| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675033 | A. Building<br>B. Wing | 10/23/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Mesquite Tree Nursing Center | 434 Paza Dr<br>Mesquite, TX 75149 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48560<br><br>Based on observation, interview, and record review, the facility failed to ensure residents were free from abuse for one (Resident #2) of four residents reviewed for abuse.<br><br>The facility failed to protect Resident #2 from physical abuse by HA B. On 2/16/24 at 9:45 PM , HA B physically grabbed snacks from Resident #2, then proceeded to grab his arm and became involved in a physical interaction of tugging items back and forth with Resident #2 until Resident #2 fell on the ground without any physical injuries or harm.<br><br>The noncompliance was identified as Past Noncompliance (PNC). The noncompliance began on 02/16/24 at 9:45 PM and ended on 02/23/24. The facility had corrected the noncompliance before the Incident investigation began on 10/22/24.<br><br>The facility terminated HA B on 02/16/24, with no other incidents that involved Resident #2, and staff were reeducated regarding Abuse and Neglect on 02/16/24 through 02/20/24.<br><br>This failure could place residents at risk of serious injury and harm.<br><br>Findings included:<br><br>Record review of the facility policy titled, Policy and Procedures: Abuse, Neglect and Exploitation revised 9/6/2024, reflected, It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property.<br><br>Record review of Resident #2's face sheet, dated 12/23/24, revealed Resident #2 was a [AGE] year-old male, with original admitted [DATE] with diagnoses that included: Paranoid Schizophrenia, hypertension, Cognitive Communication Deficit, Major depressive disorder, and Unsteadiness on feet.<br><br>Record review of Resident #2's Quarterly MDS assessment dated [DATE] revealed that he was unable to complete the BIMS with score of 0. Resident #2 was independent for ADL for toileting and personal hygiene. Quarterly MDS also revealed, Resident #2 did not exhibit any behaviors.<br><br>(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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675033 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/23/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: Mesquite Tree Nursing Center | | STREET ADDRESS, CITY, STATE, ZIP CODE: 434 Paza Dr Mesquite, TX 75149 | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of Resident #2's Care Plan dated revised on 08/17/2021 reflected, that Resident #2 had been Care planned for Focus: Cognitive Impairment: [Resident #2] has impaired cognition and is at risk for a further decline in cognitive and functional abilities related to: Psych Diagnosis, Paranoid Schizophrenia, Auditory Hallucinations, Delusional Disorder and Other Amnesia. Goal: Resident will have needs met in a timely manner, dignity will be maintained, and current level of functioning will be maintained through the next 90 days. Intervention . COMMUNICATION: Identify yourself at each interaction. Face resident when speaking and make eye contact. Stop and return if the resident becomes agitated.<br><br>Record review of Provider Investigation Report (PIR) (Form 3613-A of Texas Health and Human Services) dated 02/23/24 reflected that, Incident date and time as 2/16/2024 on 9:45 PM. Incident report within the PIR completed by LVN E reflected, LVN E was called to dining room, received report that altercation between Resident #2 and staff [HA B], the Resident #2 was sitting on the floor. Upon visual assessment, [Resident #2] noted to be in no distress and [Resident #2] refused for 911 to be called, stating [Resident #2] was alright. [Resident #2] denied hitting his head on the floor or any pain. [LVN E] stayed with the resident in the dining room for safety. [Resident #2] reported that the staff [HA B] push him down while they were going back and forth of altercation. No Injuries observed at time of incident. Incident report within the PIR completed by LVN E also revealed predisposing physiological factors: Gait Imbalance. Incident report within the PIR completed by LVN E reflected, [Resident #2] allowed the [LVN E] to assess his upper body, he refused to allow [LVN E] to assess beyond that point. No Injuries observed at time of incident. The resident was alert and ambulated without assistance. The resident was oriented to time, place, person, and situation.<br><br>In an observation and attempt to interview on 10/22/24 at 10:09 AM, Resident #2 was standing in the hallway by himself. Resident #2 appeared to be sensitive to noises as evidenced by covered his ears while the housekeeping Staff was vacuuming the floors on the hallway. The writer attempted to speak with Resident #2, resident crossed his arms in X form and walked away. Observed resident had a very slow gait.<br><br>In an interview on 10/22/24 at 10:23 AM, with CNA M, stated she had worked at the facility for about 5 months. She stated she was familiar with Resident'#2's care and stated he kept to himself, frequently refused ADL care from staff members. She stated Resident #2 was sensitive to voices, usually would walk around the facility, especially the dining room. She stated Resident #2 had an unsteady gait.<br><br>In another observation and attempt to interview on 10/22/24 at 1:36 PM, Resident #2 was in his room that had 2 beds in the room with door closed. Resident was by himself in the room and sitting on the unoccupied bed with curtains drawn. Resident #2 refused to speak with the writer.<br><br>In an attempted phone interview on 10/22/24 at 1:53 PM with HA B, left voice message for the staff to call back the writer.<br><br>(continued on next page) |

