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	06/03/2026

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

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interview and record review, the facility failed to ensure that 5 of 6 residents AR2, AR3, AR4, AR5, and AR6 had a right to organize and participate in resident groups. The facility failed to provide regular resident council meetings without staff interference. This failure could place residents at risk of not having the freedom to voice their concerns in a resident meeting setting. Findings included: During an interview on 6/1/2026 at 2:02 PM, the ADM brought in 3 meeting notes from past meetings and stated the Activity Director quit and the facility was working on getting a good Resident council group going. During a confidential interview at an undisclosed date and time, AR 2, AR3, AR4, AR5, and AR6 said resident council meetings were with staff in Town hall meetings. AR4 said the facility held their first meeting in the hallway and staff were in the hallway and they shut the door. During a confidential interview at an undisclosed date and time, AR3 said the facility was without an Activity Director for a couple of months and the residents just had their first resident council meeting. During an interview on 6/2/2026 at 11:00 AM, the Ombudsman said the facility had not had a Resident Council meeting in 2 years. The Ombudsman said all the department heads were in the town hall meetings. During an interview on 6/3/2026 at 11:29 AM, the AD said she had held one Resident Council meeting on 5/28/2026 at 2:00 PM. She said the meetings were held in the dining room area. The AD said the ADM and the ADON started the meeting and then she took notes for the residents. The AD said the residents allowed her to take part in the meeting to take notes. The AD said she was not sure why there were no resident council meetings in the past. The AD said the facility had town hall meetings, but she had only been at the facility for 1 month. The AD said she was not sure how the residents voted for the Resident Council President. The AD said she had gone over the Resident Rights in the meeting and had provided them with the Ombudsman phone number and the State number. The AD said the ADM was previously responsible for setting up the resident council meetings, but she was responsible now. The AD said she does place signs on the doors during the meetings. The AD said staff should not be walking in and out of the area while the residents were conducting their meeting. The AD said staff should have respected the resident council time. The AD said it could hurt the residents' feelings because it was their home and they need their privacy. During an interview on 6/3/2026 at 11:48 AM, CNA B said the facility had town hall meetings one time a month. CNA B said the staff were in the meetings with the residents and said someone should be in there with them to direct them. CNA B said she used to attend the meetings. CNA B said the ADM was responsible for ensuring the meetings were private. During an interview on 6/3/2026 at 12:01 PM, CNA G said she came through the hallway while the meeting was going on. CNA G said she had not attended any meetings in the past. CNA G said she had never observed a sign on the door. CNA G said staff should not be going in and out while the resident council was having their meeting. CNA G said it was a privacy issue. She said it could make the residents wonder why staff were passing through while their meeting was going on. CNA G said the ADM was responsible for making sure the residents have private meetings. During an interview on 06/03/2026 at 1:11 PM, the ADON said resident council meetings were monthly. The ADON said the facility started doing the Town halls prior to the last survey. The ADON said the residents would meet with staff during the town hall. The ADON said the residents would tell us what meal they would like and the Ombudsman would come up. The ADON said (continued on next page)

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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the residents voted on the Resident Council President. The ADON said the President wanted something to do but she cannot remember that. The ADON said the staff should not be passing by during a meeting unless invited. The ADON said the residents need to have the freedom to complain and be able to express themselves without staff being there to monitor it. The ADON said she thought the AD was responsible for ensuring the residents have privacy. During an interview on 06/03/2026 at 1:57 PM, the DON said the AD was responsible for putting together the Resident Council. The DON said the residents should be able to voice concerns and complaints, and staff members should not be in the meeting other than the AD. The DON said nobody should be walking down hallway while the residents were having a meeting. The DON said the residents could be distracted or may not express their concerns or feel like they will not be able to speak. During an interview on 06/03/2026 at 2:15 PM, the ADM said they were using Townhall but was in the form of Resident Council format. The ADM said he attended at the beginning of the meeting. The ADM said he would go over the fact that he was the abuse coordinator. The ADM said he helped kick things off to get the meeting going. The ADM said prior to having a President, the AD stayed in there with them. The ADM said a CNA was doing the Activities. The ADM said they were without an AD since April 16, 2026. The ADM said the department heads filled in. The ADM said Resident Council meetings happened, and the residents voted during a meeting through an election. The ADM said he expected the Resident Council to be able to meet without interruptions from outside staff. The ADM said the AD becomes the trusted staff. The ADM said the Resident Council meetings the facility hosted had signs posted on each door. The ADM said besides putting guards out, he said he did not know how to keep staff out of the meeting. Record review of the facility's policy titled, Resident Council Meetings, dated 3/1/2026, indicated .the facility supports the rights of residents to organize and participate in resident groups.resident or family group.is defined as a group of residents or residents' family members that meet regularly to discuss and offer suggestions about facility policies and procedures.is a formal resident group with a President who is appointed by other residents. All residents are eligible to participate.The President serves as a liaison between the group and facility staff.meets at least quarterly, but no less than as determined by the group. The date, time, and location of the meetings are noted on the Activity Calendar.the activity director shall be designated, if approved by the group, to serve as a liaison between the group and the facility's administration and other staff members.names of residents in attendance, follow-up from previous meetings, issues discussed, recommendations from group to facility staff, and names of staff members, speakers, and other guest present in the meeting.the facility shall act upon concerns and recommendations of the council, makes attempts to accommodate recommendations to the extent practicable and communicate its decisions to the council.scheduling of meetings and meeting topics, upon request by the council.

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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** Based on interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan to meet each resident's medical, nursing, mental and psychosocial needs for 4 of 21 residents reviewed for care plans. (Resident #63, Resident #45, Resident #5, Resident #28) 1. The facility failed to develop the comprehensive person-centered care plan for Resident #63 by not documenting their use of a psychotropic (Quetiapine Fumarate Oral Tablet 100 MG) medication. 2. The facility failed to develop a person-centered care plan for Resident #5's psychotropic medication Seroquel 150 mg every evening prescribed on 4/2/2026. 3.The facility failed to develop a person-centered care plan for Resident #28's psychotropic medication Zyprexa 5 mg every day and Zyprexa 7.5 mg every evening prescribed on 11/26/2025. 4.The facility failed to develop a person-centered care plan for Resident #45's admission to Hospice Care on 5/15/2026. This failure could place residents at risk of not having individual needs met, a decreased quality of life, and cause residents not to receive needed services 1. Record review of Resident #63's face sheet, dated 04/09/26, revealed a [AGE] year old female admitted on [DATE] with diagnoses including Alzheimer's Disease (Alzheimer's is a progressive, irreversible brain disorder and the most common cause of dementia), Major Depressive Disorder (a serious mood disorder characterized by persistent sadness, loss of interest in activities, and an inability to function normally), and Anxiety Disorder (Anxiety disorders involve persistent, excessive worry or fear that is disproportionate to the situation and interferes with daily life). Record review of physician's orders for Resident #63, dated 05/30/26, indicated an order for Quetiapine Fumarate Oral Tablet 100 MG. Order shows that mediation was to be administered 1 tablet by mouth at bedtime. Record review of Resident #63's admission MDS assessment, dated 04/21/26, indicated Resident #63 was understood and understood others. The MDS indicated a BIMS of 08 indicating moderate cognitive impairment for Resident #63. The MDS indicated Resident #63 used psychotropic medication. Record review of Resident #63's care plan, dated 4/14/26, revealed there was no care planning or documentation regarding the use of Quetiapine Fumarate Oral Tablet 100 MG. During an interview on 6/3/26 at 12:00 p.m., the Director of Nurses said that antipsychotic medication use should be care planned. She said it was the responsibility of nursing staff to ensure that care plans were developed properly. She said that residents could be placed at risk of not receiving proper care if their care plans were not sufficiently documented. During an interview on 6/3/26 at 12:05 p.m., the Administrator said he expected nursing staff develop residents care plans to encompass all aspects of residents' care including psychotropic medications. He said that residents could be placed at risk if their care plans were not completed as staff may not meet all of a resident's needs. 2. Record review of Resident #5's Face sheet, dated 6/2/2026, indicated an [AGE] year-old female readmitted [DATE]. Resident #5 had diagnoses which included fracture of right femur, vascular dementia (a decreased blood flow, which can damage brain tissue), paranoid personality disorder (a (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mental health condition marked by pervasive distrust and suspicion of others without sufficient reason) and delusions (a type of mental health condition in which a person can't tell what's real from what's imagined). Record review of Resident #5's Significant change in condition MDS assessment, dated 4/7/2026, indicated she was able to make self-understood and was able to understand others. Resident #5 had a BIMS score of 3 indicating she was severely cognitively impaired. Resident #5 was dependent with toileting, bathing, and dressing upper and lower body. The MDS care area indicated Resident #5 was on psychotropic medication triggering a care area. Record review of Resident #5's Care plan, initiated on 11/14/2025, indicated Resident #5 resided on the secure memory care unit due to elopement risk. Resident #5's care plan also indicated she had impaired cognitive function, dementia, or impaired thought processes. Interventions included administration of medications as ordered, monitor/document for side effects, ask yes/no questions to determine the resident needs. Resident #5's care plan did not address psychotropic medications. Record review of a physician order, dated 6/3/2026, indicated Resident #5 was ordered to have Seroquel 100 mg tablet every evening and Seroquel 50 mg tablet every evening to equal 150 mg daily for behavioral hallucinations. The physician order summary also included behavioral monitoring related to antipsychotics such as mania (an abnormally elevated, energetic, or irritable mood that lasts at least a week and severely impacts daily functioning), auditory hallucinations (the perception of hearing a sound-such as a voice, music, or environment noise- when no actual external source exists), visual hallucinations (involve seeing things that do not actually exist), delusions (a fixed, false belief that is firmly held despite clear evidence to the contrary), paranoia (an intense, irrational feeling of suspicion and distrust without a solid basis), biting, danger to self, danger to others, smearing feces, kicking, extreme fear, or striking out. Interventions included activity, adjusting room temperature, changing positions, administration of fluids or foods, redirect, or toileting. Record review of MAR/TAR, dated 5/1/2026-5/31/2026, indicated Resident #5 was prescribed Seroquel 100 mg by mouth at bedtime and Seroquel 50 mg by mouth every evening to equal 150 mg at bedtime related to behavioral hallucinations. The TAR indicated monitoring of behaviors such as mania, auditory hallucinations, visual hallucinations, delusions, paranoia, biting, danger to self, danger to others, smearing feces, kicking, extreme fear, or striking out. Interventions included activity, adjusting room temperature, changing positions, administration of fluids or foods, redirect, or toileting. 3. Record review of Resident #28's Face sheet, dated 6/2/202,6 indicated an [AGE] year-old male admitted [DATE]. Resident #28 had diagnoses which included vascular dementia (a decreased blood flow, which can damage brain tissue), chronic systolic congestive heart failure (a serious condition where the heart's ability to pump blood efficiently is impaired over time, primarily affecting the left ventricle), and delusional disorder (a type of mental health condition in which a person can't tell what's real from what's imagined.). Record review of Resident #28's quarterly MDS assessment, dated 5/12/2026, indicated he was able to make self-understood and was able to understand others. Resident #28 had a BIMS score of 7 indicating he was severely cognitively impaired. Resident #28 was dependent with toileting, bathing, and required moderate to substantial assistance with dressing lower body. The quarterly MDS did not indicate Resident #28 had any behaviors and he had a psychotic disorder. The MDS indicate Resident #28 was on psychotropic medication. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #28's Care plan, revised on 2/2/2026, indicated Resident #28 resided on the secure memory care unit due to exit seeking and constant wandering. Resident #28's care plan also indicated he had impaired cognitive function, dementia, or impaired thought processes. Interventions included asking yes/no questions to determine the resident needs, communicating with Resident #28/RP/caregivers regarding Resident #28's capabilities and needs, and keep Resident #28's routine consistent and trying to provide consistent care givers as much as possible. Resident #28's care plan did not address psychotropic medications. Record review of a physician order, dated 6/3/2026, indicated Resident #28 was ordered Zyprexa 5 mg every day and Zyprexa 7.5 mg every evening for behaviors on 11/26/2025 with side effect monitoring for behaviors included restlessness, pacing, continuous crying for help, afraid/panic, repetitious movements, verbalization of anxiety. The physician order summary indicated interventions such as activity, adjust room temperature, backrub, change in position, administer fluids, offer food, redirect, and remove resident from environment. Record review of MAR/TAR dated 5/1/2026-5/31/2026 indicated Resident #28 was prescribed Zyprexa 5 mg every day and Zyprexa 7.5 mg every evening for behaviors. The MAR/TAR indicated Resident #28 was monitored for side effects and behaviors including restlessness, pacing, continuous crying for help, afraid/panic, repetitious movements (any physical action, task, or movement that is performed continuously or frequently over time), and verbalization of anxiety. Interventions on the MAR/TAR were 1 on 1 activity, adjust room temperature, backrub, change in position, offer fluids, offer food, redirect, or remove from environment. 4. Record review of Resident #45's Face sheet, dated 6/3/2026, indicated an [AGE] year-old male w readmitted [DATE]. Resident #45 had diagnoses which included acute posthemorrhagic anemia (a condition caused by blood loss, leading to reduced red blood cells and hemoglobin), vascular dementia (a decreased blood flow, which can damage brain tissue), hypertension (a common condition where the force of blood against the artery walls are consistently too high) and malignant neoplasm of the prostate (uncontrolled growth of cells in the prostate, a gland in the male reproductive system). Record review of Resident #45's significant MDS assessment, dated 5/28/2026, indicated he was able to make self-understood and was able to understand others. Resident #45 had a BIMS score of 5 indicating he was severely cognitively impaired. The quarterly MDS also indicated Resident #45 had verbal behavioral symptoms directed toward others and required moderate assistance with toileting, bathing, and dressing upper body. The MDS indicated Resident #45 was admitted to Hospice while a resident. Record review of Resident #45's Care plan, revised o5/13/2026, indicated Resident #45 resided on the secure unit due to elopement risk. Resident #45's care plan also indicated he used psychotropic medications related to disease process of vascular dementia with behaviors and delusional disorder. Interventions included administration of psychotropic medications as ordered by physicians. The care plan included intervention to observe for and report to the nurse any side effects and effectiveness. The Care plan did not indicate Resident #45 was on Hospice Care. Record review of a physician order, dated 6/3/2026, indicated Resident #45 had an order indicating he could be admitted to Hospice Care on 5/18/2026. (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 6/3/2026 at 12:17 PM, LVN D said psychotropic medications should be on the care plan. LVN D reviewed Resident #5 and Resident #28's care plan and said there were no care plans for the psychotropic medications. LVN D said psychotropic medications should have their own care plan with specific interventions for the medications. LVN D said Resident #45 did not have a care plan for Hospice Care. LVN D said Resident #45 was admitted to Hospice on 5/15/2026. LVN D said DON and MDS nurse were responsible for adding the psychotropic medications to resident's care plans. LVN D said the MDS nurse and the DON should update in the morning meeting. LVN D said it could negatively impact residents if the staff did not know what side effects or interventions were if a resident took psychotropic medications and a resident might not receive the care or interventions that needed to be monitored. During an interview on 06/03/2026 at 1:25 PM, the ADON said