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	02/27/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49640 Based on observation, interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source, are reported immediately, but no later than 2 hours after the event, if the events result in serious bodily injury, or no later than 24 hours if the events do not result in serious bodily injury, to the Administrator of the facility and to other officials (including to the State Survey Agency) in accordance with state law through established procedures for 1 (Resident #1) of 7 residents reviewed for abuse. CNA A failed to immediately notify the Administrator on 09/03/24 Resident #1 had bruising on the right arm of unknown origin. This failure could place residents at risk for abuse and neglect. Findings Included: Record review of admission record dated 02/27/25 revealed Resident #1 was an [AGE] year-old woman admitted to the facility on [DATE] with diagnoses which included unspecified visual loss, unspecified osteoarthritis, anxiety disorder, muscle wasting and atrophy (the wasting away or shrinking of an organ, tissue, or muscle), other lack of coordination, unspecified lack of coordination, hypertension, and long term (current) use of anticoagulants (blood thinners). A record review of Resident 1's admission MDS assessment dated [DATE] revealed Resident #1 was assessed to have the ability to usually understand others and could make herself understood. Further review revealed a Brief Interview for Mental Status was not conducted due to a code zero entered which indicated, resident is rarely/never understood. Resident #1 had clear speech and adequate hearing and severely impair vision. Record review of Resident #1's care plan, dated 10/11/22, reflected, [Resident #1] is receiving anticoagulant therapy r/t Atrial fibrillation .Goal . [Resident #1] will be free from discomfort or adverse reactions related to anticoagulant use through the review date.Interventions . Daily skin inspection. Report abnormalities to the nurse. Record review of a Skin Only Evaluation completed by RN B, dated 09/04/24, reflected new issue: right upper arm bruise noted. Location: right forearm. Skin issue: bruising. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an undated statement by CNA A reflected, I noticed a dark discoloration on Resident #1's arm. I reported it to [LVN 1], but I'm unsure if he had heard me as I spoke in a lower tone than normal. Record review of a statement by LVN C dated 09/10/24 revealed, was notified of resident bruise from previous shift nurse-bruise on right upper arm assessed by me. In an interview on 02/25/2025 at 10:18am with Family Member D revealed she visited Resident #1 on 08/29/2024 and there were no concerns. Family Member D stated when she visited Resident #1 on 09/03/24, Resident #1 had a large deep purple bruise on her right arm. Family Member D stated she asked LVN E to look at the bruise. Family Member D stated LVN E stated the DON would be informed and Family Member D would be contacted. Family Member D stated CNA A came into the room and stated the bruise was noticed a few days ago and it was reported to LVN C. Family Member D stated she contacted the DON on 09/05/24, due to not receiving a call 09/04/24, and the DON stated she did not know anything about the issues and was not informed by any facility staff members. An attempted interview with Resident #1 on 02/25/25 at 11:05am revealed Resident #1 responded to questions with rambling speech. Resident #1's rambling speech continued on-going during the interview. Resident #1 was observed sitting up in bed and the call light within reach. No visible injuries observed. An interview with CNA A on 02/25/25 at 2:28pm revealed he has worked at the facility for 7 years. CNA A revealed he noticed a bruise on Resident #1's forearm and LVN 1 was informed immediately. CNA A stated he has worked at the facility for 7 years. CNA A stated abuse should be reported as soon as it happens to the DON or Administrator. CNA A stated he probably should have informed the Administrator but informed the charge nurse instead. Telephone interview with LVN C on 02/27/25 at 8:05am revealed CNA A did not inform him of the bruise. LVN C stated had he been informed; he would have followed protocol. LVN C stated the protocol included notifying the family, the DON, completing a skin assessment and incident report. LVN C stated abuse was reported immediately to the DON and Administrator. An interview with the DON on 02/27/25 at 3:58pm revealed she spoke with Family Member D but was unsure when. The DON stated CNA A stated LVN C was informed of the bruise but was unsure if LVN C heard him. The DON stated the interim Administrator was informed of the bruise on 09/05/24. The DON stated the protocol for injury of unknown origin was the CNA reported to the nurse, who assessed the resident, an incident report was completed, and the physician and family members were notified. The DON stated Resident #1 was on blood thinners and she flails her arms, and the assumption was Resident #1 may have hit the side rail of the bed. The DON stated the risk of staff failure to report an injury of unknow origin was delayed time with resolution of injury/treatment. An interview with the Administrator, the Abuse Coordinator, on 02/25/25 at 4:18pm, revealed his employment and training started the end of September with the interim Administrator. The Administrator stated he was unaware of Resident #1's bruise and unsure if the interim Administrator was aware. The Administrator stated the expectation was notification of a bruise that is out of the ordinary, what it is and where the bruise is located to find the root cause of the bruise. The Administrator stated the lack of notification was concerning and it is an opportunity for education for the staff on reporting abuse. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy titled, Investigating Resident Injuries, revised April 2021, reflected all resident injuries are investigated. The director of nursing services or a designee assesses all resident injuries and documents findings in the medical record. If the nursing and medical assessment determines an injury of unknown source the investigation will follow the protocols set forth in our facility's established abuse investigation guidelines.

