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	05/20/2026

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure assessments accurately reflected the resident's status for 2 of 5 residents (Resident #1 and Resident #4) reviewed for resident assessments.The facility failed to accurately assess and document Resident #1's active medical diagnosis of depression.The facility failed to accurately assess Resident #4's antidepressant medication status.The facility failed to accurately document Resident #4's active medical diagnosis.These failures could place residents at risk of having inaccurate diagnoses and inappropriate identification of care needs.1. Record review of Resident #1's face sheet, dated 05/20/2026 revealed a [AGE] year-old male with a primary diagnosis of encephalopathy (abnormal brain function, lead to cognitive impairment). Other pertinent diagnoses include cerebral infarction (stroke), cognitive communication deficit (impaired ability to communicate), and mild cognitive impairment (noticeable cognitive decline). Record review of Resident #1's quarterly MDS assessment, dated 03/17/2026, revealed he had a BIMS score of 09 (indicating moderate cognitive impairment). In Section I - Active diagnoses of the MDS assessment, depression was not documented as an active diagnosis. In Section N - Medication, Resident #1 was documented as taking an antidepressant. Record review of Resident #1's care plan, dated 05/20/2026, revealed Resident #1 uses psychotropic medications, antidepressants (Fluoxetine). related to depression. Record review of Resident #1's orders, dated 05/20/2026, reflected:- FLUoxetine HCl Capsule 10 MG Give 1 capsule by mouth in the evening for depression Given with 20mg for a total of 30mg. Order Date: 02/06/2026- FLUoxetine HCl Capsule 20 MG Give 1 capsule by mouth in the evening for depression Given with 10mg for a total of 30mg. Order Date: 02/06/2026 Record review of Resident #1's psychiatric evaluation and consultation note, dated 05/01/2026, revealed Resident #1 had a diagnosis of major depressive disorder and was actively treated for depression with the psychoactive medication, Fluoxetine HCl. Record review of Resident #1's recent psychological services notes, dated 05/06/2026, 05/13/2026, and 05/18/2026, all revealed he had a diagnosis of major depressive disorder and was actively treated for depression. Record review of Resident #1's informed Consent for Psychoactive Medications, dated 2/14/2025, revealed Resident #1's RP consented for an antidepressant to be given for depression. During an observation and interview on 05/20/2026 at 10:19 AM with Resident #1 revealed he was in a pleasant mood. Resident #1 mumbled some, during the interview, but was able to state he was doing therapy and it was going very well. 2. Record review of Resident #4's face sheet revealed a [AGE] year-old female, with a primary diagnosis of displaced intertrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing (bones of upper right leg previously broken and now in healing phase). Other pertinent diagnoses included dementia (brain disease that alters brain function and causes a cognitive decline) and cognitive communication deficit (impaired ability to communicate). Record review of Resident #4's quarterly MDS, dated [DATE], revealed Resident #4 had a BIMS score of 01 (severe cognitive impairment). In Section I - Active Diagnoses, Resident #4 was documented to have depression. In Section N - Medication, active medications did not include antidepressants. Record review of Resident #4's care plan, revised 02/18/2026, revealed Resident #4 uses psychotropic medications, antidepressants (Sertraline) related to depression. Record review of (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #4's orders, dated 05/20/2026, reflected:- Sertraline HCl Tablet Give 50 mg by mouth in the morning for Depression. Order date: 12/11/2025 Record review of Resident #4's psychiatric evaluation and consultation note, dated 05/01/2026, revealed Resident #4 had a diagnosis of major depressive disorder and was actively treated for depression with the psychoactive medication, Sertraline HCl. Record review of Resident #4's informed Consent for Psychoactive Medications, dated 11/24/2024, revealed Resident #1's RP consented for an antidepressant to be given for depression. Record review of Resident #4's progress note, dated 05/20/2026, reflected: Details: Chief complaint: APSP- Sertraline assessmentHistory of present illness:[AGE] year-old long-term care resident with dementia and depression seen today for APSP follow-up for sertraline. Resident remains on sertraline 50 mg by mouth daily for depression, with 100% adherence per MAR. Resident is a poor historian due to cognitive impairment and limited reliability. Provider [NP]. During an interview on 05/20/2026 at 11:56 AM with Resident #4's RP, she revealed Resident #4 was prescribed Sertraline prior to being admitted to the facility, by a neurologist. The RP said prior to admitting, Resident #4 was not diagnosed with depression but was prescribed an antidepressant to keep Resident #4 from becoming depressed due to her dementia. The RP said it was used as a preventative. During an interview on 05/20/2026 at 12:25 PM with the NP revealed Resident #1 was on an antidepressant due to having a history of depression. She said based on her assessments of his behaviors, psych notes, and his order for an antidepressant, Resident #1 should have a diagnosis of depression. The NP said Resident #4 was taking an antidepressant for depression and should have a diagnosis for depression. The NP said Resident #4 had a flat effect, meaning Resident #4 did not smile and did not show joy; she said Resident #4 had been like that since she admitted and dementia would cause this. The NP said the risk of discrepancies in resident records was staff and healthcare providers would see there was no diagnosis for medication the resident was taking. She said there should be a diagnosis to correlate with the medications taken, because she was treating them for a diagnosis. The NP said she would talk to psych (providers) to make sure residents' medications correlate with their diagnoses. The NP said she understood the question of why a resident would take a medication that there was no diagnosis for. During an interview on 05/20/2026 at 1:03 PM with the LPC, she said Resident #1 was on her caseload. She said Resident #1 did have depression, and she did not know why it was not on his face sheet as a diagnosis. The LPC said that she, psychiatry, and the NP were able to determine if residents had depression. She said she communicated with the DON or the NP about resident who had depression. The LPC said based on her and the NP's assessments, they had agreed Resident #1 had depression. During an interview on 05/20/2026 at 3:14 PM with the DON revealed she did not know why there were discrepancies in the residents' records regarding their treatment for depression, but it could have been a technological issue in the systems. The DON said there were weekly meetings with her, the MDS nurse, therapy, and others to go over residents' care. She said the issue with discrepancies in resident records was resident may not get treated for conditions if their charts did not have all the proper information. The DON said to correct discrepancies, staff would do a review of all residents' medications and make sure there was a correlating diagnosis. During an interview on 05/20/2026 at 4:00 PM with the MDS LVN revealed she was not sure why there with discrepancies in residents' records, but she would start making sure that if a resident was on an antidepressant, there would be a diagnosis to match. The MDS LVN said accurate MDS assessments were important to ensure residents received proper care, and to make sure residents did not take a medication they possibly did not need. During an interview on 05/20/2026 at 4:17 PM with the ADM revealed she recently became the ADM of the facility. She said, to correct the discrepancies in resident records, the facility would need to do an audit and go through resident charts to make sure diagnoses, care plans, and medication all match. The ADM said she would make sure meetings occurred to discuss each patient and diagnoses. Record review of the facility's MDS Accuracy Guidelines, dated 10/24/2022, reflected: PurposeThe purpose of the MDS guideline is to ensure each resident receives an accurate assessment by qualified staff that are familiar with his/her physical, mental, and (continued on next page)

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