she did not enter the care plan. The ADON said the MDS nurse or the nurse entered the care plan. The ADON said the care plan should be individualized for each resident. The ADON said the care plan should be updated within the next couple of days if a resident was admitted to Hospice or had a psychotropic medication. The ADON said it was important for all medications to be on the care plan so the staff would know how to treat the residents. The ADON said it would not impact the residents because the facility staff would not do anything without a Physician order. During an interview on 6/3/2026 at 1:36 PM, the MDS nurse said she oversees the care plans. MDS nurse said the IDT met every morning and discussed anything new to care plans or any updates. MDS nurse reviewed Resident #5, Resident #28 and Resident #45's care plan. The MDS nurse said Resident #5 and Resident #28 did not have a care plan for psychotropic medications. The MDS nurse did not have an explanation why the care plan was not updated with the psychotropic medications. The MDS nurse said she had been in her new role for about 3 months. The MDS nurse said Resident #45 should have a care plan for Hospice Care and she had Resident #45 marked on her white board in her office indicating his admission date of 5/15/2026. The MDS nurse said she did not care plan hospice. The MDS nurse said she had about 14 days and usually does it right when she was made aware. The MDS nurse said she was responsible for ensuring the care plans were updated. The MDS nurse said it was important so the staff would know what was going on with the residents. The MDS nurse said it could negatively impact the residents because the care plan was a way for the staff to know what care to provide for the residents. During an interview on 6/3/2026 at 2:03 PM, the DON said she expected the psychotropic medications to be on the care plan because they were required. The DON said the nurse management (DON, ADON, and MDS nurse) were responsible for care planning psychotropic medications and Hospice care plan. The DON said she did not know any negative effect on the residents. During an interview on 06/03/2026 at 2:25 PM, the ADM said the care plan should be updated by the DON or IDT. The ADM said he would want the clinical team to update the care plan if a resident was placed on Hospice Care and if a resident was prescribed a psychotropic medication. The ADM said there was potential for the care plan to not be followed and have a negative impact on the residents but did not elaborate on what could occur. Record review of a facility policy titled, Comprehensive Care Plan, dated 3/1/2026, indicated .it is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident.includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychological needs and ALL services that are identified in the resident's comprehensive assessment.Person-centered care.to focus on the resident as the focus of control and support the (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident in making their own choices.Policy Explanation and Compliance guidelines.1. The care planning process will include an assessment of the resident's strengths and needs and will incorporate the resident's personal preferences.2.will be developed within 7 days after the completion of the comprehensive MDS assessment.3.will describe, at minimum, the following: a. The services that are to be furnished to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being. B. Any services that would otherwise be furnished but are not provided due to the resident's exercise of his or her rights.c. any specialized services.d.resident's goals for admission and desired outcomes.e. Discharge plans.f.specific interventions that reflect the resident's needs and preferences.g. Individualized interventions for trauma services.4. The comprehensive care plan will be prepared by an interdisciplinary team.a.attending physician or non-physician practitioner designee.b. registered nurse with responsibility for the resident.c. nurse aide.d.a member of the food and nutrition services.e. The resident and the resident's representative.5.reviewed and revised by the interdisciplinary team after each comprehensive and quarterly assessment.6.will include measurable objectives and timeframes to meet the resident's needs.7. The physician, other practitioner, or professional will inform the resident and resident representative of risk and benefits of proposed care, of treatment and alternatives.8. Qualified staff responsible for carrying out interventions specified in the care plan.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 3 of 16 residents (Resident #2, Resident #26 and Resident #13) reviewed for infection control practices. 1. The facility failed to ensure LVN D donned a gown when prior to administering medications via G-tube (gastrostomy tube) (a medical device inserted through the abdomen directly into the stomach) for Resident #2 on enhanced barrier precautions on 6/2/26. 2. The facility failed to ensure LVN D donned a gown prior to administering Resident #26's Daptomycin (a powerful, intravenous, cyclic lipopeptide antibiotic) intravenously via PICC line (peripherally inserted central catheter) (a long, thin, flexible tube inserted into a vein in the upper arm and threaded to a large vein near the heart). 3.The facility failed to ensure CNA A and CNA B donned a gown before performing catheter care on Resident #13 who was on EBP. These failures could place residents at risk for cross contamination and the spread of infection. Findings include: 1.Record review of Resident #2's face sheet dated 6/3/26 reflected a [AGE] year-old male who was initially admitted on [DATE] and was readmitted to the facility on [DATE]. Resident #2 had diagnoses which included: diffuse traumatic brain injury with loss of consciousness of 30 minutes or less (widespread damage caused when rapid acceleration, deceleration, or rotational forces twist and tear the brain's long connecting nerve fibers), quadriplegic (a medical condition involves the partial or total loss of motor), cognitive communication deficit, gastrostomy status (having a surgically created opening in the stomach (a G-tube) and need for assistance with personal care. Record review of Resident #2's MDS assessment, dated 5/28/26, reflected Resident #2 sometimes understood and usually understood by others. There was no BIMS assessment conducted for Resident #2. Resident #2 was dependent on ADLs. Resident #2 was always incontinent of bowel and bladder. Record review of Resident #2's care plan dated 5/1/26 reflected Resident #2 has an abrasion to right wrist. The intervention: provide wound care per treatment order. Resident review of Resident #2 care plan date 7/15/25 reflected Resident #2 has impaired cognitive function or impaired thought process related to traumatic brain injury. Record review of Resident #2's care plan dated 10/16/24 reflected Resident #2 had impaired cognitive function. The intervention: encourage resident to participate in simple, structured activities. Record review of Resident #2's order summary report reflected, clean right wrist wound with wound cleanser, pat dry, and apply Leptospermum honey. Cover with dry dressing. Change every day and as needed, every day shift for wound care, dated 5/20/26. Record review of Resident #2's order summary report reflected, Resident #2 on enhanced barrier precautions due to peg tube (a flexible feeding tube surgically placed through the abdominal wall directly into the stomach), dated 3/31/26. Record review of Resident #2's order summary report reflected, may cocktail meds, dated 10/3/24. During an observation on 6/2/26 at 8:18 AM, LVN D prepared and administered Resident #2 medications via peg tube. LVN D did not donn a gown prior to administering the resident's medication. Resident #2 had an enhanced barrier precaution sign upon entry of room. During an interview on 6/2/26 at 8:50 AM LVN D stated Resident #2 was on enhanced barrier precautions. She stated it was a personal preference if staff wanted to wear the PPE to protect themself. She stated if the staff had something going on such as sickness, they should wear the PPE. She stated a negative effect was spreading infection to the next person. She stated she had been in-serviced over enhanced Barrier Precautions before. During an interview on 6/2/26 at 10:27 AM the Assistant Director of Nursing stated, the nurses were supposed to be wearing PPE during incontinent care, transferring and giving medications via gastrostomy tube when a resident was on enhanced barrier precautions. She stated she was the Infection Control Preventionist and she and the Director of Nursing were both responsible for ensuring the nurses wore PPE. She stated she has done an in-service on applying PPE for residents on (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	enhanced barrier precautions with staff on 6/2/26. She stated a negative effect of enhancement barrier precautions not followed was that staff does not know if the residents have bacteria on them and staff could spread it to others. 