required someone with her when she smoked. The MDS Coordinator said it was important for smoking and the use of a vape to be included in the residents' care plans so people could look at the care plan and see how to manage the residents' care. 2. Record review of a face sheet dated 04/23/2024 indicated Resident #6 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included schizoaffective disorder (mood disorder that can include depression, delusions, hallucinations, disorganized thoughts, speech and behavior) and mild intellectual disabilities (a condition that limits intelligence and disrupts abilities necessary for living independently). Record review of Resident #6's Comprehensive MDS assessment dated [DATE] indicated she was considered by the PASRR process to have serious mental illness and an intellectual disability. Record review of Resident #6's Quarterly MDS assessment dated [DATE] indicated she was understood, and she understood others. The MDS assessment indicated Resident #6 had a BIMS score of 15, which indicated her cognition was intact. The MDS assessment indicated Resident #6 received an antipsychotic. Record review of Resident #6's Order Summary Report dated 04/23/2025 indicated clozapine 100 mg give 3. 5 tablets orally two times a day with a start date of 09/19/2024. Record review of Resident #6's care plan with a target date of 12/01/2024 indicated, Focus The resident uses psychotropic medications (SPECIFY medications) r/t. There were no interventions. The care plan did not include Resident #6's use of clozapine and interventions related to the use of clozapine. The care plan did not address that Resident #6 was considered by the PASRR process to have serious mental illness and an intellectual disability. During an interview on 04/24/2025 at 10:11 AM, the DON said the responsibilities of the care plans were shared between the DON, social worker, and the MDS Coordinator. The DON said any of them could have care planned Resident #2's smoking and vape use. The DON said Resident #6's positive PASRR status and services should have been care planned by the IDT. The DON said Resident #2's use of a vape and smoking and Resident #6's PASRR positive status and services were not care planned due to the change in ownership that occurred October 2024. The DON said it was important for the residents' care plans to include all their needs and services to ensure they knew how to take care of the resident. 47612 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.Record review of Resident #9's face sheet dated 04/23/2025, revealed Resident # 9 was an [AGE] year-old female who admitted on [DATE] with the diagnoses of vascular dementia (a form of dementia caused by reduced blood flow to the brain, leading to cognitive decline), bipolar disorder (a mental illness characterized by extreme shifts in mood, energy, and activity levels, including both manic (elevated mood) and depressive (low mood) periods), and mild cognitive impairment of uncertain or unknown etiology(memory and thinking problems that are more pronounced than normal aging but don't meet the criteria for dementia). Record review of Resident #9's quarterly MDS assessment dated [DATE] indicated Resident #9 understood and could make herself understood by others. Resident #9 had a BIMS score of 09 which indicated moderate cognitive impairment. The MDS revealed Resident #9 had no behaviors or refusal of care. Record review of Resident #9's comprehensive care plan, dated 11/01/2024, indicated a risk for wondering and elopement. Goals: the resident will not leave the facility unattended. Interventions: clearly identify resident's room and bathroom. Identify if there was a certain time of day the resident's wandering and elopement attempts. The care plan did not address the memory care unit. During an interview on 04/24/2025 at 9:09 a.m., the MDS Coordinator stated she was the one responsible for completing the residents' care plans. The MDS Coordinator stated the care plan should be done on admission, quarterly, and with a change in condition. The MDS Coordinator said Resident #9 residing on the memory care unit should have been included in her care plan. The MDS Coordinator said Resident #6's use of clozapine should have been included in her care plan. The MDS Coordinator said Resident #6's PASRR positive status should have been in her care plan. The MDS Coordinator stated because of the changeover things had been missed. The MDS Coordinator stated if the residents do not have a care plan, there would be a possibility of confusion about the care to be provided or the care would be not provided at all. During an interview on 04/24/2025 at 10:44 AM, the Administrator said his expectations for the residents' care plans were for the care plans to reflect the services the residents were receiving. The Administrator said the IDT was responsible for ensuring the residents' care plans included all the services they received. The Administrator said there was a potential, if the residents care plan did not reflect everything, that they may miss out on services or orders they needed. Record review of the facility's policy, Care Plans, Comprehensive Person-Centered, revised March 2022 indicated, Policy Statement A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. 3. The care plan interventions arc derived from a thorough analysis of the information gathered as part of the comprehensive assessment . 11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change .

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Capstone Healthcare of Daingerfield	507 E W M Watson Blvd Daingerfield, TX 75638

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on observations, interviews, and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain grooming and personal hygiene for 2 of 3 residents reviewed for ADLs. (Resident #11 and 26) The facility failed to ensure Resident #11 and #26 received their showers as scheduled. This failure could place residents at risk of not receiving services/care, decreased quality of life, and decreased self-esteem. Findings included: 1. Record review of Resident #26's face sheet dated 04/23/25, indicated an [AGE] year-old female who initially admitted to the facility on [DATE]. Resident #26 had diagnoses which included congestive heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), atrial fibrillation (irregular heartbeat), muscle weakness, and need for assistance with personal care. Record review of Resident #26's quarterly MDS assessment dated [DATE], indicated Resident #26 was understood and understood others. Resident #26 had a BIMS score of 15, which indicated her cognition was intact. Resident #26 did not have behaviors or rejected care. Resident #26 required supervision or touching assistance with personal hygiene and showering/bathing. Record review of Resident #26's comprehensive care plan dated 11/12/24, indicated Resident #26 was a risk for self-care deficit related to bathing, dressing, and feeding. The care plan interventions indicated to maintain consistent schedule with daily routine and provide assistance with ADLs as needed. Record review of Resident #26's Skin Monitoring: Comprehensive CNA Shower Review sheets for the following dates indicated Resident #26 had received a shower: 03/04/25, 03/06/25, 03/11/25, 03/13/25, 03/18/25, 03/20/25, 03/25/25, 04/08/25, 04/10/25. There were no shower sheets provided for the following dates: 03/08/25, 03/15/25, 03/22/25, 03/27/25, 03/29/25, 04/01/25, 04/03/25, 04/05/25, 04/12/25, 04/15/25, and 04/19/25. Record review of Resident #26's ADLs point of care report dated 04/09/25- 04/19/25, indicated Resident #26 had received a shower on 04/10/25 and 04/17/25. During an interview on 04/21/25 at 12:05 PM, Resident #26 said she had not received a shower since Tuesday of last week (04/15/25). Resident #26 said her shower days were on Tuesday, Thursday, and Saturday. Resident #26 said it made her feel dirty not getting one. Resident #26 said when the shower aide was pulled to the floor, they did not get a shower. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	2. Record review of Resident #11's face sheet dated 04/23/25, indicated a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included diabetes (a group of diseases that result in too much sugar in the blood), cerebral infarction (stroke), irritable bowel syndrome (an intestinal disorder causing pain in the belly, gas, diarrhea, and constipation), and need for assistance with personal care. Record review of Resident #11's quarterly MDS assessment dated [DATE], indicated she was able to make herself understood and understood others. Resident #11 had a BIMS score of 15, which indicated her cognition was intact. Resident #11 did not refuse care or had behaviors. Resident #11 required substantial/maximal assistance with showering/bathing and upper body dressing. Record review of Resident #11's comprehensive care plan 10/28/24, indicated Resident #11 was at risk for self-care deficient regarding bathing, dressing, and feeding. The care plan interventions indicated to maintain consistent schedule with daily routine and provide assistance with ADLs as needed. Record review of Resident #11's Skin Monitoring: Comprehensive CNA Shower Review sheets for the following dates indicated Resident #11 had received a shower or bed bath: 03/06/25, 03/13/25, 03/20/25, 04/03/25, 04/08/25, 04/10/25. There were no shower sheets provided for the following dates: 03/04/25, 03/08/25, 03/15/25, 03/18/25, 03/22/25, 03/25/25, 03/27/25, 03/29/25, 04/01/25, 04/05/25, 04/12/25, 04/15/25, and 04/19/25. Record review of Resident #11's ADLs point of care report dated 04/09/25- 04/19/25, indicated no documentation was completed for Resident #11's showers. During an interview on 04/21/25 at 10:42 AM, Resident #11 said within the last 2 weeks she had missed 3 showers. She said when the shower aide was assigned to work as a CNA on the floor, she received a bed bath by her assigned aide. She said it made her feel not good when she did not receive a shower. During an interview on 04/22/25 at 10:28 AM, CNA A said she was usually the shower aide unless she was assigned to a hall. CNA A said when she was working the floor the nurse aide assigned to each hall was responsible for providing their own showers. CNA A said she had residents complain to her that they did not receive their showers when she did not work as the shower aide . CNA A said by not proving showers as scheduled placed residents at risk for skin issues or infections. During an interview on 04/23/25 at 10:51 AM, CNA A said when she completed a shower, she filled out a shower sheet. CNA A said she did not chart in the point of care system and assumed the aide on the hall was charting when a shower was given. She said she knew now that was not being completed. She said if there were no shower sheets completed and there was no documentation indicating a shower was given, then the shower was not done. CNA A said failure to provide showers as scheduled placed residents at risk for skin issues. During an interview on 04/24/25 at 09:03 AM, the DON said when the shower aide was pulled from giving showers then she expected the aide on the floor to provide the showers assigned. The DON said it was brought to her attention the shower task was not triggering in the point of care system. The DON said it was the nurse's responsibility to ensure the showers were being provided. The DON said by not receiving their showers routinely placed the residents at risk for infections. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 04/24/25 at 09:58 AM, the Administrator said his expectations were to provide showers as per the shower schedule. He said if the shower aide was pulled to the floor, then it was the responsibility of the aide on the hall to provide the showers. The Administrator said if the resident refused their shower, it should be documented. He said the residents were at risk for issues concerning their health by not receiving their showers on a routine basis. The Administrator said it was the responsibility of the charge nurse to ensure the showers were being provided. Record review of the facility's policy Bath, Shower/Tub revised February 2018, indicated . The purpose of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin .

