STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676252	A. Building B. Wing	01/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capstone Healthcare Estates at Veterans Memorial	1424 Fallbrook Drive Houston, TX 77038

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48923 Based on interview and record review, the facility failed to maintain medical records in accordance with accepted professional standards and practices for 1 (CR #1) of 4 residents reviewed for medication administration. 1-LVN A and LVN B documented CR #1 was being monitored for behaviors and medication side effects and documented CR #1 was administered medication in the evening of 12/27/2024 and the day of 12/28/2024 while he was at the hospital. 2-LVN A documented CR #1 had a pain level of 3 (on a scale of 0-10, with 10 being the most pain) on 12/29/2024 while he was at the hospital. This failure could possibly lead to resident injury due to inaccurate documentation and reflection of resident health and care. Findings included: Record review of CR #1's face sheet last captured 12/29/2024 revealed a [AGE] year-old male originally admitted on [DATE]. His medical diagnoses included: Bipolar Disorder, Unspecified Dementia, Hypertension (high blood pressure), muscle wasting and atrophy, Diverticulitis of the intestine, slow transit constipation and congestive heart failure. He was discharged on [DATE]. Record review of CR #1's Quarterly MDS (a resident assessment screening tool) dated 10/25/2024 revealed a BIMS (Brief Interview of Mental Status) score of 3, indicating severe impaired cognition. CR #1 required moderate assistance with eating and oral hygiene, and required substantial to maximal assistance with toileting, showering, dressing, putting on and taking off footwear, and personal hygiene. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of CR#1's care plan last updated 10/25/2024 revealed CR #1 had potential to have behaviors due to his poor cognition due to Dementia, with interventions including: administering medications as ordered, analyzing times of day, places, circumstances, triggers, and what de-escalates behavior and documenting, and providing physical and verbal cues to alleviate anxiety. CR #1 also had a history of having Dementia and took a routine antipsychotic medication, putting him at risk of side effects with an initiated date of 3/2/2023, and interventions including: monitoring, documenting, and reporting PRN any adverse reactions of Psychotropic medications such as unsteady gait, frequent falls, diarrhea, muscle cramps, nausea, behavior symptoms not usual to the person. Record review of CR #1's progress notes dated 12/27/2024 at 8:00 am revealed 911 was called at 8:03am and CR #1 was transported to the ER. CR #1's RP (Responsible Party, the person who can make decisions for a resident) was notified and was aware, and the DON was notified of the incident as well. A late entry note created 12/29/2024 at 4:40pm revealed CR #1 was sent to the ER due to a change in condition of Respiratory arrest. Record review of Resident #1's Medication Administration Record for December 2024 revealed: -Antidepressant Monitoring for Sertraline and Trazadone every shift for side effects with a start date 07/21/2023 was marked as No for behaviors documented on 12/27/24 6pm-6am shift and signed by LVN B, and for behaviors documented on 12/28/2024 6am-6pm shift and signed by LVN A. -Behavior Monitoring for Antidepressant Medication: Sertraline Document # of Times Resident has Exhibited the Above Behavior During Shift and Intervention Codes: with a start date of 6/5/2023 was marked No for behaviors documented on 12/27/24 6pm-6am shift and signed by LVN B, and for behaviors documented on 12/28/2024 6am-6pm shift and signed by LVN A. -Monitor for signs and symptoms of adverse reaction: Interocular hemorrhage, abdominal pain, flatulence . ASPIRIN every shift with a start date of 07/02/2024 documented as completed/administered on 12/27/24 6pm-6am shift and signed by LVN B, and as completed/administered on 12/28/2024 6am-6pm shift and signed by LVN A. -Pressure Reducing Mattress to bed every shift with a start date of 2/22/2023 document as completed/administered on 12/27/24 6pm-6am shift and signed by LVN B, and as completed/administered on 12/28/2024 6am-6pm shift and signed by LVN A. -Senna-Plus Oral tablet 8.6-5.0 MG (Sennosides-Docusate Sodium) Give 1 tablet by mouth two times a day for constipatin [sic] with a start date of 4/30/2023. Record review of CR #1's SNF/NF to Hospital Transfer Form revealed LVN A documented that 12/29/2024 at 4:44pm CR #1 had a pain level of 3. The form also noted that CR #1 was transferred from the facility to the hospital on 12/27/2024 at 8: 15am. Interview with LVN A on 1/2/24 at 11:15am, she said 6am to 6pm was her normal shift. She said she documented in CR #1's nursing progress notes that he was sent to the hospital and clicked on No for all his orders. She would review his Orders and can make Late Entry notes to correct any incorrect documentation. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DON on 1/2/24 at 1:17pm, she said that LVN A and LVN B should have documented that Resident #1 was in the hospital and not documented medications as given. The DON said that not accurately documenting that information could delay the resident's treatment. When asked what risk it could have posed to CR #1 if medications were documented as given when it was not, she said, I don't know how else to answer that. The DON called back later and said that LVN A will do a late entry in the system, and that LVN B will do so as well, and that she would conduct individual in-services for both nurses on medication documentation. Later interview with the Administrator and the DON on 1/3/24 at 3:03pm, the DON reviewed Resident #1's MAR and stated that the Senna was the only medication that was incorrectly documented as given. The DON also said she would begin conducting in-services on accurate documentation for the rest of her staff. Record review of the facility's Pharmacy Services Overview policy last revised April 2019 revealed that pharmaceutical services consist of the processes of receiving and interpreting prescriber's orders, including distributing, administering, and monitoring response to medications, biologicals, and chemicals. Record review of the facility's Documentation of Medication Administration policy last revised November 2022 stated, A medication administration record is used to document all medications administered and that a nurse or certified medication aide documents all medications administered immediately after it is given. The documentation is to include reasons why a medication was withheld, not administered or refused.