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| | 675033 | A. Building<br>B. Wing | 10/23/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Mesquite Tree Nursing Center | 434 Paza Dr<br>Mesquite, TX 75149 |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 10/22/24 at 2:45 PM, RN D revealed that she usually worked the 2 -10 PM shift in the facility. She stated that on her 2-10 PM shift on 02/16/24 around 09:45 PM, she heard loud noises from the dining room. She stated that when she entered the dining room, she saw HA B was speaking loudly with Resident #2. She stated from what she could see was Resident #2's back, before RN D could reach him, Resident #2 staggered backwards and lost his balance and fell to the floor. She then stated that HA B continued to loom over Resident #2 and engaged in loud verbal disagreement with him. RN D and CNA C ensured that HA B and Resident #2 were separated immediately. She stated that at this time, she called Resident #2's assigned nurse [LVN E] to the dining room and it was determined that Resident #2 was fine, and no injuries were sustained. RN D then left the dining hall to care for her residents.<br><br>In an interview on 10/22/24 at 3:00 PM, LVN E revealed that she was the assigned nurse for Resident #2 on 2/16/24 2-10 PM shift. She stated that she did not witness the incident. She was called to the dining room by a staff member and received report that altercation between Resident #2 and HA B. When she came to the dining room, Resident #2 was sitting on the floor. She stated that upon visual assessment, Resident #2 noted to be in no distress, and he refused to go to the hospital and denied hitting his head on the floor. Resident #2 refused head to toe assessment initially but then allowed LVN E to complete assessment until his back only, after the DON spoke with him. She stated that police came to the facility, but she was not sure if they were able to speak with Resident #2. She stated Resident #2 was alert and oriented, ambulated without assistance. LVN E added she had care for Resident #2 multiple times and was familiar with his care. Resident #2 had a history of unsteady gait and often refused ADL care. She also stated Resident #2 usually kept to himself and did not like anyone invading his personal space.<br><br>In a phone interview on 10/22/24 at 3:27 PM, HA B started working in the facility on 02/07/24 as a Hospitality Aide. She stated she was on on-the-job training on 02/16/24 on the 2 - 10 PM shift and Resident #2 was one of the residents on her assigned hall. She stated that she no longer worked in the facility. She stated around 9:30 - 9:45 PM on 2/16/24, Resident #2 had taken night-time snacks that belonged to other residents. She asked Resident #2 to give back the snack packets that were in his possession. She stated Resident #2 refused to comply, so she reached for the snacks in his jacket. She stated that when she reached for the snacks, Resident #2 tried to swing at her and stated his rights. She stated that there was verbal argument with Resident #2, and he made threats to her. She stated she tried to remove his possessions and held Resident #2's arm. She added there was a physical tussle between her, and Resident #2 and he then threw hot liquid from his cup on her face. She stated that she called for help from other staff and tried to push him back to maintain distance to protect her safety. Resident #2 started losing his balance and she eased him to the ground. As he was getting to the floor, she saw two other employees reaching the dining room. She stated that called the police to report the incident since she was pregnant. She stated she does not remember if she received training on abuse and neglect when she started her employment with the facility.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675033 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/23/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Mesquite Tree Nursing Center | 434 Paza Dr<br>Mesquite, TX 75149 |

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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 0600

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

In an interview on 10/22/24 at 3:39 PM with CNA C who also worked the PM -10 PM shift on 2/16/24 in the facility stated that she was taking the leftover trays to the dining room. She saw Resident #2 standing in the dining room. She stated HA B was a new employee and asked CNA C if she had seen Resident #2. She stated that Resident #2 was in the dining hall and left to take care for her assigned residents. She stated that around 9:45 PM on 2/16/24, she heard someone screaming help, help from the dining room. RN D and herself ran to the dining hall, where HA B was screaming that Resident #2 poured hot water on HA B. She stated that she did not witness this incident. She stated that HA B was talking very loudly to Resident #2 and continued to engage verbally with the resident. CNA C asked HA B to leave the Resident #2 alone, and she was acting like she was trying to push at Resident #2, but he staggered and fell . CNA C stated that LVN E came to dining room and she left the dining room to attend to her residents.

