STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455617	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Christian Care Center	1000 Wiggins Pkwy Mesquite, TX 75150

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 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50222 Based on interview and record review, the facility failed to provide pharmaceutical services (the process of receiving and interpreting prescriber's orders and to provide procedures that assure the accurate acquiring, receiving, dispensing, and administration of all drugs) to meet the needs of each resident for one (Resident #1) of four residents reviewed for pharmaceutical services. The facility failed to ensure the hospital discharge order to continue Eliquis (anticoagulant commonly known as a blood thinner medication) was accurately transcribed and administered to Resident #1 as ordered from 8/26/2024 to 9/26/2024 (30 days). The noncompliance was identified as past noncompliance (PNC). The IJ began on 8/26/2024 and ended on 10/19/2024. The facility had corrected the noncompliance before the state's investigation began. This failure could place residents at risk for not receiving medications as ordered by their physician or per manufacturer's directions. Findings included: Record review of Resident #1's PPS MDS assessment dated [DATE] revealed Resident #1 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of atrial fibrillation (irregular heart rhythm), displaced intertrochanteric fracture of the left femur (fractured left hip), and encounter for other orthopedic aftercare (care after surgery). The MDS also revealed a BIMS score of 15 (suggested no cognitive impairment). Record review of Resident #1's care plan revised on 10/23/2024 revealed Resident #1 was at risk for bleeding due to anticoagulant use and interventions included evaluating the skin for evidence of impaired coagulation (bruising, petechia, bleeding). Record review of Resident #1's MAR for August 2024 revealed Eliquis was ordered and administered to Resident #1 from 8/08/2024 until 8/23/2024. Record review of Resident #1's hospital H&P dated 8/26/2024 revealed Resident #1 was transferred to the hospital on 8/23/2024 and was on Eliquis for atrial fibrillation. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's hospital discharge summary dated 8/25/2024 revealed orders to continue Eliquis after discharge from the hospital. Record review of Resident #1's physician orders revealed there was not an order for Eliquis from 8/26/2024 to 9/26/2024. Record review of Resident #1's MAR for August 2024 revealed Eliquis was not administered or ordered from 8/26/2024 until 8/31/2024. Record review of Resident #1's MAR for September 2024 revealed Eliquis was not administered or ordered from 9/01/2024 until 9/26/2024. In an interview on 12/17/2024 at 10:03 a.m., MA B reported the MAR showed her what medications to administer to each resident and what time to administer the medications. MA B stated she was not able to add or remove medications from the MAR because the nurses had to enter the orders into the EHR. MA B stated only nurses were able to add medications to the MAR. In an interview on 12/17/2024 at 4:03 p.m., LVN A reported she transcribed Resident #1's discharge medication orders when Resident #1 returned from the hospital on 8/26/2024. LVN A stated she reviewed the medications with the physician and entered them into the EHR. LVN A reported she did not know why the order for Eliquis was missing because she thought she entered it into Resident #1's EHR. LVN A reported she was not aware the order was missing at that time and would never intentionally not give the resident her medicine. LVN A was not asked the risk to the resident. In an interview on 12/17/2024 at 9:50 a.m., LVN D stated a resident would be at risk for a blood clot, stroke, or embolism if they were not given Eliquis as ordered. Record review of Resident #1's hospital H&P dated 9/27/2024 revealed Resident #1 was admitted to the hospital on 9/26/2024 and was found to have a non-salvageable limb ischemia (no blood supply to the leg). On 9/26/2024 Resident #1 had a mechanical thrombectomy (removal of blood clot) for an occluded superficial femoral artery (blood vessel) in the left leg. Resident #1 underwent a left above the knee amputation because blood flow was not restored after the thrombectomy (removal of blood clot). Record review of nursing progress note dated 9/30/2024 at 6:53 p.m. revealed