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on observation, interview, and record review the facility failed to ensure a resident with limited range of motion received appropriate treatment and services to increase range of motion/and or to prevent further decrease in range of motion for 1 of 4 residents reviewed for range of motion. (Resident #10) The facility to ensure Resident #10's splint for his right-hand contracture (a permanent tightening of the muscles, tendons, skin, and surrounding tissues that causes the joints to shorten and stiffen) was being applied as ordered. This failure could place residents who had limited range of motion at risk of not attaining/or maintaining their highest level of physical, mental, and psychosocial well-being. Findings included: Record review of Resident #10's face sheet dated 04/23/25, indicated a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included cerebral infarction (stroke), hypertension (high blood pressure), right upper arm muscle wasting and atrophy (loss of muscle mass and strength), and right-hand contracture. Record review of Resident #10's quarterly MDS assessment dated [DATE], indicated he was sometimes understood and sometimes understood others. Resident #10 had short term/long term memory problems and his cognition was severely impaired. Resident #10 did not have behaviors or refused care. The MDS assessment indicated Resident #10 had an upper and lower extremity impairment on one side of his body that interfered with daily functions. Resident #10 required substantial/maximal assistance with toileting, showering, dressing, and personal hygiene. Record review of Resident #10's comprehensive care plan initiated on 04/22/25, indicated Resident #10 required the use of a supportive device to promote independence. Resident #10 had a right palm guard splint to minimize contracture to right hand. The care plan interventions indicated for therapy to oversee splint and make adjustments as needed. The care plan did not indicate Resident #10 refused his splint to be applied. Record review of Resident #10's order summary report dated 04/23/25, indicated he had an order to clean right hand, apply splint daily and remove splint and clean hand at bedtime with an order date of 01/05/25. Record review of Resident #10's progress notes dated 03/24/25-04/24/25 did not reveal any documentation indicating Resident #10 had refused the application of the splint to his right hand. Record review of Resident #10's treatment administration record dated 04/01/25-04/30/25, indicated Resident #10 had an order to clean right hand splint daily and remove splint and clean hand at bedtime. The treatment administration record indicated this was being completed during the 6:00 AM - 6:00 PM and 6:00 PM- 6:00 AM shifts. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an observation on 04/21/25 at 09:47 AM, Resident #10 was sitting up in his wheelchair. Resident #10's right hand was contracted and in a fist position. There were no interventions in place to Resident #10's right hand. During an observation on 04/22/25 at 08:34 AM, Resident #10 was up in his wheelchair and was propelling himself in the hallway. There were no interventions in place to Resident #10's right hand. During an observation on 04/22/25 at 2:28 PM, Resident #10 was sitting in his recliner. His right-hand contracture continued with no interventions in place. Resident was unable to speak but was able to shake his head to yes and no questions. Resident #10 shook his head no when asked if he allowed the staff to apply the splint to his right hand. During an observation and interview on 04/23/25 at 11:15 AM, LVN D said she was Resident #10's nurse. LVN D said Resident #10 sometimes refused care. LVN D said the CNAs were able to apply the splint to Resident #10's right hand. LVN D went to Resident #10 and observed the splint was not in place to his right hand. LVN D said Resident #10 sometimes refused the splint to be applied because his right hand was tender. LVN D said the refusal should be documented in his progress notes and his care plan should be updated. LVN D said she had already clicked off on Resident #10's MAR that morning that the splint had been applied to his right hand. LVN D said she should have verified that was completed before signing off on it. LVN D said it was Resident #10's shower day and therefore was waiting until after his shower to apply the splint. LVN D said failure to apply the splint as ordered could cause Resident #10's contracture to worsen. LVN D said she was responsible for ensuring the splint was applied or the refusal was documented. During an interview on 04/23/25 at 11:24 AM, CNA E said Resident #10 refused at times for the splint to be applied because his right hand was tender. CNA E said the aides were able to apply the splint, but it was the nurse's responsibility to ensure it was in place. CNA E said failure to apply the splint could cause Resident #10's contracture to worsen. During an interview on 04/24/25 at 09:03 AM, the DON said Resident #10 will refuse to have the splint applied and try to fight the staff . The DON said the nurse should not have checked the MAR as the splint being applied to Resident #10's right hand until it was applied. The DON said Resident #10's refusal should have been documented in the progress notes. The DON said the nurse was responsible for ensuring the splint was applied as ordered and failure to do so could place Resident #10's contracture to worsen. During an interview on 04/24/25 at 9:58 AM, the Administrator said if the nurse was having issues following the physician's orders, then there should be documentation as to why it was not completed. The Administrator said the nurse was responsible for applying the splint, for documenting the refusals and notifying nurse leadership. The Administrator said failure to apply the splint as ordered place the resident at risk for his condition to worsen. Record review of the facility's policy Resident Mobility and Range of Motion revised July 2017, indicated . 2. Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM . 2. As part of the comprehensive assessment, the nurse will also identify conditions that place the resident at risk for complications related to ROM, including . e. contractures . 5. The care plan will include specific interventions, exercise, and therapies to maintain, prevent avoidable decline in, and/or improve mobility range of motion .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** 46892 Based on observation, interview, and record review, the facility failed to ensure the resident environment remains as free of accident hazards as is possible for 1 of 2 residents (Residents #2) reviewed for accident hazards. The facility failed to ensure Resident #2 did not keep a vape (electronic cigarette) on her over bed table. The facility failed to have documentation that Resident #2 was evaluated for use of electronic cigarette use. This failure could place residents at an increased risk for injury. Findings included: Record review of a face sheet dated 04/23/2025 indicated Resident #2 was a [AGE] year-old female with diagnoses which included hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side (weakness and paralysis of left side of the body), type 2 diabetes mellitus with diabetic neuropathy (insulin resistance, with or without insulin deficiency that induces organ dysfunction) progressive death of nerve fibers, which leads to loss of nerves, increased sensitivity, and the development of foot ulcers), and anxiety disorder. Record review of Resident #2's Comprehensive MDS assessment dated [DATE] indicated she understood others and was understood. Resident #2's BIMS was a 15, which indicated her cognition was intact. The MDS assessment indicated Resident #2 was dependent on staff for showering/bathing, toileting, dressing, and personal hygiene. The MDS assessment indicated Resident #2 used tobacco. Record review of Resident #2's care plan with a target date of 02/09/2025 did not indicate she used a vape or smoked. During an observation and interview on 04/21/2025 starting at 9:20 AM, Resident #2 had a vape on her over bed table. Resident #2 said she used the vape. During an observation on 04/21/2025 at 2:02 PM, Resident #2 had a vape device on her overbed table. During an interview on 04/22/2025 at 4:12 PM, LVN B said when Resident #2 got out of bed she went to smoke sometimes. LVN B said Resident #2 used a vape device. LVN B said she did not know if the residents could keep their vape devices in their rooms. LVN B said smoking assessments were completed by the MDS nurse on admission. LVN B said the risks associated with Resident #2 having a vape in her room could be that the device could leak, and it could explode. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 04/23/2025 at 4:00 PM, LVN L said Resident #2 smoked when she was up in her wheelchair. LVN L said she was aware Resident #2 had a vape, but she had not seen her use it in her room. LVN L said most of the time they kept cigarettes and lighters at the desk. LVN L said that she was aware Resident #2 was the only one with a vape. LVN L said the smoking assessments were completed quarterly by the charge nurses, but she did not know when Resident #2's smoking assessment was last completed. LVN L said the only risk she could think of with a vape would be that it could cause a burn. During an interview on 04/24/2025 at 10:17 AM, the DON said she was aware Resident #2 smoked and used a vape. The DON said she did not know if the residents could keep vapes in their rooms, and she did not know of any ill effects associated with the residents having one in their room. The DON said the nurses were supposed to be completing the smoking assessments quarterly. The DON said she did not know why Resident #2's smoking assessment was not completed. During an interview on 04/24/2025 at 10:20 AM, the ADON said if a resident had a vape, they were able to keep them in their rooms, but they were not supposed to smoke them inside the building. The ADON said she did not know Resident #2 still had a vape. The ADON said she did not know if Resident #2 could have her vape in her room, but she was presuming she was not supposed to have it. The ADON said the smoking assessment did not apply to the vape. The ADON said she did not know of any risks associated with the residents keeping their vapes. The ADON said Resident #2 was the only one that she was aware of that used a vape. During an interview on 04/24/2025 at 10:52 AM, the Administrator said vapes should not be kept at the bedside. The Administrator said he was aware Resident #2 kept a vape at her bedside. The Administrator said if someone was an unsafe smoker with the electronic cigarette there was a potential for Resident #2 to intake more nicotine than was healthy for her. The Administrator said it was his responsibility for ensuring Resident #2 did not keep a vape at bedside. Record review of the facility's incidents and accidents from 10/01/2024-04/21/2025 did not indicate any burns or incidents related to smoking/vape. Record review of the facility's policy titled, Smoking Policy-Residents, revised August 2022, indicated, The facility has established and maintains safe resident smoking practices 1. Electronic cigarettes (e-cigarettes) are not considered smoking devices with respect to the risk of ignition, but they are considered a risk for residents related to: a. potential health effects for the smoker, such as respiratory illness or lung injury which may present with symptoms of breathing difficulty, shortness of breath, chest pain, mild to moderate gastrointestinal illness, fever or fatigue; b. second-hand aerosol exposure; c. nicotine overdose by ingestion or contact with the skin; and d. explosion or fire caused by the battery. 2. To prevent accidents associated with e-cigarettes and to respect the rights of resident who do not want to be exposed to second-hand aerosol, residents are permitted to use e-cigarettes with supervision and in designated smoking areas only. 3. Residents who wish to use e-cigarettes are assessed for their ability to safely handle the devices (including batteries and refill cartridges) on an individual basis. 4. Residents who wish to use e-cigarettes are instructed on battery safety and tips to avoid battery explosions per FDA recommendations. Instruction specific to e-cigarette safety is documented in the resident care plan.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 2 residents (Resident #3) reviewed for treatment and services related to indwelling catheters. The facility failed to ensure Resident #3's foley catheter was secured on 04/22/2025. This failure could place residents at risk for urinary tract infections, catheter dislodgement and a decreased quality of life. Findings included: Record review of Resident #3's face sheet dated 04/23/25 indicated an [AGE] year-old female who admitted to the facility on [DATE]. Resident #3 had diagnoses of diabetes (a group of diseases that result in too much sugar in the blood), dementia (a group of thinking and social symptoms that interferes with daily functioning), protein calorie malnutrition (inadequate intake of food), and urine retention. Record review of Resident #3's quarterly MDS assessment dated [DATE], indicated she was usually understood and usually understood others. Resident #3 had a BIMS score of 3, which indicated her cognition was severely impaired. The MDS assessment indicated Resident #3 had an indwelling catheter. Record review of Resident #3's comprehensive care plan revised on 04/04/25, indicated Resident #3 had an indwelling catheter related to neurogenic bladder (lack of bladder control due to brain, spinal cord or nerve problems). The care plan interventions included to secure catheter tubing to leg to minimize trauma to the insertion site, make sure tubing was free of kinks and urine was present in the tube. Record review of Resident #3's order summary report dated 04/23/25, indicated the following orders: o Check foley catheter stabilizer to make sure it is in place every shift with an order start date of 09/25/24. Record review of Resident #3's nursing MAR dated 04/01/25-04/30/25 indicated Resident #3's foley catheter stabilizer was being checked every shift. During an observation and interview on 04/22/25 at 2:28 PM, Resident #3 was in bed. CNA E entered Resident #3's room and checked Resident #3's catheter. Resident #3's foley catheter was not secured to her leg. CNA E said Resident #3 should have had a leg strap to secure the catheter to her leg to prevent pulling of the catheter. CNA E said failure to properly secure Resident #3's catheter could cause injury. CNA E said the nurse was responsible for ensuring the foley catheters were properly secured. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an observation and interview on 04/22/25 at 2:58 PM, LVN C entered Resident #3's room to check her foley catheter. Resident #3's foley catheter was not secured to her leg. LVN C said Resident #3 usually tore the adhesive part of the statlock (foley securement device) and left the clamp on. LVN C said Resident #3's foley catheter should be properly secured to prevent pulling of the catheter. LVN C said failure to properly secure the foley catheter could cause trauma or bleeding to the insertion site. LVN C said the nurses and the aides were responsible for ensuring the foley catheters were properly secured. During an interview on 04/24/25 at 09:03 AM, the DON said she expected the resident's catheters to be properly secured. The DON said the nurses were responsible for ensuring the stat lock or leg strap were in place but there were residents that removed them and Resident #3 was one of them. The DON said failure to properly secure the catheter could place the resident at risk for dislodgement. During an interview on 09:58 AM, the Administrator said he expected for the foley catheters to be secured. The Administrator said it was the nursing team responsibility to ensure this occurred. The Administrator said if the catheter was not secured it could potentially be pulled. Record review of the facility's policy Catheter Care, Urinary revised August 2022, indicated . The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections 4. Ensure that the catheter remains secure with a securement device to reduce friction and movement at the insertion site. The policy did not address the privacy of catheter drainage bag.