In a final attempt to interview on 10/23/24 at 9:52 AM, with Resident #2, he quoted he is not taking any visitors today and to respect his space.

In an observation on 10/23/24 at 10:26 AM, the facility camera along with the Administrator, timestamped 2/16/24 21:42:05 (9:42 PM) to 2/16/24 21:45:04 (9:45 PM) revealed during the incident, the camera in the dining room showed Resident #2 standing in the dining room eating snacks. HA B talked with another resident in the dining room and came near to Resident #2. HA B and Resident #2 have some conversation [which could not be heard since the camera only had video footage and no audio] and HA B tried to stick her hand in the pocket of Resident #2's jacket he was wearing. Resident #2 knocked HA B's hand away. The camera further revealed that the two talked again for few seconds and HA B tried to reach for Resident #2's jacket one more time. Resident #2 again tried to knock her hand away and then HA B grabbed the coffee cup that he was drinking out of. Further, camera footage revealed that HA B may have picked multiple of his items, and they tugged back and forth. HA B went ahead to set the cup on the table while continuing to hold one of Resident #2's arm. She took the items from him and had walked away, when Resident #2 picked up his coffee cup and threw the liquid on HA B. At this point, HA B walked back towards Resident #2, grabbed his things, and tussled with him. This went for a brief time, until HA B grabbed Resident#2's arm that made the Resident #2 propel backwards, HA B continued to argue with Resident #2 until he became unsteady on his feet and fell to the floor. The video revealed CNA C and RN D arrived at the incident location while the resident was falling on the ground and had to separate HA B from Resident #2 as she continued to engage verbally with the resident.

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675033 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/23/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Mesquite Tree Nursing Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 434 Paza Dr Mesquite, TX 75149 | |

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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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 10/23/24 at 10:30 AM, the Administrator revealed that HA B was a new employee. When she heard about the incident from the facility staff, she immediately reached the facility. She stated she was the designated abuse coordinator for the facility and investigated and reported the incident. She stated that HA B was reaching for Resident #2 jacket for snacks. She stated that HA B made a choice to get the snacks out from Resident #2 by reaching for it physically and was pointing fingers, being verbally aggressive with the resident. She added that further investigation revealed as Resident #2 was about to go to the floor, RN D and CNA C entered the dining room. RN D and CNA C had to separate HA B from Resident #2, while HA B continued to be argumentative. She stated that, later when she had a statement from HA B, who verbalized she was upset and angry with Resident #2 and made a choice to grab his arm after he threw the hot liquid on her. Resident #2 refused to have head to toe assessment initially, then allowed to look at his back only. She stated Resident #2 did not sustain any injuries during or after the incident. She stated that police were called regarding the incident. The Administrator stated, as a result of the investigation, she confirmed the allegation of resident abuse by HA B as evidenced by HA B's physical aggressiveness and abuse towards Resident #2. The administrator verbalized that HA B was first suspended and then terminated on 02/16/24. She stated that her expectation was for all staff to always follow abuse and neglect protocols and policies and maintain resident safety. She stated an in-service for abuse and neglect was conducted for all staff members following the incident.