STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676154	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2025
NAME OF PROVIDER OR SUPPLIER: Capstone Healthcare of Hughes Springs		STREET ADDRESS, CITY, STATE, ZIP CODE: 215 Fm 161 Business South Hughes Springs, TX 75656	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47708 Based on interviews and record review the facility failed to ensure residents were free from abuse for 4 of 42 residents (Resident #1, #2, #4, and #5) reviewed for resident abuse. The facility did not ensure Resident (Resident #1, #2, #4, and #5) were free from abuse. This failure could place residents at risk of physical harm, mental anguish, or emotional distress. The findings included: 1. Record Review of Resident #1's face sheet dated 1/28/25 at 1:43 p.m., indicated Resident #1 was an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of COPD-chronic obstructive pulmonary disease with (acute) exacerbation (chronic inflammatory lung disease that causes obstructed airflow from the lungs), atherosclerotic heart disease of native coronary artery without angina pectoris (buildup of cholesterol plaque in the walls of arteries causing obstruction of blood flow), osteoarthritis (degeneration of joint cartilage and the underlying bone), and GERD (gastro-esophageal reflux disease) (stomach acid or bile irritates the food pipe lining). Record Review of Resident #1's MDS assessment dated [DATE] indicated, Resident #1 sometimes understood others and sometimes made herself understood. The MDS assessment indicated Resident #1 had a BIMS score of 11, which indicated Resident #1 was moderately impaired. The MDS assessment indicated Resident #1 had no behaviors of hitting, kicking, pushing, scratching, grabbing, or abusing others sexually. The MDS assessment indicated verbal behavior directed towards others occurred 1 to 3 days (threatening others, screaming at others, cursing at others). The MDS assessment indicated Resident #1's need for assistance with bathing, dressing, using the toilet, or eating was not coded on the MDS assessment. Record Review of Resident #1's care plan, dated on 12/11/24, indicated Resident #1 had impaired physical mobility. The care plan interventions included, encourage use of prescribed assistive devices; evaluate skin for areas of blanching or redness; determine level of needed assistance based on ADLs / IADLs evaluation; and Educate Resident / Representative on safety precautions. (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Record Review of Resident #2's face sheet dated 1/28/25 at 1:47 p.m., indicated Resident #2 was an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of dementia without behavioral disturbance (loss of memory, language, problem solving, and other thinking abilities that were severe enough to interfere with daily life), kidney disease unspecified (a progressive decline in kidney function over time), type 2 diabetes mellitus without complications (chronic condition that affects the way the body processes blood sugar), and essential hypertension (high blood pressure). Record Review of Resident #2's MDS assessment dated [DATE] indicated, Resident #2 understood others and made herself understood. The MDS assessment indicated Resident #2 had a BIMS score of 6, which indicated Resident #2 had a severe impairment. The MDS assessment indicated Resident #2 had no behaviors of hitting, kicking, pushing, scratching, grabbing, or abusing others sexually. The MDS assessment indicated Resident #2's need for assistance with bathing, dressing, using the toilet, or eating was not coded on the MDS assessment. Record Review of Resident #2's care plan, dated on 8/14/24, indicated Resident #2 had behavior symptoms. The care plan indicated, Resident #2 had potential for problems related to behaviors: verbal aggression, physical aggression, socially inappropriate behavior, low frustration tolerance, and cursing at staff/other residents. The care plan interventions included approach in a slow calm manner, explain to resident why behaviors were not appropriate, allow resident time to express self, listen closely to reasons for resident actions, record frequency of inappropriate behaviors, administer medication per order, record and report any cognitive changes, notify physician of any physical or cognitive changes, meet physical needs of resident, and remove resident from public area when behavior was unacceptable. Record review of an All Staff Inservice Training for Employees: Resident-To-Resident Altercations, dated 12/16/24, revealed in-service training, which was signed by all employees, on resident-to-resident altercations, behavior awareness, prevention of resident-to-resident abuse, and abuse and neglect policy. Record Review of the intake investigation worksheet dated 8/14/24 at 6:30 p.m. indicated, Narrative of The Incident: Residents #1 and Resident #2 engaged one another in the smoke area over an ash tray. Each resident claims the other slapped them. Staff member laundry aid C was present in smoke area and states both residents slapped one another. Neither resident has any visible marks or injury from altercation. Both residents tell me they are fine mentally, emotionally, and physically. Actions and Notifications: Staff separated the two residents immediately. Notified Admin, DON, physician, and family. Administrator directed Charge Nurse to keep the two separated the rest of the night. Notified ombudsman. Started in service. Record Review of grievance log reviewed on 1/27/25 at 10:01 a.m. Record Review of abuse and neglect policy reviewed on 1/27/25 at 10:26 a.m. Record Review of in-services reviewed on 1/27/25 10:31 a.m. (continued on next page)

