

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455423	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2025
NAME OF PROVIDER OR SUPPLIER Mesa Hills Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. (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 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to coordinate assessments with the PASRR program, including incorporating the recommendations from the PASRR level II determination and the PASRR evaluation report into a resident's care planning for two (Resident #1 and Resident #2) of seventeen residents positive for PASRR. The facility failed to ensure the service request form was sent to the state PASRR unit, within 30 days of the IDT meeting, to assist Resident #1 and Resident #2 with receiving services identified in the meeting plan. This failure could affect PASRR positive residents by placing them at risk of their specialized needs not being met. Findings included: 1. Review of Resident #1's Resident Face Sheet dated 7/16/25, reflected he was a [AGE] year-old female who admitted to the facility 10/8/24. She was diagnosed with bipolar disorder (a mental health condition characterized by extreme shifts in mood, energy, and activity levels, alternating between periods of mania or hypomania and depression), anxiety disorder (a group of mental health conditions characterized by excessive, persistent, and uncontrollable feelings of worry, fear, and unease), severe intellectual disabilities (a condition that limits intelligence and disrupts abilities necessary for living independently). Review of Resident #1's care plan dated 10/9/24 reflected he required total care, and 1-2 person assists with all ADLs including bed mobility, transfers, dressing, eating, toileting, hygiene, and bathing. Record review of Resident #1 PASRR evaluation revealed: Positive pasarr evaluation done on 10/21/24 from tropical. PASRR comprehensive service plan form done on 4/29/25 revealed initial spt meeting took place at mesa hill for [NAME], services agreed to ILST, HC and habilitative physical and occupational therapy. No needs identify for behavioral supports, employment assistance supported employment, day habilitation. 2. Review of Resident #2's Resident Face Sheet dated 7/17/25, reflected he was a [AGE] year-old female who admitted to the facility 3/11/24. She was diagnosed with bipolar disorder (a mental health condition characterized by extreme shifts in mood, energy, and activity levels, alternating between periods of mania or hypomania and depression), severe intellectual disabilities (a condition that limits intelligence and disrupts abilities necessary for living independently). Review of Resident #2's care plan dated 3/11/24 reflected he required total care and 1-2 person assists with all ADLs including bed mobility, transfers, dressing, eating, toileting, hygiene, and bathing. Record Review of Resident #2 PASRR evaluation revealed: Pasarr evaluation was done on 4/11/24. The outcome resident had a negative pasrr evaluation. On 6/26/24. Resident was positive pasrr evaluation. The initial meeting was 7/9/24 and the recommendation was ILST OT PT and ST. During an observation on 7/16/25 at 3:00 p.m. Resident #1 was not able to communicate. During an observation on 7/16/25 at 3:05 p.m. Resident #2 was not able to communicate. During an interview on 7/16/25 at 3:20 p.m. MDS Nurse A said she was responsible for submitting PASRR specialized services through the Simple Online Portal, but that she was not working in the facility when Resident #1 and Resident #2 were admitted to the facility. MDS Nurse A said that there was a 30 days' time frame for submitting the PASRR recommendations from the Interdisciplinary Team from the first meeting. MDS Nurse A said that Resident #1 and Resident #2 were receiving physical and occupational therapy thru Medicare part B but not thru PASRR. During an interview on 7/17/25 at 1:00pm the ADON said that what she knew about PASRR was that the residents must come with a PASRR level I from the hospital and if the PASRR is positive the MDS nurse has to report it to the specialized services. The ADON said that the negative outcome was that the residents were not receiving the PASRR benefits. During an interview on 7/17/25 at 3:42pm the DON said that he was not that familiar with the PASRR, but as a DON he knew that when there was a resident with positive PASRR the facility had to report it within a time frame, but he was not sure what the time frame was. The DON said that what he knew was that all positives and negatives needed to be report it to the state. The DON said that the negative outcome was that the residents were not receiving the PASRR benefits. During an interview on 07/17/25 at 4:40 PM the Administrator said the facility was deficient and had not submitted the necessary forms to the state in order for the resident to receive specialized services agreed upon in the IDT meeting for Resident #1 and Resident #2. Record Review of facility policy titled PASRR pre-admission screening & resident review) undated revealed: To ensure each patient in the facility is screened for a mental disorder or intellectual disability prior to admission and that individuals with mental disorder or intellectual disability are evaluated and receive care and services in the most integrated setting appropriate to their needs</p>		