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	04/17/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47828 Based on interview, and record review the facility failed to ensure residents had the right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely for 4 of 10 (Resident #3, Resident #4, Resident #5, and Resident #6)) residents reviewed for environment. 1.The facility failed to ensure Resident #3's room was thoroughly cleaned, the walls and in good condition. 2.The facility failed to ensure Resident #4's room was thoroughly cleaned, and in good condition. 3.The facility failed to ensure Resident #5's room was thoroughly cleaned; and in good condition; and had privacy from the outside. 4.The facility failed to ensure Resident #6's door to bathroom did not have a hole and walls were painted and free from black spots. These failures could place residents at risk of living in an unsafe, unclean, and unsanitary environment which could lead to a decreased quality of life. The findings included: 1.Record review of Resident #3's admission record, dated 04/17/25, reflected an [AGE] year-old male admitted to facility on 12/09/24. His relevant diagnoses included dementia (brain disorders that cause a gradual decline in cognitive abilities, such as memory, thinking, and reasoning) and cognitive communication disorder (communication impairment where difficulties arise due to problems with cognitive processes, rather than speech or language production itself). Record review of Resident #3's quarterly MDS assessment dated [DATE] reflected his BIMS score was 11, which indicated his cognition was moderately impaired. Record review of Resident #3's quarterly care plan dated 03/17/25 reflected Resident #3 resided in the secured unit related to his diagnosis of dementia, his interventions in part were to monitor for safety every 2 hours. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation of Resident #3's room on 04/15/25 at 12:46 p.m., reflected the following: the sink was missing the hot water knob, sink was cracked in the center, the area where the sharp dispenser was removed was left unpainted with four round holes on the wall, the bathroom door had a hole and paint was chipped and scuffed, brown sticky substances were on the corners of the floor. 2. Record review of Resident #4's admission record, dated 04/17/25, reflected a [AGE] year-old male admitted to facility on 07/15/24. His relevant diagnoses included encephalopathy (disease of the brain, often involving alterations in brain structure or function), schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly) and bipolar disorder (a mental illness characterized by extreme and persistent shifts in mood, energy, and activity levels). Record review of Resident #4's quarterly MDS assessment dated [DATE] reflected his BIMS score was 09, which indicated his cognition was moderately impaired. Record review of Resident #4's quarterly care plan dated 03/08/25 reflected: He resided in the memory unit due to his exit seeking behavior, interventions in part included to maintain his safety. He had a behavior problem/hygienic, the goal was to have Resident #6 live in clean condition through next review (date initiated 03/11/25) His interventions in part included to have dispatched to his room prn, housekeeping would round more often during the day and would clean his room before they left for the day, and staff would assist to keep his room clean for hygienic purposes throughout the day. During an observation of Resident #4's room on 04/15/25 at 12:51 p.m., reflected the following: four rubber gloves tied to the a/c vent, broken ceiling tiles throughout the room, horizontal blinds had broken and missing slats, soiled toilet paper on the bathroom floor next to trashcan, food particles on his chair, floor and mattress. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.Record review of Resident #5's admission record, dated 04/15/25 reflected a [AGE] year-old male admitted to facility on 12/27/24 and an original admitted [DATE]. His relevant diagnoses included encephalopathy (disease of the brain, often involving alterations in brain structure or function), and bipolar disorder (a mental illness characterized by extreme and persistent shifts in mood, energy, and activity levels). Record review of Resident #5's quarterly MDS assessment dated [DATE] reflected his BIMS score was 00, which indicated his cognition was severely impaired. Record review of Resident #5's quarterly care plan dated 04/01/25 reflected: He was an elopement risk/wanderer related encephalopathy, interventions in part included to be housed in the memory unit. He preferred to lay on the floor, his interventions in part included to keep floor clean. During an observation of Resident #5's room on 04/15/25 at 1:00 p.m., reflected the following: a hospital bed with no mattress on A side, a mattress was on the floor with floor mats on each side on B side, the window had no blinds for privacy, the privacy curtain had the call light tied around it and laying on top of the overhead light on A side, the bed pad had a brown stain, closet door was ajar and unable to completely close, there were holes on the wall, bathroom door paint was chipped and scuffed, and Mutiple food particles on the floor. 