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	676154	A. Building B. Wing	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capstone Healthcare of Hughes Springs	215 Fm 161 Business South Hughes Springs, TX 75656

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on1/28/25 at 9:34 a.m., Laundry aid C stated Resident #2 got the ash tray off the table to put her cigarette ashes in and then Resident #1 said to Resident #2 Why did you take that ash tray, how did you know I was done using it. Laundry aid C stated Resident #2 replied and said, Did you pay for it. Laundry aid C stated next Resident #1 said she would come and take the ash tray back. Laundry aid C stated next Resident #2 said, If you do take my ash tray, I will slap you. Laundry aid C stated next Resident #1 tried to take the ash tray from Resident #2. Laundry aid C stated that's when Resident #2 slapped Resident #1 across her head. Laundry aid C stated she was not sure if the slap from Resident #2 went across Resident #1 left or right side of head. Laundry aid C stated she believed the slap from Resident #2 to Resident #1 was made on Resident #1's right side of her head. Laundry aid C stated Resident #1 then slapped Resident #2 back across her hand. Laundry aid C stated she was not sure if the slap from Resident #1 to Resident #2 was made to her left or right hand. Laundry aid C stated Resident #1 started the incident. Laundry aid C stated neither resident occurred any injuries. Laundry aid C stated it was not a hard slap from neither resident. Laundry aid C stated the two residents slapped each other and that was it. Laundry aid C stated, I got a nurse to come help me separate the two residents. Laundry aid C stated she could not remember if any in-services were completed following this incident. Laundry aid C stated this incident occurred around 6 in the evening. Laundry aid C stated she was outside with the residents on the smoking patio when this incident occurred. Laundry aid C stated she reported this incident to LVN D on the night shift. During an interview on 1/28/25 at 10:07a.m., the Administrator stated Resident #2 passed last year on the 21st of August 2024. During an interview on 1/28/25 at 10:12 a.m., Resident #3 stated Resident #2 took the ash tray that Resident #1 was using. Resident #3 stated, It made Resident #1 mad. Resident #3 stated Resident #1 tried to take back the ash tray and that's when Resident #2 hit her. Resident #3 stated next the nursing broke up the fight between the two residents. Resident #3 stated, Resident #1 tried to hit Resident #2 back. Resident #3 stated Resident #2 had grabbed arm to keep her from hitting her back. Resident #3 stated this incident happened so long ago and she was doing her best at remembering this incident. Resident #3 stated, Resident#1 had some bruising on her arm from where Resident #2 grabbed her arm. Resident #3 stated this incident happened on the smoke patio outside. During an interview on 1/28/25 at 10:17 a.m., Resident #1 stated she did not remember the incident. Resident #1 stated, This incident happened so long ago I'm afraid I don't remember. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 1/28/25 at 10:57 a.m., the Administrator stated he had been employed for 2 years. The Administrator stated the two residents, (Resident #2) and (Resident #1), were roommates for a good year prior to this altercation. The Administrator stated both residents, (Resident #2) and (Resident #1), had strong personalities and were very funny. The Administrator stated eventually they got on each other's nerves when they were out in the smoke area. The Administrator stated usually there was about 3 or 4 ash trays out on the smoke patio. The Administrator stated Resident #2 got one of the ash trays. The Administrator stated Resident #1 did not like that she got the ash tray. The Administrator stated both residents were fussing at each other. The Administrator stated, Resident #1 rolled over and kicked the ash tray then Resident #2 slapped Resident #1. The Administrator stated the staff member interceded and got them apart. The Administrator stated, When Resident #2 slapped Resident #1 that her glasses came off her face. The Administrator stated, Resident #1 had bruising on her arm from when Resident #2 grabbed her arm. The Administrator stated there were no injuries from either resident. The Administrator stated staff separated the residents. The Administrator stated, Resident #2 was put on 15m check to make sure the resident was not re-engaging with Resident #1. The Administrator stated after this incident the residents were not put back in the same room. The Administrator stated, Resident #2 wanted to apologize but Resident #1 did not want her apology. The Administrator stated this resident-to-resident altercation was discussed in QAPI meeting. The Administrator stated the police were not called. The Administrator stated the residents