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	03/05/2026

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.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives and time frames to meet residents' mental and psychosocial needs, for three residents (Resident #1, Resident #2, and Resident #3) of 11 residents reviewed for care plans.The facility did not develop a comprehensive person-centered care plan to address the discharge plans of Resident #1, Resident #2, and Resident #3.This failure could place residents at risk of not having their discharge goals met.The findings were:Resident #11) Record review of Resident #1's Face Sheet reflected a 56 years-old male who was re-admitted to the facility on [DATE] with diagnoses including in part: sepsis (a life-threatening reaction to an infection), metabolic encephalopathy (a change in how the brain works due to an underlying condition), and multiple sclerosis (a disease where the immune system attacks the brain and spinal cord).Record review of Resident #1's Quarterly MDS, dated [DATE], reflected Resident #1 had an overall goal for discharge to remain in the facility and that active discharge planning was not already occurring for the resident to return to the community.Record review of Resident #1's comprehensive care plan, dated 12/11/25 reflected no focus, goals, or interventions were documented for Resident #1's discharge plans.Resident #22) Record review of Resident #2's face sheet reflected a 74 years-old male who was re-admitted to the facility on [DATE] with diagnosis including in part: sepsis (a life-threatening reaction to an infection), metabolic encephalopathy (a change in how the brain works due to an underlying condition), and pneumonia (an infection that inflames the lungs).Record review of Resident #2's Quarterly MDS, dated [DATE], revealed the MDS did not identify an overall goal for discharge and reflected that active discharge planning was not already occurring for the resident to return to the community.Record review of Resident #2's comprehensive care plan dated 12/22/25 reflected no focus, goals, or interventions were documented for Resident #2's discharge plans.Resident #32) Record review of Resident #3's face sheet reflected a 89 years-old male who was admitted to the facility on [DATE] with diagnosis including in part: intervertebral lumbar disc degeneration with pain (cushioning between the discs of the lower back wear away causing pain), dementia (a group of symptoms affecting memory, thinking and social abilities), and heart failure (when the heart muscle doesn't pump blood as well as it should).Record review of resident #3's Quarterly MDS, dated [DATE], revealed the MDS did not identify an overall goal for discharge and reflected that active discharge planning was not already occurring for the resident to return to the community.Record review of resident #3's comprehensive care plan, dated 12/22/25 reflected no focus, goals, or interventions were documented for Resident #3's discharge plans.In an interview on 3/04/2026 at 02:00 p.m., LVN A confirmed that Resident #1, Resident #2, and Resident #3 did not have discharge plans and goals included on their care plans. She stated that she had worked in the MDS position for approximately 1-2 years and that as the MDS nurse it was her responsibility to add to residents' care plans any item that was triggered by the MDS assessment. She stated it was the responsibility of the DON and ADONs to enter onto the care plan any acute care items such as falls, medications, isolations, (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	antibiotics, and anything else not triggered by the MDS assessment. She stated that when the care plans were updated, the discharge plans and goals should have been added if they were not already included. She stated that the discharge plans and goals being placed on the care plan were important because it, documents the patients' intent or plan to go home or be long-term.In an interview on 3/04/2026 at 02:10 p.m., the DON stated that the MDS nurse, the DON, and the ADONs all contributed to residents' care plans. She stated that Resident #1, Resident #2, and Resident #3 were long-term residents. She stated she would provide the facility policy on residents' care plans.In an interview and record review on 3/04/2026 at 02:30 p.m., RN B stated that Resident #1 had a discharge goal included on his care plan at one point, but that it had been inadvertently resolved. She stated that the discharge plan and goals should not have been resolved but should have remained active on the care plan. She stated the facility had now added a discharge plan and goals to the care plans for Resident #1, Resident #2, and Resident #3. She stated that the Social Workers would be entering the discharge goals on the care plans in the future, and that as an interdisciplinarian team effort, the MDS nurse, the DON, and ADONs will follow up to ensure it was done. She stated that all residents' care plans were now being audited to ensure the inclusion of the discharge plan and goals. She stated the failure to add a discharge plan to the care plans of Resident #1, Resident #2, and Resident #3 was not a risk to these residents as they intended to remain in long-term care, but you always want to give them an option because things can change.Review of the facility policy titled, Comprehensive Care Plans dated 2/10/2021 revealed, The comprehensive care plan will describe, at a minimum, the following: d. The resident's goals for admission desired outcomes, and preferences for future discharge. e. Discharge plans, as appropriate.

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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. Based on observation, interview, and record review, the facility to store, prepare, distribute, and serve food in accordance with professional standards for food safety in the facility's only kitchen. The facility failed to ensure Dietary Aide A wore a hairnet.The facility failed to ensure two 32-ounce pitchers of dark red liquid were labeled with the name of the product and dated with the use by date.The facility failed to ensure that meat that was submerged in a bowl full of water in the sink was thawed out under running water.The facility failed to ensure on 03/03/26 1 of 2 drink pitchers that held a dark yellow orange liquid were labeled with the name of the product and dated with the use by date, in 1 of 2 stand-by refrigerators.The facility failed to ensure a 3.5-gallon tea urn was labeled with the name of the product and dated with the use by date.The facility failed to ensure ground meat in a metal bin not in its original package, brown meat in a metal bin not in its original package, and vegetables with meat in a metal bin and not in its original package were labeled and dated with the use by date, in 2 of 2 stand-by refrigerators. These failures could affect residents by placing them at risk for cross-contamination and foodborne intoxication.Findings included: Observation on 03/03/26 at 9:08 A.M., upon entry to the kitchen revealed Dietary Aide A had a baseball cap on with hair that was a little pass her ears and no hairnet. Observation on 03/03/26 at 9:10 A.M., revealed two pitchers containing a dark red liquid covered with plastic wrap, had no label of the product or use by date, sitting on a cart. Observation on 03/03/26 at 9:11 A.M., revealed chicken breast sitting in a metal bowl not in its original package on one side of the sink and submerged in water, but contained no running water from the faucet, and no label or use by date. Observation on 03/03/26 at 9:13 A.M., of stand-by refrigerator 1 of 2 revealed two pitchers of a yellow-orange liquid covered with plastic wrap had no label of the product or use by date. Observation on 03/03/26 at 9:15 A.M. revealed a 3.5-gallon tea urn, with steam coming from the liquid, had no label of the product and use by date, at the back of the food line. Observation on 03/03/26 at 9:17 A.M., of stand-by refrigerator 1 of 2 revealed the following: Ground meat in a metal bin not in its original package, with plastic wrap covering the top of it, had no label. [NAME] meat in a metal bin not in its original package, with plastic wrap covering on the top of it, had no label. Vegetables and meat in a metal bin not in its original package, with plastic wrap covering the top of it, had no label or use by date. In an interview on 03/03/26 at 9:12 AM, Dietary Aide A stated the two tea pitchers with dark red liquid was tea. In an interview on 03/03/26 at 9:20 AM, the DM stated that the meat found in the sink that was submerged in a bowl full of water was chicken breast. The DM stated the two tea pitchers found with yellow orange liquid inside of stand-by refrigerator 1 of 1 was orange juice. The DM stated the ground meat that was found covered with plastic wrap was ground turkey. The DM stated the brown meat found inside the second silver container was breakfast sausage. The DM stated the food with the vegetables found in the third silver container was shepherd's pie that they made yesterday on 03/02/26. In an interview on 03/03/26 at 10:43 AM, the DM stated all employees were expected to have hairnets on when they entered the kitchen if they had hair. The DM stated Dietary Aide A had been told to put on a hairnet before. The DM stated he could not explain why Dietary Aide A did not have a hairnet on. He stated she had been working in the kitchen for 5 years and she was aware she was supposed to have a hairnet on. The DM stated he were responsible for making sure all staff had hairnets on when they were working in the kitchen. He stated the risk of an employee not wearing a hairnet while in the kitchen could cause contamination. The DM stated the chicken breasts were supposed to be thawed out under running water. The DM stated he was not sure why the chicken was just sitting in a bowl full of water, and he stated he had not arrived yet to have an explanation as to why the chicken was not thawed out correctly. The DM stated the risk of the chicken sitting in a bowl full of water without running water over it could cause the chicken to be in the temperature danger zone. The DM stated the two tea pitchers that were found should have been labeled with the product name and use by date and that he (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	should have discarded them. The DM stated the orange juice in the two pitchers that were found in refrigerator 1 of 2 should have been labeled with the product name and dated with the use by date. The DM stated that the ground turkey, shepherd's pie, and breakfast sausage that were found in refrigerator 2 of 2 should had been labeled with the product name and dated with the use by date as well. The DM stated that the freshly made tea in the 3.5-gallon tea urn should have also been labeled with the product name and use by date. The DM stated that all items in the kitchen should be labeled with the product name and dated with use by dates. The DM stated he normally did his rounds in the kitchen to be sure every item was labeled with the product name and use by date, but he had not had the chance to have that done. The DM stated the risk of not having items in the kitchen labeled with the product name