4. Record review of Resident #6's admission record dated 04/15/25 reflected a [AGE] year-old female admitted to facility on 09/24/24 and an original admitted [DATE]. Her relevant diagnoses included dementia (brain disorders that cause a gradual decline in cognitive abilities, such as memory, thinking, and reasoning) and schizoaffective disorders (a mental health condition including schizophrenia and mood disorder symptoms). Record review of Resident #6's quarterly MDS assessment dated [DATE] reflected her BIMS score was 01, which indicated her cognition was severely impaired. Record review of Resident #6's quarterly care plan dated 03/20/25 reflected she resided in the memory unit due to her diagnosis of dementia. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation of Resident #6's room on 04/15/25 at 1:19 p.m., reflected the following: unpainted area where the sink used to be that had multiple black spots, and the bathroom door had a hole. During an interview on 04/15/25 at 1:20 p.m., Resident #6 said she had not had a mirror over her sink in a long time. She said she would like a mirror so she could see herself when she washed her hands. In an interview on 04/15/25 at 1:45 p.m., CNA H said Residents #3, #4, #5, and #6 was 1 of 2 resided on one of the memory units. He said Resident #4 and Resident #5 had destroyed furniture, fixtures and would throw things on the floor constantly. He said Resident #3 was bed bound and did not use the sink. CNA H said he was not aware Resident #6 was missing the mirror that was over her sink. CNA H said he knew Resident #5 did not have a blind on his window. He said Resident #5 would destroy the blinds as soon as they were replaced. He said for incontinent care, Resident #5 would be changed to the restroom because he had no privacy in the area where his mattress was. CNA H said it was the responsibility of the housekeeping department to clean the resident rooms. He said if he noticed a resident's room needed to be cleaned, he would call housekeeping. CNA H said the housekeeper had not gone to Hall 100 yet that day, he said they would usually go towards the end of the shift which was between 2:00 and 2:30 p.m. He said they would only go 1 time a day. CNA H said he had notified his charge nurse and the Maintenance Supervisor that there were some rooms with broken ceiling tiles, holes in the walls, and blinds missing. In an interview on 04/15/25 at 1:50 p.m., CNA J said she said she was aware Resident #3, #4, and #5 rooms needed to be cleaned and maintained, she said she had informed her charge nurse and the Maintenance Supervisor several times. She said Resident #3 was bed bound and would not use the sink. She said the facility had recently discharged a resident who resided in that hall that caused a lot of damage to the rooms. She said he would wander into Resident #3's room and would peel the paint off, break furniture, and would throw things on the floor. CNA J said Resident #4 liked to throw things on the floor and destroy the blinds. She said she was aware Resident #5 did not have a window blind. She said he would destroy it as soon it was replaced. She said during peri-care Resident #5 would be taken to the restroom. She said she was not aware there were food particles on the floor in Resident #5's room. She said he liked to crawl on the floor and a negative outcome could be that he would put the food particles in his mouth. She said she was not aware Resident #6 was missing the mirror that was above her sink. In an observation and interview on 04/15/25 at 2:01 p.m., the housekeeper said his shift had started at 7:00 a.m. on 04/15/25 and he had not yet cleaned the memory unit. He said he was not aware Resident #3's room needed to be cleaned. He said Resident #4 and #5 liked to throw food, wrappers, and toilet paper on the floor. He said it was his responsibility to ensure the resident rooms were cleaned daily and as needed. He said Hall 100 was the last hall he cleaned before his shift ended and said it was between 2:00 and 2:30 p.m. He said the residents in the secure unit make a lot of mess. He said it was too much for one person to clean but had not complained in fear that he would be terminated. He was observed as he inspected Resident #3, #4, #5 room and he said he had not been informed those room needed to be cleaned. He said the he cleaned the rooms one time a day unless staff would notified him it needed to be cleaned prn. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/15/25 at 2:17 p.m., the Maintenance Supervisor said he oversaw the maintenance and housekeeping departments. He said the facility had 5 housekeepers and each was assigned to different areas. He said Hall 100 (memory unit) was the last hall to be cleaned for the day. He accused a resident who had recently been discharged from the memory unit of destroying the ceiling tiles, broken fixtures, chipped walls and making holes in the walls. He said he had not been notified Resident #3, #4, #5's rooms needed to be cleaned. He said he would walk each hall daily and had not noticed anything broken. He was not able to say if there were any negative outcome to Resident #3, #4, #5 for not having their room clean and living in a room that was maintained. He said he had not noticed Resident #6's mirror was missing and said the black spots on the wall was humidity. In an observation and interview on 04/15/25 at 2:27 p.m., the Administrator said he was shocked to see Resident #3, #4, #5 and #6 rooms dirty and with furniture/fixtures/walls that needed repair. He said it was a known problem that some residents would break their blinds as soon as they were replaced. He said he was working on a plan to replace all the window blinds in Hall 100 (memory unit) with solar screens soon. He said it was the responsibility of all staff that entered the Hall 100 memory unit to ensure the resident's room was clean. He said a negative outcome for having broken ceiling tiles could be that they could fall on the residents. He was not able to say what the negative outcome of not having a clean room would be for the residents. Record review of the facility's work orders from January 2025 to April 2025 reflected no orders for blinds, holes in the wall or fixtures for Hall 100 memory unit. Record review of the facility's Resident Environment Quality policy not dated reflected: It is the policy of this facility to be designed, constructed, equipped, and maintained to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. Policy Explanation and Compliance guidelines: 4. Resident rooms must be designed and equipped for adequate nursing care, comfort, privacy of residents: d. Be designed or equipped to assure full visual privacy for each resident. 5. The facility must provide each resident with: d. Functional furniture appropriate to the resident's needs . General Guidelines: 1. Preventive maintenance schedules, for the maintenance of the building and equipment, should be followed to maintain a safe environment. 12. All facility personnel are responsible for reporting broken, defective or malfunctioning equipment or furnishings immediately upon identification of the issue.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 48278 Based on observation, interview, and record review, the facility failed to ensure adequate supervision was provided for 1 of 3 residents reviewed for accidents and supervision. (Resident #1) The facility failed to ensure Resident#1 received adequate supervision to prevent elopement. Resident #1 eloped from the facility on 04/12/2024 and was found by the police department approximately 4.3 miles away from the facility. The non-compliance was identified as past non-compliance. The Immediate Jeopardy began on 04/12/2024 and ended on 04/25/2024. The facility had corrected the noncompliance before the survey began. This failure could prevent residents from receiving appropriate supervision which could lead to residents sustaining serious injury, harm, or death. Findings included: Record review of Resident #1's electronic facility face sheet dated 04/15/2025, revealed he was a [AGE] year-old male admitted to the facility on [DATE]. Diagnosis of Dementia, Schizophrenia (a mental condition that affects how people think, feel and behave), Alzheimer's Disease (a brain disorder that slowly destroys memory and thinking), Psychosis (when people lose some contact with reality), Muscle Weakness (loss of muscle tissue), Malnutrition (poor nutrition), and Lack of Coordination. Record review of Resident #1's quarterly MDS assessment, dated 01/20/2025 revealed a BIMS score of 02 indicating Resident #1 was severely cognitive impaired and ambulates independently. No mobilities devices needed. Record review of admission progress note dated 04/01/2024, revealed the report received from hospital nurse stated Resident #1 was found wandering streets and he had been trying to elope from home and ER. Resident #1 was admitted to the secured unit. Record review of incident report dated 04/13/2024, revealed on 04/12/24 at around 06:00 pm Resident #1 eloped from their facility. Staff found out after a change of shift, past 07:00pm. LVN A notified DON E. He then called the Administrator. ADON F called the police, started a case, and shared Resident #1's picture. The administrator sent a flyer for a Silver Alert to the PD. Resident #1 was found around 09:00 pm at a gas station approximately 4.3 miles away from the facility. DON E picked up Resident #1 and brought him back safe to their facility. Resident #1 was in good spirits; no injuries found during the head-to-toe assessment. Family and doctor were notified. Record Review of CNA B written statement for incident on 04/12/2024 indicated that around 04:45-05:00 p. m. Resident #1 came up to her and asked if he could look in a bag. After CNA B went to get residents to go to the dining room and later provided incontinent care. CNA B noticed an alarm sound. She opened the room door to check, and it was the alarm from the back door. She proceeded to turn the alarm off. CNA B thought someone forgot to turn it off when they came in. She did not think of anything afterwards. (continued on next page)