2.Record review of Resident #26's face sheet dated 6/3/26 reflected a [AGE] year-old male who was initially admitted on [DATE] and readmitted to the facility on [DATE]. Resident #26 had diagnoses which included: other chronic osteomyelitis (aa persistent, progressive bone infection lasting longer than four weeks), osteomyelitis of vertebra (a serious, potentially debilitating infection of the spine bones) and acquired absence of left leg above knee. Record review of Resident #26's MDS assessment, dated 4/26/26, reflected Resident #26 understood and understood by others. Resident #26 required maximal assistance with ADLs. Record review of Resident #26's care plan dated 3/31/26 reflected Resident #26 has an infection of the lumbar spine Resident #26 has a PICC line and receiving IV antibiotics Vancomycin.Record review of Resident #26's care plan dated 4/8/25 reflected Resident #26 has diabetic chronic ulcer to right 4th toes. Resident #26 requires enhanced barrier precautions due to his wound. Record review of Resident #26's order summary report reflected, Daptomycin Intravenous Solution Reconstituted 500 mg (Daptomycin) use 850 mg intravenously one time a day for osteomyelitis until 6/19/26 2:59 PM to give in 50 ml Normal Saline at 100 ml/hr., start dated 6/2/26. Record review of Resident #26's order summary report reflected, PICC Line Dressing and cap change weekly using sterile technique per protocol one time a day every Monday for wound care treatment, dated 4/27/26. Record review of Resident #26's order summary report reflected, Resident on enhanced barrier precautions due to wound, dated 3/31/26. During an observation on 6/2/26 at 2:39 PM, LVN D prepared Resident #26's Daptomycin and administered the medication via IV. LVN D did not donn gown prior to administering the IV medication, the resident had an enhanced barrier precaution sign on door. During an interview on 6/2/26 at 2:45 PM, LVN E stated she was supposed to apply the gown which was her PPE. She stated she was nervous about administering the medication. She stated she was responsible for applying for the PPE before she gave the medication, because he has a PICC line and a wound. She stated she was just in-serviced over enhanced barrier precautions, but she was just nervous. She stated a negative effect was the blood from the PICC line could spread germs. During an interview on 6/3/26 at 12:51 PM, LVN E stated the importance for enhanced barrier precautions for a foley, intravenous and gastrostomy tube was splashing. She stated all staff were responsible for themselves and the residents. She stated a negative effect of improper EBP was exposure to bacteria for the staff and the residents. 3.Record review of Resident #13's undated face sheet indicated she was a [AGE] year-old female that originally admitted [DATE] with a readmission date of 1/30/26. Record review of the physician's orders dated 6/2/26 indicated Resident #13 had diagnoses that included: Paraplegia (partial or complete loss of motor and sensory function in the lower half of the body, including both legs), metabolic encephalopathy (temporary or permanent brain dysfunction caused by chemical imbalances or underlying systemic diseases rather than a direct head injury), other specified sepsis (extreme life threatening response to an infection). Record review of Resident #13's quarterly MDS dated [DATE] indicated she had a BIMS of 14 meaning she was cognitively intact. The MDS indicated she required substantial/maximal assistance to roll to the left and to the right and was dependent on staff for a chair to bed or bed to chair transfer. Resident #13 had an indwelling catheter (a flexible, sterile rubber or plastic tube inserted through the urethra into the bladder to drain urine.) Record review of Resident #13's care plan with a revised date of 4/1/26 indicated she required the use of EBP due to her foley (brand of catheter) catheter and wound. The care plan indicated she had an indwelling catheter related to neurogenic bladder (when nerve damage disrupts the signals between your brain and bladder, requiring careful treatment to prevent kidney damage). During an interview and observation on 6/01/2026 at 9:28 AM, Resident #13 was in bed brushing her teeth. Water was on her bedside table. She said she was just back from the hospital with a UTI. She had a catheter and the bag was covered. She said she was paralyzed from the waist down, so she had no symptoms of a UTI. She said staff was very kind to her and everyone loved her. There (continued on next page)

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	675755	A. Building B. Wing	06/03/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was an EBP sign on her door that indicated: Stop. Enhanced Barrier Precautions, everyone must: Clean their hands, including before entering and leaving the room. Providers and staff must also: Wear gloves and a gown for the following High-Contact Resident Care Activities: Dressing, Bathing Showering, Transferring, Changing Linens, Providing Hygiene, Changing briefs or assisting with toileting, Device care or use: central line (long flexible tube inserted into the chest, neck, arm, or groin), urinary catheter, feeding tube, tracheostomy, Wound care: any opening requiring a dressing. Written on the sign was B-bed which was Resident #13's bed. During an observation on 6/02/2026 at 10:27 AM, this surveyor, CNA A and CNA B entered Resident #13's room. A sign on the door indicated Enhanced Barrier Precautions. Near the door to the room was a container with drawers that contained PPE including gowns. CNA A and CNA B performed catheter care for Resident #13. CNA A and CNA B did not donn gowns in preparation for or during catheter care. During an interview on 6/02/2026 at 10:40 AM CNA A said she forgot to put on a gown and she knew she was supposed to, because she just had an in-service on EBP precautions. She said not wearing a gown could cause infection to staff and residents. During an interview on 6/02/2026 at 10:41 AM, CNA B said she was supposed to put on a gown before performing catheter care to protect herself, other staff, and residents from infection. She said she had just had an in-service on wearing PPE for EBP, but she had forgotten. During an interview on 06/03/2026 at 12:00 PM, the ADON, said the importance of EBP and using PPE was, per CMS, that staff must assume there was bacteria in any type of resident tubing, whether a g-tube (gastrostomy tube, a medical device inserted directly through the abdomen into the stomach), IV (intravenous, a medical technique to deliver fluids, medications, or nutrients directly into a person's bloodstream), or a catheter that staff was unaware of which presented a danger of infection to staff and residents. She said an infection could be spread to staff, residents, or both. Wearing a gown would help to prevent infection transmission. During an interview on 06/03/2026 at 12:05 PM, the DON said Residents that were on EBP were at higher risk for MDRO's. She said when performing care on a resident that was on EBP, staff should wear a gown and gloves. She said PPE was used to protect staff and residents from transmitting infection. Record review of an Enhanced Barrier Precautions Policy, dated 3/1/26, provided by the DON indicated: Policy:It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Definitions: ?Enhanced Barrier precautions' (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. Policy Explanation and Compliance Guidelines: 1.Prompt recognition of need:a. All staff receive training on enhanced barrier precautions upon hire and at least annually and are expected to comply with all designated precautions. b. All staff receive training on high risk activities and common organisms that require enhanced barrier precautions. c. The facility will have the discretion on how to communicate to staff which residents require the use of EBP, as long as staff are aware of which residents require the use of EBP prior to providing high-contact care activities. 3. Implementation of Enhanced Barrier Precautions: a. Make gowns and gloves available immediately near or outside of the resident's room. Record review of Enhanced Barrier Precautions (EBP)-What Do I Need to Know? In-service dated 6/2/26 indicated: What is EBP?-Wear gown and gloves during specific resident care activities-Used to reduce the spread of multidrug-resistant organisms (MDRO's) When is EBP used? -An MDRO.-A wound and/or indwelling medical device (regardless of MDRO status). Wear Gown and Gloves for High-Contact Care Activities such as: -dressing, bathing, or showering-Transferring/resident lifting-changing linens-toileting/incontinence care-wound care -Device care (urinary catheter, feeding tube, trach (small hole in the front of the neck and directly into the windpipe), IV/PICC (Peripherally Inserted Central Catheter), etc.- Assisting with hygiene. What is not required?-Gown and gloves are not required for casual contact, social activities, or simply entering the room unless performing a high-contact care activity. This in-service was signed by CNA A, CNA B, and LVN D on 6/2/26.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure assessments accurately reflected the status for 3 of 21 residents reviewed for assessments. (Resident #1, #10, and #65) 1.The facility failed to ensure the MDS was appropriately coded for bed rails/restraints for Resident #1. She did not have bed rails. 2.The facility failed to ensure the MDS was appropriately coded for insulin for Resident #10. She did not take insulin. 3.The facility to ensure Resident #65's MDS assessment accurately reflected he was discharged with return anticipated. This failure could place residents at risk for decreased quality of care due to inaccuracy of assessments. 1.Record review of Resident #1's face sheet, dated 6/2/26, indicated she was a [AGE] year-old female, with an original admission date ofadmitted [DATE]. She had diagnoses that included: Alzheimer's Disease with early onset (a progressive, irreversible brain disorder destroying memory, cognitive abilities and the ability to carry out daily tasks), Dementia (decline in cognitive abilities-such as memory, reasoning, and communication severe enough to interfere with daily life), Rheumatoid Arthritis (autoimmune disease where the body's immune system attacks the lining of the joints), and chronic pain. Record review of the quarterly MDS assessment, dated 3/22/26, indicated Resident #1 had clear speech, understood others, and was understood by others. She had a BIMS score of 15 indicating she was cognitively intact. Resident #1 was independent with a bed to chair or chair to bed transfer. Section P/Restraints and Alarms, of the MDS indicated she had a bed rail/restraint. Record review of the undated care plan indicated Resident #1 had acute and chronic pain, impaired cognitive function/dementia or impaired thought processes. The care plan indicated she had side rails to promote independence. During an interview and observation on 6/1/26 at 9:17 AM, Resident #1 was in her room in her wheelchair. She had a lot of personal items in her room. She wore a toboggan on her head. She said staff treated her well, kindly and professionally. She said the food was excellent and the portion sizes were good. She said she got her shower when she was supposed to. She had enabler bars on her bed. She said she did most things herself. She said she had not been and was not restrained in any way. 2.Record review of Resident #10's face sheet, dated 6/3/26, indicated she was a [AGE] year-old female that admitted [DATE]. She had diagnoses that included: Hemiplegia and Hemiparesis following cerebral infarction affecting left dominant side (due to a stroke a blood vessel in the brain is blocked or narrowed causing complete or partial paralysis on one side due to damage in parts of the brain that control voluntary muscle movement), seizures (uncontrolled burst of electrical activity in the brain), and Diabetes Mellitus type 2 with polyneuropathy (the body resists insulin or cannot produce enough with prolonged high blood sugar that damages peripheral nerves). Record review of the quarterly MDS assessment, dated 4/8/26, indicated Resident #10 had clear speech, understood others, and was understood by others. She had a BIMS score of 14 indicating she was cognitively intact. Section N-Medications N0300.-Injections: indicated Resident #10 received injections 7 of 7 days. Section N-Insulin N0350 indicated Resident #10 received insulin 7 of 7 days. Record review of the undated care plan indicated Resident #10 had an unstable blood glucose level, and Diabetes Mellitus. Diabetes medications should be taken per doctor's orders. The Care plan indicated Resident #10 had a Cerebral Vascular accident (CVA/stroke) affecting non dominant side related to disease processes and seizures. Record review of the physician's orders, dated 6/2/26, indicated Resident #10 did not take insulin. She had orders for: 9/24/24 Check blood glucose level once weekly, one time a day every Friday. 9/18/24 Metformin tab 500 mg, give 1 tablet by mouth two times a day related to Type 2 Diabetes Mellitis without complications. During an interview and observation on 6/01/2026 at 9:38 AM, Resident #10 was dozing in her bed with her glasses on. She had coffee on her overbed table. She said her favorite was to order off the menu for lunch. She said staff treated her okay. During an interview on 6/1/26 at 12:07 PM, LVN F said Resident #10 had never taken insulin as far as she knew. During an interview on 6/1/26 at 1:43 PM, Resident #10 said she had not ever taken insulin. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.Record review of Resident #65's face sheet, dated 6/3/26, indicated he was an [AGE] year-old man that admitted [DATE]. He had diagnoses that included: Acute on Chronic Systolic (Congestive) Heart Failure (the heart muscle is too weak or stiff to pump blood efficiently), Ventricular Tachycardia (a fast abnormal heart rhythm originating in the heart's lower chambers/ventricles), and a cardiac defibrillator (a medical device used to treat life-threatening heart rhythms and sudden cardiac arrest). Record review of the quarterly MDS assessment, dated 3/18/26, indicated Resident #65 had clear speech, usually understood others and was usually understood by others. He had a BIMS of 10 indicating he had moderate cognitive impairment. Record review of an MDS Nursing home Discharge, dated 5/20/26, indicated Resident #65 was discharging return not anticipated. The MDS indicated it was an unplanned discharge, and he had discharged to a Short-Term General Hospital. Record review of a MDS Nursing Home and Swing Bed Tracking Item Set, dated 5/21/26, indicated Resident #65 had entered the facility on 5/21/26 from a Short-Term General Hospital. Record review of Resident #65's care plan dated 5/28/26 indicated he had impaired cognitive function or impaired thought processes and oxygen therapy related to Congestive Heart Failure. During an interview and observation on 6/01/2026 at 10:31 AM, Resident #65 was lying in bed resting. Resident #65 stated that no one had been mean or abusive to him. He said Tthe food was fair. He said he got his medication on time and showersshowered 3 times per week. Resident #65 stated Sstaff responded to his call light timely. During an interview on 6/01/2026 at 1:26 PM, the MDS nurse said Resident #1 had never had bed rails and she should not have been marked for bed rails/restraints. She said she was unsure who had done the MDS, but she would check. She said she did not remember Resident #10 ever being on insulin. She said if Resident #10 was marked for taking insulin, it must have been a mistake, and she would check on that, too. She said she would modify both those MDS's. During an interview on 6/01/2026 at 1:32 PM, the MDS nurse said she marked the MDS wrong for Resident #10. She said on section N/Medications of the MDS, on 4/10/26 she marked Resident #10 for receiving insulin 7 of 7 days and marked she had injections for 7 of 7 days. She said that was incorrect and she would modify the MDS now. She said she wouldwill check on the MDS for Resident #1. During an interview and record review on 6/1/26 at 1:45 PM, the MDS nurse showed this surveyor a sheet indicating she had exported MDS modifications for Resident #10 for her assessment on 3/22/26 and Resident #1 for her MDS dated [DATE]. During an interview on 6/01/2026 at 1:50 PM, the MDS nurse said she had modified Resident #1's MDS to show she did not have bedrails. She said Resident #1 never had restraints or a bed rail, and it must have been a technical error because she did not intentionally mark that. During an interview on 6/3/26 at 10:25 AM, the MDS nurse said Resident #65's MDS dated [DATE] should not have been marked discharged with a return not anticipated. She said he had gone to the emergency room, and she knew he was coming back. She said it must have been a technical error. She said it was an easy fix and she would do a modification to show discharged , return anticipated. During an interview on 6/03/2026 at 12:00 PM, the ADON said she did not know much about MDS's. She said they would not want to lie or misrepresent a resident. The ADON said Ifif the care plan was done from the MDS and the MDS was wrong, they could be thinking an issue was there for a resident that was not. She said as nurses they would look at the orders and be able to see what was going on with a resident. During an interview on 6/03/2026 at 12:05 PM, the DON said Resident #10 being marked for insulin when she was not on insulin and Resident #1 being marked for bedrails when she did not have them presented an inaccurate picture and inaccurate assessment of those residents. She said Resident #65 should not have been marked discharged , return not anticipated because that would give CMS an inaccurate picture of those residents. During an interview on 6/03/2026 at 12:18 PM, the ADM said Resident #65's MDS being marked discharged , return not anticipated was a communication issue. He said for Resident #1 being marked for bedrails could have thrown off the reimbursementthe reimbursement rate. The ADM said Resident #10 being marked for receiving insulin when she did not, could cause confusion regarding continuity of care. Record review of a Conducting an Accurate Resident Assessment, dated 3/1/26, provided by the DON indicated: Policy:The purpose of this policy (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	is to assure that all residents receive an accurate assessment, reflective of the residents' status at the time of the assessment, by staff qualified to assess relevant care areas. Definition: Accuracy of assessment means that the appropriate, qualified health professionals correctly document the resident's medical, functional, and psychosocial problems and identify resident strengths to maintain or improve medical status, functional abilities, and psychosocial status using the appropriate Resident Assessment Instrument (RAI) (i.e. comprehensive, quarterly, significant change in status). Policy Explanation and Compliance Guidelines: 1.The Administrator will ensure that all participants in the assessment process have the requisite knowledge to complete an accurate assessment. 2.Qualified staff who are knowledgeable about the resident will conduct an accurate assessment addressing each resident's status, needs, strengths, and areas of decline. The assessment will be documented in the medical record. 3.The appropriate, qualified health professional will correctly document the residents medical, functional, and psychosocial problems and identifies resident strengths to maintain or improve medical status, functional abilities, and psychosocial status.