Resident #1 returned to the facility with a left above the knee amputation. Record review of Resident #1's MAR for October 2024 revealed Eliquis was ordered and administered to Resident #1 from 10/01/2024 until 10/17/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 12/17/2024 at 1:17 p.m., the DON reported she was notified on 10/18/2024 by a case worker from the hospital that Resident #1 had not received her Eliquis previously while at the facility. The DON stated the case workers at the hospital reconciled medications on their end but were unable to notify the facility of the discrepancy because they had the wrong DON email address. The DON reported she immediately notified the Medical Director, the family, and the ombudsman of the error. The DON stated that the Medical Director would have to answer if there were any adverse reactions or risks to Resident #1. The DON stated previously the floor nurse reviewed the medications with the doctor and transcribed them to the EHR. The DON stated the admission process was updated to include additional checks by the unit manager and DON to ensure medications were transcribed accurately. The DON stated the floor nurse was responsible for reconciling the medications with the doctor, then the unit manager would verify the medications were accurately transcribed. The DON stated then she would review the medications again and the medication list would be sent to the pharmacy to be reviewed for accuracy. The DON reported a medication reconciliation competency was completed for every nurse. In an interview on 12/17/2024 at 1:48 p.m., the Medical Director reported Resident #1 had multiple things wrong with her and was doing poorly after hip surgery in August 2024. The Medical Director reported Resident #1 had an above the knee amputation on the left leg because Resident #1 had a blood clot. The Medical Director stated the Eliquis was prescribed for atrial fibrillation, and venous (veins) clots were prevented with Eliquis. The Medical Director stated Resident #1 had an arterial (arteries) clot. In an interview on 12/18/2024 at 12:55 p.m., the Medical Director stated the nurses completing admissions were expected to look at all of the discharge orders and review them with the doctor. The Medical Director stated the Eliquis was on the discharge orders for Resident #1 but could not state if the nurse mentioned it or not when she called to reconcile the medications on 8/26/2024. Record review of the Medication Guide Eliquis, revised September 2021, revealed Eliquis is a prescription medicine used to: reduce the risk of stroke and blood clots in people who have atrial fibrillation. Reduce the risk of forming a blood clot in the legs and lungs of people who have just had hip or knee replacement surgery. In an interview on 12/17/2024 at 2:29 p.m., a medical information specialist for Eliquis stated the premature discontinuation of Eliquis increases the risk of thrombotic events (formation of blood clots) and to reduce the risk consider coverage with another anticoagulant (blood thinner). The medical information specialist stated thrombotic events (blood clots) could occur in veins or arteries. In an interview on 12/18/2024 at 8:38 a.m., the ADM stated their back up checks failed, and a mistake was made. The ADM stated on 8/26/2024 that the admission nurse was not working that day (who assisted in checking the medication orders) and that they would have given the medication if the order had been transcribed. The ADM stated at the time that Resident #1's Eliquis was not transcribed, that the facility had an admission checklist, but it was only monitored by the admission nurse and the DON. The ADM stated all discharge orders are expected to be transcribed. The ADM did not state the risk to the resident not receiving the prescribed medication. Record review of admission/discharge report dated 12/17/2024 revealed Resident #1 was transferred to another facility on 10/18/2024. (continued on next page)

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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 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of facility policy titled Adverse Consequences and Medication Errors, with a revision date of April 2014, stated The interdisciplinary team evaluates medication usage in order to prevent and detect adverse consequences and medication-related problems. Facility policy for admission orders/transcribing orders not received a the time of exit. The facility took the following actions to correct the noncompliance prior to the investigation: In an interview on 12/18/2024 at 8:38 a.m., the ADM reported the admission checklist was updated and required the floor nurse, nurse manager, and the DON to review medications on all new admissions. The ADM stated the DON was responsible for monitoring the admission checklist and ensuring the medications were transcribed. The ADM stated the facility reviewed all new admissions during meetings on Thursdays, and she monitored the admission checklist to ensure it was completed during monthly meetings. Record Review of new admission checklist revealed section for floor nurse to initial medications were reviewed with the physician and entered into the EHR. The form revealed an area for the floor nurse to sign, the unit manager to sign, and for the DON to sign once reviewed. Record Review of facility's admission binder revealed completed new admission checklist forms for admissions from 10/20/2024 to current. In an interview on 12/17/2024 at 1:17 p.m., the DON stated the admission process was updated to include additional checks by the unit manager and DON to ensure medications were transcribed accurately. The DON stated the floor nurse was responsible for reconciling the medications with the doctor, then the unit manager would verify the medications were accurately transcribed. The DON stated then she would review the medications again and the medication list would be sent to the pharmacy to be reviewed for accuracy. The DON reported a medication reconciliation competency was completed for every nurse. Record Review of Competency Assessment Reconciliation of Medications on Admission forms revealed the competency checklist was completed for 28 nurses on 10/19/2024. In an interview on 12/17/2024 at 9:17 a.m., RN C stated they implemented a new protocol and there were three checks now for the medication reconciliation. RN C stated the floor nurse was the first one responsible for transcribing medications when a resident was admitted . RN C stated then the unit manager would perform the second check, and the DON would perform the third check. RN C stated they had an updated checklist that he received training for and for reconciling medications. In an interview on 12/17/2024 at 9:50 a.m., LVN D stated she received training for medication orders and the admission process. LVN D stated the nurse that completed the admission would reconcile the medications from the hospital discharge paperwork with the physician. LVN D stated the nurse manager and DON would check the medications afterwards. In an interview on 12/17/2024 at 10:15 a.m., LVN E stated discharge orders were reviewed with the doctor and then entered into the EHR. LVN E stated the nurse managers check the medications after the floor nurse, and then the DON checks the medications. LVN E stated she received training for medication reconciliation. (continued on next page)

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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 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 12/17/2024 at 10:27 a.m., Unit Manager F stated the floor nurse would review medications with the doctor, and the unit manager would do a second check to ensure all medications were entered. Unit manager F stated the DON would review the medications after the unit manager, and the medications would also be checked again by the pharmacy consultant. Unit Manager F reported she received one-to-one training from the DON concerning the medication reconciliation process. In an interview on 12/17/2024 at 12:53 p.m., RN G stated that when a new admit arrived then the medication orders were verified with the doctor and emailed to the pharmacy consultant. RN G stated then a nurse manager would check the orders, and the DON checked them after the nurse manager. RN G stated she received in-person training for medication reconciliation and completed a checkoff list for medication reconciliation competency. In an interview on 12/17/2024 at 4:03 p.m., LVN A stated she received training for the admission process and the medication reconciliation process. LVN A stated she received one-to-one training from the DON. LVN A stated the nurses would review the medications one by one with the doctor and would complete the admission checklist. LVN A stated the nurse manager checked the medications after the nurse entered them, and then the DON would recheck them.