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Record Review of facility incident report revealed CNA B was terminated 4/17/24. Surveyor attempted to interview CNA B on 04/15/2025 at 01:53 p.m. CNA B did not answer, left voicemail to return call. In an interview on 04/15/2025 at 02:45pm with LVN A stated Resident #1 was last seen at approximately 05:00 p.m. when CNA B was getting residents ready for dinner. LVN A stated he noticed Resident #1 was not in his room during shift change at approximately 07:00 p.m. He said he called DON E and started a search with staff. Then other staff started the elopement protocol. LVN A stated Resident #1 came back to the facility at approximately 09:00 p.m. and Resident #1's family member was present at the facility at this time. In an interview on 04/15/2025 at 04:30pm with DON E stated Resident #1 was missing for about 1-1.5 hours. He notified the family and doctor. DON E stated that all staff were looking for Resident #1. He stated that CNA B was performing patient care and turned off the alarm without checking with anyone if a resident was missing. DON E stated CNA B was terminated for not following elopement protocol. He stated PD gave Resident #1 a ride to a convenient store approximately 4.3 miles away. DON E said PD who gave him a ride notified facility after hearing the Silver Alert at around 09:00 pm. He said PD told them of Resident #1's location. DON E picked him up and took him back to the facility. He stated resident was placed on a 15-minute visual checks by nurse and the code was changed to the secure unit doors. DON E stated he a wander guard was placed, and medications were reviewed. DON E stated that the facility added a camera with motion detection on the back door and a fence to the back. DON E stated that the staff had elopement in-services and drills weekly. Staff had elopement in-services and drills. In an interview on 04/16/2025 at 09:23am with Administrator stated Resident #1 probably went out through the back door. The administrator said the exit door had a code and CNA B did not follow procedure. CNA B turned the alarm off and failed to notify the nurse. This was around 05:45pm. CNA B shift change came in at 06:00 p.m. and noticed that Resident #1 was missing. The administrator stated the resident was missing for less than 2 hours. Resident #1 was returned to the facility around 09:00 p.m. He stated the code was changed to the secure unit doors, added a camera with motion detection on the back door, and a fence to the back of the facility. He stated CNA B was terminated. The administrator stated there has been no elopements since the incident on 04/12/2024. Record review of an Elopement Policy with date of 10/2023, revealed Policy: It is the policy of this facility to ensure that the facility provides a safe and secure atmosphere for all residents in the facility. Purpose: To ensure that residents a risk for elopement are properly monitored. The Administrator was notified on 04/16/2025 at 02:21 p.m., that a past noncompliance Immediate Jeopardy situation had been identified due to the above failures. It was determined these failures placed Resident #1 in an Immediate Jeopardy situation on 04/12/2024. The facility had implemented the following interventions: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident was placed on a 15-minute visual checks by nurse for 72 hours. Wander guard. Code changed to the Secure Unit Doors. Added a camera with motion detection on the back door. Added a fence to the back of the facility for an extra layer of security. Staff were trained in elopement/supervision procedures on 04/17/2024 and 04/25/2024. The care plan was updated on 04/12/2024 to include a wander guard and medications were reviewed. During an observation on 04/15/2025 at 5:05 p.m. revealed the cameras on the back door and the fence in the back area of the facility. Record review of an In-Service Attendance Record with subject of Elopement Drill and procedure, dated 04/17/2024 and 04/25/2024, indicated that staff signed the in-service record. In interviews on 04/15/2025 at 04:00 p.m. - 04/17/2025 at 09:58 a.m., 4 CNAs from different shifts were able to identify residents at risk for elopement, she was knowledgeable of the elopement policy and procedure. They were aware of the expectations of not turning off the alarm without notifying the nurse immediately. In interviews on 04/15/2025 from 02:45 p.m. - 04/17/2025 10:09 a.m., 5 LVNs from different shifts were able to identify residents at risk for elopement, all were knowledgeable of the elopement policy and procedure. The non-compliance was identified as past non-compliance. The Immediate Jeopardy began on 04/12/2024 and ended on 04/25/2024. The facility had corrected the noncompliance before the survey began.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50487 Based on observation, interview, and record review, the facility failed to ensure residents who were fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding, for one Resident (Resident #2) of two residents reviewed for feeding tubes, in that: Certified Nurse Aide (CNA) C was not competent in and did not follow facility protocols regarding feeding tube nutrition and care. CNA A adjusted Resident #2's feeding pump while providing Resident #2 with incontinent care. This failure could place residents with feeding tubes at risk for reflux, aspiration, nausea, vomiting, cramps, or diarrhea. Findings included: Review of Resident #2's Face sheet dated 4/17/25 revealed age [AGE] year-old female admitted on [DATE] with the diagnosis gastrostomy (opening in the stomach for food status. Record Review of Resident #2's Care plan dated 3/12/21 revealed: The resident requires tube feeding related to dysphagia and history of swallowing problem. Date initiated 3/25/24. Goal: The resident will remain free of aspiration through the review date. Interventions: Monitor/document/report PRN any signs and symptoms of: Aspiration- fever, Shortness of breath, Tube dislodged, Infection at tube site, Self-extubation, Tube dysfunction or malfunction, Abnormal breath/lung sounds, Abnormal lab values, Abdominal pain, distension, tenderness, Constipation or fecal impaction, Diarrhea, Nausea/vomiting, Dehydration. Record Review of Resident #2's Minimum Data Set, dated dated dated [DATE] revealed: BIMS: 99 the resident was unable to complete the interview. Cognitive skills for daily decision making - severely impaired. Toilet use requires total dependence, two persons physical assist. Personal Hygiene- how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (excludes baths and showers) requires total dependence, one persons physical assist. Nutritional Approaches - feeding tube while a resident During an observation of care for Resident # 2 on 4/17/25 at 11:05 AM, walked into a room, CNA C and CNA D were rendering incontinent care to Resident #2 . The resident's head was lowered; the feeding machine was on hold. After, CNA C and Nurse aide D changed the resident, CNA C pushed a button on the feeding pump to start the feeding. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with CNA C on 4/17/25 at 11:25 AM, she revealed the facility and charge nurses did not allow CNAs to pause or run the resident's feeding machines when they needed to provide care. She revealed she would have a nurse with her at times and when the nurse was there, the nurse would pause or stop the g-tube feeding pump but usually the CNA's just pause it to provide care. She stated, CNAs were not allowed to turn off and turn on the pumps but I did it because did not see any nurse close. CNA C said that she was not properly trained on feeding pumps. During an interview with CNA D on 4/17/25 at 11:30 AM revealed while CNAs were in the resident's room to provide care, CNAs were not allowed to pause G-tube feeding machines. CNA D said that she was not properly trained on feeding pumps. She revealed she would have a nurse with her at times and when the nurse was there, the nurse would pause or stop the g-tube feeding pump but sometimes CNAs paused the feeding pumps when providing care. During an interview with LVN G on 4/17/25 at 11:35 AM revealed she paused the g-tube feeding machines before CNAs provide care or lowering the head of the bed. She said CNAs were not supposed to pause the feeding machine because was not under their scope of practice. LVN G said that CNAs did not call her to pause or restart the feeding machine. LVN G said that CNAs could forget to start the feeding machine, and the resident would not get the nutrients needed. During an interview with DON on 4/17/25 at 11:45 AM it was revealed CNAs were not supposed to pause, stop, or turn on feeding machines. He stated, they were to call a charge nurse that was licensed to do it before providing care. He revealed it was not within the CNAs scope of practice. When care needed to be provided to a g-tube resident, and they needed the feeding paused the CNAs should get a nurse to assist them. He revealed the importance of getting a charge nurse to assist the CNAs in handling feeding machines, was because it was not in the CNAs scope of practice. DON said that was not able to find a policy indicating to stop or start feeding machines by CNAs. Record review of CNA job description for dated March 2024 documented no skills for pausing or adjusting feeding tubes. Record review of the facility's Enteral feedings, safety precautions policy and procedure dated 11/18, revealed: To ensure the safe administration of enteral nutrition