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	675755	A. Building B. Wing	04/24/2025

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on observation, interview, and record review, the facility failed to ensure residents fed by enteral means received the appropriate treatment and services to prevent complications for 1 of 3 resident (Resident #41) reviewed for enteral nutrition. The facility failed to ensure Resident #41's physician's order for her enteral feedings (a form of nutrition that is delivered into the digestive system as a liquid form via the feeding tube) indicated the type of feeding she was supposed to have been receiving. This failure could affect residents receiving enteral nutrition and hydration by placing them at risk of health complications. Findings included: Record review of Resident #41's face sheet dated 04/23/25, indicated a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included cerebral palsy (a congenital disorder of movement, muscle tone, or posture), epilepsy (seizures), hypertension (high blood pressure), and gastrostomy status (surgical opening in stomach to provide nutrition and medications). Record review of Resident #41's quarterly MDS assessment dated [DATE], indicated Resident #41 was usually understood and usually understood others. Resident #41 had a BIMS score of 2, which indicated her cognition was severely impaired. Resident #41 was dependent on staff with toileting, showering, and personal hygiene. The MDS indicated Resident #41 had a feeding tube and had not had any weight loss/gain of 5% or more in the last month or 10% or more in the last 6 months. Record review of Resident #41's comprehensive care plan dated 04/04/25, indicated Resident #41 required a feeding tube related to dysphagia (difficulty swallowing), medical condition of cerebral palsy, swallowing problem, and required gastrostomy tube to aide in her nutritional needs. The care plan interventions indicated to assist with administration of tube feeding and water flushes per MD order. The care plan did not specify the type of feeding Resident #41 required. Record review of Resident #41's order dated 01/01/25, indicated to give one can (237ml) bolus feeding via gastrostomy tube 5 times a day for supplement. The order did not indicate the type of feeding Resident #41 required. Record review of Resident #41's nursing MAR dated 04/01/25-04/30/25, indicated Resident #41 received one can of bolus feeding via her gastrostomy tube 5 times a day at 2:00 AM, 07:00 AM, 12:00 PM, 4:00 PM, and 9:00 PM. The MAR did not indicate the type of feeding Resident #41 was supposed to receive. During an observation on 04/21/25 at 10:45 AM, Resident #41 had an 8-ounce carton of Jevity 1.5 cal sitting on her nightstand. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 04/21/25 at 2:22 PM, Resident #41 continued to have the 8-ounce carton of Jevity 1.5 cal sitting on her nightstand. During an interview on 04/22/25 at 2:48 PM, LVN C said Resident #41 received Jevity 1.5 cal five times a day. LVN C said since Resident #41's enteral feeding order did not specify the type of feeding she could receive any type of formula. She said this could cause Resident #41 to have an adverse reaction. LVN C said the nurse was responsible for ensuring the order was accurate with the specific enteral feeding to be administered. During an interview on 04/24/25 at 09:03 AM, the DON said the specific enteral feeding to be used should be on the order. The DON said failure to specify the feeding to be administered could place the resident at risk to receive the wrong feeding. The DON said it was the ADON's and her responsibility to ensure the orders were accurately transcribed. The DON said she reviewed orders daily during morning meeting. The DON said she was unsure of how the order was missed. During an interview on 04/24/25 at 09:58 AM, the Administrator said he expected Resident #41's order to specify the enteral feeding she required. The Administrator said it was the nurse's responsibility to ensure the correct feeding was being administered to Resident #41. He said by not specifying the feeding required placed Resident #41 at risk for receiving the wrong feeding. Record review of the facility's policy Enteral Nutrition revised February 2018, indicated . Adequate nutritional support through enteral nutrition is provided to residents as ordered . 11. The Nurse confirms that orders for enteral nutrition are complete. Complete orders include: a. the enteral nutrition product .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47708 Based on observation, interview, and record review the facility failed to ensure that residents requiring respiratory care were provided such care, consistent with professional standards of practices for 2 of 3 residents (Resident #43 and Resident #23) reviewed for respiratory care. 1. The facility failed to ensure Resident #43's oxygen was administered between 2-3 liters per minute via nasal cannula as prescribed by the physician. 2. The facility failed to ensure Resident #23's nasal cannula was stored properly. This failure could place residents who receive respiratory care at risk for developing respiratory complications. Findings included: 1. Record review of the face sheet, dated 04/23/25, revealed Resident #43 was a [AGE] year-old female who initially admitted to the facility on [DATE] with diagnoses dementia without behavioral disturbance (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life), Hyperlipidemia (blood has too many lipids (or fats), bradycardia (slow heart beat) and hypertension (high blood pressure). Record review of the MDS assessment, dated 02/14/25, revealed Resident #43 had clear speech, was sometimes understood and sometimes made herself understood. The MDS revealed Resident #43 BIMS was not coded on the MDS assessment. Record review of the comprehensive care plan, revised on 12/04/24, revealed Resident #43 was using oxygen prn as needed. The care plan goal was, Resident #43 will follow all safety guidelines; will have no episodes of respiratory distress. The interventions included: Administer breathing treatments in apartment as ordered; Monitor for increasing difficulty breathing and report to nurse/MD and use Oxygen. Directions (specify storage, maintenance and provider). Record Review of Physician orders for oxygen concentrator dated on 9/29/2024 at 6:15 p.m., indicated, May use Oxygen 2-3L/NC as needed for Shortness of breath. During observation on 4/21/25 at 09:51 a.m., Resident # 43 was sitting in her wheelchair next to foot of bed. Resident #43 was wearing oxygen nose cannula. Resident #43 oxygen concentrator was set at 4 1/2 liters per minute. During an attempted phone call interview on 4/23/25 at 2:06 p.m., LVN B was unavailable to be reached by phone. Surveyor was unable to leave a voice message for a return phone call due to voicemail being full. During an attempted phone call interview on 4/23/25 at 2:28 p.m., LVN B was unavailable to be reached by phone. Surveyor was unable to leave a voice message for a return phone call due to voicemail being full. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 4/24/25 at 8:28 a.m., the DON stated she had been employed at the facility since 10/1/24. The DON stated she oversaw the nurses at the facility. The DON stated the oxygen concentrator should have been set between 2-3 liters per minute. The DON stated Resident #43 fiddled with the oxygen setting. When asked did the facility document that the resident fiddled with the oxygen concentrator the DON stated, Well it was not documented because I did not ever witness the resident fiddling with the oxygen concentrator. The DON stated she did not know when in-services on the oxygen concentrators were last completed at the facility. The DON stated her process for monitoring the oxygen concentrator was to go in each room and check the oxygen concentrators on every shift. The DON stated the charge nurses was responsible for ensuring the oxygen concentrators were set at the correct liters per minute as prescribed by the physician. The DON stated it was important to ensure staff were following the physician orders for oxygen concentrators to make sure the patient was getting the optimal benefit from the oxygen. When asked what harm could be potentially caused to the resident if the oxygen concentrator setting was not set at the correct liters per minute as prescribed by the physician the DON stated, I can't speculate if this could cause any harm to the resident if the oxygen concentrator were not set at the correct liters per minute. During an interview on 4/24/25 at 8:36 a.m., the Administrator stated he had been employed at the facility since 8/1/22. The Administrator stated he oversaw the nursing department at the facility. The Administrator stated he did not know what Resident #43's oxygen concentrator should be set on. The Administrator stated he did not think Resident #43 had the capabilities to change the settings on the oxygen concentrator herself. The Administrator stated it was possible that the oxygen concentrator got accidently bumped into. The Administrator stated he was not made aware of Resident #43's oxygen concentrator was not set to the right liters per minute as prescribed by the physician. The Administrator stated he oversaw the DON. The Administrator stated he did not know when staff last completed in-services on the oxygen concentrators. When asked what his process was for monitoring the oxygen concentrator, the Administrator stated, It would be a charge nurse task when he or she was making their rounds and if leadership identified an issue with the charge nurses not making sure the liters per minute was set that the facility would set a system to start monitoring the oxygen concentrators. When asked why it was important to ensure staff was following the physician order for oxygen concentrators, The Administrator stated, As a nursing facility, we operate by following the physician's orders. 46892 2. Record review of a face sheet dated 04/23/2025 indicated Resident #23 was an [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included chronic obstructive pulmonary disease (chronic inflammatory lung disease that causes obstructed airflow from the lungs), heart failure (chronic, progressive condition in which the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen) and essential primary hypertension (high blood pressure). Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #23 was understood by others and understood others. The MDS assessment indicated Resident #23 had a BIMS score of 15, which indicated her cognition was intact. The MDS assessment indicated Resident #23 was dependent for toileting and showering/bathing self, independent for eating, and required partial to moderate assistance with ADLs. The MDS assessment indicated Resident #23 required oxygen therapy while a resident at the facility. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of Resident #23's Order Summary Report dated 04/23/2025 indicated an order for check oxygen saturation every shift and apply oxygen at 2-4 liters per minute via nasal cannula as needed to maintain oxygen saturation more than 92% every shift with a start date of 10/23/2024. Record review of Resident #23's care plan with a target date of 11/17/2024 indicated she had impaired gas exchange and to administer oxygen as prescribed or per the standing order. During an observation and interview on 04/21/2025 at 9:36 AM, Resident #23's nasal canula was hanging from the rail on her bed, not stored in a bag. Resident #23 said she used her oxygen at night and as needed. Resident #23 said the nasal cannula was always kept unbagged that the staff did not place it in a bag. During an observation on 04/22/2025 at 1:07 PM, Resident #23's nasal cannula was on top of her oxygen concentrator, unbagged. During an interview on 04/23/2025 at 3:56 PM, LVN L said Resident #23 used her oxygen as needed. LVN L said they nasal cannulas for the oxygen should be stored in a bag to keep them clean. LVN L said the CNAs and the nurses were supposed to place the nasal cannulas in a bag if they saw it was not bagged. LVN L said the nasal cannulas should be stored in a bag because bacteria could get on them and cause an infection. During an interview on 04/24/2025 at 10:25 AM, the ADON said the nasal cannulas should be stored in a bag. The ADON said she rounded weekly to ensure the nasal cannulas were kept in a bag when not in use. The ADON said she rounded Monday (04/21/2025) and placed a bag on Resident #23's oxygen concentrator for the staff to place her nasal cannula in. The ADON said Resident #23 did not keep her nasal cannula in the bag. The ADON said all the staff were responsible for ensuring the nasal cannulas were stored in a bag. The ADON said when the staff went in the resident's room they should be placing the nasal cannulas in the bag. The ADON said it was important to keep the nasal cannulas stored in a bag for infection control. During an interview on 04/24/2025 at 10:30 AM, the DON said the nasal cannulas should be stored in bags. The DON said the nursing staff and anybody walking by the room should ensure the nasal cannulas were placed in a bag when not in use. The DON said this should be monitored by everybody when they rounded every 2 hours. The DON said the nasal cannula not being in a bag was a risk for infection. During an interview on 04/24/2025 at 11:00 AM, the Administrator said he expected for the nasal cannulas to be stored properly, and the CNAs and charge nurses were responsible for ensuring this happened. The Administrator said nurse management was responsible for ensuring the charge nurses were storing the nasal cannulas properly and remained in compliance. The Administrator said the nasal cannulas should be kept in a bag for infection control and overall cleanliness. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of the facility's policy titled, Oxygen Administration, revised October 2010, indicated, Purpose The purpose of this procedure is to provide guidelines for safe oxygen administration. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration . I. Oxygen therapy is administered by way of an oxygen mask, nasal cannula, and/or nasal catheter . The nasal cannula is a tube that is placed approximately one-half inch into the resident's nose . Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered . The policy did not address the storage of the nasal cannula.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47612 Based on interviews, and record review, the facility failed to ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident for 1 of 1 resident's (Resident #'s 50) reviewed for trauma-informed care. The facility did not ensure Resident #50 had a trauma screening that identified possible triggers when Resident #50 had a history of trauma. These failures could put residents at an increased risk for severe psychological distress due to re-traumatization. The findings included: Record review of the face sheet, dated 04/23/2025, indicated Resident #50 was a [AGE] year-old male, admitted to the facility on [DATE] with diagnoses of Wernicke's encephalopathy (a serious neurological condition caused by a deficiency of thiamine (vitamin B1), often due to chronic alcohol use or malnutrition), post-traumatic stress disorder (a mental health condition that can develop in people who experience or witness a traumatic event), anxiety disorder (condition in which a person has excessive worry and feelings of fear, dread, and uneasiness). Record review of the MDS assessment, dated 01/23/2025, revealed Resident #50 had a BIMS score of 03, which indicated severe cognitive impairment. The MDS revealed Resident #50 had no behaviors or refusal of care. Record review of the comprehensive care plan, revised on 10/30/2024, revealed Resident #50 did not address post-traumatic stress disorder. During an interview on 04/23/2025 at 3:53 p.m., the Social Worker stated she was responsible for ensuring trauma assessments were done on admission. The Social Worker stated she did not have a trauma assessment on Resident # 50. The Social Worker stated the trauma assessment was important, so the staff was aware of Resident #50's history. The Social Worker stated the failure was the staff may not be able to assess Resident # 50 needs and Resident# 50 may become upset or refuse care. During an interview on 04/24/2025 at 10:00 a.m., the DON stated she expected trauma assessments to be done on admission. The DON stated the trauma assessment was the social services responsibility. The DON stated the trauma assessment was important because if the resident has PTSD it could play into his problems. The DON stated the failure of not having a trauma assessment was the resident could harm self or others. The DON stated she would monitor on admission and weekly with the social worker. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 05/24/2025 at 10:46 a.m., the Administrator stated he excepted the trauma assessment to be done on admission. The Administrator stated it was social services responsibility to complete the trauma assessment. The Administrator stated the failure was the staff would not know the triggers and would not be able to provide the best care. The Administrator stated he would monitor during morning meetings. Record review of facility policy, Trauma-Informed and Culturally Competent Care revised August 2022, to guide staff in providing care that is culturally competent and trauma- Informed in accordance with professional standards of practice To address the needs of trauma survivors by minimizing and/or re-traumatization.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892 Based on observation, interview, and record review, the facility failed to ensure that licensed staff were able to demonstrate the specific competencies and skill sets necessary to care for resident's needs for 3 of 3 staff (MA G, MA F, and LVN C) reviewed for competencies. The facility failed to ensure MA G, MA F, and LVN C were competent in medication administration. This failure could potentially affect residents by placing them at an increased and unnecessary risk of exposure to staff who lack the appropriate skills and competencies to provide safe care and minimize infections. Findings included: 1. Record review of Resident #41's face sheet dated 04/23/25, indicated a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included cerebral palsy (a congenital disorder of movement, muscle tone, or posture), epilepsy (seizures), hypertension (high blood pressure), and gastrostomy status (surgical opening in stomach to provide nutrition and medications). Record review of Resident #41's quarterly MDS assessment dated [DATE], indicated Resident #41 was usually understood and usually understood others. Resident #41 had a BIMS score of 2, which indicated her cognition was severely impaired. The MDS indicated Resident #41 had an active diagnosis of hypertension. Record review of Resident #41's comprehensive care plan dated 01/13/25, indicated Resident #41 had hypertension. The care plan interventions indicated to give antihypertensive medications as ordered. Record review of Resident #41's order summary report dated 04/24/25, indicated she had an order for metoprolol tartrate 100mg give one tablet enterally one time a day related to hypertension with a start date of 01/01/25. The order indicated to hold if SBP less than 110 or DBP is less than 65. Record review of Resident #41's Nursing MAR dated 04/01/25-04/30/25, indicated Resident #41 had an order for metoprolol 100mg tablet give one tablet in the morning with instructions to hold for SBP less than 110 or DBP less than 65. On 04/13/25 at 08:00 AM, Resident #41's blood pressure was 104/72. The MAR had a check mark which indicated Resident #41 was administered a metoprolol 100 mg tablet outside the parameters by LVN C. On 04/16/25 at 08:00 AM, Resident #41's blood pressure was 97/59. The MAR had a check mark which indicated Resident #41 was administered a metoprolol 100 mg tablet outside the parameters by LVN C. On 04/21/25 at 08:00 AM, Resident #41's blood pressure was 106/81. The MAR had a check mark which indicated Resident #41 was administered a metoprolol 100 mg tablet outside the parameters by LVN C. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/22/25 at 3:41 PM, LVN C said a check mark on the medication administration record indicated the medication was administered. LVN C reviewed Resident #41's MAR and said Resident #41's received the metoprolol tablet on 04/13/25, 04/16/25, and 04/21/25 when her blood pressure was outside of the ordered parameters. LVN C said according to Resident #41's parameters the metoprolol should have been held. LVN C said it was the nurse's responsibility to ensure medications were being administered as per the physician's orders. LVN C said she had been checked off on medication administration competency. 2. Record review of a face sheet dated 04/23/2025 indicated Resident #23 was an [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included chronic obstructive pulmonary disease (chronic inflammatory lung disease that causes obstructed airflow from the lungs), heart failure (chronic, progressive condition in which the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen), and essential primary hypertension (high blood pressure). Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #23 was understood by others and understood others. The MDS assessment indicated Resident #23 had a BIMS score of 15, which indicated her cognition was intact. The MDS assessment indicated Resident #23 was dependent for toileting and showering/bathing self, independent for eating, and required partial to moderate assistance with ADLs. Record review of Resident #23's care plan with a target date of 11/17/2024 indicated she had hypertension, and the goal was for her blood pressure to be within normal limits with an intervention to evaluate blood pressure. Record review of Resident #23's Order Summary Report dated 04/23/2025 indicated, she had an order for metoprolol tartrate 25 mg give 0.5 tablet by mouth two times a day for hypertension hold for systolic blood pressure less than 110 and diastolic blood pressure less than 60 with a start date of 10/26/2024. Record review of Resident #23's April 2025 MAR indicated metoprolol tartrate 25 mg give 0.5 tablet by mouth two times a day hold for systolic blood pressure less than 110 and diastolic blood pressure less than 60. o On 04/07/2025 Resident #23's blood pressure was 104/59 the MAR indicated Resident #23's metoprolol was documented as administered by MA G. o On 04/20/2025 Resident #23's blood pressure was 106/74 the MAR indicated Resident #23's metoprolol was documented as administered by MA F. 3. Record review of a face sheet dated 04/23/2025 indicated Resident #31 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included end stage heart failure (heart's ability to pump blood effectively is severely impaired, leading to progressive symptoms and a reduced quality of life) and essential primary hypertension (high blood pressure). (continued on next page)

