

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 12/02/2025
NAME OF PROVIDER OR SUPPLIER Town East Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3617 O'Hare Dr Mesquite, TX 75150	

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. (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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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility did not ensure residents who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding for 1 (Resident#1) of 5 residents reviewed. The facility failed to ensure unlicensed/untrained nursing staff did not adjust G-Tube pumps. This failure could place residents at risk of malnutrition. Record review of Resident#1's face sheet, dated 10/24/25 reflected, he was a [AGE] year-old male who was originally admitted on [DATE] and readmitted on [DATE], diagnosed with but not limited to: Hemiplegia, unspecified affecting left nondominant side (a condition where there is weakness or paralysis on the left side of the body, but the specific cause or severity of the weakness is unknown), aphasia (a language disorder that affects a person's ability to communicate), bed confinement status (a medical condition where a patient is unable to get out of bed or move without assistance, often due to injury or illness), moderate protein-calorie malnutrition (moderate protein-calorie malnutrition), unspecified nontraumatic intracerebral hemorrhage in hemisphere (a type of stroke where bleeding occurs within a cerebral hemisphere) and Gastrostomy status (refers to the presence of a surgical opening (gastrostomy) in the stomach that allows for the insertion of a tube for feeding or other purposes). Record review of Resident#1's quarterly MDS, dated [DATE] reflected his BIMS score was 99 which indicated Resident#1. Was unable to complete the interview. Record review of Resident#1's care plan, undated reflected: Resident#1 had a ADL self-care performance deficit r/t impaired balance, Musculoskeletal impairment, stroke with left sided weakness. Resident#1 ADL's needs were met by care staff. Resident#1 interventions included: Resident#1 was totally dependent on 1 care staff for feeding, he is NPO statis, currently received feeding via G-Tube. Record review of Resident #1's progress note, dated 08/17/25 at 12:50 am reflected, CNA reported resident [sic] had vomited. Asked CNA to make sure she had turn feeding tube off and just wash emesis off face and neck and [LVN A] would be there. Written by LVN A at Attempted to speak to LVN A in person on 10/15/25 between 6:22 am to 9:00am During an interview on 10/15/25 at 7:38 a.m., LVN C stated CNAs are not allowed to touch the G-Tube pumps. LVN C stated when a resident needed to be changed or taken off of the G-Tube the charge nurse for the hall was responsible for the pump. During an interview on 10/15/25 at 8:30 a.m., LVN E stated CNAs should not touch the G-Tube pumps. LVN E stated the licensed nurses had been trained on G-Tube policies and procedures. During an interview on 10/25/25 at 9:10 a.m., LVN F stated only the LVNs are supposed to provide care to the G-tube site and pump. During an interview on 10/25/25 at 9:30 a.m., CNA G stated she would press the hold button on the G-Tube pump when she checked and changed the resident every 2 hours. CNA G stated some residents pump automatically started back up after 5 minutes. CNA G stated she had observed the nurse put the G-tube machine on hold and she knew how to do it. CNA G did not know reach nurses. During an interview on 10/25/25 at 9:24 a.m., CNA H stated she would press the hold button on the G-Tube machine to change the residents. CNA H did not know of the risked to the residents. During an interview on 10/25/25 at 9:40 a.m., LVN I stated most CNAs know how to pause the G-Tube pump. LVN I stated he goes behind the CNAs to make sure the pumps are turned back on and working properly. LVN I stated he worked with his CNAs to make sure they know how to operate the G-Tube pump. During an attempted interview on 10/15/2025 at 10:30 am Resident#1 was not able to answer questions. Resident#1 looked at surveyor and continued to watch television. Attempted to call LVN A on 10/15/25 at 11:15 am, unable leave voicemail. During an interview on 10/15/25 at 10:15 a.m., the Regional Nurse stated there was not a policy specifically who was responsible for providing service to the G-Tube machine. The Regional Nurse stated only the LVNs should handle the G-Tube machines. The Regional Nurse stated she only expected licensed staff to touch the G-Tube machines. The regional Nurse completed in-service with nursing staff when surveyor addressed the incident with Resident#1 and unlicensed staff adjusting G-Tube. The Regional Nurse stated their was not a specific G-Tube policy that stated who was responsible for adjusting the G-Tube. Record review of in-service training report, dated 10/15/25, titled G-Tube Operation reflected only licensed staff are allowed to adjust or put pumps on hold.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on observation, interviews, and record review the facility failed to ensure all drugs and biologicals were stored securely for 6 medication carts (MC#1, MC#2, MC#3, MC#4, MC#5, and MC#6) of 6 medication carts observed for medication storage. -The facility failed to lock medication carts #1, # 2, 3, #4, #5, and #6 at the nurses' station on 10/15/25 at 6:10 AM. These failures could place residents at risk of a drug diversion, or ingesting medications not prescribed for them. Findings included: During an observation on 10/15/25 at 6:10 am, medication carts #1, # 2, 3, #4, #5, and #6 were unlocked at the nursing station with drawers facing outward toward the hallways. No staff was present at the nursing station. During an interview on 10/15/25 at 6:22 am, LVN A stated the medication carts should be locked when not in use. LVN A stated she would be back after she counted the medication cart with LVN C. Surveyor asked to speak to LVN A till 10 am, and LVN A did not complete interview. During an interview on 10/15/25 at 6:55 am, LVN C stated the medication cart should be locked when not in use. LVN C stated residents can get into the medication and take the medications. LVN C stated that she did not know why all the medication carts were unlocked at the nursing station. During an interview on 10/15/25 at 8:15 am, CMA D stated all medication carts should be locked when not in use even when the medication carts are at the nursing station. CMA D stated she did not know why the medication carts was open. CMA D stated she had just gotten her keys earlier from overnight staff when surveyor entered the building. During an interview on 10/25/25 at 9:40 am, LVN I stated medication carts needed to be locked and secured when not in use. LVN I stated residents, staff and visitors could be addicted to drugs. During an interview on 10/15/25 at 10:15 am, the Regional Nurse stated no medication carts should be left unlocked when not in use even if the cart was at the nursing station. The Regional Nurse said there was a risk of residents taking medications and drug diversion. The Regional Nurse stated her expectation was for nursing staff to lock the medication carts when not in use. The surveyor did not obtain clarification on who left the medication carts unlocked and unsecured at the nursing station. Record review of facility policy, revised 04/2019 , titled Storage of Medication reflected, The facility stores all drugs and biologicals in a safe, secure, and orderly manner.1. Drugs and biologicals used in the facility are stored in locked compartments.3. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.</p>		