

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455617	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2025
NAME OF PROVIDER OR SUPPLIER Christian Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview and record review, the facility failed to ensure each resident received adequate supervision for 1 of 2 residents (Resident #1) reviewed for accidents. Resident #1 walked out of the facility unattended with a wander guard on and was missing for approximately 10 - 20 minutes on 05/01/2025. The noncompliance was identified as a PNC. The IJ began on 05/01/2025 and ended on 05/02/2025. The facility had corrected the noncompliance before the investigation began. This failure could place residents at risk for serious injury or death. Findings Include: Record review of Resident #1's face sheet dated 08/12/2025 revealed he was a [AGE] year-old male admitted to the facility on [DATE]. Resident discharged to another from facility on 05/03/2025. Admitting diagnosis was Metabolic Encephalopathy (a condition where brain's dysfunction occurs due to issues with the body's metabolism, which can manifest confusion, impaired thinking, or even coma); Cerebral Infarction, Unspecified (a stroke where there is an unspecified blockage of blood flow to the brain, resulting in brain tissue damage); Aphasia following Cerebral Infarction (a language disorder that affects the ability to communicate, stemming from damage to the brain's language centers). Record review of Resident #1's admission MDS assessment dated [DATE] revealed his BIMS score to be 03 indicating severe cognitive function. Resident #1 exhibited inattention which caused resident to have difficulty focusing attention, was easily distracted, and had difficulty keeping track on what was being said to him. Resident #1 had disorganized or incoherent thinking which led to rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject. Resident #1 ambulated independently. Record review of Resident #1's care plan initiated 04/02/2025 revealed resident was an elopement risk/wanderer r/t impaired safety awareness. Resident wandered aimlessly. Goals were to maintain resident's safety through next review. Interventions: distract resident from wandering, identify pattern of wandering; provide structured activities; wander guard left ankle; monitor closely when sister would leave due to being a trigger for increased wandering and elopement; picture and personal information update placed in elopement notebook at nurse's station and receptionist desk; resident placed on 1:1 on 05/01/2025; Wander Guard placement was checked each shift with functionality. Record review of Resident #1's Order Summary Report revealed resident required a Wander Guard r/t exit seeking behavior. Check Wander Guard placement every shift. Order date: 04/02/2025. End Date 04/29/2025 Wander Guard Placement Secured LEFT ANKLE CHECK FOR PLACEMENT Q SHIFT CODE ALERT#9000-0413M every shift for Wander Guard Placement Secured. Order date: 04/29/2025. End date: 05/02/2025 Wander Guard Placement Secured Right ANKLE CHECK FOR PLACEMENT Q SHIFT CODE ALERT#9000-0413M Expiration date 030228 every shift for Wander Guard Placement Secured. Order Date: 05/02/2025. End date: 05/03/2025. Wander Guard three times a day for check Wander Guard. Verbal 04/01/2025 Discontinued 04/02/2025 updated Resident requires a Wander Guard r/t exit seeking behavior every shift for check Wander- guard. Verbal Discontinued 04/02/2025 04/02/2025 04/27/2025. Record review of Resident #1's Elopement assessment dated [DATE] revealed he was a high risk of elopement. Resident #1 was cognitively impaired with poor decision-making skills, ambulated independently, and was a new admission who did not accept the new situation. Elopement assessment dated [DATE] revealed he continued to be a high risk of elopement with cognitively impaired with poor decision-making skills and ambulated independently. Record review of Resident #1's social services note dated 03/31/2025 at 4:30 PM p.m. signed by the SW revealed she met with Family Member #1 and Family Member #2 of Resident #1 the day of admission. During the conversation, one of the Family Members stated, Do not be surprised if he tries to leave. SW asked Family Member in the conversation if Resident #1 tried to leave the hospital and Family Member said no but he did not like being there. SW notified nursing staff that Resident #1 was an elopement risk. Record review of Resident #1's progress note dated 04/01/2025 at 11:46 a.m. and signed by DON revealed Resident #1 continued to be confused at baseline and able to walk through the community unsupervised. Resident #1's family members had discussed the safety of Resident #1 and came to the agreement that he would be safer on the secured unit. Resident #1 transferred to