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	675755	A. Building B. Wing	04/24/2025

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

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #31's Quarterly MDS assessment dated [DATE] indicated, he was understood by others and understood others. The MDS assessment indicated Resident #31 had a BIMS score of 15, which indicated her cognition was intact. The MDS assessment indicated Resident #31 required substantial/maximal with toileting, showering/bathing, and set-up or cleanup assistance with personal hygiene. Record review of Resident #31's care plan revised 04/11/2025, indicated he was at risk for decreased cardiac output related to a diagnosis of hypertension with a goal for his blood pressure would be within normal limits and an intervention to evaluate his blood pressure. Record review of Resident #31's Order Summary Report dated 04/23/2025 indicated, he had an order for metoprolol tartrate 25 mg give 0.5 tablet by mouth two times a day for hypertension hold for systolic blood pressure less than 110 and diastolic blood pressure less than 60 with a start date of 10/17/2024. Record review of Resident #31's April 2025 MAR indicated metoprolol tartrate 25 mg give 0.5 tablet by mouth hold for systolic blood pressure less than 110 and diastolic blood pressure less than 60. o On 04/02/2025 Resident #31's blood pressure was 109/62 the MAR indicated Resident #31's metoprolol was documented as administered by MA F. o On 04/08/2025 Resident #31's blood pressure was 101/63 the MAR indicated Resident #31's metoprolol was documented as administered by MA F. o On 04/20/2025 Resident #31's blood pressure was 104/64 the MAR indicated Resident #31's metoprolol was documented as administered by MA F. During an interview on 04/22/2025 at 1:34 PM, MA F said blood pressure medication should be held for blood pressure less than 100/60. MA F said she was not sure if she had administered Resident #23's and Resident #31's blood pressure medications when their blood pressure was out of parameters, but she thought she had not. MA F said when a medication was documented as administered on the MAR it indicated it was administered. MA F said if the medication was held the medication would not be documented as administered. MA F said giving a blood pressure medication when the blood pressure was not within parameters could result in heart failure and death. During an attempted phone interview on 04/22/2025 at 2:00 PM, MA G did not answer the phone. During an attempted phone interview on 04/23/2025 at 3:28 PM, MA G did not answer the phone. During an interview on 04/24/2025 at 10:11 AM, the ADON said she was still looking for the nurse competencies because they were under the previous facility. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/24/2025 at 10:14 AM, the DON said the nurse or medication aide should be checking the parameters of blood pressure medications when they administered them. The DON said correct administration of medications was being monitored by competency check offs and if they were notified of an issue, they conducted another check off. The DON said the ADON and herself reviewed the MARs and they had not noticed any discrepancies. The DON said it was hard for them to review the MARs, when they had to work the floor. The DON said if blood pressure medication was administered with the blood pressure being too low it could lower the blood pressure, but she could not speculate on what could happen to the residents. During an interview on 04/24/2025 at 10:20 AM, the ADON said when she reviewed the MARs, she had noticed some medications not documented as administered, but as far as the medications being administered with the blood pressure out of parameters, she had not noticed any issues. The ADON said if a resident received blood pressure medication when their blood pressure was low, their blood pressure could be lowered more, and they could pass out from the low blood pressure or fall. During an interview on 04/24/2025 at 10:44 AM, the Administrator said if a resident's blood pressure was out of parameters, he expected the staff to re-check the residents blood pressure. The Administrator said the nurses and medication aides were responsible for ensuring the residents' blood pressures were within parameters before administering blood pressure medications to them. The Administrator said if they noticed there was an issue with medication administrator nursing and himself were responsible for ensuring the medication aides and nurses were doing their job appropriately. The Administrator said to his knowledge there was not an accountability system in place for monitoring that the residents were receiving medications appropriately. The Administrator said if you were giving medications that were designed for a specific purpose and it was outside of the parameters it could have a negative impact on a person's health. During an interview on 04/24/2025 at 12:32 PM, the Administrator said they did not have any competency checks for the nurses and medication aides, so they would not be able to produce them. During an interview on 04/24/2025 at 12:39 PM, the Administrator said they had not completed any competency checks for the nurses and medication aides through their current company, and he did not have a file with them from the previous company. The Administrator said he took responsibility for not having the competency checks. The Administrator said the competency checks were necessary to ensure the staff was competent. During an interview on 04/24/2025 at 1:00 PM, the DON said nursing administration was responsible for ensuring the competency checks for the nurses and medication aides were completed. The DON said competency checks were completed with the previous company, but they did not have them. The DON said the medication pass audit completed by the pharmacist was the facility's competency check for the medication aides because who better to do it than the pharmacist. The DON said if the competency checks were not completed, they could not say the staff performed skills correctly. The DON said competency checks were supposed to be completed as needed and upon hire. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a Medication Pass Audit for MA F, completed by the pharmacist, dated 01/23/2024 indicated, she did not administer medications in accordance with current physician orders, did not check each medication package against the MAR before administering medications to the resident, and did not ensure the medication cart was locked while she was in the room. She did check blood pressure prior to medication administration when appropriate, and she charted administration of medications or charted held or refused meds immediately after medication administration. Record review of a Medication Pass Audit for MA G, completed by the pharmacist, dated 03/22/2024 indicated, she administered medications in accordance with current physician orders, blood pressure was taken prior to medication administration when appropriate, the medication cart was locked at all times, and she charted administration of medications or charted held or refused meds immediately after medication administration. Record review of the facility's policy, Staffing, Sufficient and Competent Nursing, revised August 2022, indicated, Our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment .1. Competency is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully. 2. All nursing staff must meet the specific competency requirements of their respective licensure and certification requirements defined by state law. 3. Staff must demonstrate the skills and techniques necessary to care for resident needs including (but not limited to) the following areas . j. Medication management . Competency requirements and training for nursing staff are established and monitored by nursing leadership. Record review of the Facility Assessment, dated 01/15/2025, indicated, .Staff Competency . competency demonstrations, certifications, educational and training requirements, etc., are reviewed/verified, as appropriate, at the time of hire, before position changes, annually, and/or as needed. We measure staff competence through knowledge, skills, abilities, behaviors, and other characteristics that staff need to perform work roles or occupational functions successfully as determined by the care needs of our resident population. Documentation of these reviews are maintained as part of our facility's employment history records .

