STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675033	A. Building B. Wing	09/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mesquite Tree Nursing Center	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (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 0677 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 observations, interviews, and record review the facility failed to provide the necessary services for residents who were unable to carry out activities of daily living to maintain good grooming and personal hygiene for 2 (Resident #1, and Resident #2) of 11 residents reviewed for ADLs. The facility failed to ensure:- Resident #1 had his fingernails cleaned and trimmed.- Resident #2 had his fingernails trimmed. These failures could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections, and a decreased quality of life. 1- Record review of Resident #1's Quarterly MDS assessment dated [DATE], reflected Resident #1 was a [AGE] year-old male admitted to the facility on 02 /14/25, and readmission on [DATE] with diagnoses of Cerebrovascular Accident (Occurs when blood flow to the brain is interrupted, leading to brain cell death and potential neurological damage), Seizure Disorder or Epilepsy (a neurological condition characterized by recurrent seizer), Asthma (a chronic lung condition that causes inflammation and narrowing of the airways, leading to recurrent episodes of wheezing, shortness of breath, chest tightness, and coughing), Chronic Obstructive Pulmonary Disease (a type of progressive lung disease characterized by long term respiratory symptom and airflow limitation), Respiratory Failure, muscle wasting and atrophy (the decrease in size or wasting away of a body part, such as muscle or tissue, due to cell shrinkage or cell death). Resident#1 had a BIMS score of 06 which indicated severe cognitive impairment. Review of the functional ability section reflected that Resident #1 required substantial assistance with showering and personal hygiene. Record review of Resident #1's Comprehensive Care Plan revised on 07/29/25 reflected, Focus: Resident has an ADL Self Care Performance Deficit and is at risk for not having their needs met in a timely manner. Goal: Resident will participate to the best of their ability and maintain current level of functioning with activities of daily living (ADLs) through the next review date. Interventions: Personal Hygiene: Limited x[BR1] 1. Bathing: Dependent x1 Provide shower, shave, oral care, hair care, and nail care per schedule and when needed. In an observation and interview on 09/16/25 at 10:37 AM with Resident #1, revealed his fingernails on both hands were dirty with black discoloration underneath the nails and the nails were jagged. The fingernails were 0.5-0.7 centimeter in length extending from the tips of his fingers. Resident #1 stated he would like his nails to be cleaned and trimmed. 2- Record review of Resident #2's Quarterly MDS assessment dated [DATE], reflected Resident #2 was a [AGE] year-old male admitted to the facility with initial admission date of 05 /09/25, with diagnoses of Hypertension (Elevated blood pressure), Asthma, Chronic Obstructive Pulmonary Disease, muscle weakness, and cognitive communication deficit. Resident#2 had a BIMS score of 13 which indicated intact cognition. Review of functional ability section reflected that Resident #2 required substantial/maximal assistance with showering and setup or clean-up assistance for personal hygiene. Record review of Resident #2's Comprehensive Care Plan revised on 07/21/25 reflected, Focus: Resident has an ADL Self Care Performance Deficit and is at risk for not having their needs met in a timely manner. Goal: Resident will participate to the best of their ability and maintain current level of functioning with activities of daily living (ADLs) through the next review date. Interventions: Personal Hygiene: Limited x1. Bathing: Dependent x1 Provide shower, shave, oral care, hair care, and nail care per schedule and when needed. In an observation and interview on 09/16/25 at 10:50 AM with Resident #2, revealed his fingernails on both hands were dirty with black discoloration underneath the nails, and the fingernails were 0.4-0.6 centimeter in length extending from the tips of his fingers. Resident #2 stated he would like his nails to be cleaned and trimmed. In an interview/observation on 09/16/25 at 11:00 AM CNA A checked both residents' fingernails and stated they needed to be cleaned and trimmed. CNA A stated CNAs and nurses were responsible for nail care. She stated that nurses were responsible for nail care for diabetic residents. She stated nail care for residents was done on shower days and as needed. She added the risk to the resident for not trimming or cleaning their nails was decreased skin integrity and risk of infections. In an interview on 09/16/2 11:14 AM with LVN B revealed, CNAs were responsible for resident nail care, unless the resident had diagnoses of diabetes, then nurses were responsible for trimming the resident's nails. She stated dirty, long fingernails could expose the residents to the risk of developing infections or skin tears. LVN B further stated that although CNAs were responsible for nail care, it was ultimately the responsibility of the charge nurse to ensure residents' fingernails were always cleaned and trimmed. Interview on 09/16/25 at 2:24 PM the DON stated all the staff were responsible for the residents fingernail care. She stated CNAs should make sure residents' fingernails were cleaned and trimmed all the time, and if the resident had

