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	02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Christian Care Center	1000 Wiggins Pkwy Mesquite, TX 75150

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27070 Based on observation, interview and record review, the facility failed to ensure all assistive devices were maintained and free of hazards for five (Residents #10, #12, #53, #69, and #183) of eighteen residents reviewed for essential equipment. The facility failed to properly maintain wheelchairs for Residents #10, #12, #53, #69, and #183. This failure could place residents at risk for equipment that is in unsafe operating condition, which could cause injury. Findings included: Review of Resident #10's quarterly MDS assessment , dated 1/16/24, reflected she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses of Dementia (confusion and forgetfulness), generalized weakness, and heart failure (heart weakness). Resident #10 had a BIMS score of 99 indicating she was severely cognitively impaired and unable to make decisions for herself. Further review of section GG revealed she was dependent for mobility use of a wheelchair. Review of the Resident #10's plan of care dated 01/16/24 with updates reflected goals and approaches to include wheelchair mobility for locomotion. Observation on 02/06/24 at 12:00 p.m. revealed Resident #10 was sitting in her wheelchair on the memory care unit and had no skin problems. The wheelchair's left and right armrests were cracked with exposed foam. Review of Resident #12's quarterly MDS assessmen t, dated 11/18/2023, reflected she was an [AGE] year-old female admitted to the facility on [DATE], with diagnoses dementia (confusion and forgetfulness), diabetes (increase in sugar), and generalized weakness (instability). Resident #12 had a BIMS score of 9 reflecting she was moderately cognitively impaired and able to make decisions for herself. Further review of the MDS revealed section GG she was dependent for Wheelchair mobility. Review of the Resident #12's plan of care dated 12/21/2023 with updates reflected goals and approaches to include wheelchair mobility. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 02/07/2024 at 10:30 a.m. revealed Resident #12 sitting in her wheelchair, during a confidential group meeting. Resident #12 revealed the wheelchair's left and right armrewere loose. Resident #12 was asked about her wheelchair, and she stated, It was needing some work, and the wheelchair had been provided to her by the facility. Resident #12 stated she had told the charge nurse but could not recall when or which nurse. There were no skin tears on arms. Review of Resident #69's quarterly MDS assessment , dated 01/27/2023, reflected she was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses of dementia (confusion and forgetfulness), difficulty in walking, and muscle weakness. Further review of the MDS section GG revealed she was dependent for wheelchair mobility. Review of the Resident #69's updated plan of care dated 12/28/2023 with updates reflected goals and approaches to include wheelchair mobility. Observation on 02/06/2024 at 12:05 p.m. revealed Resident #69 was in her wheelchair on the memory care unit, and the wheelchair's right and left armrests were cracked with the foam exposed. There were no skin tears on arms. Review of Resident #53's quarterly MDS assessment , dated 01/19/2023, reflected he was an [AGE] year-old male admitted to the facility on [DATE], with diagnoses of dementia (confusion and forgetfulness) and lack of coordination and weakness. Further review of the MDS section GG she was dependent for wheelchair mobility. Review of the Resident #53's updated plan of care dated 12/14/23 with updates reflected goals and approaches to include wheelchair mobility. Observation on 02/06/2024 at 12:15 p.m. revealed Resident #53 was in his wheelchair on the memory care unit, with no skin problems. The wheelchair's right armrest and the left armrest were cracked with the foam exposed. Review of Resident #183's admission Face Sheet, dated 02/05/2024, reflected she was an [AGE] year-old female admitted to the facility on [DATE], with diagnoses of dementia (confusion and forgetfulness), abnormality of gait and mobility, and instability of left knee. Resident was a new admit the MDS was still in not completed at the time of the visit. Review of the Resident #183's baseline plan of care dated 02/05/2024 with updates reflected goals and approaches to include wheelchair mobility and skin not being in contact with hard surfaces since she has thin skin and a history of skin tears and bruising on her hands. Observation on 02/06/2024 at 12:45 p.m. revealed Resident #183 was in her wheelchair on the memory care unit and had no skin problems. The wheelchair's left and right armrests were cracked with the foam exposed. Resident #183 was unable to be interviewed. In an interview on 02/07/2024 at 12:27 p.m. CNA B stated when a resident's wheelchair needed repair the staff were to tell the charge nurse or the therapy department. CNA B stated she had not reported anything recently, concerning wheelchairs. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/07/2024 at 12:30 p.m. LVN C stated when a resident's wheelchair needed repair the staff were to tell the therapy department. The Therapy department kept all the parts to fix them. LVN C stated she should tell the Director of Rehabilitation the wheelchairs needed new armrest. LVN C usually she would keep up with that but recently she had been too busy. In an interview on 02/08/2024 at 1:46 p.m. the Director of Rehabilitation stated that the therapy department was responsible for the repair of wheelchairs. He stated the wheelchairs of the resident's that were on therapy services were the wheelchairs they had looked at first. The other wheelchairs they had encouraged the nursing staff to report to them, this is a new program that we just started on and we do talk about it in the stand-up meeting each morning The Director Rehabilitation stated he had recently ordered new armrest and they would be placed on whoever needs them. The investigator had him review the PO (purchase orders) order, the Administrator had provided, he stated yes, he had ordered those, but they were not intended for the wheelchair on the memory care unit, he was unaware any of those wheelchairs required repair. When ask if there was log or repair communication book, he stated, no there is no log or book when the staff tells us we fix the problem right away. A review of the facility's policy and procedure Adaptive Devices and Equipment dated January 2020 reflected Policy Statement Our facility maintains and supervises the use of assistive devices and equipment for residents . 6. The following factors and addressed to the extent possible to decrease the risk of available accidents associated with devices and equipment . c. Devices condition-devices and equipment are maintained on schedule and according to manufacturer's instructions. Defective or worn devices are discarded or repaired .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46486 Based on observation, interviews, and record reviews the facility failed to ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety for the facility's only kitchen, reviewed for food storage, labeling, dating, and kitchen sanitation. 1. The facility failed to ensure food in the facility's refrigerator, was labeled and dated according to guidelines. 2. The facility failed to ensure food in the facility's refrigerator, was not exposed from air-borne contaminants. 3. The facility failed to dispose of expired foods items in the refrigerator and freezer. These failures could place residents who receive food prepared in the facility's kitchen at an increased risk of exposure to food-borne illnesses. Findings included: Observation of the Refrigerator on [DATE] at 9:20 AM revealed the following: On back wall, bottom row had peeled potatoes inside a container filled with water, no date. On back wall, top shelf had brown liquid substance in a pitcher covered, no date. On back wall, middle shelf had opened salad mix, no date. On right side wall, middle shelf box had limes with brown markings expired, [DATE] On right side wall, three packages of tortilla shells opened, exposed to air expired, [DATE]. On right side front wall, bottom shelf had bag of liquid egg mix expired, February 2, 2024 Observation of the freezer on [DATE] at 9:45 AM revealed the following: On middle shelf, bottom row had a bag of chicken wings sitting in a box, no date on bag or box. On back shelf, top row had cauliflower not in a box in bag, no dates. On right shelf, cooked plates of puree, no prepared date or used by date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Dietary Supervisor on [DATE] at 11:22am, she stated their policy was to place received dates on items when truck arrives, once opened should have opened date and expired or if cooked a best used by date. She stated they have trouble with the date staying on products, due to the type of markers they use. In the refrigerator they use labels which have date received and expired dates. Once items are opened staff knows to relabel with best used by date. They cannot use labels in the freezer as they fall off. This was done to prevent food borne illness. Interview with the Puree Cook A on [DATE] at 01:00pm, reflected she cooked puree meals the day before the meal was served and then froze the meal. She would date the frozen meals with preparation dates but did not add a use by date. Interview with the Dietary Manager on [DATE] at 1:45pm revealed he was responsible for receiving goods off the truck. He would date the boxes with received dates. Once taken out the box staff knows they need to transfer date received or place date opened on the packaging. If items were expired, they will throw them out. They check the refrigerator daily for goods that were about to or had expired. If the expiration date was approaching the Puree Cook A was asked to prepare/cook the puree meal and then freeze. Once the meal was bagged, the preparation date and the used by date was added. The DM stated the risk of the not labeling, expired food items, and exposed food item concerns not being addressed could result in food-borne illnesses. Record Review on of the undated refrigerator and freezer policy reflected All foods shall be appropriately dated to ensure proper rotation by expiration dates.Received dates will be marked on cases and on individual items removed from cases for storage. Use by dates will be completed w/expiration dates on unopened food will be observed and used by dates once food is opened Review of the U.S. Food and Drug Administration (FDA) Code (2022) revealed, PACKAGED FOOD shall be labeled as specified in LAW, including 21 CFR 101 FOOD Labeling, 9 CFR 317 Labeling, Marking Devices, and Containers, and 9 CFR 381 Subpart N Labeling and Containers, and as specified under S ,d+[DATE].18. FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts ,d+[DATE] - ,d+[DATE].