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. 46892 Based on observation, interview, and record review the facility failed to post the daily nurse staffing information with the current date, resident census, and numbers of staff actual hours worked at the beginning of each shift for 1 of 1 facility reviewed for nurse staffing. The facility failed to update and post the daily nurse staffing information from 04/20/2025-04/24/2025. This failure could affect residents, their families, and facility visitors by placing them at risk of not having access to information regarding the numbers of staff caring for the residents each shift and the facility census. The findings included: During an observation and interview on 04/24/2025 at 11:32 AM, the daily staffing posting was hanging at the nurse's station, and it was dated 04/19/2025. LVN D said the daily staffing was completed by the night shift nurse. LVN D said the daily staffing posting should be completed daily so that everyone knew how much staff was supposed to be in the facility to care for the residents. During an interview on 04/24/2025 at 11:42 AM, the DON said the night shift nurses completed the daily staffing posting. The DON said the ADON usually checked to ensure the daily staffing was posted. The DON said the daily staffing should be posted to keep up with the number of staff in the building. During an interview on 04/24/2025 at 11:44 AM, the ADON said the night shift nurse was responsible for completing the daily staffing posting. The ADON said she presumed it was not completed since 04/19/2025 because they had a temporary nurse working at night. The ADON said she normally checked it. The ADON said the daily staffing should be posted so anybody that went to the facility, including the nurses and visitors, knew the census and the staffing hours. During an attempted interview on 04/24/2025 at 11:55 AM, LVN M, night shift nurse, did not answer the phone. During an attempted interview on 04/24/2025 at 11:57 AM, LVN N, night shift nurse, did not answer the phone. Record review of the facility's policy titled, Staffing, Sufficient and Competent Nursing, revised August 2022, indicated, .Direct care daily staffing numbers (the number of nursing personnel responsible for providing direct care to residents) are posted in the facility for every shift .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on observation, interview and record review, the facility failed to establish a system of receipt and disposition of all controlled drugs in sufficient detail to enable accurate reconciliation and determine that drug records were in order and that an account of all controlled drugs were maintained and periodically reconciled for 1 of 21 residents (Resident #8) reviewed for pharmacy services. The facility failed to ensure MA F accurately reconciled Resident #8's narcotic medication log when she administered Resident #8's acetaminophen-codeine (controlled medication used for pain) tablet on 04/22/25. This failure could place residents at risk for loss of prescribed medications, resident's safety, and drug diversion. Findings included: Record review of Resident #8's face sheet dated 04/23/25, indicated an [AGE] year-old female who initially admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), diabetes (a group of diseases that result in too much sugar in the blood), and heart failure (a chronic condition in which the heart doesn't pump blood as well as it should). Record review of Resident #8's quarterly MDS assessment dated [DATE], indicated she was able to make herself understood and understood others. Resident #8 had a BIMS score of 15, which indicated her cognition was intact. Resident #8 occasionally had pain and received scheduled pain medication. The MDS assessment indicated Resident #8 was taking an opioid (a class of drug used to reduce pain) medication. Record review of Resident #8's comprehensive care plan dated 11/12/24, indicated Resident #8 had acute pain with interventions to administer medications and evaluate pain. Record review of Resident #8's order summary report dated 04/23/25, indicated Resident #8 had an order for acetaminophen-codeine 300mg-60mg tablet give one tablet by mouth four times a day for pain with an order date of 10/02/24. Record review of Resident #8's medication administration record dated 04/01/25-04/30/25, indicated she had received one tablet of acetaminophen-codeine 300mg-60mg four times a day . The MAR indicated Resident #8 received one tablet of acetaminophen-codeine 300mg-60mg at 09:00 AM on 04/22/25. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an observation and interview on 04/22/25 at 09:21 AM, MA F prepared Resident #8's morning medication. MA F opened the narcotic box located on the medication cart and removed one tablet of acetaminophen-codeine 300mg-60mg tablet from the medication cart and added it to the medicine cup. MA F proceeded to administer Resident #8's medications. MA F failed to document the administration of the acetaminophen-codeine 300mg-60mg tablet on Resident #8's narcotic record. MA F said the correct process when administering a narcotic medication was to sign the narcotic record when the medication was administered. MA F said she was nervous because she was being observed by the surveyor, so she forgot to sign the narcotic record. MA F said a miscount could occur for not signing the narcotic record when the medication was given. MA F said she was responsible for ensuring the narcotic medications were reconciled. During an interview on 04/24/25 at 09:03 AM, the DON said she expected the narcotic record to be signed off as soon as a narcotic medication was administered. The DON said failure to document the narcotic medication could cause a discrepancy. The DON said the person administering the medications was responsible for documenting when a narcotic medication was administered and removed from the narcotic card. During an interview on 04/24/25 at 09:58 AM, the Administrator said he expected the narcotic record to be signed after the resident took the medication. He said by not signing off the narcotic record when the medication was administered could cause the count to be off. The Administrator said the person administering the medications was responsible for documenting when a narcotic medication was administered. Record review of the facility's policy Documentation of Medication administration revised November 2022, indicated . A medication administration record is used to document all medications administered . 2. Administration of medication is documented immediately after it is given . Record review of the facility's policy Controlled Substances revised April 2019, indicated . The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications . 8. Controlled substances are reconciled upon receipt, administration, disposition, and at the end of each shift . 10. Upon Administration: a. The nurse administering the medication is responsible for recording: (1) Name of the resident receiving the medication; (2) Name, strength and dose of the medication; (3) Time of administration; (4) Method of administration; (5) Quantity of the medication remaining; and (6) Signature of nurse administering medication .

