STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675755	A. Building B. Wing	02/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capstone Healthcare of Daingerfield	507 E W M Watson Blvd Daingerfield, TX 75638

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 - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44128 Based on observation, record review, and interview , the facility failed to treat each resident with respect and dignity and provide care in a manner that promoted maintenance or enhancement of his or her quality of life for 1 of 18 residents reviewed for resident rights. (Resident #45) The facility failed to ensure Resident #45 was served lunch on 02/25/24 at the same time as others at his table. This failure could place residents at risk for decreased quality of life, decreased self-esteem and increase anxiety. Findings included: Record review of a face sheet dated 02/26/24 indicated Resident #45 was [AGE] years old and was admitted on [DATE] with diagnoses including Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), vitamin deficiency, and pain in left shoulder. Record review of the MDS dated [DATE] indicated Resident #45 was sometimes understood and sometimes understood others. The MDS indicated a BIMS score of 7 which indicated severe cognitive impairment. The MDS indicated Resident #45 was dependent for most ADLs. Resident #45 required setup assistance for eating. Record review of a care plan revised on 01/31/24 indicated Resident #45 was at risk for nutritional problems. There was an intervention to bring the resident to the dining room for meals and to provide supervision/assistance as needed. During an observation on 02/25/24 at 12:02 p.m., Resident #45 was sitting at a table with 2 other residents. The other two residents were served their lunch tray at this time. During an observation and interview 02/25/24 at 12:15 p.m., Resident #45 had still not been served. The two other residents at the table were eating. Resident #45 said he was hungry and would like to eat. Resident #45 put his hat on and was looking down. Resident #45 said, I guess they want me to miss this meal. Staff were present. No staff acknowledged him. CNA B was noticeably irritated and asked the kitchen about his tray. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 2/25/24 at 12:20 p.m., CNA R told Resident #45 that she did not know he was eating in the dining area and his tray was sent to his room. CNA R left the dining room to retrieve meal. The other residents at Resident #45's table were finished eating at this time. During an interview on 02/26/24 at 12:31 p.m., CNA R said she was in the dining room during the noon meal on 2/25/24. She said Resident #45 was in the dining room. She said he did not get his tray when the others at his table did because it had been sent down the hall on the cart. She said she was the staff member that went to get the tray off the cart. She said it could not have been too long because all the trays on the cart had not been passed. She said the resident did not seem upset. During an interview 02/26/24 at 1:40 p.m., Resident #45 said at lunch on 2/25/24 the other residents at his table were served and he did not have a tray. He said by the time he got his tray the other residents at his table they had finished eating. He said he was upset about not having a tray. During an interview on 02/26/24 at 1:54 p.m., CNA B said Resident #45 ate lunch in his room at times. She said she had brought him to the dining room and failed to let kitchen staff know he was there. She said it was less than 20 minutes that Resident #45 went without his tray. She said she did get irritated. She said she was irritated because the other staff passing the trays in the dining room had not bothered to go get his tray from the cart on the hall. She said the irritation was not towards the resident. During an interview on 02/27/24 at 11:50 a.m., the DON said she would have expected staff to have gone to get Resident #45's tray from the hall or at least had kitchen staff make him a new tray. She said staff should have made sure the entire table was served before moving on to the next table. She said a resident not being served at the same time as others at the same table could make them feel left out. If you are hungry, you are hungry. During an interview on 02/27/24 at 11:42 a.m., the Administrator said he would expect staff to know where the resident was going to be during dining services, so that trays could be passed in a timely fashion. He said he would have expected staff to have fixed the issue with Resident #45's tray. He said a resident not being served while others at the table were served meals could make them feel there was a break in communication. Review of an undated Resident Rights facility policy indicated, .Employees shall treat all resident with kindness, respect, and dignity .Federal and state laws guarantee certain basic right to all resident in this facility. These rights include the resident's right to .a dignified existence .be treated with respect, kindness, and dignity .

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596 Based on interview and record review, the facility failed to ensure each Minimum Data Set was electronically completed and transmitted to the CMS System within 14 days after completion for 4 of 18 (Resident #59, #62, #63, and #61) residents reviewed for MDS transmittal in that: Resident #59's, discharge MDS assessment dated [DATE] was not submitted as of 02/26/2024. Resident # 62's discharge MDS assessment dated [DATE] was not submitted as of 02/26/2024. Resident # 63's discharge MDS assessment dated [DATE] was not submitted as of 02/26/2024. Resident # 61's discharge MDS assessment dated [DATE] was not submitted as of 02/26/2024. This deficient practice could place residents at risk of not having their assessments transmitted timely. The findings included: 1.Record review of Resident #59's face sheet dated 02/27/2024 indicated Resident #59 was a [AGE] year-old female, admitted to the facility on [DATE] and discharged on [DATE]. Resident #59 had diagnoses including acute embolism of right femoral vein (presence of a blood clot in the femoral vein of the leg), diabetes type II, and hypertension. Record review of Resident #59's admission MDS dated [DATE] indicated Resident #59 had a BIMS of 15. Resident #59 required supervision for ADLs. Resident #59 had plans to discharge to community. 2.Record review of Resident # 62's face sheet dated 02/27/2024 indicted Resident # 62 was a [AGE] year-old male, admitted to the facility on [DATE] and discharged on [DATE]. Resident #62 had diagnoses including sleep apnea (disorder that causes people to stop breathing for short periods during sleep), atrial fibrillation (quivering or irregular heartbeat), and diabetes type II. Record review of Resident #62's admission MDS dated [DATE] indicated Resident #62 had a BIMS of 15, which indicated no cognitive impairment. Resident #62 required limited assistance with ADLs. Resident #62 had planned to discharge to the community. 3.Record review of Resident # 63's face sheet dated 02/27/2024 indicated Resident #63 was a [AGE] year-old female, admitted to the facility on [DATE] and discharged on [DATE]. Resident #63 had diagnoses including sepsis (infection of the blood stream resulting in a cluster of symptoms such as drop in a blood pressure, increase in heart rate and fever), diabetes type II, and sleep apnea (disorder that causes people to stop breathing for short periods during sleep). Record review of Resident #63's admission MDS dated [DATE] indicated Resident #63 had a BIMS of 15, which indicated no cognitive impairment. Resident #63 required supervision assistance with ADL's. Resident #63 had a discharge to the community planned. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4.Record review of Resident #61's face sheet dated 02/27/2024 indicated Resident #61 was an- [AGE] year-old male, admitted to the facility on [DATE] and discharged on [DATE]. Resident #61 had diagnoses including Benign prostatic hypertrophy (noncancerous enlargement of the prostate gland that can cause urinary symptoms), prostate cancer, and an inguinal hernia (hernia that occurs in the abdomen near your groin area). Record review of Resident # 61's admission MDS dated [DATE] indicated Resident #61 had a BIMS of 11, which indicated mild cognitive impairment. Resident #61 required limited assistance with ADLs. Resident #61 had a discharge to the community planned. During an interview on 02/26/2024 at 10:00 a.m., the MDS Coordinator stated she was responsible for creating, completing, and transmitting all MDSs in the facility. The MDS Coordinator stated that all entry and discharge assessments are required to be transmitted to CMS in a timely manner. The MDS Coordinator stated she was new when Residents # 59, #62, #63, and #61 were discharged and she accidentally checked the section not to transmit the discharge assessments. Review of the facility policy, MDS Completion and Submission Timeframes, revised July 2017, revealed, Our facility will conduct and submit resident assessments in accordance with federal and state submission timeframes and 1. The Assessment Coordinator or designee is responsible for ensuring that resident assessments are submitted to CMS' QIES (internet-based system that includes and survey and certification functions) Assessment Submission and Processing (ASAP) system in accordance with current federal and state 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** 48958 Based on observation, interview, and record review, the facility failed to provide the necessary services to maintain good nurtrition, grooming, and personal and hygiene to residents who were unable to carry out activities of daily living for 1 of 18 resident (Resident #16) reviewed for quality of life. The facility failed to removal facial hair from Resident #16 on his request 02/26/2024. This failure could result in a decrease in resident self-esteem, decrease social interaction and cause depression. Findings included: Record review of Resident #16's face sheet dated 02/26/2024 indicated Resident #16 was an 61- year- old male initially admitted to the facility on [DATE] with a diagnoses of multiple sclerosis (a disease in which the immune system eats away at the protective covering of nerves) [Primary, Admission], Moderate intellectual disabilities, Unspecified osteoarthritis (a progressive, degenerative joint disease), unspecified site, Essential [primary] hypertension, Other recurrent depressive disorders [History of]. Review of the quarterly MDS assessment dated [DATE] indicated Resident #16 was understood and understood others. The MDS assessment indicated Resident #16 had a BIMS score of 7, which indicated moderate cognitive impairment. The MDS assessment indicated Resident #16 required partial/moderate assistance with personal hygiene. The MDS did not indicate the number of staff required to assist with personal hygiene. Record review of the care plan dated 01/10/2024 indicated Resident #16 needed partial/moderate assistance with ADLs. Resident #16 had Multiple sclerosis and was weak and had debility. Resident #16 voiced needs and wanted and called for assistance. Resident #16 needed bath assistance x 1 person if weak for transfer. Resident #16 needed assistance to wash and dry body. Record review of an order Summary Report on 02/26/2024 at 10:12 AM indicated Resident #16 may participate in social/creative activities as tolerated with an order started in 09/24/2015. During an interview on 02/25/24 at 09:37 AM Resident #16 said he would like his face shaved. Resident #16 said he preferred a shaved face. During an observation 02/26/24 at 10:04 AM Resident #16 was sitting up in his wheelchair in the dining area getting ready to play bingo. Resident #16's face was not shaved. During an interview on 02/26/24 at 11:14 AM Resident #16 said he told staff yesterday (02/25/2024) he wanted his face shaved. Resident #16 said he had forgotten who he told. Resident #16 said he wanted all the hair on his face shaved off except for his mustache. Resident #16 said he did not tell the nurse, just the aide. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/26/24 11:21 at AM CNA R said she was the CNA on Resident #16 hall. CNA R said Resident #16 had not informed her that he wanted to be shaved. CNA R said she would see if she could get Resident #16 shaved before lunch. CNA R said she asked Resident #16 if he wanted to be shaved and Resident #16 agreed but went to therapy. During an observation and interview on 02/26/24 at 3:44 PM Resident #16 was sitting up in his wheelchair in his bedroom and had not been shaved. Resident #16 was asked if he wanted to be shaved and he said yes. During an observation on 02/27/24 at 07:25 AM Resident #16 sitting in the hallway in his wheelchair and had not been shaved. During an interview on 02/27/24 at 09:22 AM CNA R said she had everything ready to shave Resident #16 yesterday then therapy took Resident #16. CNA R said Resident #16 was done with therapy about 10 minutes prior to Lunch so there was not enough time to shave Resident #16 prior to Lunch. CNA R said she reported to CNA C and CNA B that Resident #16 requested to be shaved. CNA R said CNA B assured her they would shave Resident #16. During an interview on 02/27/24 at 9:52 AM CNA C said CNA R told her before she left that Resident #16 wanted to be shaved but by the time, she finished evening rounds, it slipped her mind, and she went home. CNA C said Resident #16 had never complained to her about not being shaved, but she never asked him if he wanted to be shaved. CNA C said Resident #16 has been shaved. During an interview on 02/27/24 at 11:03 PM CNA B said CNA R told her Resident #16 needed to be shaved. CNA B said CNA R left yesterday about 1:00 PM. CNA B said CNA R came to get the clippers to shave Resident #16, then CNA R brought the clippers back and told me she did not get to shave him, because therapy came and got him. During an interview on 02/27/24 at 11:12 AM the DON said CNAs were responsible for shaving residents in the mornings before 10:00 AM. DON said the facility tried to offer Resident #16 an shave yesterday and he told them to wait because it was in the middle of activities and therapy. The DON said the facility also offered to shave Resident #16 during his shower yesterday but he refused. She said the facility did not document the refusal. The DON said the negative effect of Resident #16 not being shaved could cause body image disturbance. During an interview on 02/27/24 at 12:22 PM the Administrator said he thought if a resident had facial hair and wanted it shaved, the facility should provide that help.