did not want him to call the police. The Administrator stated this was a mutual engagement from both residents. The Administrator stated an in-service on resident-to-resident altercations, awareness and prevention, abuse, and neglect policy was completed following this incident. The Administrator stated the families and physician were notified after this incident. The Administrator stated the interventions that were put in place after the resident-to-resident altercation was Resident #2 was placed on 15m checks for 24 hours and 30m checks thereafter or until he told staff to stop the checks, training was completed, and a referral to for behavior. The Administrator stated the resident-to-resident altercation was discussed in QAPI. The Administrator stated the DON, the ADON, the infection preventionist, the business office manager, social services, the housekeeping supervisor, the diet supervisor, maintenance, CNA, and himself attended QAPI meetings. The Administrator stated the medical director was not able to go to the all the meetings, but he sat down with the medical director and talked about what was discussed in QAPI. The Administrator stated QAPI was completed every month usually the 3rd week of the month. 2. Record Review of Resident #4's face sheet dated 1/28/25 at 1:50 p.m., indicated Resident #4 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of GERD (gastro-esophageal reflux disease) (stomach acid or bile irritates the food pipe lining), hemiplegia (part of the brain controlling movement is damaged) affecting right dominant side), type 2 diabetes mellitus without complications (chronic condition that affects the way the body processes blood sugar), and essential hypertension (high blood pressure). Record Review of Resident #4's MDS assessment dated [DATE] indicated, Resident #4 usually understood others and usually made herself understood. The MDS assessment indicated Resident #4 had a BIMS score of 7, which indicated Resident #4 had a severe impairment. The MDS assessment indicated Resident #4 had no behaviors of hitting, kicking, pushing, scratching, grabbing, or abusing others sexually. The MDS assessment indicated Resident #4's need for assistance with bathing, dressing, using the toilet, or eating was not coded on the MDS assessment. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Record Review of Resident #4's care plan, dated on 1/27/25, indicated Resident #4 was at Risk for Harm: Self Directed or Other-Directed due having history of fighting with another resident. The care plan goal indicated; Resident #4 will be free of physically aggressive behaviors. The care plan interventions included administer medications as prescribed, to evaluate and treat as indicated, if resident poses a potential threat to injure self or others notify provider, if wandering or pacing, initiate visual supervision during acute episode, monitor for signs / symptoms of agitation, and utilize calming touch. Record Review of Resident #5's face sheet dated 1/28/25 at 1:47 p.m., indicated Resident #5 was an [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of metabolic encephalopathy (brain chemical imbalance in the blood), hypokalemia (deficiency of potassium in the bloodstream), type 2 diabetes mellitus without complications (chronic condition that affects the way the body processes blood sugar), and essential hypertension (high blood pressure). Record Review of Resident #5's MDS assessment dated [DATE] indicated, Resident #5 understood others and made himself understood. The MDS assessment indicated Resident #5 had a BIMS score of 6, which indicated Resident #5 had a severe impairment. The MDS assessment indicated Resident #5 had no behaviors of hitting, kicking, pushing, scratching, grabbing, or abusing others sexually. The MDS assessment indicated Resident #5's need for assistance with bathing, dressing, using the toilet, or eating was not coded on the MDS assessment. Record Review of Resident #5's care plan, dated on 1/27/25, indicated Resident #5 was at risk for harm: other-directed due to having altercation in the past. The care plan goal indicated; Resident #5 will be free of non-aggressive behaviors. The care plan interventions included administer medications as prescribed, to evaluate and treat as indicated, monitor for cognitive, emotional, or environmental factors that may contribute to violent behaviors, monitor for signs / symptoms of agitation, and provide verbal feedback to resident regarding behavior. Record Review of grievance log reviewed on 1/27/25 at 10:01 a.m. Record Review of abuse and neglect policy reviewed on 1/27/25 at 10:26 a.m. Record Review of in-services reviewed on 1/27/25 10:31 a.m. Record Review of intake investigation worksheet dated 12/6/24 at 4:00 p.m. indicated, Narrative of The Incident: Staff member reports observing Resident #4 approach and slap Resident #5. Staff member states Resident #5 was accusing his roommate Resident #4 of taking his pants immediately before this incident. Altercation was witnessed by CNA B and CNA A. Head to toe assessment shows no injuries, bruising, scratches, related to this incident. Actions and Notifications: Separated residents. Roommates moved to separate rooms. Resident #4 placed on 15-minute checks. Staff directed to keep residents separated. Notified DON, Administrator, Physician, families, and Ombudsman. During observation on 1/27/25 at 3:30 p.m., Resident to Resident interactions were observed in the lounge area of the facility and no issues was observed. During observation on 1/28/25 at 11:00 a.m., Resident to Staff interaction were observed on the smoke patio outside and no issues was observed. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	During observation on 1/28/25 at 11:00 a.m., Resident to Resident interactions were observed on the smoke patio outside and no issues was observed. During a phone interview on 1/27/25 at 2:32 p.m., CNA A stated she witnessed Resident #4 slap Resident #5 in the face. CNA A stated the residents was separated after the slap to the face in the dining room. CNA A stated after the residents were separated that the two residents were screaming at each other from across room in the dining room. CNA A stated Resident #5 was taken to a separate area to calm down. CNA A stated neither resident had injuries. CNA A stated she reported this incident to the Administrator. During an attempted phone interview on 1/27/25 on 2:36 p.m., CNA B was unavailable to be reached by phone. Record Review of a written statement undated signed by the CNA B indicated, I (CNA B) was coming out of room [ROOM NUMBER] when I was stopped by Resident #5. He asked me did I steal a pair of his pants out of the closet his back was facing the nurses station and my face is facing towards the nurses as Resident #5 and I are talking Resident #4 rolls towards Resident #5 and I and was aggressive, Resident #4 calls Resident #5 a bitch and I stand in between the Resident #5 back is still facing towards Resident #4 as I'm standing between Resident #4 and Resident #5 I push Resident #4 back towards the nurses station he rolls back up takes his left hand and goes across Resident #5 face I separated them CNA A 6/2 shift got the RN E and she took over from there this happened between 3:30 and 4:00 p.m. During an interview on 1/27/25 at 2:55 p.m., Resident #5 stated he did not remember being hit by Resident #4. Resident #5 stated he could not recall what the altercation was about. Resident #5 stated staff was nice to him. Resident #5 stated he did feel safe in the facility but wanted to go home with his. During an interview on 1/27/25 at 2:50 p.m., Resident #4 stated he could not recall the incident. Resident #4 stated he did feel safe. Resident #4 stated staff were nice to him. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 1/28/25 at 10:47 a.m., the Administrator stated he had been the administrator for 2 years. The Administrator stated the two residents, (Resident #4) and (Resident #5), were roommates. The Administrator stated the aid was trying to help Resident #4 change clothes because he had spilled something on his clothing. The Administrator stated Resident #5 accused the aide of putting his pants on Resident #4. The Administrator stated Resident #4 rolled to Resident #5 and hit him along the face or head area. The Administrator stated there was no injuries or bruising on either resident. The Administrator stated the aide was not sure if Resident #5 made contact to Resident #4's face. The Administrator stated each resident resided on different halls now. The Administrator stated in-services were completed on Behaviors and being aware of behaviors before they escalate to something else. The Administrator stated, I just did an in-service on trying to look for ways to prevent things that frustrated with the residents that leads to altercations. The Administrator stated the police were not notified about this incident. The Administrator stated he asked the resident if they wanted him to call the police and each resident replied that they were fine and not to call the police. The Administrator stated neither resident went to the hospital following this incident. The Administrator stated the family, and the physician were notified about this incident. The Administrator stated the resident-to-resident altercation was discussed in QAPI. The Administrator stated the DON, the ADON, the infection preventionist, the business office manager, social services, the housekeeping supervisor, the diet supervisor, maintenance, CNA, and himself attended QAPI meetings. The Administrator stated the medical director was not able to go to the all the meetings, but he sat down with the medical director and talked about what was discussed in QAPI. The Administrator stated QAPI was completed every month usually the 3rd week of the month. The Administrator stated the interventions that were put in place after the resident-to-resident altercation was Resident #4 was placed on 15m checks for 24 hours and 30m checks thereafter or until he told staff them to stop the checks, training was completed and referral to deer oaks clinic for behavior. Record Review of the facility's abuse and neglect policy dated 2/1/23 indicated, (g) Physical Abuse - includes hitting, slapping, pinching, kicking, or controlling behavior through corporal punishment. (8) All completed Abuse, Neglect, and Misappropriation investigations will be reported to and reviewed by the QAPI committee. The QAPI committee will review and analyze trends and patterns to seek out improved performance opportunities and find ways to prevent future issues.