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on interview and record review the facility failed to ensure that residents were free of significant medication errors for 3 of 10 residents reviewed for pharmacy services. (Resident #'s 23, 31 and 41) 1. The facility failed to ensure Resident #41's metoprolol (blood pressure medication) was not administered when her blood pressure was outside of the ordered parameters on 04/13/2025, 04/16/2025, and 04/21/2025. 2. The facility failed to ensure MA G and MA F did not administer Resident #23's metoprolol (blood pressure medication) on 04/07/2025 and 04/20/2025, when her blood pressure was not within the required parameters per the physician's order. 3. The facility failed to ensure MA F did not administer Resident #31's metoprolol (blood pressure medication) on 04/02/2025, 04/08/2025, and 04/20/2025, when his blood pressure was not within the required parameters per the physician's order. These failures could place the resident at risk of medical complications and not receiving the therapeutic effects of their medications. Findings included: 1. Record review of Resident #41's face sheet dated 04/23/25, indicated a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included cerebral palsy (a congenital disorder of movement, muscle tone, or posture), epilepsy (seizures), hypertension (high blood pressure), and gastrostomy status (surgical opening in stomach to provide nutrition and medications). Record review of Resident #41's quarterly MDS assessment dated [DATE], indicated Resident #41 was usually understood and usually understood others. Resident #41 had a BIMS score of 2, which indicated her cognition was severely impaired. The MDS indicated Resident #41 had an active diagnosis of hypertension. Record review of Resident #41's comprehensive care plan dated 01/13/25, indicated Resident #41 had hypertension. The care plan interventions indicated to give antihypertensive medications as ordered. Record review of Resident #41's order summary report dated 04/24/25, indicated she had an order for metoprolol tartrate 100mg give one tablet enterally one time a day related to hypertension with a start date of 01/01/25. The order indicated to hold if SBP was less than 110 or DBP was less than 65. Record review of Resident #41's Nursing MAR dated 04/01/25-04/30/25, indicated Resident #41 had an order for metoprolol 100mg tablet give one tablet in the morning with instructions to hold for SBP less than 110 or DBP less than 65. o On 04/13/25 at 08:00 AM, Resident #41's blood pressure was 104/72. The MAR had a check mark which indicated Resident #41 was administered a metoprolol 100 mg tablet outside the parameters by LVN C. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	o On 04/16/25 at 08:00 AM, Resident #41's blood pressure was 97/59. The MAR had a check mark which indicated Resident #41 was administered a metoprolol 100 mg tablet outside the parameters by LVN C. o On 04/21/25 at 08:00 AM, Resident #41's blood pressure was 106/81. The MAR had a check mark which indicated Resident #41 was administered a metoprolol 100 mg tablet outside the parameters by LVN C. During an interview on 04/22/25 at 3:41 PM, LVN C said a check mark on the medication administration record indicated the medication was administered. LVN C reviewed Resident #41's MAR and said Resident #41's received the metoprolol tablet on 04/13/25, 04/16/25, and 04/21/25 when her blood pressure was outside of the ordered parameters. LVN C said failure to hold her blood pressure medication placed Resident #41 at risk for her blood pressure dropping. LVN C said according to Resident #41's parameters the metoprolol should have been held. LVN C said it was the nurse's responsibility to ensure medications were being administered as per the physician's orders. LVN C said she had been checked off on medication administration competency. 46892 2. Record review of a face sheet dated 04/23/2025 indicated Resident #23 was an [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included chronic obstructive pulmonary disease (chronic inflammatory lung disease that causes obstructed airflow from the lungs), heart failure (chronic, progressive condition in which the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen), and essential primary hypertension (high blood pressure). Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #23 was understood by others and understood others. The MDS assessment indicated Resident #23 had a BIMS score of 15, which indicated her cognition was intact. Record review of Resident #23's care plan with a target date of 11/17/2024 indicated she had hypertension, and the goal was for her blood pressure to be within normal limits with an intervention to evaluate blood pressure. Record review of Resident #23's Order Summary Report dated 04/23/2025 indicated, she had an order for metoprolol tartrate 25 mg give 0.5 tablet by mouth two times a day for hypertension hold for systolic blood pressure less than 110 and diastolic blood pressure less than 60 with a start date of 10/26/2024. Record review of Resident #23's April 2025 MAR indicated metoprolol tartrate 25 mg give 0.5 tablet by mouth two times a day hold for systolic blood pressure less than 110 and diastolic blood pressure less than 60. On 04/07/2025 Resident #23's blood pressure was 104/59, the MAR indicated Resident #23's metoprolol was documented as administered by MA G. On 04/20/2025 Resident #23's blood pressure was 106/74, the MAR indicated Resident #23's metoprolol was documented as administered by MA F. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Record review of a face sheet dated 04/23/2025 indicated Resident #31 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included end stage heart failure (heart's ability to pump blood effectively is severely impaired, leading to progressive symptoms and a reduced quality of life) and essential primary hypertension (high blood pressure). Record review of Resident #31's Quarterly MDS assessment dated [DATE] indicated, he was understood by others and understood others. The MDS assessment indicated Resident #31 had a BIMS score of 15, which indicated her cognition was intact. Record review of Resident #31's care plan revised 04/11/2025, indicated he was at risk for decreased cardiac output related to a diagnosis of hypertension with a goal for his blood pressure would be within normal limits and an intervention to evaluate his blood pressure. Record review of Resident #31's Order Summary Report dated 04/23/2025 indicated, he had an order for metoprolol tartrate 25 mg give 0.5 tablet by mouth two times a day for hypertension hold for systolic blood pressure less than 110 and diastolic blood pressure less than 60 with a start date of 10/17/2024. Record review of Resident #31's April 2025 MAR indicated metoprolol tartrate 25 mg give 0.5 tablet by mouth hold for systolic blood pressure less than 110 and diastolic blood pressure less than 60. On 04/02/2025 Resident #31's blood pressure was 109/62, the MAR indicated Resident #31's metoprolol was documented as administered by MA F. On 04/08/2025 Resident #31's blood pressure was 101/63, the MAR indicated Resident #31's metoprolol was documented as administered by MA F. On 04/20/2025 Resident #31's blood pressure was 104/64, the MAR indicated Resident #31's metoprolol was documented as administered by MA F. During an interview on 04/22/2025 at 1:34 PM, MA F said blood pressure medication should be held for blood pressure less than 100/60. MA F said she was not sure if she had administered Resident #23's and Resident #31's blood pressure medications when their blood pressure was out of parameters, but she thought she had not. MA F said when a medication was documented as administered on the MAR it indicated it was administered. MA F said if the medication was held the medication would not be documented as administered. MA F said giving a blood pressure medication when the blood pressure was not within parameters could result in heart failure and death. During an attempted phone interview on 04/22/2025 at 2:00 PM, MA G did not answer the phone. During an attempted phone interview on 04/23/2025 at 3:28 PM, MA G did not answer the phone. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/24/2025 at 10:14 AM, the DON said the nurse or medication aide should be checking the parameters of blood pressure medications when they administered them. The DON said correct administration of medications was being monitored by competency check offs and if they were notified of an issue, they conducted another check off. The DON said the ADON and herself reviewed the MARs and they had not noticed any discrepancies. The DON said it was hard for them to review the MARs, when they had to work the floor. The DON said if blood pressure medication was administered with the blood pressure being too low it could lower the blood pressure, but she could not speculate on what could happen to the residents. During an interview on 04/24/2025 at 10:20 AM, the ADON said when she reviewed the MARs, she had noticed some medications not documented as administered, but as far as the medications being administered with the blood pressure out of parameters, she had not noticed any issues. The ADON said if a resident received blood pressure medication when their blood pressure was low, their blood pressure could be lowered more, and they could pass out from the low blood pressure or fall. During an interview on 04/24/2025 at 10:44 AM, the Administrator said if a resident's blood pressure was out of parameters, he expected the staff to re-check the residents blood pressure. The Administrator said the nurses and medication aides were responsible for ensuring the residents' blood pressures were within parameters before administering blood pressure medications to them. The Administrator said if they noticed there was an issue with medication administrator nursing and himself were responsible for ensuring the medication aides and nurses were doing their job appropriately. The Administrator said to his knowledge there was not an accountability system in place for monitoring that the residents were receiving medications appropriately. The Administrator said if you were giving medications that were designed for a specific purpose and it was outside of the parameters it could have a negative impact on a person's health. Record review of a Medication Pass Audit for MA F, completed by the pharmacist, dated 01/23/2024 indicated, she did not administer medications in accordance with current physician orders and did not check each medication package against the MAR before administering medications to the resident. She did check blood pressure prior to medication administration when appropriate, and she charted administration of medications or charted held or refused meds immediately after medication administration. Record review of a Medication Pass Audit for MA G, completed by the pharmacist, dated 03/22/2024 indicated, she administered medications in accordance with current physician orders, blood pressure was taken prior to medication administration when appropriate, and she charted administration of medications or charted held or refused meds immediately after medication administration. Record review of the facility's policy Medication and Treatment Orders revised July 2016, indicated . Orders for medications and treatments will be consistent with principles of safe and effective order writing.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47612 Based on observations, interviews, and record review the facility failed to ensure that all drugs and biologicals used in the facility were labeled and stored in accordance with professional standards for 2 of 21 residents (Resident #'s 55 and 10), 1 of 5 medication carts (200 hall medication cart), and 1 of 1 medication storage rooms reviewed for drugs and biologicals. 1. The facility did not ensure Resident #55's Rexall (pain/ fever relief), Purzee (sleep supplement), and Melatonin (sleep aid) were properly safe and secured on 04/23/2025. 2. The facility failed to ensure a lock box in the Medication Room refrigerator with 2 bottles of Lorazepam (controlled medication for anxiety) was permanently affixed. 3. The facility failed to ensure Resident #10's clobetasol cream (used to reduce swelling, redness, itching, and rashes caused by skin conditions) was properly secured and not left on his nightstand on 04/21/25 and 04/22/25. 4. The facility failed to ensure MA G secured the 200 hall Medication Cart when she left it unattended on 04/21/25. 5. The facility failed to ensure MA F secured the 200 hall Medication Cart when she turned away from it on 04/22/25. These failures could place residents at risk of not receiving drugs and biologicals as needed, medication errors, medication misuse, and drug diversion. Findings included: 1.Record review of Resident #55's face sheet dated 04/23/2025, revealed Resident # 55 was an [AGE] year-old male who admitted on [DATE] with the diagnoses of metabolic encephalopathy (a brain dysfunction caused by underlying metabolic disorders or conditions that disrupt the brain's energy supply or chemical balance), type 2 diabetes mellitus with hyperglycemia (a person diagnosed with type 2 diabetes has persistently high blood sugar levels), essential (primary) hypertension (the most common type of high blood pressure). Record review of Resident #55's comprehensive MDS assessment dated [DATE] indicated Resident #55 understood and could make herself understood by others. Resident #55 had a BIMS of 13 which indicated cognitive function intact. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #55's care plan dated 03/25/2025 indicated Resident #55's Goal: would be free of pain and discomfort. Interventions: elevate pain, utilize non-medication intervention for pain relief. Focus: risk for insomnia. Goal: resident will achieve and maintain a consistent sleep pattern. Interventions: establish bedtime routine with resident, evaluate for history of sleep-disordered breathing (periods of apnea, prior Use of CPAP/BiPAP), evaluate for respiratory distress when lying flat or while sleeping, evaluate medication schedule and possible pharmacologic causes of insomnia. During an observation and interview on 04/23/2025 at 9:34 a.m., revealed a bottle of Rexall, Purzee and Melatonin were on Resident #55's bedside table. Resident #55 stated a family member brought him the medication to take when he needed help sleeping. Record review of the order summary report dated 04/23/2025 did not address the use of Rexall (pain/ fever relief), Purzee (sleep supplement), and Melatonin. During an interview on 04/23/2025 at 11:40 a.m., MA F stated she saw the medication on the bedside table on 04/22/2025 and told LVN C. MA F stated the resident should not have medication at the bedside. MA F stated it was important for the resident to not have the medication because he could take too much or take it at any time. MA F stated the failure was the resident could take too much medication or another resident could take the medication. During an attempted interview on 04/23/2025 at 2:15 p.m., the surveyor attempted to contact LVN C by phone. During an interview on 04/23/2025 at 4:16 p.m., LVN D stated she did not know Resident #55 had medication on his bedside table. LVN D went into Resident #55's room and removed the medication. LVND stated it was important to know what the resident was taking so he did not overdose or have a adverse reaction. LVN D stated the failure was his roommate could have taken the medication. 2.During an observation of the Medication Room and interview with the DON on 04/23/2025 at 3:53 p.m., revealed a lock box was in the medication refrigerator. The DON took the clear plastic lock box out of the refrigerator, and there were 2 bottles of Lorazepam inside the lock box. The lock box was not affixed to the refrigerator. The DON stated she thought they had it locked correctly. The DON stated it was her and the charge nurse's responsibility to make sure the narcotic was locked. The DON stated it was important to make sure the narcotics were lock because they were controlled substance and did not want a drug diversion. The DON stated the failure was the narcotics could be taken just like any other medication could be. During an interview on 04/24/2025 at 10:00 a.m., the DON stated she did not know the narcotic lock box had to be affixed to the refrigerator. The DON stated it was her and responsibility to ensure the lock box was affixed to the refrigerator. The DON stated the failure was a possible drug diversion. During an interview on 05/24/2025 at 10:46 a.m., the Administrator stated lock boxes containing controlled medications should be affixed. The Administrator stated the DON was responsible for ensuring the lock boxes were affixed. The Administrator stated it was important for the lock boxes with controlled medications to be affixed so they were not removed easily from the facility or that room because they were a controlled substance. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	46928 3. Record review of Resident #10's face sheet dated 04/23/25, indicated a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included cerebral infarction (stroke), hypertension (high blood pressure), right upper arm muscle wasting and atrophy (loss of muscle mass and strength), and right-hand contracture. Record review of Resident #10's quarterly MDS assessment dated [DATE], indicated he was sometimes understood and sometimes understood others. Resident #10 had short term/long term memory problems and his cognition was severely impaired. Record review of Resident #10's comprehensive care plan dated 11/11/24, indicated Resident #10 was at risk for impaired skin integrity. The care plan interventions included to evaluate skin areas for blanching or redness and provide skin care per facility guidelines. Record review of Resident #10's order summary report dated 04/23/25, indicated he had an order for clobetasol cream 0.05% apply to dry patchy areas of skin topically as needed with a start date of 09/18/24. Record review of Resident #10's treatment administration record dated 04/01/25-04/30/25, indicated Resident #10 had an order for clobetasol cream 0.5% apply to dry, patchy areas of skin topically as needed. The treatment administration record indicated Resident #10 had only received the clobetasol cream on 04/09/25. During an observation on 04/21/25 at 09:47 AM, revealed Resident #10 had a Clobetasol propionate cream on his nightstand. During an observation on 04/21/25 at 1:42 PM, revealed Resident #10 continued to have the Clobetasol propionate cream on his nightstand. During an observation on 04/22/25 at 08:34 AM, revealed Resident #10 continued to have the Clobetasol propionate cream on his nightstand. During an observation on 04/22/25 at 2:20 PM, revealed Resident #10 continued to have the Clobetasol propionate cream on his nightstand. During an interview on 04/22/25 at 2:48 PM, LVN C said Resident #10 should not have medications at bedside because the resident or another resident could get ahold of it. LVN C said anyone who cared for the resident was responsible for ensuring the medications were properly secured. 4. During an observation on 04/21/25 at 10:08 AM revealed the 200-hall medication cart was unattended and unlocked. Staff and residents were noted to be walking next to the unlocked medication cart. MA G exited a resident's room and said she should not have left the medication cart unlocked. MA G said she forgot to lock the medication cart because she was in a hurry to administer the resident her medication. MA G said someone could get medication out of the unlocked medication cart. MA G said it was her responsibility in ensuring the medication carts were locked when leaving them unattended. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During an observation interview on 04/22/25 at 09:21 AM, revealed MA F went into a resident's room to administer her routine medications. MA F left the 200-hall medication cart unlocked with the keys attached to the narcotic drawer. MA F turned her back to the cart. MA F said she thought it was okay to leave the cart unlocked if it was facing the room. MA F said she should not have left the keys attached to cart because someone could get into it. MA F said it was her responsibility to ensure the cart was locked when turning her back to it and keeping the keys in her possession. During an interview on 4/23/25 at 2:17 PM, LVN D said the keys should not be left on the cart or the cart unlocked when going in a resident's room because it not was not within the view of the person responsible for the medication carts. LVN D said anyone passing by could get into the cart and obtain medication. LVN D said the person administering the medications was responsible for ensuring the cart was kept locked and the keys in their possession. During an interview on 04/24/24 at 09:03 AM, the DON said she expected medication carts to be to be locked when stepping away and medications to be properly secured. The DON said there was a potential for a drug diversion or someone getting in the medication cart by not locking the medication cart. The DON said there should not have been medications at bedside unless the residents were able to safely administer their medications. She said she currently did not have any residents at the facility that were deemed safe to administer their own medications. The DON said by not properly securing medications placed the residents at risk for potentially taking the medication. The DON said it was the medication aide and nurse's responsibility in ensuring the carts were locked and medications were properly stored. During an interview on 04/24/25 at 09:58 AM, the Administrator said he expected medication carts to be to be locked when stepping away and for medications to be properly secured. He said failure to lock the medication carts was a potential for someone to get into the cart and obtain something that did not belong to them. He said by not properly securing medications could place the residents at risk for potentially taking the medication without appropriate orders. The Administrator said it was the medication aide and nurses' responsibility in ensuring the carts were locked and medications were properly stored. Record review of the facility's policy Storage of Medications revised November 2020, indicated . The facility stores all drugs and biologicals in a safe, secure, and orderly manner . 1. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. Only persons authorized to prepare and administer medications have access to locked medications . 6. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals are locked when not in use. Unlocked medication carts are not left unattended . Record review of the facility's policy titled, Controlled Substance, revised 11/2022 indicated Controlled Substance are separately locked in a permanently affixed compartment