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview, and record review, the facility failed to provide the necessary services to maintain personal hygiene for 1 of 21 residents reviewed for ADLs (Residents #20.) The facility did not clean or trim Resident #20's fingernails. This failure could place residents at risk of not receiving care and services to meet their needs which could result in poor care, risk for skin breakdown, feelings of poor self-esteem, lack of dignity and health.Findings included: Record review of Resident #20s face sheet, dated 01/20/2026, revealed Resident #20 was a [AGE] year-old male admitted [DATE] and re-admitted [DATE] with diagnoses including Cerebral Infarction (A cerebral infarction, commonly known as an ischemic stroke, occurs when a blood vessel in the brain is blocked or narrowed), Seizures (A seizure is a sudden, uncontrolled burst of electrical activity in the brain), and Urticaria (a skin reaction characterized by raised, itchy, red or skin-colored welts). Record review of Resident #20's quarterly MDS assessment, dated 03/05/2026, revealed a BIMS score of 13, which indicated resident #20's cognition was intact. The MDS also revealed, Resident #20, required total dependance with personal hygiene. Resident #20 required one-person physical assistance with personal hygiene, including nail hygiene. Record review of Resident #20's care plan problem, dated 1/31/2025, revealed that Resident #20 had a self-care deficit: bathing, dressing, and feeding. Interventions included staff were to check nail length, trim, and clean on bath day and as necessary andreport any changes to the nurse. During an interview and observation on 6/1/26 at 10:00 a.m., Resident #20 was observed with long black and brown fingernails. His nails were approximately a half inch long. There was a black and brown substance underneath the nails. He said that he could not cut his own nails as he did not have use of his left arm. He said that a staff cuts and cleans his nails. He said that it bothered him that his nails were in the condition they were in and wanted them cut. He said that it was well over a week since his nails were cut. During an interview and observation on 6/03/26 at 9:55 a.m., Resident #20 said his nails had not been cut all week. He said that he was still waiting for his nails to be cut. He said that no staff had offered to cut his nails. Resident #20's nails were approximately half an inch and had black and brown substances underneath the nail bed. During an interview on 6/03/26 at 10:05 a.m., CNA C said that it was the responsibility of CNAs or any nursing staff to cut residents' fingernails. She said that Resident #20 was dependent on care. She said he couldn't use his left arm, and he said he could not cut his nails on his own. She said that she did not know why his nails had not been cut for so long, but she did not usually work in this hall. She said today she was working the hall with Resident #20 and she noticed his nails were long and dirty. She said she offered to cut his nails and he agreed. She said she had not cut his nails yet because she was waiting for when she had free time. She said that it could be unsanitary if residents did not have their nails trimmed and cleaned regularly. During an interview on 6/3/26 at 12:00 p.m., the Director of Nurses said that it was the responsibility of nursing staff to ensure residents who were dependent for ADLs had their needs met including cutting and cleaning of their nails. She said failure to do so could place residents at risk of infection. During an interview on 6/3/26 at 12:05 p.m., the Administrator said that it was the responsibility of nurses to cut and clean nails of residents. He said that residents could be placed at risk of infection if they did not have their nails cleaned. Record review of the facility policy titled, Activities of Daily Living, dated 3/1/2026, revealed that the purpose of this policy was to: The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: Bathing, dressing, grooming and oral care. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to act upon the recommendations of the pharmacist report of irregularities and to ensure the attending physician documented in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it in response to the pharmacist report for 1 of 3 residents (Resident #5) reviewed for (MRR) Medication Regimen Review. 1. The facility failed to act on signed GDR orders to decrease Seroquel (Quetiapine) (an atypical antipsychotic medication used to treat schizophrenia, bipolar disorder and depressive disorder) from 150 mg to 125 mg for Resident #5 on 3/31/2026. These failures could place residents at risk from maintaining their highest practicable level of physical, mental, and psychosocial well-being, and could place them at risk for adverse consequences related to medication therapy.Findings included: 1. Record review of Resident #5's Face sheet dated 6/2/2026 indicated an [AGE] year-old female who was readmitted to the facility on [DATE]. Diagnoses included fracture of right femur (a break or a crack in the right thighbone, the largest and strongest bone in the body), vascular dementia (a decreased blood flow, which can damage brain tissue), paranoid personality disorder (a mental health condition marked by pervasive distrust and suspicion of others without sufficient reason) and delusions (a type of mental health condition in which a person can't tell what's real from what's imagined). Record review of Resident #5's Significant change in condition MDS dated [DATE], indicated she was able to make self-understood and was able to understand others. Resident #5 had a BIMS score of 3 indicating she was severely cognitively impaired. Resident #5 was dependent with toileting, bathing, and dressing upper and lower body. Record review of Resident #5's Care plan, initiated on 11/14/2025 indicated Resident #5 resided on secure memory care unit due to elopement risk. The care plan indicated she had impaired cognitive function, dementia or impaired thought processes. Interventions included administration of medications as ordered, monitor/document for side effects, ask yes/no questions to determine the resident needs. The care plan did not indicate Resident #5 was on a psychotropic medication. Record review of a physician order, dated 6/3/2026, indicated Resident #5 was ordered to have Seroquel (Quetiapine) 100 mg tablet every evening and Seroquel (Quetiapine) 50 mg tablet every evening to equal 150 mg daily for behavioral hallucinations. The physician order summary also included behavioral monitoring related to antipsychotics such as mania, auditory hallucinations, visual hallucinations, delusions, paranoia, biting, danger to self, danger to others, smearing feces, kicking, extreme fear, or striking out. Interventions included activity, adjusting room temperature, changing positions, administration of fluids or foods, redirect, or toileting. Record review of MAR/TAR dated 3/1/2026-3/31/2026 indicated Resident #5 was administered Seroquel (Quetiapine) 100 mg by mouth at bedtime and Seroquel (Quetiapine) 50 mg by mouth every evening to equal 150 mg for behavioral hallucinations starting on 2/20/2026. The TAR indicated monitoring of behaviors such as mania, auditory hallucinations, visual hallucinations, delusions, paranoia, biting, danger to self, danger to others, smearing feces, kicking, extreme fear, or striking out. Interventions included activity, adjusting room temp, changing positions, administration of fluids or foods, redirect, or toileting. Record review of MAR/TAR dated 4/1/2026-4/30/2026 indicated Resident #5 was prescribed Seroquel (Quetiapine) 100 mg by mouth every evening and Seroquel (Quetiapine) 50 mg every evening to equal 150 mg at bedtime related to behavior and hallucinations. The MAR/TAR indicated monitoring of behaviors such as mania, auditory hallucinations, visual hallucinations, delusions, paranoia, biting, danger to self, danger to others, smearing feces, kicking, extreme fear, or striking out. Interventions included activity, adjusting room temp, changing positions, administration of fluids or foods, redirect, or toileting. Record review of MAR/TAR dated 5/1/2026-5/31/2026 indicated Resident #5 was prescribed Seroquel (Quetiapine) 100 mg by mouth at bedtime and Seroquel (Quetiapine) 50 mg by mouth every evening to equal 150 mg (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at bedtime related to behavioral hallucinations. The MAR/TAR indicated monitoring of behaviors such as mania, auditory hallucinations, visual hallucinations, delusions, paranoia, biting, danger to self, danger to others, smearing feces, kicking, extreme fear, or striking out. Interventions included activity, adjusting room temp, changing positions, administration of fluids or foods, redirect, or toileting.Record review of MAR/TAR dated 6/1/2026-6/30/2026 indicated Resident #5 was prescribed Seroquel (Quetiapine) 100 mg by mouth at bedtime and Seroquel (Quetiapine) 50 mg by mouth every evening to equal 150 mg at bedtime related to behavioral hallucinations. The MAR/TAR indicated monitoring of behaviors such as mania, auditory hallucinations, visual hallucinations, delusions, paranoia, biting, danger to self, danger to others, smearing feces, kicking, extreme fear, or striking out. Interventions included activity, adjusting room temp, changing positions, administration of fluids or foods, redirect, or toileting. Record review of Resident #5's Consultant Pharmacist/Physician Communications, dated MRR Date 3/20/2026 indicated: .Resident is receiving the following antipsychotic medication (s) which is due for review.CMS regulations, please evaluate resident for trial dose reduction .Medication: Quetiapine 150 mg Daily.Suggest change.Quetiapine 125 mg DailyThe Physician/Prescriber Response was written to decrease Quetiapine 