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	08/16/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure that medications were secure and inaccessible to unauthorized staff and residents for two (one medication cart for Hall 200 and one medication cart for Hall Burgundy on the rehab unit) of five medication carts reviewed for medication storage. 1. The facility failed to ensure medication supplies were all stored in locked compartments and permit only authorized personnel to have keys, when CMA A's one medication cart for Hall 200 were left unlocked and unattended by CMA A. 2. The facility failed to ensure medication supplies were all stored in locked compartments and permit only authorized personnel to have keys when LVN B's one medication cart for Hall Burgundy for Rehab and was left unlocked and unattended by LVN B. This failure could result in resident access and ingestion of medications leading to a risk for harm and possible drug diversion.Findings included: An observation on 08/16/2025 at 9:14 a.m. revealed MA A's one medication cart was left unlocked for Hall 200. MA A was in room [ROOM NUMBER] giving medications to the resident. The lock on the medication cart were popped out showing the red bottom indicating the cart was unlocked. An observation and interview on 08/16/2025 at 9:25 a.m. revealed, one resident sitting in a wheelchair, coming out of the room to the unlocked medication cart on Hall 100. The resident stated he was looking for the MA he needed something for his pain. The medication cart remained unlocked and not in direct site of the MA. The MA came out of the other resident's room and ask the other resident what he needed, he shared his concern about his pain, she said she would let the nurse know. MA stated that she knew that the medication cart should always be locked when she is not using it. She just left it unlocked, and she forgot and was talking in the other resident's room, but she would try to do better, keeping it locked. MA A stated if the medication cart was left unlocked a resident or a staff member could get the medications, this could lead to medications being stolen or a resident taking something they should not have. An observation on 08/16/2025 at 9:28 a.m. revealed LVN B's one medication cart was left unlocked for Hall Burgundy on the Rehab unit. LVN B was two rooms down across the hall from the unlocked cart. The Medication cart had four syringes and three vials of unknown medication on top of the medication cart. The lock on the medication cart were popped out showing the red bottom indicating the cart was unlocked. In an interview on 08/16/2025 at 9:33 a.m. with LVN B revealed she was coming down the hallway and the resident called her and she went into her room. The LVN stated I was busy doing my medication pass, but I stopped to see what she needed. The LVN stated that she always leaves her medication cart unlocked during her medication pass. The LVN stated she had left the supplies out on the cart because she was going to use them soon, easier to get to. LVN B stated she knew the medication cart should always be locked when you are not using it, but I do not do that, it is too hard to unlock and relock and unlock again. LVN B stated if the medication cart was left unlocked a resident or a staff member could get the medications, this could lead to medications being stolen or a resident taking something they should not have. In an observation on 08/16/2025 at 10:00 a.m. with MA A of the medication cart for Hall 200 revealed: for Resident #1 Bupropion 300mg (depression), calcium 800 +D (calcium D), citalopram 20mg (panic disorder), metoprolol 25mg (High blood pressure), and mirtazapine 7.5mg (for weight loss). MA A confirmed these were Resident #1's ordered medications. In an observation on 08/16/2025 at 10:30 a.m. with LVN B of the medication cart for the Burgundy Hall on the rehab unit revealed: for Resident #2 Levothyroxine 7.5mg (thyroid), losartan Potassium 50mg (high blood pressure), levetiracetam 500mg (seizures), and meclizine 25mg (nausea). In an interview on 08/16/2025 at 2:00 p.m., the interim ADON stated it was her expectation that medication carts should be locked when not in use. The ADON said that the nurses and medication were responsible to keep the medication carts locked when not in use. She stated if they were not locked, residents and unauthorized staff could get into the cart and there would be opportunities for harm and medication diversion. When the ADON was asked who was responsible to monitor the carts to ensure they were locked she said that would be the staff that was using the carts. In an interview on 08/16/2025 at 2:30 p.m. with Administrator revealed she had already begun to perform in-services and had written up both employees for their lack of professionalism and following the facility's policy. The Administrator stated she made it clear to the staff this was not acceptable, and she expected better performance than this. Review of the Policy and Procedure Security of Medication Cart dated revised April 2007, reflected, The Medication cart shall be secured during medication passes. 1. The nurse must secure the medication cart during the medication pass to prevent unauthorized entry. 4. Medication carts