STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675033	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mesquite Tree Nursing Center	434 Paza Dr Mesquite, TX 75149

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48235 Based on observations, interviews and record review, the facility failed to ensure each resident had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 1 of 8 residents (Resident #60) reviewed for reasonable accommodations. The facility failed to ensure the call light in resident room [ROOM NUMBER] A used by Resident #60 was always within reach. This failure could place resident at risk of being unable to obtain assistance for activities of daily living or in the event of an emergency. Findings included: Review of Resident #60's face sheet dated [DATE] reflected she was an [AGE] year-old female with an admitted [DATE]. Admission diagnoses reflected Resident #60 had a diagnosis of type 2 diabetes, fracture of shaft of left ULNA (fracture of left forearm), cognitive communication deficit (a condition makes it difficult to communicate). Review of the current diagnosis dated [DATE] reflected resident #60 was diagnosed with Enterocolitis due to clostridium difficile (an inflammation of intestines caused by bacteria). Review of Resident #60's MDS assessment dated [DATE] revealed Resident #60 had a BIMS score of 12 which indicates moderate cognitive impairment, required substantial/maximal assistance with toileting hygiene, moderate assistance with transfers, and always incontinent of bowel and urine. Review of Resident #60's care plan dated [DATE] reflected Resident #60 was at risk for unstable blood sugar levels and abnormal lab results, had an ADL selfcare performance deficit and was at risk for not having needs met in a timely manner, resident was incontinent of bowel/bladder. (continued on next page)

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
	675033	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mesquite Tree Nursing Center	434 Paza Dr Mesquite, TX 75149

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and observation of Resident #60 on [DATE] at 11:39 AM in her room revealed the resident was on isolation for contact and droplet precautions due to Enterocolitis due to clostridium difficile. The resident was lying on her bed, the call light was found on the floor, away from resident's reach. Resident #60 stated she wanted to call the nurse for assistance at that time but noticed the call light was not attached to her pillow/bedsheet, nobody could hear her verbally calling the nurse since the door was closed as she was on isolation. The surveyor observed the call light was lying on the floor, away from the resident's reach. Resident stated she could not remember since how long the call light was not within her reach. Interview with LVN C on [DATE] at 11:44 AM in Resident #60's room revealed he was the charge nurse for Resident #60. Resident #60 was on isolation precaution for enterocolitis due to clostridium difficile. LVN C observed Resident #60's call light was not within reach and was lying on the floor. LVN C stated he did not know the call light was not within the reach of the resident, the call light device was used by the residents to alert the staff about resident's needs and the call light was expected to be working and within the reach of the resident all the time. LVN C stated the absence of a call light device within reach could create several problems for the residents such as not getting changed or cleaned on time, not getting drinks or snacks as needed, not getting help during a health crisis. LVN C stated he had received in-services on call lights on a regular basis, the last time he received an in-service was 2 weeks ago. LVN C sated all the staff working with the resident were responsible to ensure the call light device was working and within reach of the resident. Interview with CNA G on [DATE] at 01:47 PM. She stated it was the responsibility of all the employees to ensure the call light was always within the reach of the residents, not having a call light within reach could lead to fall, injury, dehydration, missing nursing care, incontinent care. CNA G stated she had received in service on call lights within the past few weeks. Interview with ADON D on [DATE] at 10:35 AM revealed all residents were expected to always have their call light within reach and it was the responsibility of all the employees to ensure the call light was within reach of each resident. ADON D stated not having a call light within reach could put a resident at risk for going without incontinent care after a bowel movement, going without care at the time of a health crisis. Interview with the Administrator on [DATE] at 11:27 AM revealed she was not aware the Resident #60's call light was not within reach, she stated it was her expectation for all the employees to make sure the resident call light was always within reach and not having the call light within reach could lead to the risk of not getting assistance in a timely manner, it could lead to not receiving incontinent care, skin break. The Administrator stated all the employees received in service regarding call lights every month and after each incident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675033	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mesquite Tree Nursing Center	434 Paza Dr Mesquite, TX 75149

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's call light response policy dated [DATE] reflected The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. The policy stated the process as follows . All staff will be educated on the proper use of the resident call system, including how the system works and ensuring resident access to the call light . With each interaction in the resident's room or bathroom, staff will ensure the call light is within reach of resident and secured, as needed . Staff will report problems with a call light or the call system immediately to the supervisor and/or maintenance director and will provide immediate or alternative solutions until the problem can be remedied .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675033	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mesquite Tree Nursing Center	434 Paza Dr Mesquite, TX 75149

