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	09/19/2024

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50445 Based on interview, and record review, the facility failed to immediately report an allegation of abuse to HHSC for one (Resident #3) of five residents reviewed for abuse. The facility failed to report an allegation of abuse as required when Resident #3's family member reported to the facility that Resident #3 had been abused by PT B. This failure could place residents at risk for unreported allegations of abuse. Findings included: Record review of the Minimum Data Set (MDS) dated [DATE] indicated Resident #3 was admitted on [DATE], was a [AGE] year old female, and her diagnoses in part included Hypertension (elevated blood pressure), Obstructive Uropathy (occurs when urine cannot drain through the urinary tract), Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), Asthma (a chronic disease that affects the airways of the lungs), Open Wound, Fibromyalgia (pain in muscle and joints throughout the body), Muscle Weakness, Other Reduced Mobility, and Morbid Obesity. The MDS indicated Resident #3 was able to express ideas and wants and make herself understood, had clear comprehension, and had a Brief Interview for Mental Status (BIMS) score of 14 indicating her cognition was intact. Record review on 09/19/24 at 04:00 pm a copy of an email addressed to RN A was reviewed. The email dated August 29th, 2024, at 04:41 pm was sent from Resident #3's family member and alleged that PT B had intentionally injured Resident #3 with severe bruising that was caused by PT B trying to tighten a belt around her. Interview with Resident #3's family member was attempted by phone on 09/19/24 at 10:30 a.m. and again at 03:57 pm with no answer. Message was left identifying self and requesting call back. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview on 09/19/24 at 12:15 pm, Resident #3 reported that approximately three or four weeks prior, PT B had twice put his foot on her bed, leaned back, and jerked the gait belt around her waist to tighten it. She stated she believed that this was the cause of the bruise on her left side. She reported that PT C was a witness at the bedside at the time of the incident. The bruise to her left side was not observed. She reported that RN A had interviewed her about what had happened with PT B, the gait belt, and the bruise. She reported there had been no prior concerns or incidents with PT B and that she would be willing to work with him again. She did state that she has not worked with PT B since she became aware of the bruise. She did not state she was abused, fearful of PT B, or that PT B had intentionally injured her, but stated that she felt PT B needed further training. She stated this is what she had also reported to RN A. She did state she had been on anticoagulant therapy at some point in the weeks prior to the incident and that this could affect bruising. In an interview 09/19/24 at 01:28 pm, RN A reported that he had received a phone call from Resident #3's family member a few weeks ago (exact date unknown), alleging that PT B had purposefully injured Resident #3 using a gait belt. RN A stated he immediately notified DON of the report as the facility administrator was on medical leave. RN A reported that he assessed Resident #3, noted the bruise on her left side, and that Resident #3 reported to him that she believed the bruise was caused by PT B yanking the gait belt too tight. He denied she reported to him that the injury was intentional or that she considered it abuse. In an interview on 09/19/24 at 01:51 pm, PT C stated he assisted PT B at the bedside with Resident #3 twice in the month of August 2024, on the 16th and the 19th, and that a gait belt had been used both times without incident. He reported that he did not witness PT B put his foot on the bed and yank the gait belt at any time. He denied any knowledge of injury or abuse to Resident #3. He reported that if any abuse occurred, he would have reported it immediately to the abuse coordinator, the ADM. He reported that to his knowledge PT B had not worked with Resident #3 since the report of the allegation. In an interview on 09/19/24 at 02:07 pm, PT B stated that the only times he had worked with Resident #3 in August 2024 was on the 16th and the 19th and that the finding of Resident 3's bruise was on August 27th. He denied he put his foot on the bed or jerked her gait belt. He reported that Resident #3 had not complained that the gait belt was too tight or expressed any other concerns during those therapy sessions. He stated that PT C was at the bedside and could confirm this. He stated he removed himself from Resident #3's care immediately upon hearing of the allegation, and that he last provided her any care on August 19th, 2024. He denied any knowledge of abuse to Resident #3 or any other resident and stated he would have reported it to ADM, the abuse coordinator. In an interview on 09/19/24 at 03:09 pm, Resident #3's attending physician, MD D reported the resident was very obese and had been on blood thinners and that the bruise could have been caused by routine care such as the use of a gait belt, a Hoyer lift, or even turning the resident in bed with a draw sheet. She denied any concern of abuse and stated the bruising was inconsistent with the allegation in that she would have expected the bruising to develop the same day as the injury occurred. She also stated that Resident #3 had been experiencing a cough, and that it was possible that with her obesity and edema in the area/skin folds that superficial vessels may have broken and bled under the skin due to coughing. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of a copy of a Concern/Complaint Form dated 08/29/2024 was noted completed and signed by DON and detailed that Resident #3's family member complained about bruising and PT B Bullying Resident #3. The Concern/Complaint Form noted that Resident #3's physician had identified bruising on her left side on 08/26/24. The Concern/Complaint Form indicated that the DON interviewed Resident #3, PT B, and RN A. The Concern/Complaint Form indicated findings of the investigation included that Resident #3 denied abuse and expressed that she felt safe and apologized for her family member's behavior. The Concern/Complaint Form noted that steps that were taken to correct the concern included the MD obtained x-rays to ensure there were no injuries, resident safety was ensured, and the DON had spoken to PT B regarding the gait belt concerns. Review of in-service record dated 08/30/24 indicated that five staff in the therapy department, including PT B, had received training on the safe use of gait belts. Review of in-service record dated 08/29/24 indicated twenty-eight facility staff had received training on Abuse and Neglect and reporting it to the abuse coordinator. In an interview on 09/19/24 at 02:29 pm, CNA E reported that she has worked with Resident #3 at times during August 2024. CNA E reported that she has never witnessed or had any knowledge of abuse occurring at this facility and would have reported it immediately to the administrator and DON. She reported she had received abuse training. She stated she had not personally witnessed Resident #3 receiving therapy and had received no complaints from her regarding her care. In an interview on 09/19/24 at 03:35 pm, DON stated that when a family member reported an allegation of abuse or neglect, the facility would investigate the allegation, and if abuse was found, the facility would report it to the state immediately. She stated that if the facility's investigation revealed that the resident was cognizant and the resident denied any kind of abuse, then she would not report the allegation to the state. DON reported that she was informed of the allegation by Resident #3's family member on August 29th, 2024. She reported she did not report it to the state because Resident #3 denied any abuse. She stated that ADM was out on leave and that she was responsible for reporting abuse at the time of the complaint. She did not state what guidance she had used for reporting. DON reported that the facility responded to the allegation by assessing the resident, including skin assessment, interviewing Resident #3, PT B, and PT C, notifying the MD, and provided staff in-service training on gait belts and abuse. DON did not state how failure to report abuse could affect a resident. In an interview on 09/19/24 at 04:00 pm, the ADM reported that she was the abuse coordinator but that the incident with Resident #3 had occurred while she was on medical leave and that the abuse coordinator role was assumed by DON during that time. The ADM reported the facility's policy states that if there had been a reason for it (abuse) to be reported to the state, it would have been reported to the state. She reported that if a resident stated they had been abused and used those specific words then the facility would have reported it. The ADM reported that upon her return to the facility she learned that the facility immediately investigated the allegation. She reported that she would have talked to the resident and if the resident denied any abuse occurred, she would have gone with what the resident said. She reported that what she would have done differently from DON was she would have conducted safe surveys. The ADM stated that all allegations of abuse are investigated by the facility immediately to ensure resident safety. She reported that since her return from leave she had reviewed the resident assessment and the investigation completed by DON and noted that staff training on gait belt use and abuse had been conducted. The ADM did not state how failure to report abuse could affect a resident. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of the facility policy titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, dated 2001 and revised April 2021 stated: All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported.