STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676314	A. Building B. Wing	01/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capstone Healthcare Estates on Orem	3730 W. Orem Drive Houston, TX 77045

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 40249 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objective and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 3 residents (Resident #1) reviewed for care plans. -The facility failed to ensure Resident #1's treatment orders for Right Heel Unstageable DTI were followed as ordered by the physician on 12/18/24 . -Wound Care Nurse documented administering a treatment to Resident #1's Right Heel Unstageable DTI that she did not provide on 12/18/24 . These deficient practice could affect residents with comprehensive care plans and could result in missed or delayed continuity of care. Findings included: Record review of the admission sheet for Resident #1 revealed a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included pressure ulcer of right ankle, stage 4 (a severe, deep wound on the right ankle where the skin damage extends beyond the subcutaneous tissue, potentially exposing muscle, tendon, or bone), heart failure (a chronic condition in which the heart doesn't pump blood as well as it should) and peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). Record review of Resident #1's comprehensive MDS assessment dated [DATE] revealed a BIMS of 08 out of 15 indicating moderately impaired cognition. She required substantial/maximal assistance from staff for toilet hygiene, personal hygiene, upper/lower body dressing. Resident #1 had indwelling catheter. Resident#1 was always incontinent of bowel. Further review of Section M0150. Risk of Pressure Ulcers/injuries. Is the resident at risk of developing pressure ulcers/injuries? Coded: Yes. G. Unstageable - Deep tissue injury: coded: 0 Record review of Resident #1's Care plan dated 01/09/2021 and revised on 12/18/2024 revealed the following care plan: (continued on next page)

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Problem: [Resident#1] has DTI to Right heel Goal: [Resident#1] will have intact skin, free of redness, blisters or discoloration by/through review date. Interventions: Administer treatments as ordered and monitor for effectiveness. Assess/record/monitor wound healing Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the MD. Follow facility policies/protocols for the prevention/treatment of skin breakdown. Record review of Resident #1's physician's order dated 12/06/2024 revealed an order for Right Heel Unstageable DTI: Cleanse with normal saline or wound cleanser, pat dry apply Skin Prep 3 times a week, PRN. Every day shift every Mon, Wed, Fri. Record review of Resident #1's TAR for the month of December 2024 revealed an order for Right Heel Unstageable DTI: Cleanse with normal saline or wound cleanser, pat dry apply Skin Prep 3 times a week, PRN. Every day shift every Mon, Wed, Fri was signed off 6am-6pm on 12/18/24 by the Wound Care Nurse. Observation and attempted interview on 12/18/24 at 10:16 a.m., with Resident#1 revealed she was resting on an air mattress. Resident mumbled for about 5 minutes while being interviewed and could not respond appropriately to the questions asked about her wounds. Resident had wounds on the sacrum, Right leg/foot/shin lateral/anterior that were without the dressing. Observation on 12/18/24 at 10:31a.m., revealed Wound Care Nurse providing wound care for Resident #1. Wound Care Nurse gathered the supplies at the treatment cart in the hallway before bringing them into Resident #1's room. Continued observation revealed right heel unstageable DTI with intact skin approximately 2.0 centimeters in diameter. Wound Care Nurse failed to provide treatment to right heel as ordered. In an interview and record review on 12/18/24 at 1:13p.m., with the Wound Care Nurse, she said she provided treatment to Resident#1's right lateral shin, sacrum, right lateral foot, and right anterior shin. This Surveyor reviewed Resident #1's TAR with the Wound Care Nurse. Wound Care Nurse said she signed off on the order for unstageable DTI of the right heel but forgot to provide the treatment. When asked why she signed off on the order if she did not provide the treatment. WCN said she forgot because the right heel did not need a dressing just a skin prep. WCN said skin prep helped dry up the wound. Wound Care Nurse said it was important to follow physician order to promote wound healing. In an interview on 12/18/24 at 1:45p.m., with the DON, when asked how does staff know what treatment to provide to residents. What is the risk to the resident due to this failure? The DON said it was important to follow physician orders to facilitate wound healing. To ensure accuracy, treatment should be administered by referencing the computer orders rather than relying on memory. The DON said it was important to sign off on each order once the corresponding treatment has been completed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Wound Care policy dated (Revised October 2010) revealed read in part: . Purpose: The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Preparation: 1. Verify that there is a physician's order for this procedure .

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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 - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40249 Based on observations, interviews, and record review the facility failed to establish and 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 infection for 1 of 3 residents (Resident #1) reviewed for infection. -The facility failed to ensure Wound Care Nurse performed hand hygiene after removing soiled gloves and before applying new gloves while providing Resident #1's wound care on 12/18/24. -The facility failed to ensure Resident#1's wounds were covered after evaluation from the wound care physician on 12/18/24. These failures could place residents at risk for the spread of infection. Findings included: Record review of the admission sheet for Resident #1 revealed a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included pressure ulcer of right ankle, stage 4 (a severe, deep wound on the right ankle where the skin damage extends beyond the subcutaneous tissue, potentially exposing muscle, tendon, or bone), heart failure (a chronic condition in which the heart doesn't pump blood as well as it should) and peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). Record review of Resident #1's comprehensive MDS assessment dated [DATE] revealed a BIMS of 08 out of 15 indicating moderately impaired cognition. She required substantial/maximal assistance from staff for toilet hygiene, personal hygiene, upper/lower body dressing. Resident #1 had indwelling catheter. Resident#1 was always incontinent of bowel. Further review of Section M0150. Risk of Pressure Ulcers/injuries. Is the resident at risk of developing pressure ulcers/injuries? Coded: Yes. G. Unstageable - Deep tissue injury: coded: 0 Record review of Resident #1's Care plan dated 01/09/2021 and revised on 12/18/2024 revealed the following care plan: Problem: [Resident#1] has DTI to Right heel Goal: [Resident#1] will have intact skin, free of redness, blisters or discoloration by/through review date. Interventions: Administer treatments as ordered and monitor for effectiveness. Assess/record/monitor wound healing Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the MD. Follow facility policies/protocols for the prevention/treatment of skin breakdown. Observation and attempted interview on 12/18/24 at 10:13 a.m., with Resident#1 and the Wound Care Doctor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Wound Care Doctor said he had evaluated Resident#1's wounds and had to run to other facility. Wound Care Doctor left Resident#1's wounds uncovered. Further observation revealed old/soiled dressings had been removed and were left on the resident's bed rather than being properly disposed of. Observation and attempted interview on 12/18/24 at 10:16 a.m., with Resident#1 revealed she was resting on an air mattress. Resident mumbled for about 5 minutes while being interviewed and could not respond appropriately to the questions asked about her wounds. Resident had wounds on the sacrum, Right leg/foot/shin lateral/anterior that were without the dressing. Old/soiled dressings had been removed and were left on the resident's bed rather than being properly disposed of. Observation on 12/18/24 at 10:31a.m., revealed Wound Care Nurse providing wound care for Resident #1. Wound Care Nurse gathered the supplies at the treatment cart in the hallway before bringing them into Resident #1's room. There was no dressing on the sacrum wound. Continued observation revealed an open area of approximately 5.0 centimeters in diameter. WCN cleansed the wound with normal saline, removed her soiled gloves, and without sanitizing/washing her hands donned clean gloves and continued the treatment. In an interview on 12/18/24 at 1:13p.m., with the Wound Care Nurse, she said the wound care doctor did not cover the wounds, and she was rushed in dressing them and forgot to sanitize her gloves between gloves change. She said this failure placed risk for infection. She said she received in-serviced on infection control 3 to 4 weeks ago at this facility. Could not recall the exact date. She said the DON spot checked her once a month. In an interview on 12/18/24 at 1:45p.m., with the DON, she said the WCN should have either washed or sanitized her hands after touching a dirty area prior to moving to a clean area when performing wound care. The DON said the Wound Care Doctor should have covered the wounds and disposed of soiled dressing properly. She said these failures were risk for infection control. She said staff received in-service on infection control every 2 to 3 months. Record review of facility's COVID-19 Prevention & infection Control in-service (not dated) conducted by the ADON revealed Wound Care Nurse did not sign the in-service. Record review of the facility's Infection Control policy dated (Revised October 2018) revealed read in part: . Policy Statement: This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. Record review of the facility's Handwashing/Hand Hygiene policy dated (Revised August 2019) revealed read in part: .Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation: .7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: m. After removing gloves. 9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections .