STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676146	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Town East Rehabilitation and Healthcare Center	3617 O'Hare Dr 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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48235 [Based on observations, interviews, and record review the facility failed to ensure the resident has the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 1 of 5 residents (Resident #3) reviewed for reasonable accommodation of needs. The facility failed to ensure the call light in resident room used by Resident #3 was always within reach. This failure could place resident at risk of being unable to obtain assistance for activities of daily living or in the event of an emergency. Findings included: Record review of Resident #3's face sheet dated 01/21/2025 reflected she had an original admitted [DATE], she had a diagnosesis of Hemiplegia and Hemiparesis following Cerebral Infarction affecting left non dominant side (a condition where a person experience paralysis or significant weakness to one side of the body), Neuromuscular dysfunction of bladder (A condition where the nerves controlling the bladder function are damaged, causing incontinence), need for assistance with personal care. Record review of Resident #3's Quarterly MDS dated [DATE] reflected she had a BIMS score of 14 indicating intact cognition, frequently incontinent to urine and bowel and needed substantial/maximal assistance with lying to sitting on the side of the bed, bed to chair. Record Review of Resident #3's Comprehensive Care Plan dated 06/23/2023 revealed she had an ADL selfcare performance deficit related to stroke, resident was totally dependent on 2 staff for repositioning and turning in bed and required mechanical lift with 2 staff assistance for transfers. Observation and interview on 01/21/2025 at 10:02 AM in Resident #3's room revealed she was lying in her scoop mattress. Resident #3 stated she had a stroke, as a result she was bed bound and she could not use her left arm. Resident stated she used call light to seek for assistance, but she could not find her call light at that time. It was observed the call light was not within reach of the resident and was hanging down towards the floor, from the left side of Resident #3's bed. Resident stated some of the employees did not make sure the call light was pinned to her clothes or was within her reach before they left the room. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 01/21/2025 at 10:54 AM with CNA A revealed she was working at the facility as a PRN (as needed) for 5 months. CNA A stated she was working on the 200 hall that day, she received in services on abuse/neglect, call lights and that she always made sure the call light was within the reach of the resident at all times. She stated before she left the room after providing care to a resident, she made sure the call light was either pinned to the resident's cloth or to the bedsheet. CNA A stated not having call light within reach of the resident would lead to several issues: a resident who wanted to use the rest room might try to get up by themselves and fall, injury, dehydration if they did not get enough water to drink, delay in incontinent care which could lead to skin breakdown. She stated it was the responsibility of all the employees who provided care to the resident to ensure the call light was working and always within the reach of the resident before they left the room. She stated she received in service on call lights within the past one month. An interview and observation on 01/21/2025 at 11:14 AM with CNA B revealed she was working at the facility for 2.5 years; she was working on the 400 hall that day and she provided care to Resident #3 that day. She stated she received in service on abuse, neglect, call lights within the past one month. CNA B stated an example for neglect was when an employee not attending to the resident or not providing care in a timely manner. She stated it was important to make sure the resident's call light was working and was within the reach because someone could be in a distress or having an emergency. Someone might be trying to let the staff know that their roommate had a fall and not having the call light within reach could lead to serious consequences such as fall, injury, skin breakdown. She stated she checked on residents at least every two hours and made sure the call light was within reach of the resident before she left the room. CNA B was invited to Resident #3's room, she observed resident #3's call light was not within the resident's reach, and it was hanging towards the floor towards the left side of the bed. CNA B clipped the call light to Resident #3's cloth. CNA B stated she had changed Resident #3's brief that morning 2 hours ago and the resident had her call light within reach at that time. CNA B stated all the staff who provided care to the resident were responsible to ensure her call light was within reach. An interview on 01/21/2025 at 11:27 AM with LVN K revealed she was working at the facility for 3 months. LVN K stated her expectation from all the employees who provided care to a resident to make sure the call light was always within the reach of that resident. She stated not having a call light within reach could increase the risk of falls, injury and skin damage. She stated she and her employees received in service on call light within the past 1 month. An interview on 01/21/2025 at 01:30 PM with the facility DON revealed she was working at the facility for 9 years. She stated the CNA, nurses and all the employees were responsible to make sure the call light was always within the reach of the resident. She sated having a call light within reach was important for a resident to call for assistance whenever they were in need. She stated the risk for residents to not have a call light within reach were pain, fall, injury, hospitalization and sometimes death. An interview with the facility administrator on 01/21/2025 at 04:06 PM revealed she was working at the facility for a year. She stated all the employees were in serviced on call light every month and after each incident. She stated she expected all the employees to make sure the call light was always within the reach of the resident whether the resident was in the bed, wheelchair or in the bathroom. She stated not having a call light within reach could lead to the risk of residents not able to make the employees aware of resident's needs in a timely manner, it could lead to a fall, injury, distress, potential skin issues. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Answering the call light revised in September 2022 revealed The purpose of this procedure is to ensure timely responses to the resident's requests and needs . 5. Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 47690 Based on observation, interview, and record review, the facility failed to ensure the comprehensive care plan described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 (Resident #2) of 9 residents reviewed for comprehensive care plans. The facility failed to care plan Resident #2 for ADLs. This failure could place residents at risk for possible adverse side effects, adverse consequences, and decreased quality of life. Findings include: Record review of Resident #2's Quarterly MDS assessment dated [DATE] reflected Resident #2 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of dementia (neurological conditions that cause a decline in mental abilities that affect daily life), cerebrovascular accident (result of disrupted blood flow to the brain due to problems with blood vessels that supply it) with hemiplegia or hemiparesis. She had a BIMS score of 15/15 indicating she was cognitively intact. She was total dependent with personal hygiene and showering ADLs. Record review of Resident #2's Comprehensive Care Plan last revised 10/28/24 reflected the following Resident #2 has limited physical mobility r/t stroke and paralysis on the left side. Goal. The resident will remain free of complications related to immobility, including contractures, Skin breakdown .Intervention. Provide supportive care, . as needed. Further review revealed no indication of ADLs care were documented. Observation/interview on 01/21/25 at 10:39 AM, revealed Resident#2 was lying in bed and had a soft roll measuring six inches in length and two inches wide inside her contracted left hand, no skin issue noticed. Interview with Resident#2 revealed she had a history of stroke with left side paralyzed, and left-hand contraction. She stated they give her the soft hand roll since she was admitted to the facility on [DATE]. Resident#2 further stated the soft hand roll kept her finger from curling inside her hand and hurting her. Interview with the DON on 01/21/25 at 3:10 PM, the DON revealed residents' care plans were completed between herself, and MDS Coordinators. She stated the care plan should be patient centered and reflect the current care needs of the resident to ensure accurate care and resident wishes. In an interview with MDS Coordinator G on 01/21/25 at 2:07 PM, she was asked if Resident #2 had care plans interventions for her ADLs abilities, and her left-hand contraction. After looking, she stated no, none were care planned. MDS Coordinator G stated she was responsible for the care plans. She stated failing to have current and accurate care plans could potentially affect resident care. She stated staff would not know the interventions for the resident, and it could diminish the residents' care. She stated she was not sure how the above areas were missed, but stated she would correct them today. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with MDS Coordinator H over the phone on 01/21/25 at 3:58 PM she stated her job was to assist in certain area of the residents' care plans, like MDS questionnaire, and PASSR. She further stated any care a resident was having should be care planned. Interview with the Administrator on 01/21/25 at 4:29 PM, the Administrator stated all the residents needed their care planned, and it was the responsibility of IDT (interdisciplinary team) , nurses, and therapy services to make sure there was a care plan for all the services rendered to the residents, other ways the residents' needs would not be meet. Review of the facility's policy titled, Care Plans-Comprehensive revised December 2016, reflected, A Comprehensive, person-centered Care Plan that includes measurable objectives and timetables to meet the resident's physical, psychological and functional needs is developed and implemented for each resident .4. Each resident's Comprehensive person-centered Care Plan will be consistent with the resident's rights to . g. Receive the services and/or items included in the plan of care.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47690 Based on observation, interview, and record review the facility failed to provide the necessary services for residents who are unable to carry out activities of daily living to maintain good grooming and personal hygiene for 2 (Resident #1, Resident#2) of 9 residents reviewed for ADL's. The facility failed to ensure. 1-Resident#1 had his fingernails trimmed and cleaned. 2-Resident #2 had her 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. Findings include: 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 [DATE] and readmitted on [DATE] with of diagnoses diabetes mellites, hemiplegia or hemiparesis following cerebral infarction (result of disrupted blood flow to the brain due to problems with blood vessels that supply it), and aphasia (a language disorder that affects the ability to speak) following cerebral infarction. He had a BIMS score of 00/15 indicating he had severe cognitive impairment. Further review revealed he was total dependent for all ADLs. Record review of Resident #1's Comprehensive Care Plan last revised 10/28/24 reflected the following Problem. Resident #1 has an ADL self-care performance deficit r/t hemiplegia impaired balance. Goal. The resident will improve current level of function in through the review date. Intervention. Encourage the resident to participate in the fullest extent Observation/interview on 01/21/25 at 2:49 PM revealed Resident#1 was lying in bed. He was observed to have both hands long fingernails of approximately 0.5 cm. that were dirty . Attempted interview with Resident#1, he could not respond, he had aphasia, and he was able to nod yes or no. He indicated he would like his fingernails trimmed and cleaned. Interview on 01/21/25 at 10:26 AM with CNA C, she looked at Resident#1 fingernail and stated they were dirty and needed to be trimmed. She further stated his fingernails needed good wash, and he could get sick, develop infection, and could also scratch himself. Record review of Resident #2's Quarterly MDS assessment dated [DATE] reflected Resident #2 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including dementia (neurological conditions that cause a decline in mental abilities that affect daily life), cerebrovascular accident (result of disrupted blood flow to the brain due to problems with blood vessels that supply it) with hemiplegia or hemiparesis. She had a BIMS score of 15/15 indicating she was cognitively intact. She required moderate assistance with personal hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's Comprehensive Care Plan last revised 10/28/24 reflected the following Resident#2 has limited physical mobility r/t stroke and paralysis on the left side. Goal. The resident will remain free of complications related to immobility, including contractures, Skin breakdown .Intervention. Provide supportive care, . as needed. Observation/Interview on 01/21/25 at 9:18 AM revealed Resident #2 was lying in bed. She was observed with long fingernails of approximately 0.7 cm on both hands, with some of them chipped. Her left hand was contracted with a soft hand roll inside her hand. Interviewed with Resident #2, she stated would like her fingernails trimmed. Interview on 01/21/25 at 10:48 AM with CNA D, she looked at Resident#2 fingernail and stated they were long and some of them were chipped and needed to be trimmed. She further stated the risk to the residents they could scratch them self, and development of infection. Interview on 01/21/25 at 10:53 PM with LVN F, he stated both CNAs and LVNs were responsible for nail care. He stated if a resident had diabetes, only nurses were allowed to trim resident's nails. He stated the risk for not performing nailcare was increased risk of infection and skin break down. Interview on 01/21/25 at 1:49 PM with the DON, she stated her expectation was that nail care should be provided every shower day and as needed. She stated that 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 also stated that as the DON she conducted spot checks and daily rounds for monitoring. The DON stated residents who had dirty fingernails could be an infection control issue. Record Review of the facility policy titled Fingernails/Toenails Care of revised February 2018 reflected, The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections 1. Nail care includes daily cleaning and regular trimming

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47690 Based on observation, interview, and record review, the facility failed to ensure that residents had physician's orders for the resident's immediate care for 1 (Resident #2) of 9 residents observed for physician orders for ADLS. The facility failed to have a physician order for a soft hand roll for the contracted left hand for Resident #2. These failures could place the residents at risk of not receiving necessary care and services that could result in the worsen condition. Findings included: Record review of Resident#2's Quarterly MDS assessment dated [DATE] reflected Resident#2 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including dementia (neurological conditions that cause a decline in mental abilities that affect daily life), cerebrovascular accident (result of disrupted blood flow to the brain due to problems with blood vessels that supply it) with hemiplegia or hemiparesis. She had a BIMS score of 15/15 indicating she was cognitively intact. Record review of Resident#2's Comprehensive Care Plan last revised 10/28/24 reflected the following Resident#2 has limited physical mobility r/t stroke and paralysis on the left side. Goal. The resident will remain free of complications related to immobility, including contractures, Skin breakdown .Intervention. Provide supportive care, . as needed. Further review reflected no documentation of Resident#2 left hand contraction and care. Review of Resident #2's Physician's Order on 01/21/25 at 11:03 AM reflected no physician orders for the use of a soft hand roll in the Resident#2 left hand. Review of Resident#2 weekly skin assessment titled N Adv-Skin check dated 01/21/2025 revealed no skin issue in Resident#2 left hand. Observation/interview on 01/21/25 at 10:39 AM, revealed Resident#2 was lying in bed and had a soft roll measuring six inches in length and two inches wide inside her contracted left hand, no skin issue noticed. Interview with Resident#2 revealed she had a history of stroke with left side paralyzed, and left-hand contraction. She stated they give her the soft hand roll since she was admitted to the facility on [DATE]. Resident#2 further stated the soft hand roll kept her fingers from curling inside her hand and hurting her. Interview and observation with CNA E on 01/21/25 at 02:58 PM, she stated she knew Resident#2 had a history of stroke, and the soft roll helped with her left-hand contraction, and she stated the Resident#2 could do a lot for herself. CNA E stated nobody told her about Resident#2's soft hand roll, and that Resident #2 told her about it. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN I on 01/21/25 at 03:02 PM, she stated Resident#2 always had the soft hand roll in her left contracted hand, and she did not know that Resident#2 was supposed to have and MD order for it. RN I stated the risk to resident with no order was that the staff would not know how to use it, and that may affect the resident. Interview with the DON on 01/21/25 at 3:10 PM, the DON stated they give the soft hand roll to Resident#2 to use it for her left contracted hand on admission. The DON stated they did not know that they had to get an order for the soft hand roll. The DON did not answer the question related to the risk to resident, and stated staff know how to use it. Interview with the PT Director on 01/21/25 at 4:22 PM, she stated for the new admission they do an evaluation of the resident and will give them the soft roll if they need it. She further stated she did not know that they needed an MD order for it, and they put an order for splints. She stated when Resident#2 was admitted to the facility there use to be an organization that comes to the facility and handed the soft hand rolls to residents. She did not answer the question related to the risk to resident. Interview with the Administrator on 01/21/25 at 4:29 PM, the Administrator stated it was the responsibility of the nurse to make sure there was an order for Resident#2's hand roll. The Administrator further stated all the staff should know resident needs for contraction and that it was not progressing. The Administrator sated the staff needed the order to make sure the soft hand roll was applied properly. Review of the facility Physician order policy titled Medication and treatment order revised July 2016 revealed Orders for .and treatments will be consistent with principals of safe and effective order writing.