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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** 49640 Based on observation, interview and record review, the facility failed to provide the necessary services to maintain good personal hygiene to a resident who is unable to carry out activities of daily living for one of five residents (Resident #2) reviewed for ADL care. The facility failed to provide Resident #2, who required extensive assistance, with timely incontinence care on 02/25/25 from 6:30 a.m. to 11:30 a.m. This failure could place residents at risk of skin breakdown, urinary tract infections and loss of dignity. Findings included: Record review of Resident #2's Admission Record, dated 02/27/25, reflected a [AGE] year-old male with an admitted [DATE]. Resident #2 diagnoses included Paraplegia (paralysis that affects all or part of the trunk, legs, and pelvic organs), Flaccid Hemiplegia affection left nondominant side (loss of muscle tone on one side of the body), need for assistance with personal care, and muscle wasting and atrophy (causes muscles to lose mass and strength). Record review of Resident #2's MDS assessment dated [DATE] reflected frequent urinary and bowel incontinence. Resident #2 reflected toilet transfer was not applicable and dependent regarding toileting hygiene. Resident #2 had a BIMS of 15, which indicated he was cognitively intact. Record review of Resident #2's care plan, revised 12/28/21, reflected, Resident #2 has an alteration in elimination r/t bowel/bladder incontinence .Goal . [Resident #2] will remain free from skin breakdown due to incontinence and brief use .Interventions .Check [Resident #2] during care rounds for incontinence .Toilet use: [Resident #2] requires x1 extensive to use toilet. An interview with Resident #2 on 02/25/25 at 11:28am revealed he had not had a diaper change since 6:30am. Resident #2 revealed he had no wound issues because he took care of the area below his waist. No stains on Resident #2's bedsheet was observed nor odor in the room. An interview with CNA F on 02/25/25 at 11:44am revealed Resident #2 had not been changed since his shift began at 6am. CNA F stated he had to get residents in their wheelchairs on another hall. An interview with CNA G on 02/26/25 at 8:15am revealed incontinent residents were checked every 2 hours and more often depending on their condition. CNA G stated she worked on a different hall than Resident #2 and was very busy. CNA G stated she was assigned to Resident #2 but asked CNA F to check on Resident #2, to ensure incontinent care was provided, and charted before she left. CNA G stated the risk for delayed incontinent care to the resident could be skin breakdown, infections, wounds, or bed sores. Second interview with CNA F on 02/26/25 at 10:00am revealed Resident #2 was not his assigned room. CNA F stated Resident #2's call light was the reason why he entered Resident #2's room on 02/25/25 to change him. CNA F stated Resident #2 was assigned to CNA G on 02/25/25. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the ADON on 02/27/25 at 1:43pm revealed the expectations for incontinent residents were for CNAs to check incontinent residents when rounds were conducted and as needed. The ADON stated the risk for incontinence delay could result in skin breakdown or risk of UTIs (urinary tract infections). An interview with the DON on 02/27/25 at 3:58pm revealed the expectation regarding incontinent care was for residents to get checked every two hours. The DON stated the risk for incontinence delay was potential infection and breakdown. Record review of the facility's policy titled, Urinary Continence and Incontinence-Assessment and Management revised August 2022, reflected Management of incontinence will follow relevant clinical guidelines . The physician and staff will provide appropriate services and treatment to help residents restore or improve bladder function and prevent urinary tract infections to the extent possible.