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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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50222 Based on interview and record review, the facility failed to ensure residents are free of any significant medication errors for one (Resident #1) of four residents reviewed for medication errors. The facility failed to ensure Eliquis (anticoagulant commonly known as a blood thinner medication) was administered to Resident #1 as ordered from 08/26/2024 to 09/26/2024 (30 days). The noncompliance was identified as past noncompliance (PNC). The IJ began on 08/26/2024 and ended on 10/19/2024. The facility had corrected the noncompliance before the state's investigation began. This failure could place residents at risk for not receiving medications as ordered by their physician or per manufacturer's directions. Findings included: Record review of Resident #1's PPS MDS assessment dated [DATE] revealed Resident #1 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of atrial fibrillation (irregular heart rhythm), displaced intertrochanteric fracture of the left femur (fractured left hip), and encounter for other orthopedic aftercare (care after surgery). The MDS also revealed a BIMS score of 15 (suggested no cognitive impairment). Record review of Resident #1's care plan revised on 10/23/2024 revealed Resident #1 was at risk for bleeding due to anticoagulant use and interventions included evaluating the skin for evidence of impaired coagulation (bruising, petechia, bleeding). Record review of Resident #1's MAR for August 2024 revealed Eliquis was ordered and administered to Resident #1 from 8/08/2024 until 8/23/2024. Record review of Resident #1's hospital H&P dated 8/26/2024 revealed Resident #1 was transferred to the hospital on 8/23/2024 and was on Eliquis for atrial fibrillation. Record review of Resident #1's hospital discharge summary dated 8/25/2024 revealed orders to continue Eliquis after discharge from the hospital. Record review of Resident #1's physician orders revealed there was not an order for Eliquis from 8/26/2024 to 9/26/2024. Record review of Resident #1's MAR for August 2024 revealed Eliquis was not administered or ordered from 8/26/2024 until 8/31/2024. Record review of Resident #1's MAR for September 2024 revealed Eliquis was not administered or ordered from 9/01/2024 until 9/26/2024. (continued on next page)

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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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 12/17/2024 at 10:03 a.m., MA B reported the MAR showed her what medications to administer to each resident and what time to administer the medications. MA B stated she was not able to add or remove medications from the MAR because the nurses had to enter the orders into the EHR. MA B stated only nurses were able to add medications to the MAR. In an interview on 12/17/2024 at 4:03 p.m., LVN A reported she transcribed Resident #1's discharge medication orders when Resident #1 returned from the hospital on 8/26/2024. LVN A stated she reviewed the medications with the physician and entered them into the EHR. LVN A reported she did not know why the order for Eliquis was missing because she thought she entered it into Resident #1's EHR. LVN A reported she was not aware the order was missing at that time and would never intentionally not give the resident her medicine. LVN A was not asked the risk to the resident. In an interview on 12/17/2024 at 9:50 a.m., LVN D stated a resident would be at risk for a blood clot, stroke, or embolism if they were not given Eliquis as ordered. Record review of Resident #1's hospital H&P dated 9/27/2024 revealed Resident #1 was admitted to the hospital on 9/26/2024 and was found to have a non-salvageable limb ischemia (no blood supply to the leg). On 9/26/2024 Resident #1 had a mechanical thrombectomy (removal of blood clot) for an occluded superficial femoral artery (blood vessel) in the left leg. Resident #1 underwent a left above the knee amputation because blood flow was not restored after the thrombectomy (removal of blood clot). Record review of Resident #1's MAR for October 2024 revealed Eliquis was ordered and administered to Resident #1 from 10/01/2024 until 10/17/2024. In an interview on 12/17/2024 at 1:17 p.m., the DON reported she was notified on 10/18/2024 by a case worker from the hospital that Resident #1 had not received her Eliquis previously while at the facility. The DON stated the case workers at the hospital reconciled medications on their end but were unable to notify the facility of the discrepancy because they had the wrong DON email address. The DON reported she immediately notified the Medical Director, the family, and the ombudsman of the error. The DON stated that the Medical Director would have to answer if there were any adverse reactions or risks to Resident #1. The DON stated previously the floor nurse reviewed the medications with the doctor and transcribed them to the EHR. The DON stated the admission process was updated to include additional checks by the unit manager and DON to ensure medications were transcribed accurately. The DON stated the floor nurse was responsible for reconciling the medications with the doctor, then the unit manager would verify the medications were accurately transcribed. The DON stated then she would review the medications again and the medication list would be sent to the pharmacy to be reviewed for accuracy. The DON reported a medication reconciliation competency was completed for every nurse. In an interview on 12/18/2024 at 12:55 p.m., the Medical Director stated the nurses completing admissions were expected to look at all of the discharge orders and review them with the doctor. The Medical Director stated the Eliquis was on the discharge orders for Resident #1 but could not state if the nurse mentioned it or not when she called to reconcile the medications on 8/26/2024. (continued on next page)

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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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 12/18/2024 at 8:38 a.m., the ADM stated their back up checks failed, and a mistake was made. The ADM stated on 8/26/2024 that the admission nurse was not working that day (who assisted in checking the medication orders) and that they would have given the medication if the order had been transcribed. The ADM stated at the time that Resident #1's Eliquis was not transcribed, that the facility had an admission checklist, but it was only monitored by the admission nurse and the DON. The ADM stated all discharge orders are expected to be transcribed. Review of facility policy titled Adverse Consequences and Medication Errors, with a revision date of April 2014, stated The interdisciplinary team evaluates medication usage in order to prevent and detect adverse consequences and medication-related problems. The facility took the following actions to correct the noncompliance prior to the investigation: In an interview on 12/18/2024 at 8:38 a.m., the ADM reported the admission checklist was updated and required the floor nurse, nurse manager, and the DON to review medications on all new admissions. The ADM stated the DON was responsible for monitoring the admission checklist and ensuring the medications were transcribed. The ADM stated the facility reviewed all new admissions during meetings on Thursdays, and she monitored the admission checklist to ensure it was completed during monthly meetings. Record Review of new admission checklist revealed section for floor nurse to initial medications were reviewed with the physician and entered into the EHR. The form revealed an area for the floor nurse to sign, the unit manager to sign, and for the DON to sign once reviewed. Record Review of facility's admission binder revealed completed new admission checklist forms for admissions from 10/20/2024 to current. In an interview on 12/17/2024 at 1:17 p.m., the DON stated the admission process was updated to include additional checks by the unit manager and DON to ensure medications were transcribed accurately. The DON stated the floor nurse was responsible for reconciling the medications with the doctor, then the unit manager would verify the medications were accurately transcribed. The DON stated then she would review the medications again and the medication list would be sent to the pharmacy to be reviewed for accuracy. The DON reported a medication reconciliation competency was completed for every nurse. Record Review of Competency Assessment Reconciliation of Medications on Admission forms revealed the competency checklist was completed for 28 nurses on 10/19/2024. In an interview on 12/17/2024 at 9:17 a.m., RN C stated they implemented a new protocol and there were three checks now for the medication reconciliation. RN C stated the floor nurse was the first one responsible for transcribing medications when a resident was admitted . RN C stated then the unit manager would perform the second check, and the DON would perform the third check. RN C stated they had an updated checklist that he received training for and for reconciling medications. In an interview on 12/17/2024 at 9:50 a.m., LVN D stated she received training for medication orders and the admission process. LVN D stated the nurse that completed the admission would reconcile the medications from the hospital discharge paperwork with the physician. LVN D stated the nurse manager and DON would check the medications afterwards. (continued on next page)

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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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 12/17/2024 at 10:15 a.m., LVN E stated discharge orders were reviewed with the doctor and then entered into the EHR. LVN E stated the nurse managers check the medications after the floor nurse, and then the DON checks the medications. LVN E stated she received training for medication reconciliation. In an interview on 12/17/2024 at 10:27 a.m., Unit Manager F stated the floor nurse would review medications with the doctor, and the unit manager would do a second check to ensure all medications were entered. Unit manager F stated the DON would review the medications after the unit manager, and the medications would also be checked again by the pharmacy consultant. Unit Manager F reported she received one-to-one training from the DON concerning the medication reconciliation process. In an interview on 12/17/2024 at 12:53 p.m., RN G stated that when a new admit arrived then the medication orders were verified with the doctor and emailed to the pharmacy consultant. RN G stated then a nurse manager would check the orders, and the DON checked them after the nurse manager. RN G stated she received in-person training for medication reconciliation and completed a checkoff list for medication reconciliation competency. In an interview on 12/17/2024 at 4:03 p.m., LVN A stated she received training for the admission process and the medication reconciliation process. LVN A stated she received one-to-one training from the DON. LVN A stated the nurses would review the medications one by one with the doctor and would complete the admission checklist. LVN A stated the nurse manager checked the medications after the nurse entered them, and then the DON would recheck them.