125 mg daily and signed on 3/31/2026. During an interview on 6/3/2026 at 12:13 PM, LVN D said GDR orders were placed in the EMR by the nurse. LVN D said if she received an order, she would place the order in the EMR immediately. LVN D said she was not aware of Resident #5's GDR for Seroquel (Quetiapine) was reduced by the physician. LVN D said the DON was responsible for entering the orders. LVN D said the resident may not have a therapeutic effect on the resident. During an interview on 6/3/2026 at 1:11 PM, the ADON said the GDR should have been entered into the EMR if the order was signed. The ADON said she was the nurse sending out the GDR recommendations to the physician and once the order is signed, she would enter the new order into the EMR. The ADON said she and the DON were responsible for the orders. The ADON said she had been working the floor and the facility had Covid (a contagious disease caused by the coronavirus) in the building during that time. The ADON said it was an oversight. The ADON said a resident could negatively be impacted causing the resident to be overly sedated. The ADON said if the resident was stable on the current dose, she was not sure it would have a negative impact. During an interview on 6/3/2026 at 2:06 PM, the DON said she and the ADON were responsible for updating the orders for the GDR. The DON said it was missed and it has been completed now. The DON said Resident #5 was not overmedicated. The DON said was trying to GDR because the State makes us. The DON said she did not think there was a risk but not following the Physician order could negatively impact the resident. The DON did not elaborate on how it could impact the residents. During an interview on 06/03/2026 at 2:22 PM, the ADM said the clinical team was responsible for GDR and 3713. The ADM said he expected the medication to be decreased if the physician signed the order and the order should be put in right then. The ADM said there was a potential for a negative effect if orders are not being followed and would not elaborate.Requested GDR policy on 6/3/2026 at 2:06 PM. No policy received. Record review of the facility's policy titled, Use of Psychotropic Medication (s) dated 3/1/2026 indicated Policy.it is the intent of this policy to ensure that residents only receive psychotropic medications when other nonpharmacological interventions are clinically contraindicated. Additionally, these medications should only be used to treat the resident's medical symptoms and not used for discipline or staff convenience, which would deem it a chemical restraint. Definitions: Adequate indications for use .refers to the identified, documented clinical rationale for administering a medication that is based upon an assessment of the resident's condition.For psychotropic medications, without documentation in the record explaining that the practitioner has determined that other treatments have been deemed clinically contraindicated, the indication of use is inadequate. Policy explanation.1.affects brain activities associated with mental processes and behaviors.2.to be used only when a practitioner determined that the medication is appropriate to treat a resident's specific, diagnosed and documented condition.3.medications not classified as antipsychotic, antidepressant, antianxiety, or hypnotic medications but can affect brain (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	activity.4.when a medication is used that can affect brain activity and central nervous system agents for use in conditions such as seizures, mood disorders.5.indications for initiating, maintaining, or discontinuing medication (s) as week as the use of non-pharmacological approaches.6. Non-pharmacological approaches must be attempted.7.medical record shall include documentation of this evaluation and rationale.8.the attending physician will assume leadership in medication management.9. Prior to initiating or increasing psychotropic medication, the resident, family and resident representative must be informed of the benefit, risk and alternatives.12.shall receive gradual dose reduction, unless clinically contraindicated in effort to discontinue these drugs.14.effects of the psychotropic drugs shall receive on resident's physical, mental and psychological well-being will be evaluated on an ongoing basis.15.resident response to the medication(s), including progress towards goals and presence/absence of adverse consequences.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview, and record review the facility failed to store all drugs and biologicals in locked compartments for 2 of 16 residents reviewed for storage of drugs and biologicals (Resident #2 and Resident #30). 1.The facility failed to securely store wound care chemicals for Resident #2. 2. The facility failed to ensure Hydrocortisone 1% anti-itch liquid was properly stored and locked in accordance with currently accepted professional standards for Resident #30. This failure could place residents at risk for adverse reactions, reduced therapeutic effects of medications and supplies, risk of having access to unauthorized medication and/or lead to harm. Findings included: 1.Record review of Resident #2's face sheet dated 6/3/26 reflected a [AGE] year-old male who was initially admitted on [DATE] and was readmitted to the facility on [DATE]. Resident #2 had diagnoses which included: diffuse traumatic brain injury with loss of consciousness of 30 minutes or less (widespread damage caused when rapid acceleration, deceleration, or rotational forces twist and tear the brain's long connecting nerve fibers), quadriplegic (a medical condition involves the partial or total loss of motor), cognitive communication deficit and need for assistance with personal care. Record review of Resident #2's MDS assessment, dated 5/28/26, reflected Resident #2 sometimes understood and usually understood by others. There was no BIMS assessment conducted for Resident #2. Resident #2 was dependent on ADLs. Resident #2 was always incontinent of bowel and bladder. Record review of Resident #2's care plan dated 5/1/26 reflected Resident #2 has an abrasion to right wrist. The intervention: provide wound care per treatment order.Resident review of Resident #2 care plan date 7/15/25 reflected Resident #2 has impaired cognitive function or impaired thought process related to traumatic brain injury.Record review of Resident #2's care plan dated 10/16/24 reflected Resident #2 had impaired cognitive function. The intervention: encourage resident to participate in simple, structured activities. Record review of Resident #2's order summary report reflected, clean right wrist wound with wound cleanser, pat dry, and apply Leptospermum honey. Cover with dry dressing. Change every day and as needed, every day shift for wound care, dated 5/20/26. During an observation on 6/2/26 at 8:29 AM, the surveyor observed wound cleanser on the shelf in Resident #2's bathroom on a shelf. During an interview and observation 6/2/26 at 1:32 PM, the surveyor took the Assistant Director of Nursing to Resident #2's bathroom and showed her the wound cleanser on the shelf in the bathroom. The Assistant Director of Nursing stated sometimes the staff left wound cleanser in the resident's drawers in their rooms, but staff did not leave the wound cleanser in the bathroom. She stated the wound cleanser was not the facility product, she stated hospice probably left the wound cleanser there. She stated the negative effect was that anyone could wander into the resident's bathroom and use the wound cleanser and use it inappropriately. During an interview on 6/3/26 at 8:05 AM, LVN E stated whether the resident had a wound or not the wound cleanser should not have been left in the bathroom. She stated everybody was responsible for ensuring the wound cleanser was not in Resident #2's bathroom. She stated a negative effect of an improper stored medication was that a resident could use the wound cleanser inappropriately. During an interview on 6/3/26 at 1:02 PM, the Director of Nursing stated she expected the wound cleanser not to be accessible to the residents in the facility. She stated the wound cleanser should be stored properly. She stated staff in and out of the rooms were responsible for ensuring the wound cleanser was not in Resident #2's bathroom. She stated a negative effect of the improper storage of medications could be a severe effect if a resident got a hold to the wound cleanser. During an interview on 6/3/26 at 1:11 PM, the Administrator stated he expected all medications to be properly stored. He stated the clinical team were responsible for ensuring all medications were stored properly. He stated a negative effect was that a resident could potentially consume or administer the wound cleanser and that could cause (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an issue. 