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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** 32581 Based on observation, interviews, and record reviews the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one (Residents #182) of eight residents reviewed for infection control. The facility failed to ensure Occupational Therapist G properly donned and doffed PPE by putting on an isolation gown before entering Resident #182's contact isolation room; additionally, when Occupational Therapist G left the resident's room, she took her gown off in the hallway then went back into Resident 182's room to dispose of the gown. Then afterwards she went to two other resident's rooms. This failure could place residents at risk of cross contamination of highly infectious diseases, which could lead to the residents experiencing respiratory distress, fevers, muscle aches, vomiting and diarrhea and resulting in health decline and decreased psycho-social well-being. Findings Include: Record review of Resident #182's Admission MDS dated [DATE] revealed a [AGE] year-old female who admitted on [DATE] with a BIMS score of 15 (No cognitive impairment) .with mixed complex conditions and diagnosed with hypertension, ulcerative bowel disorder, renal insufficiency, acute kidney failure, muscle weakness, abnormal gait and mobility, ulcerative colitis, and cognitive communication deficit. Record review of Resident #182's Care Plan undated revealed, special instruction: Contact and droplet precautions for influenza Focus Resident #182 has Influenza Type A .Isolation Date initiated 02/03/24 . Resident #182 will be free from s/sx of dehydration .interventions: one person assist for bed mobility and ambulating . wear gloves and wash hands before and after treating resident .wear PPE when treating resident. Record review of Resident #182's Order Summary Report dated 02/08/24 revealed, Droplet isolation related to influenza. every shift for Precautions: Active 02/03/2024. Observation on 02/06/24 at 11:05 am revealed, Resident #182 had a droplet contact precautions sign on her closed door with instructions for to put on PPE and the PPE supplies were inside of a bin outside her room door. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and Interview on 02/08/24 at 10:56 am, Occupational Therapist G opened Resident #182's room door and asked if the resident wanted to do therapy and the resident replied yes. Occupational Therapist G performed hand hygiene and put on gloves and mask on, walked all the way into Resident #182's room and closed the resident's door. The HHSC Surveyor knocked on the door and asked Occupational Therapist G should she have on any other PPE, and she replied no and added she did not always provide therapy to Resident #182. She stated she was under the impression she just had to have on an N95 mask she was okay to go into contact isolations rooms. She stated she saw the Contact Isolation signage on the door but went by what the Director of Rehab told her as long as she had on her N95 mask and did hand hygiene and gloved up she was fine to go into the contact isolation rooms to provide therapy. She then asked could the HHSC Surveyor assist her with putting her gown on and walked into Resident #182's room without tying the straps around her neck and waist. At 11:12 am Occupational Therapist G came out of Resident #182's room with her gown on and took the gown off and rolled it up with no gloves on and looked around then asked CNA H where the trash can was so she could throw away the isolation gown. CNA H told her to throw it away in Resident #182's bathroom, then Occupational Therapist G walked back into Resident #182's room without gloves on and threw away the gown and came out and performed hand hygiene and walked away. Occupational Therapist G then walked to another room, Resident 180's room, but Resident #180 was not in the room and then she went to another room, Resident #184's room. Then Occupational Therapist G went inside Resident #184's room and closed the door and asked was he ready for therapy services and remained in the room. Interview on 02/08/24 at 11:15 am, CNA H stated Resident #182 was on contact isolation and PPE and hand hygiene was required prior to entering Resident #182's room and said she was not sure why Occupational Therapist G came out of this resident's room with an isolation gown on. Interview on 02/08/24 at 11:24 am, the Administrator stated Resident #182 was on contact isolation and anyone who entered her room had to perform hand hygiene and put on N95, gloves and gown. She stated Resident #182 was on contact isolation because she had the Flu and on droplet transmission precautions. She stated if PPE was not worn properly the staff could get the Flu and spread it around to everyone else. She stated some of the therapy staff went to some of their trainings and was not sure if the therapy staff were in their Infection Control Inservice trainings and would have to get with the Therapy Director to see what trainings they had. She stated she did not know who Occupational Therapist G was but added she would immediately address the issue. Interview on 02/08/24 at 3:02 pm, the Director of Rehab stated his staff had Infection Control trainings yearly and the last time they were trained was last year. He stated he told the staff they had contact isolation residents at this facility and to use full PPE with hand hygiene prior to entering the resident's rooms. He stated Resident #182 had the flu and the staff