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	10/31/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident was treated with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 4 (Resident #4, Resident #5, Resident #6, and Resident #7) of ten residents.The facility failed to ensure CNA G did not make Resident #4 feel threatened, make Resident #5 feel like a child, hurt Resident #6's feelings, and make Resident #7 feel not like a human.This deficient practice placed residents at risk of mental harm, anxiety and depression.Findings included:Review of Resident #4's face sheet dated 10/30/25 reflected a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left dominant side (paralysis (hemiplegia) or weakness (hemiparesis) on the right side of the body due to an unspecified cerebrovascular disease affecting the left side of the brain), Type 2 Diabetes Mellitus, and chronic kidney disease stage 3 (moderate kidney damage where the kidneys are not functioning optimally).Record review of Resident #4's care plan reflected a problem dated 09/20/23 of Resident #4 continued to use profanity as his way of communicating towards others. Resident #4 would at times refuse care. Resident #4 continued to do what he wanted and would joke with staff in an inappropriate manner. Review of Resident #4's Quarterly MDS dated [DATE], reflected a BIMS score of 11 indicating moderate cognitive impairment. Review of Resident #5's face sheet dated 10/31/25 reflected an [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] and 01/17/24 with diagnoses including Parkinson's disease without dyskinesia (neurodegenerative disorder characterized by tremors, rigidity, slowness of movement (bradykinesia), and balance problems), bipolar disorder (a mental health condition characterized by extreme mood swings between periods of high energy (mania or hypomania) and low energy (depression), and anorexia (an eating disorder that causes people to weigh less than is considered healthy for their age and height, usually by excessive weight loss).Record review of Resident #5's care plan reflected a problem dated 07/21/23 of psychological well-being due to her history of depression and bipolar with intervention dated 05/09/25 of encourage participation from resident who depends on others to make decisions. Review of Resident #5's Quarterly MDS dated [DATE], reflected a BIMS score of 12 indicating moderate cognitive impairment. Review of Resident #6's face sheet dated 10/31/25 reflected a [AGE] year old female admitted on [DATE] and readmitted on [DATE] with diagnoses including Dementia (a group of conditions that cause a decline in cognitive abilities, such as memory, thinking, problem-solving, and language), chronic obstructive pulmonary disease with acute exacerbation (a long-term lung condition characterized by airflow obstruction and inflammation) and morbid severe obesity (a severe form of obesity characterized by a body mass index (BMI) of 40 or higher).Record review of Resident #6's care plan reflected a problem dated 07/21/21 of Resident #6 has a history of depression and is at risk for poor mood stability, increased depression, and poor quality of life with an intervention dated 08/20/25 discuss with the resident any concerns or issues regarding health and/or emotional well-being.Review of Resident #6's Quarterly MDS dated [DATE], reflected a BIMS score of 13 indicating no cognitive impairment.Review of Resident #7's face sheet dated 10/31/25 reflected a [AGE] year old male admitted on [DATE] and readmitted on [DATE] with diagnoses including Dementia (a group of conditions that cause a decline in cognitive abilities, such as memory, thinking, problem-solving, and language), anorexia (an eating disorder that causes people to weigh less than is considered healthy for their age and height, usually by excessive weight loss), and epilepsy (a chronic neurological disorder characterized by recurrent seizures, which are sudden, uncontrolled electrical discharges in the brain). Record review of Resident #7's care plan reflected a problem dated 06/21/22 of Resident #7has a history of depression, bipolar disorder (a mental health condition characterized by extreme mood swings between periods of high energy (mania or hypomania) and low energy (depression) and psychosis (mental health condition characterized by a loss of touch with reality). Review of Resident #7's Quarterly MDS dated [DATE], reflected a BIMS score of 09 indicating moderate cognitive impairment. Record review of TULIP (an online system used by the Texas Health and Human Services Commission for long-term care licensing, applications, and reporting) facility self-report dated 07/09/25 reflected that on 07/09/25 Resident #4 told a staff member (name of staff member not listed) that about a week prior to this date CNA G told him he would she would, take him outside on the grass and whoop his butt. CNA G was suspended pending the outcome

