STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676146	A. Building B. Wing	12/06/2025

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

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record reviews, the facility failed to ensure the residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 1 of 6 residents (Resident #1) reviewed for abuse. The facility failed to ensure Resident #1 was free from abuse. CNA A attempted to provide Resident #1 care on the bed by herself on 11/13/2025 which led to Resident #1 falling off the bed and sustaining a left forehead injury.An IJ was identified on 12/05/25 at 09:50 a.m. The IJ template was provided to the facility on [DATE] at 12:33 p.m. While the IJ was removed on 12/06/25 at 5:17 p.m., the facility remained out of compliance at a scope of isolated and severity level of no actual harm because all staff had not been trained on abuse/neglect, incident/accidents, and reporting. The failure could place residents at risk of abuse and serious harm. A review of the MDS quarterly assessment dated [DATE] reflected Resident#1 was a [AGE] year-old male admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses including cerebrovascular accident (a medical emergency where blood flow to the brain is suddenly interrupted, causing brain cells to die from lack of oxygen, leading to potential disability or death), non-Alzheimer's dementia (forms of cognitive decline not caused by Alzheimer's disease), Parkinson's Disease (a progressive neurological disorder where brain cells producing dopamine die, leading to movement issues like tremors, stiffness, slow movement, and balance problems, alongside non-motor symptoms such as sleep issues, depression, and cognitive changes), dysphasia (difficulty swallowing food or liquids), and muscle weakness. No BIMS score was documented, and section C100-Cognitive Skills for Daily Decision Making was coded at (2) indicating moderate cognitive impairment. Section GG, which reflects functional abilities, indicated that Resident #1 was dependent, and required two-person assistance for showers, toileting, hygiene, and bed transfers.Review of the care plan dated 10/28/25 reflected that Resident #1 required two-person assistance for bed mobility, transfers and ADLs.Review of facility accident/incident report for the month of November 2025 revealed Witnessed Fall Incident [Resident#1] 11/13/2025 at 10:00 AM.Record review of the Witnessed Fall report by LVN B dated 11/13/25 10: 00 a.m. revealed 10:00 AM Received report that resident had a fall. Nurse responded to room and observed the resident on the floor lying on his left side. Nurse observed active bleeding to the left temporal area. Resident alert upon assessment with no loss of consciousness, pressure applied to site with a clean towel. 117/62, P 88, 97.4 RR 18 CNA A was witness to the incident stated while getting the resident dressed for the day, she turned the resident on his side and that was when the resident accidentally rolled off the bed. NP, DON, and Resident#1 RP notified. 911 notified Resident#1 transferred to Hospital. Resident#1 description: Resident#1 unable to give description.Record review of Witnessed Fall IDT meeting dated 11/17/25 note by DON revealed IDT met to review resident fall. Resident#1 was in bed and CNA A was assisting with getting him dressed and rolled him over and he somehow ended up falling off the bed sustained a fall with a laceration to his head. During investigation of the fall IDT determined that Resident#1 call light was within reach, CNA A was in the room with Resident#1 and resident failed to grab the rail and rolled off the bed. IDT determined that Resident#1 needed scoop mattress in place. Resident#1 is currently on therapy services, therapy plan of care updated to focus on strength and balance to prevent falls. Education was also given to the CNA A. Review of hospital records dated 11/13/25 for Resident#1 revealed Physical exam. 2 cm V shaped Laceration to left temporal region, superficial 1 cm laceration amenable to glue on scalp. date/time: 11/13/2025 2:38 p.m.location: forehead. Laceration length: 2 cm. Anesthesia: Local infiltration: Lidocaine 1% without epinephrine.wound skin closure material used: 5-0 fast gut x 4 (5-0 fast absorbing gut is a Monofilament, collagen-based, absorbable suture designed for rapid absorption (21-42 days) and 5-7 days of tensile strength). Number of sutures: 4.Procedure described (general) as Laceration repair.location: scalp. Laceration length: 1 cm .skin closure: glue. Repair type: simple.Record review revealed Resident#1 returned to the facility on [DATE] after the visit to ER with a left forehead dressing.In an interview on 12/03/25 at 12:24 p.m. over the phone, CNA A stated that on 11/13/25 she had been providing incontinent care to Resident #1. She stated that while turning Resident #1 on to his left side, Resident#1 rolled off the bed, hitting his head on the floor with active bleeding. CNA A reported that she immediately called for help. LVN B assessed Resident #1 and found out he sustain injury with active bleeding to his left forehead. She stated Resident#1 was sent to the hospital. CNA A stated she had been assigned to Resident#1 for a long time and was not aware that Resident #1 was a two-person assist. She explained that she had always provided care for him

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the residents received adequate supervision and assistance to prevent accidents and hazards for 1 of 6 (Resident #1) reviewed for accidents and hazards. CNA A failed to have another staff member help her with care, and as a result, the resident rolled out of bed and sustained a laceration on the forehead. This failure could place resident at risks for accidents and injuries. A review of the MDS quarterly assessment dated [DATE] reflected Resident#1 was a [AGE] year-old male admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses including cerebrovascular accident (a medical emergency where blood flow to the brain is suddenly interrupted, causing brain cells to die from lack of oxygen, leading to potential disability or death), non-Alzheimer's dementia (forms of cognitive decline not caused by Alzheimer's disease), Parkinson's Disease (a progressive neurological disorder where brain cells producing dopamine die, leading to movement issues like tremors, stiffness, slow movement, and balance problems, alongside non-motor symptoms such as sleep issues, depression, and cognitive changes), dysphasia (difficulty swallowing food or liquids), and muscle weakness. No BIMS score was documented, and section C100-Cognitive Skills for Daily Decision Making was coded at (2) indicating moderate cognitive impairment. 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Resident alert upon assessment with no loss of consciousness, pressure applied to site with a clean towel. 117/62, P 88, 97.4 RR 18 CNA A was witness to the incident stated while getting the resident dressed for the day, she turned the resident on his side and that was when the resident accidentally rolled off the bed. NP, DON, and Resident#1 RP notified. 911 notified Resident#1 transferred to Hospital. Resident#1 description: Resident#1 unable to give description.Record review of Witnessed Fall IDT meeting dated 11/17/25 note by DON revealed IDT met to review resident fall. Resident#1 was in bed and CNA A was assisting with getting him dressed and rolled him over and he somehow ended up falling off the bed sustained a fall with a laceration to his head. During investigation of the fall IDT determined that Resident#1 call light was within reach, CNA A was in the room with Resident#1 and resident failed to grab the rail and rolled off the bed. 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CNA A stated she was supposed to check the Kardex (a vital, often summarized, patient care tool for nurses) in the electronic medical record system to know the level of assistance each resident required. She stated, she overlooked Resident#1's level of assistance. CNA A stated the DON did a one-to-one education with her the same day after the incident. In interview on 12/04/25 at 12:25 p.m. LVN B stated she was called to Resident#1's room by CNA A. She