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 47708 Based on observations, interviews, and record review, the facility failed to provide food that was palatable, attractive, and at a safe and appetizing temperature for 1 of 3 meals reviewed for palatability, attractiveness, and appetizing. The dietary staff failed to provide food that was palatable for 1 of 3 meals observed on 4/22/2025 (lunch) meal. The failure could place residents at risk of decreased food intake, hunger, and unwanted weight loss. The findings included: Record review of the menu indicated the lunch meal items on 4/22/2025 included chicken enchiladas, Spanish rice, refried beans, and churro bites. During an interview on 04/21/2025 beginning at 09:39 a.m., Resident # 29 stated sometimes the food was good and sometimes the food was bad. Resident #29 stated the food was a hit and miss. During an interview on 04/21/25 at 12:05 p.m., Resident #26 stated the food was not good. Resident #26 stated the food was not good because of the taste and sometimes she received the food cold. During an interview on 04/21/25 at 09:46 a.m., Resident #56 stated his eggs were cold most of the time. During a confidential group meeting on 04/22/2025 beginning at 10:30 AM, the resident group said the food had a lot of herbs and the food was cold. During an observation and tasting of the lunch meal on 4/22/2025 at 12:20 p.m., the Dietary Manager stated the chicken enchiladas were good in flavor; the Spanish rice was bland and not hot, but lukewarm; the refried beans had a good temp; and the churros were bland tasting. The Dietary Manager stated she was not sure how the churros were supposed to taste. During observation and tasting of lunch meal on 4/22/25 at 12:20 p.m., five Surveyors stated the chicken enchiladas were good in flavor; the Spanish rice was bland and not hot; the refried beans had a good temp; the churros were bland tasting and did not have the cinnamon sugar taste. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/23/25 at 2:22 p.m., the dietary manager stated she had been the dietary manager for 2 years. The Dietary Manager stated she oversaw the dietary staff at the facility. The Dietary Manager stated the Administrator was her manager. The Dietary Manager stated she tasted the foods in the kitchen once a week. The Dietary Manager stated she made sure staff were following the recipe book by making sure staff looked at the recipe book so that staff knew what ingredients to use. The Dietary Manager stated staff was last in-service on the recipe book on 3/10/25. The Dietary Manager stated she handled food complaints from the residents by talking to the residents that complained about the food and addressing the food complaints while also letting the residents know that it would not happen again. The Dietary Manager stated it was important that food was palatable, attractive, and appetizing to the residents for the residents health. Record review of the Dietary staff in-services indicated following the recipe in-service was last completed on 3/10/25. During an interview on 4/24/25 at 8:44 a.m., the Administrator stated he had been employed at the facility since 8/1/22. The Administrator stated he oversaw the Dietary Manager. The Administrator stated yes, he tried to order test trays a few times a month but would love to order a test tray a few times a week, but he got busy. The Administrator stated the residents did complain about the food at the facility. The Administrator stated food complaints were handled as such by offering alternative meals to the residents. The Administrator stated, I got as many food complaints as I got for raises at the facility. The Administrator stated, You can never please everyone when it comes to food; the facility has the best food. The Administrator stated he did not know when the in-services on the following the recipe book had been last completed. The Administrator stated the Dietary Manager conducted rounds every month and she did the in-services monthly with the dietary staff. A policy on following the recipes was not received prior to exit on 4/24/25 at 8:44 a.m.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47708 Based on observation, interview, and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety in (1 of 1) kitchen and 1 of 4 halls (Hall 400) reviewed for dietary services, in that: 1) The dietary staff failed to label and date all food items. 2) The dietary staff failed to discard expired food items. 3)CNA A did not sanitize her hands in between passing meal trays on the 400 hall. These failures could place residents at risk for food contamination and foodborne illness. The findings included: During an observation of Freezer #1 with the Dietary Manager on [DATE] at 9:02 a.m., the following was observed: -(1) container of cranberry juice had no prep date and had a use by date of [DATE]. -(1) 5-pound container of sour cream had an open date of [DATE] and expiration date of [DATE]. - (1) ,d+[DATE]-quart container of orange juice was not labeled and had no preparation date or expiration date. - (1) container of Kool aide had a no preparation date and had an expiration date of [DATE]. - (1) container of unsweet tea had no preparation date and had an expiration date of [DATE]. -(1) package of salami lunch meat had an open date of [DATE] and an expiration date of [DATE]. During an observation of the dry storage area with the Dietary Manager on [DATE] at 9:17 a.m., the following was observed: -(1) 5 liters of rotini pasta was not labeled and had no open date and no expiration date. During an observation of the kitchen area with the Dietary Manager on [DATE] at 9:21 a.m., the following was observed: -(1) 4.25 ounce of cilantro had an open date of [DATE] and an expiration date of [DATE]. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 2:34 p.m., the Dietary Manager stated she had been the Dietary Manager for 2 years. The Dietary Manager stated she oversaw the dietary staff at the facility. The Dietary Manager stated the Administrator oversaw her at the facility. The Dietary Manager stated all food items in the refrigerator were to be labeled, dated with the receive date, open date and expiration date. The Dietary Manager stated staff completed in-services on labeling and dating all food items on [DATE]. The Administrator stated she conducted a daily walk through in the kitchen. The Dietary Manager stated the Administrator conducted weekly walk throughs in the kitchen. The Dietary Manager stated it was important to ensure staff were labeling, dating and discarding expired refrigerator and kitchen food items to make sure food was within reasonable date so that the food would not cause any danger to the residents like salmonella. During an interview on [DATE] at 8:48 a.m., the Administrator stated he had been employed at the facility since [DATE]. The Administrator stated he oversaw the Dietary Manager. The Administrator stated all food items in the refrigerator were to be labeled, dated with receive date, open date and expiration date. The Administrator stated in-services on labeling, dating, and discarding expired food items was last completed this week. The Administrator stated he conducted walk throughs in the kitchen once a week at least and most of the week was more than one time a week. The Administrator stated he was made aware of expired food item food in the kitchen from the Dietary Manager this week. The Administrator stated he did expect the Dietary Manager to report issues found in the kitchen to him. The Administrator stated, It was important to ensure staff were labeling, dating and discarding expired refrigerator and frozen food items because we can't give expired food products in our recipe and cannot give expired food to the residents. Record Review of the Dietary staff in-services indicated following the food labeling and dating in-service was last completed on [DATE]. 2)During an interview and observation on [DATE] at 12:15 p.m., revealed CNA A did not sanitize between passing meal trays on the 400 hall. CNA A stated she had the hand sanitizer in her pocket and had forgot to sanitize her hands in between passing the meal trays on the 400 hall. During a phone interview on [DATE] at 2:15p.m., CNA A stated she had been employed at the facility for [AGE] years. CNA A stated her job title was CNA. CNA A stated she worked the 6 a.m. to 2 p.m. shift at the facility. CNA A stated she completed hand washing in-services a few weeks ago, maybe a month ago. CNA A stated the facility went over hand washing very frequently. CNA A stated she was supposed to sanitize her hands in between passing out the meal trays. CNA A stated her nerves was the reason she did not hand sanitize her hands in between passing meal trays. CNA A stated she kept a bottle of hand sanitizer in her pockets. CNA A stated the charge nurse oversaw her. CNA A stated it was important to ensure she was sanitizing her hands in between passing meal trays for infection control. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 2:38 p.m. LVN B stated she oversaw CNA A when she worked the floor. LVN B stated she worked the 6 a.m. to 6 p.m. shift. LVN B stated she had been employed at the facility for 2 years. LVN B stated she was not made aware of CNA A not sanitizing her hands in between passing the meal trays. LVN B stated staff were to sanitize their hands in between passing meal trays. LVN B stated she did not remember when the last in-service was last completed on hand hygiene. LVN B stated the DON oversaw her. LVN B stated she ensured staff sanitized their hands by making sure hand sanitation was available and by reminding staff to use the hand sanitation. LVN B stated it was important to ensure staff was sanitizing their hands in between passing meal trays because of infection control and to prevent cross contamination. During an interview on [DATE] at 8:34 a.m., the DON stated she oversaw the nurses at the facility. The DON stated she had been employed at the facility since [DATE]. The DON stated she was made aware of CNA A not sanitizing her hands in between passing meals on the 400 hall until the surveyor had told her. The DON stated staff were to sanitize their hands in between passing meal trays. The DON stated she did not know when the last in-service on hand sanitation was last completed by all staff at the facility. The DON stated CNA A was in-serviced on hand sanitation on the same day she was made aware of this incident. The DON stated the Administrator oversaw her at the facility. The DON stated she ensured staff were sanitizing their hands in between passing meal trays by completing in-services and monitoring the dining room. The DON stated it was important to ensure staff were sanitizing their hands in between passing meal trays for safety of the resident. During an interview on [DATE] at 8:41 a.m., the Administrator stated he oversaw the DON. The Administrator stated he had been employed at the facility since [DATE]. The Administrator stated he was made aware by the DON of CNA A not sanitizing her hands in between passing meals on the 400 hall on [DATE]. The Administrator stated staff were to sanitize their hands in between passing meal trays. The Administrator stated he did not know when the last in-service on hand sanitation was completed. The Administrator stated, He ensured staff were sanitizing their hands in between passing meal trays because that's our protocol; I expect them to follow protocol. The Administrator stated it was important to ensure staff were sanitizing their hands in between passing meal trays to prevent cross contamination and infection control. Record review of hand hygiene policy dated [DATE] indicated, Policy Statement: I. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections; 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infec tions to other personnel, residents, and visitors; 3. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc.) shall be readily accessible and convenient for staff use to encourage compliance with hand hygiene policies. Record review of food receiving, and storage policy revised dated on ,d+[DATE] indicated, (1) All foods stored in the refrigerator or freezer are covered, labeled and dated (use by date). Record Review of food policy dated [DATE] indicated, Refrigerators: (a). All refrigerated foods are stored per state and federal guidelines; (e) All refrigerated foods are dated, labeled and tightly sealed, including leftovers, using clean, nonabsorbent, covered containers that are approved for food storage. All leftovers are used within 48 hours. Items that are over 48 hours old are discarded.

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	675755	A. Building B. Wing	04/24/2025