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44128 Based on observation, interview, and record review, the facility failed to provide an ongoing program of activities in accordance with the comprehensive assessment to meet the interests and the physical, mental, and psychosocial well-being for 1 of 18 residents reviewed for activities. (Residents #27) The facility failed to provide Residents #27 with consistent, scheduled activities. This failure could place residents at risk for not having activities to meet their interests or needs and a decline in their physical, mental, and psychosocial well-being. Findings included: Record review of the face sheet dated 02/26/24 revealed Resident #27 was [AGE] years old and was admitted on [DATE] with diagnoses including stroke, dementia, and aphasia (a disorder that affects how you communicate). Record review of a quarterly MDS dated [DATE] revealed Resident #27 was rarely/never understood and sometimes understood others. The MDS revealed a BIMS had not been conducted due to the resident being rarely/never understood. The MDS indicated the resident was not interviewed for activity preferences due to the resident being rarely/never understood. Record review of a care plan dated 02/07/24 indicated Resident #27 did not like to participate in group activities routinely. She enjoyed those that involve music but most of the time would rather stay in her room watching TV or wandering up and down the halls in her wheelchair people watching. There were interventions to acknowledge and all Resident #27's preferences in a daily routine and to inform Resident #27 of upcoming activities by providing an activity calendar, verbal reminders, escort and encouragement. Record review of activity progress notes for Resident #27 from 2/17/23 - 02/07/24 indicated, there were no notes for the months of 03/2023, 04/2023, 06/2023, 07/2023, 09/2023, 10/2023, 12/2023 and 1/2024. A note dated 02/07/24 indicated, (Resident #27) would attend on occasion but would sit back and watch. She did not want to participate in any type of 1:1 activity, usually becoming very agitated and rolling away. Lately, (Resident #27) has not been getting out of bed. She turns her head away when we speak to her. We will respect her desire to be left alone. If she starts to feel better, is able to get up and start roaming the halls again, we will encourage her to participate in activities. Record review of In Room Activities documentation dated 2/12/2024 - 2/25/2024 did indicate any in-room activities for Resident #27. During an observation on 02/25/24 at 9:32 a.m., Resident #27 was in bed. Her eyes were open. She did make eye contact. She did not answer questions. The resident did not have a television. There was no music playing. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 02/26/24 at 3:11 p.m., Resident #27 was resting in bed awake with no music and there was no television. Resident #27's roommate said Resident #27 was not provided activities any longer. She said staff used to get her up out of bed to attend activities but not anymore. She said it had been months since Resident #27 had been gotten up for activities. The roommate said she tried to keep her own television on as a form of entertainment for her. She said the Resident #27's television was in her closet. She said Resident #27 loved to watch games shows but her own television did not pick up game shows. She said staff never played music for the Resident #27. The roommate said she was Resident #27's only source of entertainment. She said Resident #27 did talk to her a little and the resident was very smart. She said the resident never left the room anymore. The roommate said she hung a new decoration on Resident #27's wall so she would have something new to look at. An attempt was made to interview the resident at this time. The resident made eye contact, but her speech was garbled and could not be understood. During an observation on 02/27/24 at 8:27 a.m., Resident #27 was resting in bed. There was no music playing. The resident did not have a television. There were no activities in progress. During an interview on 02/27/24 at 9:06 a.m., the Activity Director said staff had conducted one-on-one activities with Resident #27. She said in the past they had done aroma therapy and hand massages, but the resident became aggressive. The Activity Director said Resident #27 used to come out of her room for activities, but she would just sit and watch. She said she did not know why the resident no longer was brought out of her room for activities. She said the Resident #27 was brought of her room for activities until recently. She said in the past they had not found music the resident liked. She said last fall the resident attended live music out of her room and she did attend a band concert at Christmas. She said the resident did not have a television and the family would not provide one for the resident. She said the resident never liked watching television in the past. She said the Resident #27's roommate was mistaken about the television being in the closet. She said the resident had no activities provided to her for at least the last two weeks. During an observation and interview on 02/27/24 at 9:12 a.m., Resident #27's roommate said a television was in the closet. A television was observed inside a closet in the room of Resident #27. The roommate said the television had been in the closet for over a year. During an interview on 02/27/24 at 9:13 a.m., CNA B said there was a television and a mount inside the closet in the room of Resident #27. She said she had no idea the television had been in the closet. She said she would have maintenance install the television for Resident #27. During an observation on 02/27/24 at 9:43 a.m., an overhead announcement was made about an exercise activity in the dining room and for staff to assist all residents that wished to attend. The activity was scheduled for 10:00 a.m. During an observation on 02/27/24 at 10:10 a.m., an activity was in progress in the dining room. Resident #27 was not present. During an observation on 02/27/24 at 10:13 a.m., Resident #27 was in her bed . The resident was awake. She did not have a television. There was no music playing. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/27/24 at 10:15 a.m., CNA B said she had not recently seen Resident #27 at any activities lately. She did not know why Resident #27 was not brought out to activities any longer. She said she had not witnessed anyone providing one in-room activities for Resident #27. She said Resident just stayed in the bed. She said, we try to go in and play with her. She said she had never heard music playing in her room. She said it had been several weeks since she had seen her attend an activity. During an interview on 02/27/24 at 10:18 a.m., LVN Q said Resident #27 did not like to get up out of bed to do things. She said she did know that Resident #27 liked to listen to music. She said she had not witnessed any one-on-one in room activities taking place with Resident #27. During an interview on 02/27/24 at 11:50 a.m., the DON said Resident #27 did get up out of bed and went around the facility in her wheelchair. She said when she was brought to activities, she became agitated and ran into things. She said if Resident #27 was not gotten out of bed for activities, she would expect one-on-one in-room activities to have done. She said if a resident did not have activities, it could cause depression. During an interview on 02/27/24 at 11:20 a.m., the Activity Director said she had never seen a policy concerning activities or one-on-one activities. During an observation on 02/27/24 at 11:26 a.m., there was a Resident Rights posting displayed in the hallway near the entrance of the facility. The Resident Rights posting said, You have the right to .Participate in activities inside and outside the facility . During an interview on 02/27/24 at 11:42 a.m., the Administrator said months ago Resident #27 was up and active she did attend activities but did not participate in them. He said now that the resident was in bed more, he would have at least expected one-on-one activities or at least try. He said any attempts at one-on-one activities should be documented. He said a resident not having activities could cause their overall health to decline. An activities facility policy was requested at this time and was not received prior to exit.