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47690 Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and time frames to meet residents' mental and psychosocial needs, for 1 (Resident #55) of 6 residents reviewed for comprehensive care plans. The facility failed to ensure Resident #55 had a person-centered care plan to include significant advance directive code status change from full code to DNR code, when they received Resident#55 consent on [DATE]. This failure could place resident at risk of been resuscitated and not honoring her DNR wishes. Findings included: Review of Resident #55's face sheet dated [DATE] revealed the resident was a [AGE] year-old female admitted on [DATE] with diagnoses including hypertension (High blood pressure), Non-Alzheimer's Dementia (loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), Cerebrovascular accident. Review of Resident#55's quarterly MDS assessment dated [DATE] revealed Resident #55 had a BIMS score of ,d+[DATE] indicating severe cognitive impairment. Review of Resident#55 electronic medical record on [DATE] at 08:11 AM revealed a consent for DNR dated [DATE]. Review of Resident #55's Physician's Order Sheet dated [DATE] revealed Code status: DNR. Review of Resident #55's Comprehensive care plan last reviewed [DATE] revealed Focus. Full Code: Resident has physician's orders that include a status of full code. Goal: Staff will administer CPR if resident has an arrest. Interventions: Ensure Full Code order on chart. Ensure staff is aware of code status through designated systems. Monitor for changes in resident's code status and update as needed. Review at least quarterly. Begin CPR after absence of vital signs, call 911, notify physician, and notify family/responsible party. Attempted interview and observation on [DATE] at 10:08 AM with Resident#55, revealed she was lying in bed unable to participate in interview. Interview on [DATE] at 08:09 AM with the MDS coordinator, she stated the code status order for the Resident#55 was DNR. She stated according to her the care plan was updated on [DATE] when she got the order, and it stated the resident code status had been changed to DNR. She stated the SW was responsible for the care plan part for the code status of the residents. The MDS coordinator stated the importance of care plan was for the staff to know what kind of care to render to the residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675033	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mesquite Tree Nursing Center	434 Paza Dr Mesquite, TX 75149

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on [DATE] at 08:31 AM with ADON D, she stated the SW was responsible for that changing, meaning the status code for the residents in the care plan. The ADON stated if the care plan was not updated it can affect the resident's care, and in this case Resident#55 may got resuscitated against her wishes. Interview on [DATE] at 12:33 PM with the Administrator, she stated they thought they had to wait for the order to correct the care plan, and it was supposed to be done whenever they received the resident's consent. The Administrator stated the SW was responsible for the code status part of the care plan update. She stated the risk to the resident it would not following with her wishes by doing t CPR on the Resident#55, who wanted to be a DNR. Interview on [DATE] at 05:31 PM with the SW revealed she was responsible for the care plan code status update for the residents. She stated she did not update Resident#55's care plan after she received the consent, because she was waiting for the nurse to transcribe the order in the Resident#55 e-record. She stated the risk to Resident#55 if the care plan was not updated; Resident#55 could be resuscitated will she was a DNR. Review of facility Document titled Care Plan Guidance's, revised [DATE], revealed, .Care Plan Updates. The IDT will review the care plans Annually, Quarterly, and as needed to ensure all the goals and approaches are appropriate .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675033	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mesquite Tree Nursing Center	434 Paza Dr Mesquite, TX 75149

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 47690 Based on observations, interviews, and record review the facility failed to provide the necessary services for residents who were unable to carry out activities of daily living to maintain good grooming and personal hygiene for 4 (Resident #35, Resident #45, Resident#24, and Resident#40) of 16 residents reviewed for ADLs. The facility failed to ensure: - Resident #35 had her fingernails cleaned and trimmed. - Resident #45 had her fingernails trimmed. - Resident #24 had her fingernails cleaned and trimmed. - Resident #40 had her fingernails cleaned and trimmed. These failures could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections, and a decreased quality of life. Findings included: 1- Resident #35 Record review of Resident # 35's Face Sheet dated, 12/18/24, reflected a [AGE] year-old female admitted to the facility with initial admitted [DATE] with relevant diagnoses of Alzheimer's (brain disorder that gradually decreased memory function), reduced mobility (inability to move around freely or without pain), generalized muscle weakness and dysphagia (difficulty swallowing). Record review of Resident #35's Quarterly MDS assessment dated [DATE], reflected Resident #35 had a BIMS score of 0 which indicated Resident #35's cognition was severely impaired. It also reflected that Resident #35 required substantial assistance with showering and personal hygiene. Record review of Resident #35's Comprehensive Care Plan revised on 9/18/2021 reflected, Focus: [Resident #35] has an ADL Self Care Performance Deficit and is at risk for not having their needs met in a timely manner. Goal: [Resident #35] has an ADL Self Care Performance Deficit and is at risk for not having their needs met in a timely manner. Interventions: Personal Hygiene: Extensive assistance with 1 staff [member]. Record review of Resident #35's Comprehensive Care Plan revised on 3/8/2023 reflected, Focus: Resistant to Cares: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675033	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mesquite Tree Nursing Center	434 Paza Dr Mesquite, TX 75149

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[Resident#35] is resistant to cares and at risk for injury, a decline in functional abilities, and not having their needs met in a timely manner. Resistance is related to refuses to allow staff to cut her fingernails. Goal: Resistance behaviors will not interfere with ADLs being met in a timely manner on a daily basis through the next review. Interventions: o Approach resident in a calm manner, call by name, speak slowly, and maintain eye contact. Talk while providing cares, allow time for a response, and do not rush. o Give a clear explanation of daily care activities prior to and as they occur during each contact. Encourage as much participation and interaction by the resident as possible. o Discuss the possible outcomes of not complying with therapeutic regime. In an observation and interview on 12/17/24 at 8:47 AM with Resident #35, revealed fingernails on both hands were dirty with black discoloration underneath the nails as well as jagged. The fingernails were 0.5-0.7 centimeter in length extending from the tip of her fingers. Resident #35 stated she had not had her nails cut in a long time and would like her nails to be cleaned and trimmed. 2- Resident #45 Record review of Resident # 45's Face Sheet dated, 12/18/24, reflected an [AGE] year-old female admitted to the facility with initial admitted [DATE] with relevant diagnoses of Heart failure (condition where heart cannot pump enough blood and oxygen to the body organs), Hypertension (high blood pressure), Arthritis (chronic conditions that causes inflammation in the joints). Record review of Resident #45's Admission MDS assessment dated [DATE], reflected Resident #45 had a BIMS score of 13 which indicated Resident #45's cognition was intact. It also reflected that Resident #45 required substantial assistance with showering and personal hygiene. Record review of Resident #45's Comprehensive Care Plan revised on 11/27/24 reflected, Focus: ADLs: [Resident #45] has an ADL Self Care Performance Deficit and is at risk for not having their needs met in a timely manner. Goal: [Resident #45] will participate to the best of their ability and maintain current level of functioning with activities of daily living (ADLs) through the next review date. Interventions: Provide shower, shave, oral care, hair care, and nail care per schedule and when needed. In an observation and interview on 12/17/24 at 9:07 AM with Resident #45, revealed fingernails on both hands were long, about 0.5-0.75 centimeter in length extending from the tip of her fingers. Resident #45 stated she was new to the facility and had been in the facility for about 4-5 weeks. She stated that neither CNAs nor nurses have offered to cut her nails, she cannot trim her nails by herself and needed assistance with nail care related to diagnoses of arthritis. In an interview on 12/17/24 at 9:20 AM with CNA B revealed CNAs and Nurses were responsible for nail care. She stated that Nurses were responsible for nail care for diabetic residents. She stated nail care for residents were done on shower days and as needed. She added the risk to resident for not trimming or cleaning nails was decreased skin integrity and risk of infections. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675033	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mesquite Tree Nursing Center	434 Paza Dr Mesquite, TX 75149

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an Interview on 12/17/24 11:03 AM with LVN C revealed, CNAs were responsible for resident nail care, unless the resident had diagnoses of Diabetes, then Nurses were responsible for trimming resident nails. He stated dirty, long fingernails can expose the residents to the risk of developing infections or skin tears. LVN C further stated that although CNAs were responsible for nail care, it was ultimately the responsibility of the charge nurse to ensure residents fingernails were always cleaned and trimmed. In another observation and interview on 12/18/24 10:31 AM with LVN C revealed both Resident # 35 and Resident #45 had their nails cleaned and trimmed. LVN C stated that Resident #35 initially refused to cut her nails, however when approached by a different staff member, allowed the staff member to trim and clean her nails. He also stated that he offered Resident #45 to cut her nails. 3-Resident#24 Record review of Resident # 24's Face Sheet dated, 12/20/24, reflected a [AGE] year-old female admitted to the facility with initial admitted [DATE] with relevant diagnoses of Dementia (loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), reduced mobility (inability to move around freely), generalized muscle weakness and dysphagia (difficulty swallowing). Record review of Resident#24's MDS assessment dated [DATE], reflected Resident#24 had a BIMS score of 09/15 indicating moderately impaired cognition. It also reflected that Resident#24 required substantial assistance with showering and personal hygiene. Record review of Resident#24's Comprehensive Care Plan revised on 9/18/21 reflected, Focus: ADLs: Resident#24 has an ADL Self Care Performance Deficit and is at risk for not having their needs met in a timely manner. Goal: Resident#24 will participate to the best of their ability and maintain current level of functioning with activities of daily living (ADLs) through the next review date. Interventions: Provide shower, oral care, hair care, and nail care per schedule and when needed. Observation and interview on 12/18/24 at 9:13 AM with CNA E, revealed, he looked at Resident#24 fingernails on both hands and stated they are long, and dirty. Resident#24 both hands fingernails were long, about 0.4-0.5 centimeter in length extending from the tip of her fingers, with black matter underneath some of them. CNA E stated he was supposed to check residents' fingernails each time he had encounter with the resident. He stated the risk to residents was they could injure themself, harbor germs in their hands, could swallow them, and develop infection. CNA E stated he received in service on resident care including fingernails during his orientation a month ago. 4-Resident#40 Record review of Resident#40's Face Sheet dated, 12/20/24, reflected a [AGE] year-old female admitted to the facility with initial admitted [DATE] with relevant diagnoses of Dementia (loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), reduced mobility (inability to move around freely), generalized muscle weakness and dysphagia (difficulty swallowing). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675033	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mesquite Tree Nursing Center	434 Paza Dr Mesquite, TX 75149