the secured unit due to confusion and wandering. On 04/01/2025 at 7:15 p.m., his family requested Resident #1 to be moved off secured unit due to resident not adjusting well to the change. Resident #1 was confused and wandering. Wander Guard was placed on Resident #1's ankle. Record review of Resident #1 Licensed Nurse MAR for April 2025 and May 2025 indicated staff checked his Wander Guard device on ankle every shift to ensure it</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure in accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are complete; accurately documented; readily accessible; and systematically organized for 1 (Resident #1) of 2 for accuracy of records. The facility failed to accurately document an incident of elopement in progress notes that occurred r/t Resident #1. The failure can affect residents by putting them at risk of preventing further elopements r/t the lack of accurate documentation of incident. Findings included: Record review of Resident #1's face sheet dated 08/12/2025 revealed he was a [AGE] year-old male admitted to the facility on [DATE]. Resident discharged to another from facility on 05/03/2025. Admitting diagnosis was Metabolic Encephalopathy (a condition where brain's dysfunction occurs due to issues with the body's metabolism, which can manifest confusion, impaired thinking, or even coma); Cerebral Infarction, Unspecified (a stroke where there is an unspecified blockage of blood flow to the brain, resulting in brain tissue damage); Aphasia following Cerebral Infarction (a language disorder that affects the ability to communicate, stemming from damage to the brain's language centers). Record review of Resident #1's admission MDS assessment dated [DATE] revealed his BIMS score to be 03 indicating severe cognitive function. Resident #1 exhibited inattention which caused resident to have difficulty focusing attention, was easily distracted, and had difficulty keeping track on what was being said to him. 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Record review of Resident #1's nursing noted dated 05/01/2025 at 3:05 p.m. written by DON revealed Resident #1 back in facility with Family Member #3 at side. Resident #1 went to room with nurse and family member. Head to toe assessment completed no injuries or s/s of distress. No c/o pain or discomfort voiced. ROM to all ext. noted. Resident #1 ambulating without difficulty. Wander Guard intact and functioning to left ankle. Resident #1 answering simple questions and conversing with Family Member#3 and staff without difficulty. Resident #1 refused for vital signs to be taken at this present time. Resident #1 placed on 1:1 immediately with staff. MD entered facility and made aware. Call placed to another Family Member #1, and she is aware of resident leaving. Progress note did not indicate resident eloped from the facility. Requested the incident/accident reported r/t Resident #1's elopement but did not receive it. In interview on 08/12/2025 at 2:20 p.m. with the DON revealed Resident #1 eloped around 2 p.m. on 05/01/2025. She stated Resident #1 would ambulate throughout the facility. He was located by the gates up front of property but was still on the property. His Family Member was coming to visit and found him by the gates. No injuries noted. This was the only time Resident #1 left the building. Drills were completed quarterly now with the staff. Pink binders are at the nurse's station, and the code is Code Pink for elopement. She stated she had been employed since April 07, 2025. She stated she had read that Resident #1's Family Members did not want him back on the unit. The facility placed a Wander Guard on the resident. On 08/13/2025 at 11:28 a.m., in a second phone interview with the DON, revealed in completing the documentation r/t Resident #1's return to the building with Family Member on 05/01/2025, she did not mention he had eloped from the facility but did not give a reason for not including the elopement in documentation. She stated the elopement book was put in place on 05/01/2025. The staff were instructed to document daily on each shift. She stated that the facility was no longer going to accept residents with Wander Guards. The resident would have to qualify for the memory care unit to be admitted to facility should that resident be an elopement risk. In an interview on 08/12/2025 at 2:37 p.m. with the ADM revealed she was on vacation the week of May 5th for 2 weeks. She stated Resident #1 left the building and was found by the gate on the property. He had no injuries. The cameras showed that he was still on property. She stated she would not be able to provide the camera footage. She stated that the receptionist would not have known if the resident was a possible visitor or an independent living resident</p>		