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596 Based on observation, interview, and record review, the facility failed to ensure the necessary treatment and services, based on the comprehensive assessment and consistent with professional standards of practice, to promote the healing of pressure ulcers for 1 of 3 residents reviewed for pressure ulcers. (Resident # 37) The facility did not follow wound care ordered by the wound care specialist (NP) from 01/08/2024 to 02/20/2024 by dressing the wound with medical honey instead of the calcium alginate ordered by the wound care nurse practioner. The facility did not ensure Resident #37's alternating pressure mattress (LAL) was working properly to promote healing to her Stage III pressure ulcer and prevent the worsening of the wound. Resident #37 did not have the MD ordered alternating pressure mattress on the bed for 2 of 3 days observed. The facility failed to ensure off loading of the pressure ulcer occured by failing to ensure medical equipment of alternating pressure mattress (LAL) was plugged in, resulting in Resident #37 observed lying on a deflated mattress through which the metal bed frame could be felt. The facility failed to ensure a system was in place to have staff designated to track weekly wound care reports, order changes, and weekly wound measurments by the wound care specialist. These failures could place residents at risk for new development or worsening of existing pressure ulcers, pain, infection, decreased quality of life, and hospitalization . Findings included: 1.Review of a face sheet dated 02/27/2024 indicated Resident #37 was an [AGE] year-old female, admitted on [DATE] with the diagnoses of dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), contractures (occurs when muscles, tendons, joints, or other tissue tighten/ shorten causing deformity), and hypothyroidism (when thyroid gland does not make enough thyroid-hormones to meet the body's needs). Review of the quarterly MDS assessment dated [DATE] indicated Resident #37 had no BIMS completed. Resident #37 was rarely/never understood. Resident #37 required dependent assistance with ADLs. Resident #37 had (1) Stage II pressure ulcer and (1) unstageable pressure ulcer. Resident #37 had daily treatments, pressure relieving device to chair and pressure reduction mattress noted on the MDS. Review of Resident #37's care plan last updated 11/23/2023 indicated Resident #37 had an open area to left buttock. The wound care orders were to cleanse area with wound cleanser, pat dry, apply collagen and cover with calcium alginate, apply dry dressing, and change daily. The intervention included providing treatment as ordered. Review of wound care specialist's progress notes included the following: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	09/11/2023- Resident #37 again referred to wound management services for pressure ulcer to sacrum measuring 0.6 cm x 0.3 cm x 0.1 (Stage III). The wound had eschar and dry skin of peri wound (area surrounding wound). The wound was free of signs and symptoms of infection. No odor. Cleansed with (cleaning) solution, collagen applied to wound and secured with border foam dressing. 10/23/2023- Wound improved measuring 0.4cm x 0.6 cm x 0.3 cm. Peri wound area pink. Wound scrubbed vigorously with moist 4x4 (gauze). Collagen applied to wound base. Covered with calcium alginate and secured with border foam dressing. 11/13/2023- Wound has improved measuring 0.5 cm x 0.4 cm x 0.1 cm. Collagen placed to wound. Covered with calcium alginate and secured with foam border dressing. 12/04/2023-Wound appeared better, peri wound area had improved, however, due to satellite lesions wound is much larger. Wound cleansed, collagen applied to wound base, covered with calcium alginate, and secured with border foam gauze. 12/18/2023- No notable change to wound. Peri wound pink and fragile, instructed (RN U) for barrier cream to be applied to peri wound. Wound to be cleansed with wound cleanser, collagen applied to wound base. Covered with calcium alginate and secured with border foam dressing. Resident is bed/chair bound and unable to turn self. Educate staff to keep resident on a regular turning schedule. Verbalized understanding. 01/08/2024- Resident (#37) lying in bed on arrival, wound deteriorated measuring 1.8cm x 1.3cm x 0.1 cm. Wound now with centrally located slough. Wound debrided with minimal bleeding controlled with light pressure. Discussed resident offloading with RN and protein intake. Discussed the need for use of overlay or air mattress for offloading and prevention of further skin breakdown. Wound cleansed and dressed per orders, calcium alginate with foam dressing to cover. 01/22/2024- Wound deteriorating measures 2.0cm x 1.6 cm x 0.1 cm. Wound with deep purple/ dark red peri wound. Scrubbed with moist gauze to remove nonviable tissue. Collagen applied to wound bed, covered with calcium alginate, and secured with border foam dressing. 02/05/2024- Resident (#37) was not offloaded at this time. Wound with deterioration measuring 1.8 cm x 1.1 cm x 0.1 cm. Peri wound area very red and fragile with skin breakdown noted. No sign of infection. Wound scrubbed vigorously with moist gauze to remove nonviable tissue. Collagen applied to wound, covered with calcium alginate, and secured with bordered foam dressing. 02/12/2024- No off loading at this time. Encouraged staff to turn regularly with staff verbalizing understanding. Wound 1.5 cm x 2.5 cm x 0.1cm. Wound developed adjacent, connecting sacral and coccyx wound. Peri wound fragile. Erythema noted. No signs of infection. Wound scrubbed with moist gauze to remove nonviable tissue. Collagen applied to wound. Covered with calcium alginate and secured with bordered foam dressing. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	02/19/2024- Offloaded in right lateral recumbent position with wedge. Wound with severe deterioration. 6. 5cm x 4.9 cm x 0.3 cm. Peri wound area deep purple and dark red with linear area of black tissue. Wound debrided with use of curette to remove nonviable tissue. Medical honey had been used to wound. Encouraged staff to not use medical honey due to moisture and it not being the correct order. Understanding verbalized. Wound cleansed with wound cleanser, collagen applied to wound base. Covered with calcium alginate, secured with border foam dressing. Resident (#37) was not on an alternating pressure air mattress as previously discussed. It is reported the previous mattress kept going flat and that may have contributed to deterioration of wound. Review of wound care specialist progress notes dated 01/08/2024 to 02/19/2024 indicate the orders for the treatment of the stage III coccyx wound were to cleanse with wound cleanser, pat dry, apply collagen, cover with calcium alginate, cover with foam border dressing, and change daily and prn. Review of Resident #37's consolidated orders for 01/10/2024 to 02/20/2024 indicated the orders for the treatment of the stage III coccyx wound were to cleanse with wound cleanser, pat dry. Apply medical honey to slough adhered to wound bed and cover with foam dressing. Change daily and as needed. Review of Resident #37's consolidated orders for 02/20/2024 to present were to cleanse open area to coccyx with wound cleanser, pat dry, apply barrier cream to periwound area. Apply activated moisten collagen sheet or poweder to wound bed. Cover with calcium alginate dressing, then cover with foam dressing. Change daily and as needed. Review of the TARs dated January and February of 2024, indicated Resident #37's coccyx ulcer was treated daily. The treatment was for the wound to be cleansed with wound cleanser, pat dry, apply medical honey to slough adhered to wound bed, cover with foam dressing, and change daily and as needed. During an interview and /observation on 02/25/2024 at 3:00 p.m., RN U revealed Resident #37's coccyx wound had declined over the past 2-4 weeks. RN U stated the nurse assigned to the 200 hall was responsible for all treatments assigned to 200 hall residents. She stated there was not a designated treatment nurse for the facility. RN U performed wound care for Resident #37 following MD orders and failed to follow aseptic technique. RN U failed to wash her hands prior to beginning the treatment and between cleaning the wound and applying the clean dressing. RN U stated there was a wound care doctor that visited the facility on Mondays. RN U stated she spoke with him a few weeks ago and he was concerned he had not ordered medical honey for Resident #37's wound because she had moist skin from incontinence and overall skin condition, but he continued to find medical honey in her wound each Monday. RN U stated Resident #37 was not on a low air loss mattress at the time, because it kept going flat which may have contributed to the worsening of her wound. RN U stated Resident #37's ulcer started on her left sacral area and grew to include her coccyx. RN U stated proper treatment, offloading with a low air loss mattress, and proper nutrition were important to heal a wound. RN U stated not having all of those items could halt healing and lead to infection and death. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	During a phone interview on 02/26/2024 at 4:00 p.m., the wound care NP stated Resident #37 had the potential to have healed wounds if the facility would keep Resident #37 off loaded, dry, and do the treatments that had been ordered by him. He stated he did rounds every Monday morning and often Resident #37's skin was macerated from being overly moist from incontinence. He stated he had found medical honey in the wound of Resident #37 for the last 3- 4 weeks each week and he had talked to staff (RN U) about his concerns. The wound care specialist stated he never ordered medical honey for Resident #37 because it added moisture to wounds. He explained Resident #37's skin was already moist because she was incontinent at all times, and she had clammy skin. He stated he requested Resident #37 get a new LAL mattress over a week prior when he was told by RN U, Resident #37's LAL mattress was going flat, and she was still on a standard mattress. The wound care NP stated her measurements on 02/25/2024 had improved very little since the previous week because she had been left wet over the weekend when he came in on Monday to measure her wounds. He stated the new measurements were 6.1 cm x 4.5 cm x 0.3 cm, as of 02/25/2024. During an observation on 02/27/2024 at 4:30 a.m., Resident #37 was in bed asleep. Resident #37 was clean and dry with no odor, laying on her right side on an unplugged deflated LAL mattress. The cord for the LAL mattress was wrapped with a zip tie in plastic around it lying on the floor at the foot of the bed. The LAL mattress was completely flat, and the metal frame of the bed was felt under Resident #37's right hip. During an interview on 02/27/2024 at 7:00 a.m., LVN E came into Resident #37's room and stated she was unaware the LAL mattress for Resident #37 was unplugged. LVN E stated she felt it must have come unplugged when the night shift preformed incontinent care last, but there was no way to know for sure. LVN E stated Resident #37 laying directly on the frame could have worsen her wound and would not promote wound healing. LVN E plugged the bed in at this time. During an interview on 02/27/2024 at 11:20 a.m., the DON stated she was made aware the LAL mattress for Resident #37 was unplugged this morning on rounds. The DON stated she plugged the LAL mattress into the wall the prior night around 6 p.m., prior to leaving the facility for the day. The DON stated the facility did not have a weekly wound care report and no one was designated to do weekly measurements of pressure ulcers. The DON stated the facility used the measurements from the wound care specialist (NP) that visited each week. The DON stated she did not agree with the wound care NP's progress notes because she felt that his communication was poor and she was certain he had not talked to her staff about the treatment or Resident #37's care. The DON stated it was her responsibility to read the progress notes the wound care specialist emailed to her each Tuesday after his Monday visit. The DON admitted that she did not always read his progress notes. And was not sure why she had not been reading them other than she had been busy. The DON stated she was unaware the treatment of medical honey from 01/10/2024 to 02/20/2024 was not what the wound care specialist (NP) wanted to use. The DON stated RN U had not communicated the wound care specialist's concerns to her. The DON stated it was her expectation that the floor nurses follow the orders of the wound care specialist and report to her any concerns the wound care specialist had during rounds. The DON stated not following the Medical Director's orders, not having the resident on LAL mattress, and not keeping the resident off loaded could lead to worsening of the wound, development of new wounds, infection, and even death. During an interview on 02/27/2024 at 11:45 a.m., the Administrator stated he wanted the DON to monitor all of the systems she was responsible for and report any concerns she had to him. The Administrator stated he wanted the nurses to do skin assessments, wound care as ordered, and make sure the resident's had all they needed to maintain a healthy life. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Review of a policy titled Wound Care Protocol, purpose: 1. To ensure optimal healing of wounds. 2. To identify type of wound in order to provide proper wound care. Expectations: 1. Wounds are to be measured each week and should be measured by the same Registered Nurse / NP clinician for consistency. Measure the wound weekly and provide oversite and direction for the LPN/LVN. Re-evaluate wounds with changes in condition and report to the physician wound status. Revise plan of care with treating physician.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 45643 Based on interview and record review, the facility failed to follow guidelines for mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS for 1 of 4 quarters reviewed for payroll data information. (Quarter 4 2023). The facility failed to submit staffing information to CMS for the 4th quarter of the fiscal year 2023. This failure could place residents at risk for personal needs not being identified and met, decreased quality of care, decline in health status, and decreased feeling of well-being within their living environment. Findings included: Record review of the facility's Civil Rights form (3761) dated 02/26/24 indicated the following: 5 RNs 8 LVNs 33 Direct Care Staff 8 Dietary 7 Housekeeping and Laundry 5 All Others During an interview on 02/27/2024 at 09:10 a.m., the Administrator said it was the responsibility of the HR Coordinator T to submit PBJ reports. He said HR Coordinator T did not complete it in a timely fashion. He stated that he did not know if there was a sufficient staffing policy or a policy regarding the PBJ reports. He stated that he is unsure if the PBJ report was not reported in time or if it was just never reported at all. He said the surveyor would need to speak to the HR Coordinator T to understand why it was not reported. During an interview on 02/27/24 at 09:38 a.m., HR Coordinator T said there was no excuse for the PBJ report to not have been made. He said he uses the time sheets that are submitted to him to track staffing. He said if he is not given time sheets for a period he cannot submit the PBJ report. He said he is not very familiar with the time clock system and depends on others to send him the time sheets. He said if staff fail to send him the time sheets, then he does not send the PBJ data. (continued on next page)

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 02/27/2024 at 11:10 a.m., the Administrator he said that the facility does not have a PBJ reporting policy.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46062 Based on observation, interview, and record review the facility failed to ensure an infection prevention and control program designed to provide a safe and sanitary environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 7 residents (Resident #3 and Resident #56) reviewed for foley catheters and for 2 of 3 residents reviewed for wound care (Resident #8 and Resident #37). 1 .The facility failed to ensure Resident #3 and Resident #56's foley catheter (tube inserted into the bladder to drain urine) tubing and drainage bag/privacy bags were not dragging/touching the floor under their wheelchairs. 2.The facility failed to perform appropriate hand washing while wound care was performed for Resident #8 and Resident #37. These failures could place residents at risk for cross-contamination, increased risk of infection and the spread of infection. Findings included: 1. Record review of Resident #3's face sheet dated 2/25/24 indicated Resident #3 was an [AGE] year-old male and admitted to the facility on [DATE] with diagnoses including dementia (progressive or persistent loss of intellectual functioning with impairment or memory and thinking and often with personality changes), history of fall, history of hip fracture, weakness, unsteadiness on feet, history of urinary tract infection, and retention of urine. Record review of Resident #3's quarterly MDS dated [DATE] indicated Resident #3 was usually understood and usually understood others. The MDS indicated a BIMS score of 3 which indicated Resident #3 had severe cognitive impairment. Resident #3 required substantial to dependent on assistance for most ADLs. Resident #3 had an indwelling catheter (tube inserted into the bladder to drain urine). Record review of Resident #3's undated care plan indicated she had an indwelling urinary catheter and had the potential for decline in ADL function. During an observation on 2/25/24 at 11:09 AM. Resident #3 was observed sitting up in her wheelchair with her foley catheter bag in a privacy bag hooked to the underside of her wheelchair and the bag was dragging on the floor. During an observation on 2/26/24 at 11:20 AM, Resident #3 was observed sitting up in her wheelchair self-propelling herself down the hallway in front of the dining room with her foley catheter bag in a privacy bag and her catheter tubing dragging the floor under her wheelchair. During an observation on 2/26/24 at 3:35 PM, Resident #3 was observed in front of nurse's station sitting up in her wheelchair with her foley catheter bag in a privacy bag and catheter tubing touching the floor under her wheelchair. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 2/27/24 at 8:28 AM, Resident #3 was observed sitting at dining room table eating breakfast with her foley catheter bag in privacy bag and catheter tubing touching the floor. 