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident#40's MDS assessment dated [DATE], reflected Resident#40 had a BIMS score of 03/15 which indicated severe cognitive impairment. It also reflected that Resident#40 required substantial assistance with showering and personal hygiene. Record review of Resident#40's Comprehensive Care Plan revised on 05/17/23 reflected, Focus: ADLs: Resident#40 has an ADL Self Care Performance Deficit and is at risk for not having their needs met in a timely manner. Goal: Resident#40 will participate to the best of their ability and maintain current level of functioning with activities of daily living (ADLs) through the next review date. Interventions: Provide shower, oral care, hair care, and nail care per schedule and when needed. Observation and interview on 12/18/24 at 9:20 AM with CNA E revealed, CNA E looked at Resident#40's fingernails, and stated Resident#40's fingernails looked longer chipped, and dirty. CNA E stated Resident#40 was diabetic and the nurses were responsible to take care of her fingernails. CNA E denied letting the nurses know about Resident#40's fingernails status. Resident#40's fingernails on both hands were long, about 0.5-0. 6 centimeter in length extending from the tip of her fingers, and some of them were chipped. can E stated each time he had encounter with the residents, he was supposed to check their fingernails, and report the issue to the charge nurse if the resident was diabetic. He stated the risk to residents was they could injure themself, harbor germs in their hands, could swallow them, and develop infection. CNA E stated he received in service on resident care including fingernails during his orientation. Interview on 12/18/24 09:23 AM with LVN F revealed, she stated CNAs were responsible for resident nail care, unless the resident had diagnoses of Diabetes, then Nurses were responsible for trimming resident nails. She stated dirty, long fingernails can expose the residents to the risk of developing infections or skin tears. LVN F further stated the charge nurse for each Hall were responsible to ensure residents fingernails were always cleaned and trimmed. Interview on12/19/24 at 08:31 AM with the ADON G revealed all the staff were responsible for the residents' fingernails care. She stated CNAs should make sure residents' fingernails were cleaned and trimmed all the time, and if the resident had diabetes Mellitus it was strictly the responsibility of the nurses to trim their fingernails. She stated in service on residents' nails care we given a lot to all the staff, and she personally talk to the aides. She stated the risk to residents, they could be harboring germs underneath the fingernails, they could develop infection and they could injure themself. Record review of the facility policy titled, Activities of Daily Living Guidelines dated 2/11/2021 reflected, Residents will receive essential services for activities of daily living to maintain good nutrition, grooming, and personal and oral hygiene . 48560

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675033	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mesquite Tree Nursing Center	434 Paza Dr Mesquite, TX 75149