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the residents' environment remained as free of accident hazards as was possible and ensure each resident received adequate supervision and assistance devices to prevent accidents for one (Resident #1) of three residents reviewed for accidents and hazards.The facility failed to ensure CNA A, on 10/07/25, had a 2nd staff member assisting her when transferring Resident #1 from her bed to her wheelchair and failed to ensure the mechanical lift sling was free from defects. Resident #1 fell from her bed to the floor and sustained lacerations to her head resulting in 7 stitches to her left forehead and 5 staples to her posterior scalp.The noncompliance was identified as Past Noncompliance. The Immediate Jeopardy (IJ) began on 10/07/25 and ended on 10/08/25. The facility had corrected the noncompliance before the survey began.This deficient practice placed residents at risk of pain, injury, and hospitalization.Findings included:Review of Resident #1's face sheet dated 10/29/25 reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including other epilepsy, not intractable, without status epilepticus (a form of epilepsy (a chronic neurological disorder characterized by recurrent seizures caused by abnormal electrical activity in the brain) where seizures are not considered difficult to control with treatment), contracture, left knee (limiting movement and causing pain, stiffness, and an inability to fully extend the leg), and dementia in other diseases classified elsewhere, unspecified severity with agitation (dementia (a general term for a decline in mental ability that affects memory, thinking, and daily life) caused by another disease (like Alzheimer's or Parkinson's) who also exhibit agitation, such as restlessness, shouting, or aggression, and the severity of the dementia has not been specified). Review of Resident #1's care plan initiated on 03/18/21 and revised on 10/07/25 reflected Resident #1 had very limited mobility and required total assistance with all transfers via mechanical lift, putting her at risk for falls. Review of Resident #1's Quarterly MDS dated [DATE], reflected a BIMS score of 04 indicating severe cognitive impairment. Observation on 10/29/25 at 9:47 am of transfer by mechanical lift of Resident #1 from her bed to her wheelchair by CNA C and CNA D. Surveyor observed safe transfer and mechanical lift sling in good condition. During the observation of Resident #1 being transferred, Resident #1 told CNA C and CNA D, don't hurt me like you did the other day. Review of facility investigation statement dated 10/07/25 of CNA A reflected she was preparing to transfer [Resident #1] to her chair using a [mechanical lift] and sling. I positioned the sling under the resident while waiting on my coworker to assist with the transfer. As I set the resident in the sling above her bed the sling broke. She fell off the bed onto the floor. The incident happened before my coworker arrived. I immediately notified the nurse. Review of facility Accident/Incident Investigation Statement of CNA B dated 10/07/25 reflected on 10/07/25 at about 7:35 am CNA B was in the shower room assisting another resident when CNA A called and asked her to go help with a mechanical transfer. CNA B said she was finishing up with the shower and would come as soon as she could. When CNA B got to the room to help with Resident #1, Resident #1 was already on the floor. CNA A told CNA B that the sling had broken when she was waiting for help. The nurse was called right away and CNA A and CNA B stayed with Resident #1 until the nurse arrived. Review of facility investigation statement dated 10/07/25 of DON reflected at approximately 7:55 am she was called to Resident #1's room by CNA A who stated Resident #1 was on the floor at bedside. Resident #1 was on her back with a laceration above her left eyebrow and back of her head. Staff at bedside applied pressure. Resident #1 remained in the same position as when she fell from the mechanical lift. Vitals were taken and Resident #1 complained of pain to her bilateral lower extremity at a level of 4 out of 10 (Moderate pain, manageable). RP and MD notified, and orders received for emergency medical services transport for evaluation and treatment. Record review of hospital records dated 10/07/25 reflected [AGE] year-old female arrived by emergency medical service from nursing facility status post fall approximately 3 - 4 feet as patient was being carried over on a lift. Patient sustained left forehead laceration as well as posterior scalp not on any anticoagulation. Patient was at her baseline since the fall. No bruising to the rest of her body. Vital signs were stable per emergency medical services. Record review of TULIP (an online system used by the Texas Health and Human Services Commission for long-term care licensing, applications, and reporting) facility self-report dated 10/07/25 reflected Resident #1 had an observed fall. CNA A said as she was waiting for CNA B to come into Resident #1's room to assist CNA A with transferring Resident #1 from her bed to her wheelchair. While CNA A was waiting for CNA B to come, CNA A positioned the resident in the sling to get ready for CNA B to come and

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F 0694 Level of Harm - Actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. (continued on next page)