2.Record review of Resident #30's face sheet dated 6/3/2026 indicated Resident #30 was [AGE] year-old female admitted on [DATE] with diagnoses including Vascular Dementia (a decreased blood flow, which can damage brain tissue), centrilobular emphysema (a common form of COPD that primarily damages the central portions of the lung lobules, especially in the upper lobes, and is strongly associated with long-term smoking), hypertension (a common condition where the force of blood against the artery walls is consistency too high), and osteoporosis (a condition that weakens bones and increases the risk of fractures). Record review of Quarterly MDS dated [DATE] indicated Resident #30 was unable to complete the BIMS assessment due to resident was rarely/never understood and was severely cognitively impaired. The MDS indicated Resident #30 required set-up assistance with toileting, bathing, dressing upper and lower body. Record review of Resident #30's Care Plan revised on 4/23/2025 indicated Resident #30 resided on a secure memory unit with interventions which included: A structured environment will be provided to create a stress-free lifestyle, elopement assessment will be conducted upon initial admission to the facility and weekly x 4 weeks, and physician order will be obtained for the resident to reside on the memory care unit. Record review of the facility's medication record dated 6/1/2026-6/30/2026 indicated Resident #30 did not have an order for Hydrocortisone 1% anti-itch liquid. During an interview and observation on 6/1/2026 at 9:26 AM, Resident # 30 was sitting on her bed and had her side table drawer open. Resident #30 had Hydrocortisone 1% anti-itch liquid in the top drawer with her name on it. Resident #30 could not tell what the Hydrocortisone liquid was for, and she did not indicate it was used. During an interview and observation on 6/2/2026 at 1:56 PM, CNA H [NAME] said residents should not have any topical medications in their rooms. CNA H said if medications were identified in a room, she would turn medication into the nurse. CNA H said the residents could take too much of the medication or eat the topical medication or put it in their eyes causing them to go blind. CNA H said the CNAs were responsible there were no medications in the resident room and she would give the medication to the charge nurse. CNA said the CNAs checked rooms every 2 hours. CNA H said a family member brought that medication to her. CNA H went to Resident #30's room and the medication remained on her bedside table. CNA H said Resident #30's family must have brought up the medication and removed the Hydrocortisone medication. During an interview on 6/3/2026 at 11:48 AM, CNA B said residents on the secure unit should not have medications or topical medications in their rooms. CNA B said residents' visitors have brought medication in and was not always caught due to Resident #30 hiding items. CMA B said they go through the drawers weekly. CNA B said the CNAs; CMAs were responsible for checking rooms weekly and sometimes more. CNA B said a resident could drink the medication or use the medication in a way not intended. CNA B said it could make the residents sick or cause them harm if the residents got it in their eyes. During an interview on 06/03/2026 at 12:01 PM, CNA G said residents should not have medications in room. CNA G said a resident could get sick and it may not be their medication. CNA G said the residents should not have ointments, and it may not be for them. CNA G said the CNAs check the rooms every other day. CNA G said another resident could get a hold of a medication they are not supposed to have. CNA G said the nurse and CMA were responsible for making sure the residents do not have medications in room. During an interview on 06/03/2026 at 12:13 PM, LVN D said residents should not have medications in their room including ointments and creams. LVN D said the CNAs were responsible for checking daily medications while they were getting the residents ready for the day. LVN D said families bring things such as ointments that the staff were not aware of. LVN D said anything could happen. LVN D said a resident could get an ointment and get it in their eyes. LVN D said the nurses were responsible for ensuring all medications were stored properly. During an interview on 06/03/2026 at 1:29 PM, the ADON said medication should not be in a resident room. The ADON said we tell the family not to bring in medications. The ADON said the staff had been instructed to make sure medication brought in was not in the resident room within their reach. The ADON said the resident could put ointment in her eyes if her eye itched. She could put the medication in places that were not intended for. The ADON said (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	every staff member was responsible for ensuring medications were secured. During an interview on 6/3/2026 at 1:54 PM, the DON said Resident #30 should not have cream or ointments in her room. The DON said all staff were responsible for ensuring the medications were stored and secure. The DON said it could be harmful to the resident if they ingested the medication or if another resident got the medication. The DON said a resident could have a reaction or nothing could happen. During an interview on 06/03/2026 at 2:28 PM, the ADM said he expected the medication to be locked up and secure including ointments. The ADM said if there was no order for the medication, the resident could have an allergic reaction to the ointment. The ADM said the clinical team was responsible for making sure the medication were locked up. Review of a facility policy titled Medication Storage last revised in March 1, 2026 indicated It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacture's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. 1. General Guidelines: a. All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. b. Only authorized personnel will have access to the keys to locked compartments . c. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart .

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents could call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from each resident's bedside for 1 of 16 residents (Resident #40) reviewed for resident call system. The facility failed to ensure Resident #40 had a call light button attached to the call light system. Resident #40 did not have a call light available on [DATE]. This failure could place residents at risk for a delay in assistance and decreased quality of life, self-worth, and dignity.Findings include: Record review of Resident #40's face sheet, dated [DATE], reflected an [AGE] year-old male who was initially admitted to the facility on [DATE]. Resident #40 had diagnoses which included: vascular dementia (a decline in thinking and memory skills caused by restricted blood flow and oxygen to the brain), encounter for palliative care and chronic kidney disease (the progressive loss of kidney function over time, impairing the body's ability to filter waste and excess fluid from the blood). Record review of Resident #40's MDS assessment, dated [DATE], reflected Resident #40 was usually understood and usually understood by others. Resident #40's BIMS score was a 3, which indicated severe cognitive impairment. Resident #40 dependent with all ADLs. Resident #40 was always incontinent to bowel and bladder. Record review of Resident #40's care plan, dated [DATE], reflected Resident #40 has impaired thought processes related to dementia. During an observation on [DATE] at 10:05 AM, Resident #40 was lying in bed looking around. Resident #40 did not have a call light button attached to the call light system. During an observation on [DATE] at 12:45 PM, Resident #40 was lying in bed resting. Resident #40 did not have a call light button attached to the call light system. During an interview on [DATE] at 3:19 PM, the Maintenance Supervisor stated he fixed the call light in Resident #40's room that morning. He stated he put a double plate on the wall, so that there would be two call light cords instead of one. He stated before he replaced the plate that morning there was only one call light cord in the room and Resident #40's roommate had it. He stated there was another call light connection behind the television, because the staff moved the resident's bed around. He stated the staff notified him about adding the call light Friday, but he fixed it that morning. He stated every resident should have a call light in case they need to call for assistance or help. During an attempted interview on [DATE] at 8:02 AM, with Resident #40 he was asked if he could use the call light, but Resident #40 did not respond. During an interview on [DATE] at 8:05 AM, LVN E stated Resident #40 could use his call light. She stated he did not use it very often and usually his wife would get on the call light for him. She stated all staff were responsible for ensuring a resident had a call light accessible and within reach. She stated a negative effect was Resident #40 not being able to get the help he needed. During an interview on [DATE] at 1:02 PM, the Director of Nursing stated she expected all residents to have call light. She stated all staff were responsible for ensuring the residents had call light. She stated a negative effect of not having a call light accessible was that a resident would not be able to call for assistance. During an interview on [DATE] at 1:11 PM, the Administrator stated he expected all residents to have a call light accessible. He stated the maintenance team were responsible for ensuring the call lights were installed and operating properly. He stated the CNAs were responsible for ensuring the call light was within reach. He stated a negative effect was that Resident #40 did not have the ability to voice his needs or wants. Record review of the facility's policy Call Lights: Accessibility and Timely Response dated [DATE], indicated . The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to staff member or centralized location to ensure appropriate response. 5. Staff will ensure the call light is within reach of resident and secured, as needed. 6. The call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room. 8. Staff will report problems with a call light or the call system immediately to (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the supervisor and/or maintenance director and will provide immediate or alterative solutions until the problem can be remedied .