<br><br>In an interview on 10/23/24 at 11:23 AM, the DON revealed she had been the DON in the facility since December 2023. She stated that it was her expectation that all staff to always follow abuse and neglect protocols and policies as well as report any abuse or neglect to the abuse coordinator immediately. She stated that abuse and neglect in-services / training are done upon hire for all employees. She stated that the Administrator, ADONs and DON were responsible for providing abuse and neglect in-services. She stated she did not remember the incident between Resident #2 and HA B very well, however stated that Resident #2 sometimes displayed behaviors of eating from other residents' tray and getting snacks. She stated that staff were aware of Resident #2's behaviors. She further added that Resident #2 had limited food intake in the past, so the facility let him have snacks as needed. She stated HA B should have let him have the snacks and should not had intruded his personal space by reaching for items in his jacket. She stated HA B made the choice of grabbing items/snacks from Resident #2 physically and continuing to engage with him in a physical tussle. The DON added Resident #2 did not suffer any physical injuries during or after the incident.<br><br>Record review of detailed police report for Incident 24014324 was requested but not obtained until the exit.<br><br>Record review of the HA B personnel file revealed HA B was hired on 2/7/24 and terminated from Employment on 2/16/24. The facility had conducted Texas Department of Public Safety Criminal History verification and Employee Misconduct Registry Employability status check without any concerns. Record review of HA B personnel file also revealed resident had completed abuse, and neglect training on 2/7/24.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675033 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/23/2024 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Mesquite Tree Nursing Center | 434 Paza Dr<br>Mesquite, TX 75149 |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interviews on 10/22/24 and 10/23/24 across multiple shifts with various staff members (CNA C, RN D, LVN E, LVN F, LVN G, CNA H, MA I, CNA J, CNA K, CNA L, CNA M) over various shifts revealed facility had conducted abuse and neglect in-services on a routine basis and as needed. The above-mentioned staff members were able to verbalize abuse and different forms of abuse and neglect. They also stated that any incidence of alleged abuse and neglect or any abuse and neglect witnessed will be reported to the facility abuse coordinator immediately. They also verbalized that they had the abuse coordinators name and contact number handy to report abuse.<br><br>Record Review of abuse and neglect in-services conducted by the facility from 2/16/24 to 2/20/24 revealed that the facility staff was trained on abuse and neglect, types of abuse, who is the abuse coordinator and when should abuse be reported.<br><br>The noncompliance was identified as Past Noncompliance (PNC). The noncompliance began on 02/16/24 9:45 PM and ended on 02/23/24. The facility had corrected the noncompliance before the Incident investigation began. HA B was terminated from employment and Resident #2 had no other incidents. The facility staff were reeducated regarding Abuse and Neglect on 02/16/24 through 02/20/24. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48560<br><br>Based on observation, interview, and record review the facility failed to ensure a resident who was unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming and personal and oral hygiene for two of eight residents (Resident #3 and Resident #4) reviewed for ADL care.<br><br>The facility failed to ensure Resident #3, and Resident #4 had her fingernails trimmed and cleaned.<br><br>This failure could place residents at risk for loss of dignity, risk for infections and a decreased quality of life.<br><br>Findings include:<br><br>1-<br><br>Record review of Resident #3's Admission MDS assessment, dated 09/11/2024, reflected Resident #3 was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included left-sided hemiplegia (paralysis of left side of the body), Stroke, hypertension (high blood pressure), Gastro esophageal reflux disease (stomach contents leak into the esophagus), hyperlipidemia (high blood lipid levels), Seizure disorder. Resident #3 had a BIMS score of 15, which indicated Resident #3's cognition was intact. Resident #3 required moderate assistance with personal hygiene.<br><br>Record review of Resident #3's Comprehensive Care Plan, revised 10/02/2024, reflected the following: Focus: Alteration in musculoskeletal status related to contracture left-sided extremities. Goal: [Resident #3] will exhibit adequate coping skills dealing with loss of/loss of use of limb and rehabilitation through the review date. Intervention: Staff will assist [Resident #3] with cleaning and cutting of fingernails on bath days.<br><br>In an observation on 10/22/24 at 12:26 PM, in the dining room, with Resident #3 revealed the nails on the right hand was approximately 1 centimeter in length extending from the tip of his fingers and had black substance underneath the nails.