and dated with the use by date could cause spoilage of items. In an interview on 03/03/26 at 10:59 AM, Dietary Aide A stated she had been working in the kitchen for 7 years now. Dietary Aide A stated she had not been trained since she first started. Dietary Aide A stated she had always had a hairnet on and if she had a baseball cap on, she had never been told to put on a hairnet. Dietary Aide A stated the DM, her and other employees are responsible for making sure she has a hairnet on. Dietary Aide A stated the risk of not having a hairnet on is hair can fall into someone's food. In an interview on 03/04/26 at 12:54 PM, [NAME] B stated all items in the kitchen are supposed to be labeled and dated in the kitchen. [NAME] B stated everybody that works in the kitchen is responsible for labeling and dating items in the kitchen, but if she had something she needed to put in the refrigerator, she labeled and dated the items before she placed them in the refrigerator. [NAME] B stated the staff may have forgotten to label and date the items because they could have become distracted and started a new task. [NAME] B stated the risk of not labeling and dating items can build in the refrigerator too long and it could spoil and cause food poisoning so it's important to label and date the item so that they know if the item can be served or not. [NAME] B stated when food is thawed out, they are supposed to let the water run on it until it is fully thawed out. [NAME] B stated that she was off the day the items were discovered in the kitchen, and she couldn't say why the chicken breasts were just sitting in a bowl full of water. [NAME] B stated the risk of the chicken being submerged in the water could have caused the chicken to change colors if it's not properly thawed out and it depends on how long it was sitting there because some bacteria could start to grow on the chicken. [NAME] B stated she wears a hairnet all the time, especially with her being the cook she made sure she put one on. [NAME] B stated the risk of someone not wearing a hairnet could cause a hair to fall into the food. When asked if they had any recent training regarding the kitchen, [NAME] B stated all kitchen staff verbally discuss how things are supposed to be conducted in the kitchen, but they had not had any recent training on the kitchen. In an interview on 03/04/26 at 1:07 PM, Dietary Aide C stated that she had been working in the kitchen for 2 years. Dietary Aide C stated they are supposed to label and date products in the kitchen within a 12-day span. Dietary Aide C stated she is not sure why the items in the kitchen were not labeled and dated. Dietary Aide C stated she was trained on the kitchen when she was first hired but had not had any recent trainings. Dietary Aide C stated the risk of items not being labeled and dated could cause food spoilage, contamination, and can get someone sick. Dietary Aide C stated she is not sure how items are supposed to be thawed out because the cook or the DM usually thawed the food out. In an interview on 03/05/26 at 12:00 PM, the ADM stated kitchen staff will need an updated in-service, and she had planned to do that soon. The ADM stated her expectations of staff were all items should be labeled and dated before placing any item in the refrigerator and when items were prepped. She stated the risk of not labeling and dating items in the kitchen could cause staff to give residents something spoiled and, in the elderly, population could cause illnesses. The ADM stated her expectation of meat being thawed out is that staff could have had running water running over the chicken breast. The ADM stated the risk of not thawing food out and cooking it properly could cause food to have bacteria to grow on it. The ADM stated the expectation of staff in the kitchen is that they should always wear hairnets. The ADM stated she had bought all kitchen staff real cloth hairnets for dietary week. The ADM stated the staff (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	in the kitchen had been in-serviced over the kitchen last year. When asked for the in-service that was completed last year, The ADM could not provide it. The ADM stated the risk of kitchen staff not wearing a hairnet could cause a hair follicle to fall into the food and could cause harm to the residents, and she had stated it is unsanitary. Record Review of the facility's Frozen and Refrigerated Foods Storage Policy dated 07/22/22, reflected in part:Potentially hazardous foods should be thawed on a bottom shelf in the refrigerator. Thawing foods must be labeled with the date they were removed from the freezer and a use by date which is 7 days from the date removed from the freezer, unless the manufacturer guidelines are different e.g., shakes may be 14 days. This includes all meats, poultry, fish, vegetables, frozen shakes and thawing PHF/TCS foods.8. Items stored in the refrigerator must be dated upon receipt, unless they contain manufacturer use by, sell by, best by date, or a date delivered. Most pick stickers do have the delivery date on the sticker. They must also be dated with an expiration date unless they have one from the manufacturer (i.e. milk cartons, eggs)11. All refrigerated and frozen items in storage will contain a minimum label of common name of product and dated as noted above. Record Review of the facility's Personal Hygiene Policy dated 11/14/17, reflected in part: Dietary employees shall wear hair covering, beard restraint, and clothing that covers body hair. Staff that work serving in the dining room do not need to wear hair restraints. Any staff entering the kitchen must comply with hair restraints and hand washing.