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. (continued on next page)

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that residents who needed respiratory care ,including tracheostomy care and tracheal suctioning, were provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 1 (Resident #1) residents reviewed for respiratory care. The facility failed to ensure physician's orders were written for oxygen use via nasal canula for Resident #1 on readmission [DATE] to 09/16/2025. This failure could place residents at risk for incorrect treatment decisions, evaluation, and treatment plans compromising patient safety due to insufficient information records. Record review of Resident #1's Quarterly MDS assessment dated [DATE], reflected Resident #1 was a [AGE] year-old male admitted to the facility on 02 /14/25, and readmission on [DATE] with diagnoses of Cerebrovascular Accident (Occurs when blood flow to the brain is interrupted, leading to brain cell death and potential neurological damage), Seizure Disorder or Epilepsy (a neurological condition characterized by recurrent seizer), Asthma (a chronic lung condition that causes inflammation and narrowing of the airways, leading to recurrent episodes of wheezing, shortness of breath, chest tightness, and coughing), Chronic Obstructive Pulmonary Disease (a type of progressive lung disease characterized by long term respiratory symptom and airflow limitation), Respiratory Failure, muscle wasting and atrophy (the decrease in size or wasting away of a body part, such as muscle or tissue, due to cell shrinkage or cell death). Resident #1 had a BIMS score of 06 which indicated severe cognitive impairment. Review of section J. J1100. Shortness of Breath (dyspnea) revealed: C. Shortness of breath or trouble breathing when lying flat. Review of respiratory treatment C1 oxygen therapy was not market for oxygen use. Record review of Resident #1's Comprehensive Care Plan revised on 07/29/25 reflected no indication of oxygen use. Record review of Resident #1's electronic medical record on 09/16/25 revealed: 1- No physician's order for oxygen use for readmission on [DATE] to 09/16/2025 2- The MAR did not reflect oxygen use or setting. In an observation and interview on 09/16/25 at 10:37 AM revealed Resident#1 was lying in bed, on oxygen via nasal canula and his oxygen concentrator was beeping with the yellow alarm light flushing. Resident #1 stated he did not feel good. Resident #1's oxygen concentrator float/flow indicator device was not visible inside the flowmeter tube. Observation on 09/16/25 at 11:14 AM revealed LVN B responding to the Resident #1's call light. LVN B checked the oxygen concentrator and turned the knob until the float was visible in the flowmeter. LVN B adjusted the oxygen flow to 2 L/ minutes. Observation revealed LVN B asking Resident #1 how he was feeling, and he replied he was feeling better. Interview with LVN B revealed Resident #1 was on oxygen as needed, and some time Resident #1 liked to adjust the flow rate. LVN B stated, she reeducated Resident #1 not to adjust the oxygen rate for his safety. LVN B stated adjusting the oxygen flow too high or too low could affect the amount of oxygen the resident was receiving and his breathing quality. In interview on 09/16/25 at 2:29 PM the DON stated Resident #1's oxygen was as needed, and sometimes he played with the concentrator flowmeter. The DON stated her expectation was every resident with oxygen must have order, because oxygen was a medication that could be given by the physician order only. The DON stated the risk to Resident #1 for not having a physician's order for oxygen use was respiratory issue. Interview with the Administrator on 09/16/25 at 3:20 PM, she stated orders drive care and she expected nursing staff to obtain orders for care. The Administrator stated she expected Resident #1 to have orders for his oxygen use. Record review of policy titled, Consulting Physician/Practitioner Orders dated 09/28/2021, reflected Policy: The policy provide guidance on receiving and following physician orders. c. Carry out and implement physician orders d. Document resident response to physician order in the medical record as indicated . Record review of policy titled, Oxygen Administration date 01/05/2020, reflected Policy: To describe methods of delivering oxygen to improve tissue oxygenation.during a respirator emergency it is appropriate for nursing to administer oxygen immediately and then notify physician for orders and further clinical guidance. 1.Verify physician order 2. Orders should have when to call the physician parameters.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. (continued on next page)

