| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676480 | A. Building<br>B. Wing | 02/29/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Caraday Mesquite | 825 W. Kearney Street<br>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 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45268<br><br>Based on interviews, and record reviews, the facility failed to obtain from hospice the most recent hospice plan of care specific to each patient needs for 1 of 3 residents (Resident #59) reviewed for hospice services.<br><br>The facility failed to ensure Resident #1' s hospice care was care planned.<br><br>This failure could place residents at risk of needs not being met.<br><br>Findings include :<br><br>Record review of Resident #1's electronic face Sheet, dated 02/29/24, revealed she was a 73 -year-old female admitted on [DATE] with diagnosis that included malignant neoplasm of corpus uteri (endometrial cancer), chronic obstructive pulmonary disease (chronic inflammatory lung disease that causes obstructed airflow from the lungs.<br><br>Review of Resident #1's Comprehensive Care Plan dated on 11/21/23 reflected no care plan for hospice care.<br><br>Record review of Resident #1's doctor order dated 1/22/24 revealed patient admitted to hospice on 1/22/24.<br><br>Interview on 02/29/24 at 2:40PM with the DON revealed hospice care plans are kept in PCC and it would be the MDS nurse who would make sure the care plan included hospice services.<br><br>Interview on 02/29/24 on 2:56 PM with the MDS coordinator revealed IDT meetings were conducted daily to discuss changes to resident care. She stated the care plan was updated as needed and quarterly and annually. She stated if a resident was receiving hospice services it should be documented on the care plan. The MDS Coordinator stated the risk of not updating the care plan would be staff would not have a full picture of the resident care.<br><br>(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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 676480 | A. Building<br>B. Wing | 02/29/2024 |

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| Caraday Mesquite | 825 W. Kearney Street<br>Mesquite, TX 75149 |

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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 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 02/29/24 at 3:30PM with the administrator revealed the IDT team discusses needs of the residents daily and stated if a resident was on hospice it would need to be documented on the care plan. The Administrator was not sure why Resident #1's care plan did not contain the hospice information. The administrator stated there was not a risk to the resident due to hospice services not being documented on the care plan due to hospice being in the building 3-5 times a week and there being a hospice binder.<br><br>Review of the facility policy Charting and documentation revised July 2017 All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. |