STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455423	A. Building B. Wing	03/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mesa Hills Post Acute	901 Wildrose LN Brownsville, TX 78520

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50487 Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, or mistreatment, including injuries of unknown source were reported immediately to the State Survey Agency, within two hours, if the events that cause the allegation involve abuse or result in serious injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury for 1 resident (Resident #2) of 3 residents reviewed for abuse/neglect, The facility did not report the allegation of resident abuse to the State Survey Agency within the frame for Resident #1 who had been found with drug paraphernalia in his room. This failure could place all residents at increased risk for potential abuse due to unreported allegations of abuse and neglect. The findings included: Record review of Resident #2's face sheet dated 03/30/2025 reflected she was a [AGE] year-old male who was admitted to facility on 7/19/2023, relevant diagnoses were cerebral infarction (disrupted blood flow to the brain), gastrostomy (an opening into the stomach from the abdominal wall for introduction of food), chronic obstructive pulmonary disease (a group of diseases that cause long-term inflammation and damage to the airways and lungs, leading to breathing difficulties). Record review of Resident #2's quarterly MDS dated [DATE] reflected, Resident #2's BIMS score was 11 (moderate cognitive impairment). Resident #2 was impaired on both upper and lower extremities. Record review of Resident #2's progress notes dated 02/03/2025 at 23:16 p.m., revealed in part Staff detected a strong smoke odor from resident's room. Asked if he had been smoking and flatly denied hadn't smoked in his room and that he did not have anything with him. Staff searched drawers and found drug paraphernalia, removed from room. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/30/2025 at 11:45 a.m., LVN C said she was walking down the 100 hallway and detected a strong smoke odor from Resident #2's room. LVN C said that she asked resident if he had been smoking and resident denied been smoking in his room. LVN C said that she searched the room and found drug paraphernalia (refers to any equipment used for producing, concealing, or consuming illicit drugs. This includes items like bongs, roach clips, miniature spoons, and various types of pipes. In general, paraphernalia are the tools, accessories, or objects associated with a particular activity or lifestyle) and immediately removed it from room. LVN C said that she reported to the ADON. During an interview on 3/30/35 at 12:50p.m., ADON said that LVN C called her and told her about the incident with Resident #2. ADON said that she went into the facility and notify the Administrator. ADON said that the drug paraphernalia was removed from room by LVN C. ADON said that she notified the police, and asked the resident who gave the drug paraphernalia to him. ADON said that resident did not say where he got the drug paraphernalia from. During an interview on 03/30/2025 at 1:15 p.m., the DON said that was not reported to the State Agency because there was not a negative outcome and was not related to abuse and neglect. An interview on 01/10/2024 at 4:34 p.m., the Administrator said he had been informed by LVN C Resident #2's drug paraphernalia found on his room. The administrator said that he did not report it. The administrator said that to his knowledge was not supposed to be report it because that incident was not related to abuse or neglect. Record review of facility's policy on Abuse, Neglect and Exploitation dated 4/2021 reflected: Policy: Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. 9. Investigate and report any allegations within time frames required by federal requirements.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50487 Based on observation, interview, and record review, the facility failed to ensure residents received adequate supervision and assistance devices to prevent accidents for 1 of 4 residents reviewed for accidents. (Resident #3) The facility did not ensure Resident # 3's smoking supplies were stored at Nurses' station. This failure could place 4 residents who require supervision, at risk for a decreased quality of life or injury that could lead to an unnecessary hospitalization . Findings included: Record review of Resident #3's face sheet dated indicated Resident #3 was [AGE] years old male and admitted on [DATE] diagnoses of type 2 diabetes (the most common form of diabetes, characterized by the body's inability to use insulin properly, leading to high blood sugar levels, and often requiring lifestyle changes medication, or insulin injections to manage), anxiety disorder (a mental health condition characterized by persistent and excessive fear or worry that interferes with daily life, often accompanied by physical symptoms like a rapid heartbeat or sweating), nicotine dependence (a chronic condition characterized by compulsive and persistent need for nicotine, the addictive substance found in tobacco products). Record review of Resident #3's care plan dated 8/12/23 indicated Resident #3 was a smoker with interventions of the resident's smoking supplies are stored at nurses' station. Record review of Resident #3's MDS dated [DATE] revealed Resident #3's BIMS score of 14 (intact cognition). Observation conducted on 3/31/25 at 8:00 a.m. revealed Resident #3 was observed in the parking lot smoking and had a box of cigarettes and a lighter. During an interview on 3/31/25 at 8:00 a.m. with Resident #3 who stated she was outside smoking and that he forgot to give the cigarettes to the CNA D the night prior and he kept the cigarettes with him. During an interview on 3/31/25 at 9:03am with CNA D stated that she took residents to the designated area for smoking on 3/30/25 at 9:00pm. CNA D stated that she grabbed the cigarettes from the nurses' station. CNA D stated that she did not see that Resident #3 had a box of cigarettes and that she did not give the box to him. CNA D said that after residents were done smoking, she took the cigarettes back to the nurses' station. CNA D stated that resident was not supposed to keep the cigarettes and lighter with him was because he could cause a fire. During an interview on 3/31/25 at 10:00 am with the DON stated Resident #3 knew that for safety reasons he was supposed to give the cigarettes to the nurse when he came back from smoking. DON stated that a negative outcome was that resident could start a fire inside the facility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/31/25 at 11:10 a.m. with the Administrator stated resident signed out and that was why Resident #3 was smoking in the parking lot. The administrator stated this resident had a BIMS of 14 and he was his own responsible party. The administrator stated that he did not know where the resident got the cigarettes from and did not know why the resident did not give the cigarettes to the nurse. The administrator said that the negative outcome could be that resident could cause a fire in the facility. Record review of facility's policy on Smoking reflected: This facility has established and maintains safe resident smoking practices. 