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48560 Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for the facility's only kitchen. 1. The facility failed to ensure food items in the facility kitchen were covered. This failure could affect residents who received their meals from the facility's only kitchen, by placing them at risk for food-borne illness, and food contamination. Findings included: Observation on 12/17/24 at 7:58 AM of the walk-in refrigerator revealed sausages were left open in a cardboard box. Observation on 12/17/24 at 8:03 AM of the dry storage area in the kitchen revealed a box of pasta and a box of cream of wheat were left uncovered. In an interview on 12/18/24 at 1:52 PM, the Dietary Manager stated the cooks were mainly responsible for covering all food items in the kitchen. He stated that his expectation was all food items in the kitchen should be covered appropriately even if the food items were in a box. He stated the risk to residents of not covering food items could cause cross contamination resulting in food-borne illness. He added as the Dietary Manager, he conducted an in-service regarding covering food items appropriately on 12/18/24. In an interview 12/18/24 at 2:01 PM, [NAME] A revealed she has worked at the facility for four years. She stated that Cooks were responsible for covering all food items in the kitchen. She stated that she had not worked for the past two days so was unable to talk about the food items in the kitchen that were observed uncovered. She stated not covering food items could cause cross contamination and potentially cause illness in residents. She stated that she had received in-service about covering refrigerated and dry foods from the Dietary Morning on the morning of the interview. Record review of the facility policy titled Frozen and Refrigerated Foods Storage revised 12/5/2017 reflected, (Potentially hazardous/ time temperature control for safety) foods will be properly refrigerated or frozen to reduce the potential for food borne illness and maintain product integrity . Record review of the facility policy titled Dry Food and Supplies Storage revised 11/15/2017 reflected, .7. Bulk food products that are removed from original containers must be placed in plastic or metal food grade containers with tight fitting lids . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675033	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mesquite Tree Nursing Center	434 Paza Dr Mesquite, TX 75149

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Food and Drug Administration Food Code, dated 2022, reflected, .3-302.12 Food Storage Containers, Identified with Common Name of Food. Except for containers holding food that can be readily and unmistakably recognized such as dry pasta, working containers holding food, or food ingredients that are removed from their original packages for use in the food establishment, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the food 3-305.11 Food Storage.(B) .refrigerated, ready-to eat time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675033	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mesquite Tree Nursing Center	434 Paza Dr Mesquite, TX 75149

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 - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47690 Based on observation, interview and record review, the facility failed to maintain an infection control program designed to prevent the development and transmission of infection for 1 (Resident #51) of 6 residents observed for infection control. The facility failed to ensure: CNA E donned the appropriate PPE (Personal Protective Equipment) during the transfer of Resident #51 who was on enhanced barriers precautions r/t having an indwelling foley catheter. This failure could place residents at risk for infection and cross contamination of pathogens and illness. Findings included: Review of Resident #51's MDS, dated [DATE], revealed he was a [AGE] year-old male who was admitted to the facility on [DATE]. His BIMS score was 09 out of 15 which indicated moderate cognition impairment. His diagnoses included obstructive uropathy (occurs when urine cannot drain through the urinary tract), diabetes mellitus (high sugar level in the blood), and Non-Alzheimer's Dementia (loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain). Review of Resident #51's Care Plan, dated 09/16/24, revealed Focus: The resident requires Enhanced Barrier Precautions d/t Urinary Catheter. Goal: The resident will remain free from active infection with MDROs through the review date. Interventions: . Ensure EBP signage is posted outside the resident room and above the head of the resident bed. Wear down and gloves during high contact resident care activities. Observation on 12/18/24 at 11:36 AM revealed Resident #51 was on EBP. There was signage on the door that informed visitors/staff he was on enhanced barriers precautions, perform hand hygiene before and after leaving room, necessary PPE to wear in room, and donning/doffing (put on/remove) information. CNA E entered Resident #51's room without any form of PPE, there was PPE supplies inside the Resident#51 room on the right side of the room entrance. CNA E washed hands, donned gloves and procced to transfer Residnt#51 from wheelchair to bed without wearing gown. CNA E removed gloved washed hands. Interview on 12/18/24 at 11:43 AM with CNA E, he stated knew he supposed to wear a gown for the resident transfer. He stated he forgot. He stated he was in-serviced regarding different type of infection control during orientation. He stated the risk of not wearing proper PPE in enhanced barriers precautions residents' rooms was exposing himself and others to the development of infection and spreading germs from one resident to another resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675033	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mesquite Tree Nursing Center	434 Paza Dr Mesquite, TX 75149

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 - Few	Interview with ADON D on 12/19/24 at 11:52 AM, she stated all the staff were supposed to wear gown, and gloves going inside the residents on EBP for any high contact care. ADON D stated they used EBP to prevent infection to high-risk residents. She stated in service on EBP was done up on hire, and at least quarterly. Interview on 12/19/24 at 12:33 PM, with the Administrator, she stated staff should gown up, and wear gloves if they were providing care to the resident on EBP, and discard before they come out of the resident room. She stated they do in service for the staff during orientation, and annually. She further stated the EBP just came in this year, so they do in service monthly because it was a new for them. The Administrator stated risk to residents' cross contamination. Record review of the facility's policy, Infection Prevention and Control program, last revised 03/26/24, reflected, EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high -contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. EBP are indicated for residents with any of the following . b .indwelling medical devices (e.g.Urinary catheter .) .During high-contact resident care activities .Transferring