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	11/10/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, 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 except when to do so would endanger the health or safety of the resident or other residents for 1 (Resident #1) of 5 residents reviewed for reasonable accommodations.The facility failed to provide a bed extension to accommodate resident preferences.This failure could place residents at risk of not being able to meet their needs.Findings included:During a record review of Resident #1's face sheet, dated 11/10/25, revealed an [AGE] year-old man admitted on [DATE] with diagnoses of encephalopathy (disturbance of brain function), type 2 diabetes mellitus without complications (a condition where high blood sugar levels occur because the body's cells don't respond properly to insulin, but without the development of other health problems like nerve damage or heart disease), vascular dementia (a decline in memory, thinking, and reasoning caused by conditions that damage blood vessels and reduce blood flow to the brain, such as strokes or high blood pressure), depressive disorder (persistent sadness, a loss of interest in activities, and other symptoms that significantly impact daily functioning), cataract (clouding of the eye's natural lens, which leads to blurry or hazy vision), atherosclerotic heart disease off native coronary artery without angina pectoris (plaque has built up in the arteries, narrowing them and restricting blood flow, but the person does not experience chest pain), heart failure (heart can't pump enough blood and oxygen to the body), unsteadiness on feet, and reduced mobility.During a record review of Resident #1's MDS assessment, dated 10/20/2025, revealed Resident #1 did not complete the brief interview for mental status (resident was rarely/never understood). During an interview on 11/10/25 at 12:01 p.m., Resident #1's family member stated that on 8/7/25 it was verbally requested Resident #1 be placed in a longer bed and on 8/21/25 placed a second request via email to Resident #1's nurse for a longer bed. Resident #1's family member stated a third request for Resident #1 a longer bed was made on 9/30/25 during a care plan meeting with the ADM. Resident #1's family member stated the family requested Resident #1 have a longer bed because Resident #1 was six foot tall and his foot was up against the footboard of the standard sized bed. Resident #1 family member stated Resident #1 was placed in a longer bed on 9/30/2025. During an interview on 11/10/25 at 2:21 p.m., LVN A revealed Resident #1's family member requested a bed extension for Resident #1 via email. LVN[A stated she requested a longer bed through central supply. LVN A stated she saw a bed moved into Resident #1's room and thought his old bed was switched out. During an interview on 11/10/25 at 2:33 p.m., with Central Supply, revealed he received the request for a longer bed for Resident #1 on 8/21/25 and he contacted the ADM for approval. He stated the ADM approved the bed that day and the bed was transferred to Resident #1's room. Central Supply stated Resident #1 was never placed in the bed as it placed on the bed A side on 8/21/2025 and not bed B, where Resident #1 resided. Central Supply stated after the care plan meeting Resident #1 was placed in the longer bed on 9/30/25. During an interview on 11/10/25 at 3:15 p.m., the ADM revealed she was made aware of a request for a longer bed for Resident #1 on 08/21/2025. The ADM stated she gave the okay for Resident #1 to have a longer bed that day (08/21/25) via text message. The ADM stated she learned on 9/30/25 during a care plan meeting that Resident #1 had not yet received the longer bed. The ADM stated Resident #1 received a longer bed after the care plan meeting concluded. The ADM stated she was not aware of where the breakdown occurred and that her expectation of her staff was to ensure the task was completed on the day approved. The ADM stated the failure was not ensuring the task was completed. During a record review of Resident Rights policy, dated December 2016, revealed:1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights included the residents' right to:f. communication with and access to people and services, both inside and outside the facilityh. be supported by the facility in exercising his or her rights