15. Residents without independent smoking privileges may not have or keep any smoking items, including cigarettes, tobacco, etc., except under direct supervision.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50487 Based on interview and record review the facility failed to maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this was not possible or resident preferences indicate otherwise for 1 of 17 residents reviewed for nutritional status (Resident #1). The facility failed to ensure Resident #1 did not have a significant weight loss in 3 months. The facility failed to follow the dietitian recommendations to Resident #1 who had experienced significant weight loss. These failures could place residents at risk for malnourishment, illness, skin breakdown, and decreased quality of life. Findings included: Record review of a face sheet dated 3/29/2025 indicated Resident #1 was a [AGE] year-old male who was initially admitted on [DATE] and readmitted on [DATE] with the diagnoses of bipolar disorder, current episode manic severe with psychotic features (a chronic mental health condition characterized by extreme mood swings between periods of mania (elevated mood) and depression), unspecific protein-calorie malnutrition (is the state of inadequate intake of food (as a source of protein, calories, and other essential nutrients) occurring in the absence of significant inflammation, injury, or another condition that elicits a systemic inflammatory response). Record review of the comprehensive care plan dated 7/2/2024 indicated Resident #1 was at risk for nutritional deficit related to dysphagia following a stroke, diabetes, malnutrition, mechanically altered diet. The goal was Resident #1 The resident will maintain adequate nutritional status as evidenced by maintaining weight, no signs and symptoms of malnutrition through review date. The interventions included to monitor/record/report to physician as needed signs and symptoms of malnutrition, double portion, med pass 120mililliters after meals for supplement for 30 days. Record review of an admission MDS dated [DATE] indicated Resident #1 BIMS score was not indicated. The MDS indicated Resident #1 had weight loss of 5% or more in the las 6 months. The MDS indicated Resident #1's height was 69 inches, and his weight was 119 pounds. Record review of the physician orders dated 3/29/2025 indicated Resident #1 ordered at limited concentrated sweets mechanical soft diet with double portions on 12/27/2024. The physician orders indicated on 12/27/2024 Resident #1's diet reflected with an added snack in between meals three times per day for supplement and med plus 2.0 after meals for wight loss. Record review of the computerized weights on 3/28/2025 - 3/29/2025 indicated on 3/28/2025 Resident #1's weight was 109.0 and on 12/29/2024 his weight was documented as 119.0. The computerized system had no other weights documented. The weight loss was noted at 10 pounds lost, which was -8.40% weight loss in 3 months. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Nutrition-Amount Eaten dated 3/29/2025 indicated: 3/24/2025 breakfast eaten was 76%-100% 3/24/2025 lunch eaten was 76%-100% 3/24/2025 dinner eaten was 76% -100% 3/25/2025 breakfast eaten was 76%-100% 3/25/2025 lunch eaten was 76%-100% 3/25/2025 dinner eaten was 76% -100% 3/26/2025 breakfast eaten was 76%-100% 3/26/2025 lunch eaten was 76%-100% 3/26/2025 dinner eaten was 76% -100% 3/27/2025 breakfast eaten was 76%-100% 3/27/2025 lunch eaten was 76%-100% 3/27/2025 dinner eaten was 76% -100% 3/28/2025 breakfast eaten was 76%-100% 3/28/2025 lunch eaten was 76%-100% 3/28/2025 dinner eaten was 76% -100% 3/29/2025 breakfast eaten was 76%-100% 3/29/2025 lunch eaten was 76%-100% 3/29/2025 dinner eaten was 76% -100% Record review of a Nutritional Recommendation to Physician dated 1/16/2025 indicated the physician agreed to the Nutritional Recommendation. Resident #1's nutritional assessment indicated he had a significant weight loss change, and she recommended to add multivitamin with minerals and fortified cereal. During an interview on 03/29/25 at 11:00 AM, the Dietitian stated that orders come direct from doctor. She further stated I just came to the facility on [DATE]. Dietitian stated if there were issues with a resident, staff would call for a consult on admission. Yes, someone with supplements and still losing weight should be evaluated promptly . (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/29/25 at 2:45pm with LVN A stated that he was able to have the new dietitian to add a multivitamin and fortified cereal, recommendations for Resident #1. LVN said that he reported the Dietitian recommendations to the FNP and that FNP agreed with the dietitian recommendations. LVN A stated that he thought he carried out the orders from the FNP. LVN said that he forgot to put in the new order to the Point Click Care System (electronic medication record). LVN A stated he did not know how he missed the new orders. During an interview on 3/29/25 at 3:00pm with FNP who stated that he was Resident #1 was losing weight. FNP stated that resident was on supplements and that he worked with the dietitian and followed with her recommendations. FNP stated that Resident #1 was taking anti-psychotropic medication, and these medications could cause weight loss. During an interview on 3/30/2025 at 2:33 p.m., the DON said he was not the DON when Resident #1 was readmitted in the facility. The DON said weights should be monitored weekly and interventions implemented when weights start declining. The DON said weights were monitored in the standards of care meetings. DON stated he was going to arrange a care plan meeting with the family and that he would start with that. Record Review of the Nutritional Assessment, Revised date 10/2017, read in part as part of the comprehensive assessment, a nutritional assessment, including current nutritional status and risk factor for impaired nutrition, shall be conducted for each resident. Once current conditions and risk factors for impaired nutritional are assessed and analyzed, individual care plans will be developed that address or minimize to the extent possible the resident's risks for nutritional complications. Such interventions will be developed within the context of the resident's prognosis and personal preferences. Record Review of the Medication and Treatment Orders, Revision date 7/2016, read in part orders for medications and treatments will be consistent with principles of safe and effective order writing. Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state.