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F 0694 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure that residents receive parenteral fluids consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences for one resident (Resident #3) of 5 residents reviewed for treatments. The facility failed to follow facility protocol of cleaning and changing of the PICC line dressing for Resident #3, since his return from the hospital on [DATE] until he was readmitted to the hospital on [DATE]. This failure could lead to infections and related complications. Findings included:Record review of Resident #3's face sheet dated 10/30/25 revealed a [AGE] year-old male initially admitted on [DATE] and re admitted to the facility on [DATE]. His diagnoses included cellulitis (skin infections), dysphagia (difficulty to swallow) , type 2 diabetes, hemiplegia and hemiparesis (paralysis of one side), pain, muscle weakness, lack of coordination and reduced mobility.Record review of Resident #3's quarterly MDS dated [DATE] revealed a BIMS score of 8 indicating his cognition was moderately impaired. Record review of Resident #3's care plan dated 04/11/25 reflected Resident #3 was recently in the hospital and had a UTI and Sepsis[KS3] putting him at risk for having a recurrent UTI. The relevant intervention was giving antibiotic therapy as ordered. Monitor/document for side effects and effectiveness. Record review of the facility reported incident dated 07/16/25 revealed, on 07/14/25 Resident #3 was noted with an elevated temperature and was sent to the emergency room for evaluation. Upon examination Resident #3 was observed with an outdated dressing at IV site to right arm.Record review of progress notes in the E HR revealed Resident #3 was admitted to the hospital on [DATE] for UTI and discharged on 6/13/25 with PICC line[KS4] in place, after a course of IV antibiotics. He was readmitted to hospital on [DATE] as he was febrile (had a fever) and returned to facility on 7/21/25. On 07/14/25 at the hospital it was noticed that the date on the PICC line dressing was 06/11/25.Observation of the photograph of the PICC line dressing provided by FM revealed it was taken on 07/14/25. The date printed on the PICC line dressing was 06/11/25 .Record review of the MAR of June 2025 reflected:1. No order for changing the PICC line dressing.2. Imipenem/Cilastatin (Primaxin) 500mg/100ml ns injectable, 500mg/100ml mg/ml (Imipenem, Cilastatin) : Use 33.3 ml intravenously three times a day for IV ABT Therapy for 36 Administrations over 3 hours. -Start Date-06/14/2025.Record review of the MAR for July 2025 reflected:1. PICC line dressing and cap change weekly using sterile technique per protocol: At bedtime every Sunday. -Start Date-07/27/2025 -D/C Date-08/21/2025. 2. DAPTOmycin Intravenous Solution Reconstituted 500 MG(Daptomycin):Use 372 mg intravenously one time a day for Cellulitis/MRSA until 08/15/2025. Infuse 372mg q 24hrs. Original order: Daptomycin 6mg/kg q 24hr. Patient weighs 62kg (136lb). -Start Date- 07/22/2025 During an interview on 10/30/25 at 3:02pm the FM stated on 07/14/25 he had noticed the date on the PICC line dressing on Resident #3, and it was 06/11/25. He stated Resident #3 was in the hospital for IV antibiotic treatment and returned to the facility on [DATE] with the PICC line on him. The FM continued, this means the dressing was not changed at the facility ever since his return from the hospital. He stated he took a photo of the dressing, on 07/14/25 and showed it to DON. The FM stated he was not happy with this neglect from the facility side.During a telephone interview on 10/30/25 at 3:20pm LVN A stated she was the nurse who readmitted Resident #3 from hospital on 6/13/25 and probably had forgotten to get an order for changing PICC line dressing every week. She stated she was aware of the importance of changing the dressing to minimize infection. She stated, at the facility the PICC line dressing changes were scheduled every Sunday in the afternoon shift and were performed by the nurse in charge on that day. She stated she was not sure why she had forgotten to organize the order with the physician on duty on that day. She stated she attended an in service on IV care and monitoring sometime in July 2025 and did not remember the exact day.During a phone interview on 10/30/25 at 3:43pm LVN B stated she was not working in hall 400 where Resident #3 was admitted on [DATE]. She said she worked with Resident #3 afterwards however in the weekdays and had not noticed the date on the PICC line dressing. LVN B said the PICC line dressing changes were scheduled at the facility weekly on Sundays and completed by the respective nurses on that day. LVN B stated changing the PICC line dressing once a week or PRN when it is dirty is crucial to minimize infection. LVN B stated it was the responsibility of the nurse who admitted the resident to the facility to get the dressing order from the NP.During an interview on 10/30/25 at 1:38pm LVN C stated she was the wound nurse at the facility and worked Monday to Friday in the day shift. She stated she did not attend PICC line dressing changes unless there was any infection or skin