<br><br>In an interview on 10/22/24 at 1:18 PM, Resident #3 stated that she would like her nails to be cut and cleaned since she was unable to cut them by herself because of her stroke diagnosis. She stated no one in the facility had offered nail cleaning and cutting since her admission in September.<br><br>2-<br><br>Record review of Resident #4's Quarterly assessment dated [DATE], reflected Resident #4 was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included: Cerebral infarction (disruption of blood flow to the brain), Muscle weakness, Cognitive communication deficit (communication impairment caused by cognition), Repeated falls. Resident #4 had BIMS of 8, which indicated Resident #4 cognitive was moderately impaired. Resident #3 required moderate assistance with personal hygiene.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER Mesquite Tree Nursing Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 434 Paza Dr Mesquite, TX 75149 | |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of Resident #4's Comprehensive Care Plan, revised 10/22/2024, reflected the following, Focus: ADLs: [ Resident #4] is at risk for not having their needs meet in a timely manner and refusing grooming at times. Goal: Resident will maintain a sense of dignity by being cleaned, dry, odor free, and well-groomed. Intervention: Provide shower, shave, oral care, hair care, and nail care per schedule and when needed.<br><br>In an observation on 10/22/24 at 12:27 p.m., in the dining room, with Resident #4 had long, jagged, and dirty nails. The fingernails on both hands were approximately 0.5 centimeter in length extending from the tip of his fingers, had black substance underneath and some of them were chipped.<br><br>In an interview on 10/22/24 at 1:22 PM, Resident #4 stated he would like his fingernails to be cleaned and trimmed. Resident #4 stated that he was not able to clip his nails by himself and needed staff assistance.<br><br>In an interview on 10/22/24 at 1:29 PM, LVN G stated, both CNAs and Nurses were responsible for nail care during shower days and as needed. He stated if a resident had diagnosis of diabetes, only nurses were allowed to provide nailcare. He stated the risk for not performing nailcare was increased risk of infection and skin breakdown. He stated that Resident #3 was a new admit and he will ensure that the Residents nails were cleaned and trimmed soon after the interview.<br><br>In an interview on 10/22/24 at 01:38 PM, CNA J stated both CNAs and Nurses were responsible for nail care during shower days and as needed. She stated that unless the resident had diabetes, then CNAs inform staff nurses to provide nailcare. She stated the risk for not performing nailcare was increased risk of infection.<br><br>In an interview on 10/22/24 at 01:34 PM, the DON revealed her expectation was nail care should be provided every shower day and as needed. She stated both CNAs and Nurses were responsible for doing nail care on all residents; except Nurses were responsible for nailcare if resident had diagnosis of diabetes. She stated that Resident #4 has history of refusing ADLs at times, she will have staff check residents for nail care once again. She stated as the DON, she or designee rounded residents frequently to check on quality of care provided to the residents. The DON stated residents who had long, and dirty fingernails could be an infection control issue.<br><br>Record review of the facility's policy titled, Activities of daily living care guidelines revised 2/11/2021 reflected, Residents will receive essential services for activities of daily living to maintain good nutrition, grooming, and personal and oral hygiene . |

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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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47690<br><br>Based on observation, interview and record review, the facility failed to 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 #1) of seven residents observed for infection control.<br><br>CNA A failed to perform hand hygiene during incontinence care for Resident #1.<br><br>This failure could place residents at risk for the development and/or worsening of urinary tract infections, cross contamination, and skin breakdown.<br><br>Findings included:<br><br>Review of Resident #1's quarterly MDS assessment dated [DATE] reflected she was a [AGE] year-old-female admitted to the facility on [DATE]. Her BIMS score was 15 out of 15 which indicated she was cognitively intact, required extensive, one-person assistance for ADLs and was always incontinent of bowel and bladder. Her diagnoses included hypertension (high blood pressure), Seizure or Epilepsy (a chronic brain disease that causes seizures, which are episodes of abnormal electrical activity in the brain), and anxiety.<br><br>Review of Resident #1's Care Plan dated 10/14/24 reflected Focus. ADLS: Resident has an ADL self-care performance deficit .Resident requires person assist Performance deficit is related to functional limitation in range of motion or decreased mobility Goal: Resident will maintain a sense of dignity by being clean, dry, odor free . Resident#1 was incontinent of bowel, and bladder. The intervention was for the resident to be assisted by staff for incontinent care.<br><br>Observation on 10/22/24 at 11:54 a.m., revealed CNA A entered Resident #1's room, washed her hands with soap and water and put on clean gloves. CNA A unfastened Resident #1's brief and cleaned Resident #1's front area using one wipe per stoke, front to back. CNA A rolled Resident #1 to her left side and wiped her buttocks area from front to back using one wipe per stoke. CNA A rolled the dirty brief, removed it, and disposed of it in the trash can, then put the clean brief on Resident #1. CNA A rolled Resident #1 on to her back and fastened the brief without changing gloves. CNA A removed her gloves and reached into her pocket to retrieve a pair of gloves donned it without any form of hands hygiene. CNA A helped Resident #1 adjust her gown and covered her. CNA A removed gloves put them in the trash bag, then took the trash bag, and exited the room. CNA A disposed of the trash bag in the soiled room in the Hall and sanitized hands.<br><br>In an interview with CNA A on 10/22/24 at 12:00 p.m., revealed she knew she was supposed to perform hand hygiene between glove changes, and change gloves with hands hygiene when going from dirty to clean task. She stated she thought she had done it correctly and did not realize she had missed some of the steps. CNA A stated the risk to resident is the development of infection. CNA A stated could not remember the last time she had an in service on hand hygiene, and incontinent care.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675033 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/23/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: Mesquite Tree Nursing Center | | STREET ADDRESS, CITY, STATE, ZIP CODE: 434 Paza Dr Mesquite, TX 75149 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview with the ADON on 10/23/24 at 09:43 a.m., revealed staff were to sanitize their hands before care, when going from clean to dirty and every time they changed their gloves. The ADON stated CNAs should not have gloves in their pockets. The ADON stated the risk to residents' cross contamination, and development of infection. The ADON stated it was her responsibility as the infection control preventionist in the facility to make sure the direct residents care staff follow proper hands hygiene protocol. The ADON stated the last in service was two weeks ago.<br><br>Interview with the DON on 10/23/24 at 11:30 a.m., revealed staff were to sanitize their hands before care, when going from clean to dirty and after care. The DON stated staff were trained to perform hand hygiene between gloves changes. The DON stated it was her responsibility, and the responsibility of the two ADON in the facility to make sure direct residents care staff follow the proper hands hygiene. The DON stated they do staff training every monthly for one hall, with the goal of doing training for all the staff at least every six months. The DON stated the risk to residents development of infection.<br><br>Record review of CNA A skills checklist dated 10/20/24 reflected she was checked off on Hand Hygiene and SKILL#21: Provides Perineal Care (Peri-Care) for Female and she was competent in the skills.<br><br>Review of the facility's Nursing Procedure Manual titled, Incontinent Care dated February 14, 2020, reflected, Enters room .Washes hands, put on non-sterile, latex free gloves .Cleanse peri-area and buttocks .14. Remove linen/under pad and discard 15. Remove and discard gloves 16. Wash hands 17. Apply clean linen/under-pad, brief or other incontinent products, as needed .<br><br>Review of the facility's policies and procedures titled Hand Hygiene dated November 12, 2018, reflected, .3. Hands Hygiene is indicated and will be performed under the conditions listed in, but not limited to . Before applying and after removing personal protective equipment, including gloves .When during resident care, moving from a contaminated body site to a clean body site . |