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	04/10/2026

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement written policies and procedures to report and investigate abuse of residents for 2 of 4 residents (Resident #1 and Resident #2) reviewed for incident reporting and investigating. The facility failed to follow their abuse policy when they did not report and have evidence of a thorough investigation of an allegation of abuse when Resident #1 hit Resident #2 on 04/03/26. The facility failed to follow their abuse policy when they did not report and have evidence of a thorough investigation of an allegation of abuse when Resident #1 alleged a doctor or the DON hit his left leg on the bed frame on 04/03/26, resulting in a 1 centimeter skin tear. These failures could place residents at risk of abuse and/or continued abuse and could lead to a diminished quality of life and psychosocial harm. Findings included: 1. Record review of Resident #1's face sheet, dated 04/09/26, reflected a [AGE] year-old male, admitted on [DATE], diagnoses included: type 2 diabetes (high levels of sugar in blood), osteoporosis (weak and fragile bones), hepatic encephalopathy (brain dysfunction caused by liver failure), alcoholic cirrhosis of the liver (advanced scarring of the liver caused by long-term alcohol use), major depressive disorder (mental health condition with persistent feelings of sadness, loss of interest, various emotional/physical problems), adult failure to thrive (syndrome of weight loss, decreased appetite, functional decline, and social withdrawal), and personal history of other mental and behavioral disorders. Record review of Resident #1's MDS, dated [DATE], reflected a BIMS score of 12, indicating moderate cognitive impairment. The MDS reflected Resident #1 had no physical or verbal behavioral symptoms directed towards others. Record review of Resident #1's care plan, dated 04/09/26, reflected [Resident #1] was physically aggressive related to anger and poor impulse control. Date initiated: 03/03/26. Revised: 04/07/26. Interventions included when the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. Date initiated: 03/03/26. [Resident #1] has a behavior problem related to MDD (resident will have verbal outburst with staff and other residents). Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Resident on 30 minute behavior log, monitor resident behavior and document as necessary. Date initiated: 04/07/26. Record review of Resident #1's progress notes, dated 04/03/26 at 8:38 AM, revealed, [LVN A] witnessed [Resident #1] starting to verbally and physically getting aggressive with [Resident #2]. Both residents next to portable coffee stand. [Resident #1] was getting coffee. [Resident #2] asked to get a cup of coffee and [Resident #1] started yelling derogatory words towards [Resident #2]. [Resident #2] defended himself. [Resident #1] got up and started swatting [Resident #2]. This nurse and staff attempted to redirect [Resident #1]. [Resident #1] refused and kept yelling. The DON, ADM, and NP made aware. Documented by LVN A. At 12:15 PM, revealed, [Resident #1] was redirected to his room by the DON. While taking [Resident #1] back to his room, he was still yelling. Once inside his room [Resident #1] started throwing kicks and hit the frame of the bed with his left shin, as a result he had a skin tear about 1 cm long, edges well approximated. Documented by the DON. 2. Record review of Resident #2's face sheet, dated 04/09/26, reflected a (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
	455423	A. Building B. Wing	04/10/2026

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Mesa Hills Post Acute	901 Wildrose LN Brownsville, TX 78520

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[AGE] year-old male, admitted on [DATE], diagnoses included: type 2 diabetes (high levels of sugar in blood), major depressive disorder (mental health condition with persistent feelings of sadness, loss of interest, various emotional/physical problems), and unspecified dementia (decline in cognitive function, affecting memory, thinking, behavior, and ability to perform everyday activities). Record review of Resident #2's MDS, dated [DATE], reflected a BIMS score of 8, indicating moderate cognitive impairment. The MDS reflected Resident #2 had no physical or verbal behavioral symptoms directed towards others. Record review of Resident #2's care plan, dated 04/09/26, reflected [Resident #2] had impaired cognitive function/dementia or impaired thought processes related to dementia. Date initiated: 03/03/26. Record review of Resident #2's progress note, dated 04/03/26 at 2:49 PM, revealed Gave report to charge nurse of 100 hall (room change). Resident at this time has no acute distress noted and no abnormalities. Plan of care ongoing. Documented by LVN A. During an interview and observation, on 04/09/26 at 10:00 AM, Resident #1 did not wish to speak. Resident #1 was observed self-propelling in his wheelchair in the hallways and then went outside. Resident #1 had a bandage on his left shin area. During an interview, on 04/09/26 at 1:10 PM, CNA B stated she witnessed Resident #1 become aggressive towards Resident #2 when they were getting coffee. CNA B stated she assisted LVN A to intervene but Resident #1 was able to sort of push Resident #2 on his chest. CNA B stated they separated the residents and moved them away from each other. CNA B stated later on that day, Resident #1 was wheeled to his room by the DON. CNA B said she could see the doorway but did not see what happened inside the room. CNA B stated Resident #1 yelled and said he wanted the doctor to be arrested for abuse. CNA B stated Resident #1 was referring to the DON when he said the doctor. CNA B stated the ADM was aware of these incidents and spoke to the residents. During an interview, on 04/09/26 at 3:00 PM, MA D stated he saw when Resident #1 yelled at Resident #2 and called him names. MA D stated he intervened right away along with CNA B and LVN A. MA D stated later that day or the next day, Resident #1 had a bandage on his left shin area. MA D stated Resident #1 told him that he had a cut on his leg that he obtained when a doctor rolled him in a chair and banged him on the bed. MA D stated he told LVN A about what Resident #1 was saying but she was already aware because Resident #1 was telling everyone about that incident with the doctor. MA D stated the ADM already knew about what Resident #1 alleged about being banged on the bed by a doctor. During an interview, on 04/09/26 at 3:15 PM, LVN A stated on 04/03/26 in the morning, Resident #1 and Resident #2 were getting coffee and Resident #1 started cussing at Resident #2, saying that Resident #2 hated him. LVN A stated she tried to redirect them immediately and got in the middle of the residents. LVN A stated Resident #1 started swatting, trying to hit Resident #2. LVN A stated Resident #1 was able to hit Resident #2 on the arm even though she was in between them. LVN A stated she moved her arms higher so Resident #1 could not reach Resident #2 again. LVN A stated MA D and CNA B moved the residents away. LVN A stated Resident #1 and Resident #2 were not injured from the incident. LVN A stated the ADM was notified and he went to speak to the residents. LVN A stated later on that day, around lunch time, the DON took Resident #1 to his room. LVN A stated she saw the DON take Resident #1 to his room and walked away. LVN A stated she did not see the DON hurt Resident #1's leg or bang him into the bed. LVN A stated Resident #1 had a cut on his left shin after that and Resident #1 said that it was the doctor that hit him with the bed. LVN A stated there was no doctor in the facility and she did not know if Resident #1 meant the DON. LVN A stated Resident #1 had a skin tear on his left shin that was bleeding minimally and only required first aid. LVN A stated Resident #1 said that the doctor pushed him to the bed, the doctor hurt him, and that's how he got the skin tear on his leg. LVN A stated that incident was also reported to the ADM and the ADM spoke to Resident #1. During an interview, on 04/09/26 at 4:15 PM, the DON stated he was aware of the incident with Resident #1 and Resident #2 on 04/03/26 but he did not witness it. The DON stated as far as he knew, the staff intervened and separated the residents. The DON stated the residents did not hit or make any physical contact at all. The DON stated on 04/03/26 around lunch time, he wheeled Resident #1 to his room. The DON stated once in the room, Resident #1 (continued on next page)

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Mesa Hills Post Acute	901 Wildrose LN Brownsville, TX 78520