2. Record review of Resident #56's face sheet dated 10/23/23 indicated Resident #56 was a [AGE] year-old female and admitted to the facility on [DATE] with diagnoses including Multiple sclerosis (the immune system eats away at the protective covering of nerves, resulting in nerve damage that disrupts communication between the brain and the body), history of urinary tract infection, pneumonia (lung infection), and kidney failure. Record review of Resident #56's quarterly MDS dated [DATE] indicated Resident #56 was usually understood and usually understood others. The MDS indicated a BIMS score of 13 which indicated Resident #56 was cognitively intact. Resident #56 was dependent on assistance for most ADLs. Record review of Resident #56's undated care plan indicated Resident #56 had an indwelling urinary catheter, she was at risk for urinary tract infections, and had the potential for decline in ADL function. During an observation on 2/25/24 at 10:58 AM, Resident #56 was observed self-propelling herself down hallway to the common area and her foley catheter bag in a privacy and her catheter tubing dragging on the floor under her wheelchair. During an observation on 2/25/24 at 11:40 AM, Resident #56 was observed sitting in her wheelchair being pushed down the hallway by a family member and her foley catheter bag in privacy bag and catheter tubing dragging the floor under her wheelchair. During an observation on 2/26/24 at 08:22 AM, Resident #56 was observed self-propelling herself from the dining room down the hallway with her foley catheter bag in a privacy bag and catheter tubing dragging the floor under her wheelchair. During an observation on 2/26/24 at 3:40 PM, Resident #56 was observed sitting in her wheelchair in her room and her foley catheter bag was in a privacy bag and the privacy bag and tubing was sitting on the floor under the resident's wheelchair. During an interview on 2/27/24 at 8:40 AM, CNA B said she was the Lead CNA and had worked at the facility for [AGE] years. CNA B said when getting a resident up to a wheelchair who had a foley catheter, the foley catheter drainage bag should be placed in a privacy bag or some of foley catheter bags had a privacy cover on them already. CNA B said staff should curl the foley catheter tubing up and secure it with the clip to ensure that it was flowing. CNA B said the foley catheter bag and/or tubing should not touch or drag floor because the privacy bag could be adjusted to not drag the floor. CNA B said the foley catheter bag and/or tubing should not touch floor due to cross-contamination and it could cause the resident to develop an infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/27/24 at 10:06 AM, CNA C said she had worked at the facility for almost a year. CNA C said she would empty the foley catheter drainage bag and place the foley catheter bag in a catheter protector bag. CNA C said if the foley catheter tubing was long, she would curl the tubing up and use clamp to secure it, so the tubing did not touch the floor. CNA C said if the foley catheter bag and/or tubing was dragging on floor under a resident's wheelchair, it could get caught on something and pull the foley out. CNA C said it could cause the resident to get an infection from dragging on the dirty floor. During an interview on 2/27/24 at 10:16 AM, CNA D said she had worked at the facility for approximately two and half years and normally worked the day shift on the 200 hall. CNA D said when she got residents up into wheelchairs who had foley catheters, she placed the foley catheter bag in a privacy bag and made sure it was not dragging the floor, so it doesn't get caught on something and pull it out. CNA D said she make sure the foley catheter bag and/or tubing was not dragging the floor, because it could cause the resident to get an infection. CNA D said she got Resident #3 up into her wheelchair on 2/27/24 and she probably did not get the privacy bag tight enough if it was dragging the floor. During an interview on 2/27/24 at 10:25 AM, LVN E said a resident's foley catheter bag should have a protective bag and make sure the bag and/or tubing was not dragging the floor. LVN E said the foley catheter bag and/or tubing should not be dragging the floor under the resident's wheelchair because there was bacteria and germs on the floor. LVN E said the resident could get an infection, the foley catheter bag and/or tubing could hang on something, or even get pulled out. LVN E said if she saw the foley catheter bag and/or tubing dragging the floor under a resident's wheelchair, she would stop and fix it to the best of her ability. During an interview on 2/27/24 at 10:40 AM, ADON F said she had recently become the Infection Preventionist. ADON F said the resident's foley catheter drainage bag and tubing should be placed in a privacy bag, and it should be secured off the floor. ADON F said some residents can move their legs and pull the tubing out of the privacy bag, and staff should keep a close eye on it and resecure it. ADON F said if the resident's foley catheter bag and/or tubing drug the floor under their wheelchair, it could get all kinds of bacteria up that tube, get clamped off, run over, or pulled out. During an interview on 2/27/24 at 10:39 AM, the DON said she would expect staff to place the resident's foley catheter tubing and drainage in a privacy bag and secure it to the wheelchair, so it does not drag the floor. The DON said it was an infection control issue to allow the foley catheter tubing and catheter bag to drag the floor under the wheelchair. The DON said it could increase the risk of infection for the resident and/or could potentially get caught on something and pull the foley catheter out. During an interview on 2/27/24 at 10:51 AM, the ADM said allowing the foley catheter tubing and bag to drag the floor under a resident's wheelchair was an infection control issue and nothing should be dragging the floor, because the floor was not clean. The ADM said he would expect the foley catheter tubing and bag to be positioned to not allow it to drag the floor under the wheelchair. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Record review of face sheet date 02/26/2024 at 10:04 AM indicated Resident #8 was a [AGE] year old male initially admitted to the facility on [DATE] with a diagnoses which included Alzheimer's disease, unspecified[Primary, Admission](a progressive disease that destroys memory and other important mental functions), Diarrhea, unspecified, (loose, watery stools that occur more frequently than usual), Unspecified protein-calorie malnutrition (a nutritional status in which reduced availability of nutritional status in which reduced availability of nutrients leads to changes in body composition and function), Anemia, unspecified (a condition in which the blood doesn't have enough healthy red blood cells and hemoglobin, a protein found in red blood cells, to carry oxygen all through the body), Deficiency of other vitamins, Need for assistance with personal care, Pain in left hand, Weakness, Other symptoms and signs concerning food and fluid intake, Acute pulmonary edema(a condition caused by too much fluid in the lungs), Other abnormalities of gait and mobility, Other lack of coordination, Cognitive communication deficit, Unspecified