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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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892 Based on interviews and record review, the facility failed to conduct and document a facility-wide assessment to determine what resources were necessary to care for its residents competently during both day-to-day operations and emergencies for 1 of 1 facility reviewed for facility assessment. The facility failed to ensure the daily staffing needs were followed according to the facility assessment. This failure could place residents at risk of inadequate care or treatment and a decreased quality of life. Findings included: During a confidential group meeting on 04/22/2025 at 10:30 AM, the group reported getting bed baths instead of showers, call lights not being answered timely, and the CNAs telling them they were short staffed so if they did not respond to a call light timely or were taking too long to assist them that was the reason why they were taking so long. The group reported it made them feel like they should not request assistance from the CNAs. During an interview Anonymous Staff Member #1 said the CNAs often did not show up to work, and the on-call nurse and head CNA tried to fill in. Anonymous Staff Member #1 said when the CNAs did not show up to work, they were not always replaced. Anonymous Staff Member #1 said they worked shorthanded frequently. Anonymous Staff Member #1 said for sure on Sunday, 04/20/2025, they were short CNAs on the 2 PM- 10 PM shift. Anonymous Staff Member #1 said they had been at the facility until 6 PM and nobody from management showed up to assist due to the staffing shortage. Anonymous Staff Member #1 said the DON and RN K were notified of the CNA shortage on 04/20/2025. Anonymous Staff Member #1 said management was aware they had been having to work short. Anonymous Staff Member #1 said management rarely helped to cover the CNAs, if management worked, they were covering a nurse position so they could not do the CNAs job. Anonymous Staff Member #1 said lately they had been working short a lot. Anonymous Staff Member #1 said not having enough staff to provide care to the residents could affect their care because they would not get toileted on tie or they would have to wait long periods of times to be changes, and this could result in an increased risk for skin breakdown. During an interview Anonymous Staff Member #2 said they were short CNAs almost every day. Anonymous Staff Member #2 said nurse management did not help to cover the CNAs when a CNA did not show up to work. Anonymous Staff Member #2 said when a CNA that was scheduled to work did not show up, management told them they had to work with what they had. Anonymous Staff Member #2 said not having enough staff could affect the residents because they would not get the care they deserved. (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview, Anonymous Staff Member #3 said they had been short CNAs and management told them they were trying to get help, but they never did. Anonymous Staff Member #3 said when they were short CNAs, they were not able to provide all the showers, and they had to clean the residents with towels instead. Anonymous Staff Member #3 said management did not help when they were short staffed. Anonymous Staff Member #3 said the weekend RN supervisor did not help the CNAs when they were short. Anonymous Staff Member #3 said the nurses and the medication aides did not help the CNAs when they were short. Anonymous Staff Member #3 said not having enough staff could affect the residents because they would not receive the care they needed. During an interview on 04/23/2025 at 3:33 PM, RN K said she was the weekend RN supervisor. RN K said if the CNAs did not show up to work or called off, they tried to find someone to fill the position and she notified the ADON or the DON. RN K said they were not always able to fill the position and they try to pitch in together and take care of the residents. RN K said on 04/20/2025 she was told as she was going out of the door that one of the CNAs had called off. RN K said she was told that it had been covered, but she did not remember who told her. RN K said if there was not enough staff the residents would not receive the proper care that they should be getting. During an interview on 04/23/2025 at 3:57 PM, LVN L said sometimes they were short, and they tried to call in other staff members, notified the ADON and DON, and if it was the weekend they notified the weekend RN. LVN L said sometimes they were told to do the best they could. LVN L said recently they had started using agency staff to fill in. LVN L said if they did not have enough staff, it could affect the residents because they would not receive proper/timely care. During an interview on 04/24/2025 at 10:34 AM, the DON said if the staff called off nurse management worked or got somebody to work. The DON said they all together worked to take care of the residents. The DON said there were a lot of times that they had not been able to fill the gaps. The DON said the staff had told her that they were unable to complete all their daily tasks. The DON said on 04/17/2025 they started using a staffing agency to help with the staffing shortage. The DON said she could not replace somebody when they called off last minute. The DON said not having enough staff placed the residents at risk of their care not being provided efficiently. During an interview on 04/24/2025 at 11:06 AM, the Administrator said they tried to hire PRN staff to cover when staff did not show up to work, and the DON or ADON and the CNAs also helped to cover the shifts. The Administrator said they also started using a staffing agency to help with the staffing issues. The Administrator said a lot of times he did not know until the middle of the night and then the ball gets dropped, but they tried to do their best to get more people to the facility. The Administrator said typically the charge nurses reported to him that they were short, and it was also reported to him that the CNAs were not able to get to all the showers. The Administrator said he was aware that they had been staffing less than the requirements per the facility assessment. The Administrator said the staff were not supposed to tell the residents they were short staffed. The Administrator said there could be a negative effect on the quality of care the residents received if the facility was not adequately staffed. Record review of the Facility assessment dated [DATE] indicated, Facility-Wide Daily Staffing Needs Including Evening, Nights, Weekends, and Holidays: DON RN- 1 full time, 1st shift (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Staff Registered Nurses- 2 Part Time, 1st shift LVNs- 2 full time, 1st and 2nd shift CNAs- 7 full time 1st shift, 6 full time 2nd shift, 3 full time 3rd shift MAs- 1 full time 1st shift, 1 part time 2nd shift MDS/RAI Coordinator (RN)- 1 full time 1st shift Record review of time sheets dated 04/01/2025 indicated only 2 CNAs worked the entire 8 hour second (2:00 p.m.-10:00 p.m.) shift. Record review of time sheets dated 04/05/2025 indicated only 2 CNAs worked the entire 8 hour second (2:00 p.m.-10:00 p.m.) shift. Record review of time sheets dated 04/07/2025 indicated only 1 CNA worked the entire 8 hour second (2:00 p.m.-10:00 p.m.) shift. Record review of time sheets dated 04/15/2025 indicated only 1 CNA worked the entire 8 hour third (10:00 p.m.-6:00 a.m.) shift. Record review of time sheets dated 04/16/2025 indicated only 2 CNAs worked the entire 8 hour second (2:00 p.m.-10:00 p.m.) shift and only 2 CNAs worked the entire 8 hour third (10:00 p.m.-6:00 a.m.) shift. Record review of time sheets dated 04/17/2025 indicated only 1 CNA worked the entire 8 hour second (2:00 p.m.-10:00 p.m.) shift and only 2 CNAs worked the entire 8 hour third (10:00 p.m.-6:00 a.m.) shift. Record review of time sheets dated 04/20/2025 indicated only 4 CNAs worked the entire 8 hour first (6:00 a.m.-2:00 p.m.) shift, 2 CNAs worked the entire 8 hour second (2:00 p.m.-10:00 p.m.) shift and no CNAs worked the entire 8 hour third (10:00 p.m.-6:00 a.m.) shift. Record review of the facility's policy, Staffing, Sufficient and Competent Nursing, revised August 2022, indicated, Our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment. 1. Licensed nurses and certified nursing assistants are available 24 hours a day, seven (7) days a week to provide competent resident care services including: a. assuring resident safety; b. attaining or maintaining the highest practicable physical, mental and psychosocial well-being of each resident; c. assessing, evaluating, planning and implementing resident care plans; and d. responding to resident needs . Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care, the resident assessments and the facility assessment .

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892 Based on observations, interviews, and record review the facility failed to follow their own established smoking policy for the 1 of 2 residents (Resident #2) reviewed for smoking policies. The facility failed to follow the smoking policy and ensure Resident #2 had a safe smoking evaluation completed. This failure could place residents at risk of an unsafe smoking environment and an increased risk of injury related to smoking. Findings included: Record review of a face sheet dated 04/23/2025 indicated Resident #2 was a [AGE] year-old female with diagnoses which included hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side (blood flow to the brain affected with weakness and paralysis of left side of the body), type 2 diabetes mellitus with diabetic neuropathy (insulin resistance, with or without insulin deficiency that induces organ dysfunction) progressive death of nerve fibers, which leads to loss of nerves, increased sensitivity, and the development of foot ulcers), and anxiety disorder. Record review of Resident #2's Comprehensive MDS assessment dated [DATE] indicated she understood others and was understood. Resident #2's BIMS was a 15, which indicated her cognition was intact. The MDS assessment indicated Resident #2 was dependent on staff for showering/bathing, toileting, dressing, and personal hygiene. The MDS assessment indicated Resident #2 used tobacco. During an observation and interview on 04/21/2025 starting at 9:20 AM, Resident #2 had a vape on her over bed table. Resident #2 said she used the vape. During an observation on 04/21/2025 at 2:02 PM, Resident #2 had a vape device on her overbed table. Record review of Resident #2's care plan with a target date of 02/09/2025 did not indicate she used a vape or smoked. Record review of Resident #2's electronic health record on 04/24/2025 did not indicate any safe smoking evaluations had been completed. During an interview on 04/22/2025 at 4:12 PM, LVN B said when Resident #2 got out of bed she went to smoke sometimes. LVN B said Resident #2 used a vape device. LVN B said smoking assessments were completed by the MDS nurse on admission. LVN B said it was important for smoking assessments to be completed to ensure the residents were safe to smoke and so they could be assessed for safety. (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 04/23/2025 at 1:18 PM, the MDS Coordinator said she did not complete the smoking assessments. The MDS Coordinator said she knew they were done on admission, but she was not sure the frequency at which the smoking assessments should be completed. The MDS Coordinator said she was pretty sure social services completed the smoking assessments. The MDS Coordinator said smoking assessments should be completed to determine whether the residents could safely smoke on their own or not. The MDS Coordinator said if a smoking assessment was not completed this could place the residents at risk for burning themselves or starting a fire or they could get stuck if they went out and could not get back inside the building. During an interview on 04/23/2025 at 4:00 PM, LVN L said Resident #2 smoked when she was up in her wheelchair. LVN L said she was aware Resident #2 had a vape, but she had not seen her use it in her room. LVN L said the smoking assessments were completed quarterly by the charge nurses, but she did not know when Resident #2's smoking assessment was last completed. LVN L said it was important for the smoking assessments to be completed for the resident's safety. During an interview on 04/24/2025 at 10:17 AM, the DON said the nurses were supposed to be completing the smoking assessments quarterly. The DON said she did not know why Resident #2's smoking assessment was not completed. The DON said the ADON had started monitoring the smoking assessments to ensure they were completed earlier in the month of April 2025. The DON said she was aware Resident #2 smoked and used a vape. The DON said the smoking assessments needed to be completed to determine if the resident was safe to smoke. During an interview on 04/24/2025 at 10:20 AM, the ADON said she started monitoring earlier this month (April 2025) to ensure all the quarterly assessments were completed. The ADON said Resident #2 had not been getting up to smoke, so it did not trigger the nurses to complete a smoking assessment. The ADON said she knew Resident #2 had a smoking assessment completed on admission (the initial smoking assessment for Resident #2 was not provided upon exit of the facility). The ADON said it was important for the smoking assessments to be completed because there was a possible risk of the residents burning themselves, the residents not properly disposing of the cigarettes, or if they were unable to light up the cigarette burn themselves or their hair. The ADON said she did not know Resident #2 still had a vape. The ADON said the smoking assessment did not apply to the vape. During an interview on 04/24/2025 at 10:52 AM, the Administrator said Resident #2 smoked and she needed to have a smoking assessment. The Administrator said he expected for the staff to follow the smoking policy. The Administrator said smoking assessments were completed on admission and if a resident had a change in condition. The Administrator said it was important for the residents to have a smoking assessment because it let them know if the resident was a safe smoker or non-safe smoker and based on the outcome, they would determine what the resident needed. The Administrator said if the smoking assessment was not in place there was a potential for that resident to not have the proper processes in place to ensure they were being safe. Record review of the facility's policy titled, Smoking Policy-Residents, revised August 2022, indicated, 6. Resident smoking status is evaluated upon admission. If a smoker, the evaluation includes: a. current level of tobacco consumption; b. method of tobacco consumption (traditional cigarettes; electronic cigarettes; pipe, etc.); c. desire to quit smoking; and d. ability to smoke safely with or without supervision (per a completed Safe Smoking Evaluation) .8. A resident's ability to smoke safely is re-evaluated quarterly, upon a significant change (physical or cognitive) and as determined by the staff .

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 47612 Based on interview and record review, the facility failed to develop, implement, and maintain an effective training program for existing staff, consistent with their expected roles for 5 of 21 employees (Administrator, DON, ADON, LVN D, and LVN O) reviewed for required trainings. The facility failed to ensure the Administrator, DON, ADON, LVN D, and LVN O received HIV training upon hire on 10/01/2024. The facility failed to ensure the Administrator, DON, ADON, LVN D, and LVN O received Restraint training upon hire on 10/01/2024. These failures could place residents at risk for the inappropriate use of restraints and exposure to HIV. Findings included: Record review of the employee files revealed there was no HIV training completed upon hire for the following staff: *Administrator (hire date 10/01/2024), *DON (hire date 10/01/2024), *ADON (hire date 10/01/2024), *LVN D (hire date 10/01/2024), *LVN O (hire date 10/01/2024), Record review of the employee files revealed there was no resistant training completed upon hire for the following staff: *Administrator (hire date 10/01/2024), *DON (hire date 10/01/2024), *ADON (hire date 10/01/2024), *LVN D (hire date 10/01/2024), *LVN O (hire date 10/01/2024), Record review on 04/24/2025 of the employee files did not indicate the Administrator, DON, ADON, LVN D, and LVN O hire dates. (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/22/25 at 10:53 a.m., the HR/BOM Director said not all employees had the HIV and Restraint training completed. She said since the change of ownership in October of last year (2024), a lot of the trainings did not get sent out to all employees to get completed. She said corporate was responsible of assigning the required trainings to all employees. During an interview on 04/24/2025 at 11:56 a.m., the corporate HR coordinator stated HIV and restraints training should be completed initially and the month of hire for annual checks. The corporate HR coordinator stated the supervisor, HR manage and herself was responsible to making sure staff completed HIV and restraints upon hire and annually. The corporator HR coordinator stated it was important to the resident for staff to complete HIV and restraints training annually an upon hire to make sure staff was educated. The corporate HR coordinator stated this should be monitored during morning meetings. During an interview on 04/24/2025 at 12:15 p.m., the Administrator stated he expected the annual trainings to be completed. The Administrator stated corporate was responsible for making sure the facility received the information on staff that required annual training, and the HR coordinator was responsible for making sure staff completed the trainings. The Administrator stated the failure must have occurred when the facility changed ownership. The Administrator stated he understood the education dates where wrong, however, if he was going to get a tag then he would not fix them. The Administrator stated the importance of training was for resident and staff safety. The policy on required trainings was requested on 04/24/2025 at 1:00 p.m. and not received.