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F 0919 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 observations, interviews and record review, the facility failed to be adequately equipped to allow residents to call for assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from each resident's bedside for 1 of 11 residents (Resident #1) reviewed for reasonable accommodations. The facility failed to ensure the call light in the resident room, used by Resident #1, was always within reach. This failure could place residents at risk of being unable to obtain assistance for activities of daily living or in the event of an emergency. Record review of Resident #1's Quarterly MDS assessment dated [DATE], reflected Resident #1 was a [AGE] year-old male admitted to the facility on 02 /14/25, and readmission on [DATE] with diagnoses of Cerebrovascular Accident (Occurs when blood flow to the brain is interrupted, leading to brain cell death and potential neurological damage), Seizure Disorder or Epilepsy (a neurological condition characterized by recurrent seizer), Asthma (a chronic lung condition that causes inflammation and narrowing of the airways, leading to recurrent episodes of wheezing, shortness of breath, chest tightness, and coughing), Chronic Obstructive Pulmonary Disease (a type of progressive lung disease characterized by long term respiratory symptom and airflow limitation), Respiratory Failure, muscle wasting and atrophy (the decrease in size or wasting away of a body part, such as muscle or tissue, due to cell shrinkage or cell death). Resident#1 had a BIMS score of 06 which indicated severe cognitive impairment. Review of functional ability self-care was coded as (2) meaning Resident #1 Needed Some Help - Resident needed partial assistance from another person to complete any activities. Record review of Resident #1's Comprehensive Care Plan revised on [DATE] reflected, Focus: Resident has the potential for falls. Resident with poor safety awareness and impulsive. Goal: Resident will not sustain a fall related injury by utilizing fall precautions through next review date. Interventions: Reeducate the resident to use the call light when wanting to transfer. Place the resident's call light is within reach and encourage the resident to use it for assistance as needed. In an observation and interview on [DATE] at 10:37 AM revealed Resident#1 was lying in bed, on oxygen via nasal canula and his oxygen concentrator was beeping. Resident#1 stated, he did not feel good. Resident#1 was unable to call for help, because his call light was in the closed nightstand drawer. CNA A walked into the Resident #1's room and got the call light button from the nightstand drawer and clipped it to Resident #1's pillowcase. Interview on [DATE] at 11:00 AM CNA A stated, she put the call light button in the nightstand drawer this morning when she changed Resident #1's bed linen, and she forgot to put it within Resident #1's reach before leaving the room. CNA A stated she did not know the call light was not within the reach of the resident. CNA A stated the call light device was used by the residents to alert the staff about the resident's needs, and the call light was expected to be working and within the reach of the resident all the time. In an interview on [DATE] at 2:29 PM with the DON revealed all residents were expected to always have their call light within reach and it was the responsibility of all the employees to ensure the call light was within reach of each resident. The DON stated not having a call light within reach could put a resident at risk for going without incontinent care after a bowel movement, going without care at the time of a health crisis. Interview with the Administrator on [DATE] at 3:20 PM she stated it was her expectation for all the employees to make sure the resident's call light was always within reach and not having the call light within reach could lead to the risk of not getting assistance in a timely manner, it could lead to not receiving incontinent care, skin break. Record review of the facility's Call light response policy dated [DATE] reflected The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. The policy reflected the process as follows . All staff will be educated on the proper use of the resident call system, including how the system works and ensuring resident access to the call light . With each interaction in the resident's room or bathroom, staff will ensure the call light is within reach of resident and secured, as needed . Staff will report problems with a call light or the call system immediately to the supervisor and/or maintenance director and will provide immediate or alternative solutions until the problem can be remedied.