macular degeneration, Essential (primary)hypertension, Nonrheumatic aortic [valve] stenosis(a thickening and narrowing of the valve between the heart's main pumping chamber and the body's main artery, called the aorta), Unspecified systolic [congestive] heart failure, Syncope and collapse. Record review of the Quarterly MDS assessment dated [DATE] indicated Resident # 8 was understood and understood others. The MDS assessment indicated Resident #8 had a BIMS score of 15, which indicated his cognition was intact. The MDS assessment indicated Resident #8 required partial to moderate assistance with ADL's. Record review of Resident #8 care plan dated 12/20/2023 indicated Resident #8 had potential for skin breakdown related to extremely fragile skin. Interventions were listed as weekly skin assessment, assist to bathroom and aid toileting as needed, every 2hrs, keep clean and dry, encourage movement/mobility, keep bed linens smooth and wrinkle free, encourage fluid intake, turn q2hrs and PRN when in bed and apply lotion to skin as needed for dry skin. Record review of Summary Report dated 02/26/2024 at 10:45 AM indicated Resident #8 had an order to cleanse wound to left buttocks with normal saline or wound cleanser, pat dry, apply collagen powder to wound bed and cover with dry dressing. Change daily and prn soiled/dislodged. During observation of wound care performed 02/26/24 at 4:11 PM by RN U on Resident #8. RN U did not wash her hands prior to performed wound care on Resident #8 left buttocks. RN U did not change gloves after Resident #8 buttocks area was cleaned and applied new dressing. 4.Record review of face sheet date 02/26/2024 at 8:43 AM indicated Resident #37 was a [AGE] year old female initially admitted to the facility on [DATE] with a diagnoses which included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety[Primary]Pressure ulcer of left heel, stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough or bruising of the heel), Pressure ulcer of sacral region, stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough or bruising of the sacral), Valgus deformity, not elsewhere classified (a lower leg deformity that exists when the bone at the knee joint is angled out and away from the body's mid-line), left knee, Polyarthritis, unspecified(a term used when at least five joints are effected with arthritis), Deficiency of other specified B group vitamins, Vitamin D deficiency, unspecified, Vitamin deficiency, unspecified (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675755	A. Building B. Wing	02/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capstone Healthcare of Daingerfield	507 E W M Watson Blvd Daingerfield, TX 75638

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a quarterly MDS dated [DATE] revealed Resident #37 was rarely/never understood and rarely/never understood others. The MDS revealed a BIMS had not been conducted due to the resident being rarely/never understood. The MDS indicated the resident has 2 Stage II partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/rupture blister. Record review of Resident #37 care plan dated 02/21/2024 indicated Resident #37 was potential for skin breakdown related to incontinent and decreased mobility. Interventions Treatments per orders, administer vitamins and proteins as ordered, assist with shifting of weight when up in wheelchair, and monitor prealbumin (protein) levels as ordered. Record review of Summary Report dated 02/26/2024 at 10:30 AM indicated Resident #37 had an order for cleanse open area to coccyx with wound cleanser, pat dry apply barrier cream to peri wound area. Apply activate/moisten collagen sheet or powder with normal saline to wound bed. Cover with calcium alginate dressing. Then cover with foam dressing. Change daily and prn dislodged or soiled. During observation of wound care performed 02/26/24 at 3:20 PM by RN U on Resident #37. RN U did not wash her hands prior to performing wound care to Resident #37's Stage 3 pressure ulcer to coccyx. While wound care provided for Resident #37, RN U did not change gloves after removal of soiled dressing from wound area. During an interview on 02/27/2024 at 10:00 AM RN U stated, hands should be washed prior to wound care and if hands become soiled in the process of wound care. RN U said, hands should be washed after wound care performed. RN U said, she chose to use hand sanitizer prior to the performed wound care. RN U said she was taught you could use hand sanitizer prior to wound care. RN U stated, the importance of washed hands, was not to expose the resident to infection. RN U said, the negative effect of not having washed her hands prior to wound care would cause resident wound to be contaminated her gloves. During an interview on 02/27/24 at 11:12 AM the DON stated, the nurse should have washed her hands prior to wound care. Hand sanitizer should be used between glove changes. The DON said, they wash their hands prior to entrance of the resident's room prior to wound care, then use hand sanitizer while wound care performed. The DON said, the negative effect of not washing your hands can cause infection and cross contamination. During an interview on 02/27/24 at 12:22 PM the ADM stated, he expected the nurses to address the wounds, not ignore the wounds and heal the wounds. The ADM said, he expected the nurses to follow wound care orders and perform them correct. Record review of the facility's policy titled Communicable Diseases dated January 2023 revealed . it was the policy of the facility that all infections, contagious or communicable would be followed according to the Center for Disease Control guidelines to prevent the spread of diseases within their community . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675755	A. Building B. Wing	02/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capstone Healthcare of Daingerfield	507 E W M Watson Blvd Daingerfield, TX 75638

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy on Hand Washing on 02/27/2024 at 1:30 PM indicated . Some situations require hand washing in areas where sinks are not readily available. In these limited circumstances, waterless hand washing products may be used (e.g. feeding residents in the dining room, administrating medications in the dining room). These products are not a substitute for good hand washing. Hand washing with soap and water should be done as soon as possible. Waterless hand washing products are not used for skin care treatment or administration of eye drops . 48958