needed to wear a gown and face mask and gloves before leaving and dispose of the PPE In their PPE trash box in the bathroom. He stated afterwards he expected they left the room perform hand hygiene and added Occupational Therapist G was a PRN Therapy Assistant who worked at this facility three days a week. He stated he had never told Occupational Therapist G it was okay to wear just a mask and gloves to the contact isolation rooms. He stated it was brought to his attention today (02/08/24) she did not practice using the appropriate PPE and they sent her home to disinfect. He stated obviously there was an infection control breech and added Occupational Therapist G had infection control trainings last year and this year and not sure how she could have forgotten how to use PPE. He stated he had a debriefing with the DON about this matter and the DON did infection control Inservice trainings with his therapy staff. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/08/24 at 3:35 pm, COTA I stated he and the other therapy staff had an infection control training this morning (02/08/24) by this facility's DON because a therapist went into a resident's room without properly donning and doffing. He stated he would stop staff entering a contact isolation room if they did not have on the proper PPE and hand hygiene and would report it to the Rehab Director, Unit manager and DON immediately. He stated Resident #182 had the Flu with contact isolation in place. He stated they needed to wear PPE and do hand hygiene to reduce cross contamination to the other residents. He stated they did not want to walk around with what illness a resident had and spread it to others. Interview on 02/08/24 at 3:50 pm, the DON stated Resident #182 was diagnosed with the Flu on 02/03/24 and had a very slight cough and took medication to treat her infection. She stated if Resident #182 continued to improve, she should be recovered by 02/12/24 and retested . She stated their therapy staff occasionally attended their trainings and was not sure if they were in any infection control ones. She stated they had no issues with how staff donned and doffed and expected their therapy staff to practice the same contact isolation precautions and adhere to their Infection control policy as applicable. She stated the risk of not following their Infection control policy could cause other residents to possibly develop an infection. She stated today (02/08/24) she did an Inservice training with the therapy staff about the different types of Infection preventions, how to review the contact isolation signage, donning and doffing and hand hygiene. She stated she also did infection control training with all of their staff. She stated the plan to prevent infection control issues was to continue to train staff and communicate who was on contact isolation and monitor how staff were donning and doffing. She stated currently the Director of Therapy was going to follow-up with her about Occupational Therapist G and added Occupational Therapist G was no longer at the facility and was sent home immediately, particularly since she entered Resident #182's room. Interview on 02/08/24 at 4:16 pm, the Administrator stated they were able to review the camera on that hall showing Occupational Therapist G was not properly practicing good infection control techniques and she was sent home because of not following their Infection Control policy. She stated the plan was for Occupational Therapist G to get re-education and would possibly be terminated. She stated the Infection Preventionist and DON were responsible for ensuring everyone practiced appropriate donning and doffing when in contact isolation rooms. She stated her expectations was for Infection control practices to be done accordingly to their policy. She stated their therapy staff were trained today (02/08/24) on infection control to prevent this from happening again. Record review of the facility's PPE policy dated October 2018 revealed, Policy Statement: Personal protective equipment appropriate to specific task requirements is available at all times .Policy Interpretation and Implementation: .3. Not all tasks involve the same risk of exposure, or the same kind or extent of protection. The type of PPE required for a task is based on: The type of transmission-based precaution; The fluid or tissue to which there is a potential exposure; The likelihood of exposure; The potential volume of material; The probable route of exposure; and the overall working conditions and job requirements . A supply of protective clothing and equipment is maintained at each nurses' station. PPE required for transmission-based precautions is maintained outside and inside the resident's room, as needed. 5. Training on the proper donning, use and disposal of PPE is provided upon orientation and at regular intervals. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. Employees who fail to use personal protective equipment when indicated may be disciplined in accordance with personnel policies . Record review of the facility's Infection Control policies and Practices - Infection Control dated October 2018 revealed, Policy Statement: The facility's infection Control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. 1. The facility's infection control policies and practices apply equally to all personnel, consultants, contractors, residents, visitors .4. All personnel will be trained on our infection control policies and procedures upon hire and periodically thereafter .