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	turned his wheelchair on his own and then said, Oh my leg, my leg. The DON stated Resident #1 had a skin tear on his left leg and blamed the DON. The DON stated Resident #1 said that he pushed him into the room and pushed him against the bed. The DON stated that did not happen as he only wheeled Resident #1 into his room and left him by the bed in front of the nightstand. The DON stated when Resident #1 turned himself in the wheelchair, Resident #1 had kicked his leg and that's when he said, My leg, my leg. The DON stated when Resident #1 blamed him, LVN A and the ADON arrived to the room. The DON stated the ADM was notified and the ADM spoke to Resident #1 on his own. The DON stated Resident #1 was changing his mind and going back and forth about what he was saying. The DON stated the ADM was the abuse coordinator and he determined if something was abuse or not. The DON stated the incident with Resident #1 and Resident #2, and the incident of Resident #1 alleging he caused the skin tear to his leg were not reported to the State Survey Agency. During an interview and observation, on 04/09/26 at 6:00 PM, Resident #2 stated he was doing well. Resident #2 stated he did not have any problems. Resident #2 stated he tried to be respectful and the staff treated him with the same respect. Resident #2 stated the staff provided him with anything he needed. Resident #2 did not recall the alleged incident with Resident #1 and did not know who Resident #1 was. Resident #2 was able to communicate his needs/wants. Resident #2 was not injured or in distress. During the interview, Resident #1 passed by Resident #2 and neither reacted to one another in any way. During an interview, on 04/10/26 at 10:00 AM, the ADON stated she went to Resident #1's room on 04/03/26 and the DON was in the room with LVN A and Resident #1. The ADON stated she saw Resident #1 had a skin tear on his leg and it was bleeding slightly, well approximated, where the skin flaps were together. The ADON stated Resident #1 calmed down and he allowed them to take care of the cut. The ADON stated Resident #1 said that the DON had taken him to his room and that he hit his leg. The ADON stated Resident #1 did not directly say that the DON hurt his leg as she understood it as Resident #1 hit his leg on his own. The ADON stated the ADM was notified either way and arrived to speak to Resident #1. During an interview, on 04/10/26 at 10:35 AM, the ADM stated on 04/03/26 in the morning, there was an incident where Resident #1 was yelling at Resident #2. The ADM stated he was not sure what was said but the staff intervened immediately and separated the residents. The ADM stated he did not witness the incident but from what staff told him, there was no physical contact between the residents. The ADM stated the staff did not tell him that Resident #1 hit or made any contact with Resident #2. The ADM stated if he had known that there was a physical altercation or that Resident #1 was able to hit Resident #2, he would have reported the incident to the State Survey Agency, even though there was no injury. The ADM stated he investigated the incident and based on what the staff said to him, he did not report it. The ADM stated the progress notes documented by LVN A reflected his investigation for the incident between Resident #1 and Resident #2. The ADM stated he interviewed staff and obtained their statements but he did not have records to show. The ADM stated the progress notes did not really show his investigation process. The ADM stated he had nothing else to show he thoroughly investigated. The ADM stated there was another incident that day on 04/03/26 where Resident #1 alleged the DON had hurt his leg. The ADM stated he arrived to Resident #1's room and asked the DON to step out. The ADM stated he tried to redirect Resident #1 to calm down so he could explain to him what happened. The ADM stated Resident #1's comments were back and forth. The ADM stated he asked Resident #1 if he wanted to call the police and he said no. The ADM stated he told Resident #1 that he needed to interview him, to assess if there was abuse or not, and that he had 2 hours to report. The ADM stated Resident #1 said to just let the time lapse, that he did not want to get anyone in trouble. The ADM stated he told Resident #1 he could not do that. The ADM stated Resident #1 said that the DON had rammed him into the bed which caused the cut on his leg, but then he said that maybe he kicked the bed frame himself. The ADM stated that was why he did not report it to the State Survey Agency because Resident #1 had changed his statement. The ADM stated on 04/03/26, after Resident #1 alleged that the DON rammed him into the bed frame, he did not recall the time, but Resident #1 called the police. The ADM stated (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	he was still at the facility and spoke to the police after they spoke to Resident #1. The ADM stated the police told him that Resident #1 said somebody had pushed him into the bed frame causing the cut on his leg. The ADM stated the police did not specify who somebody was. The ADM stated he explained to the police the version of events Resident #1 had told him earlier. The ADM stated at that point, Resident #1 was again alleging that somebody had hurt him and he should have reported it to the State Survey Agency. The ADM stated he did not further investigate when Resident #1 voiced that the DON hit his leg because he went to Resident #1's room as soon as it happened and he did not see any other staff around. The ADM stated had he seen other staff around he would have asked them about the incident. The ADM stated the facility's policy indicated to report allegations of abuse within 2 hours, investigate allegations of abuse, and to protect the residents. The ADM stated he did what he could within the regulations to protect the residents. The ADM stated Resident #1 had behaviors but all the residents still had rights. The ADM stated he believed they did enough to protect the residents in the facility and they were not at risk of negative outcomes. The ADM stated he could have done a better job in investigating. During an interview and observation, on 04/10/26 at 11:45 AM, Resident #1 stated the other day, a doctor (did not know which doctor) brought him to his room and banged his leg into the bed frame. Resident #1 stated this bed frame that he was laying on which was made of metal and it hurt. Resident #1 stated he got a cut on his leg and it was bleeding. Resident #1 stated the nurses took care of the cut. Resident #1 stated he called the cops because he wanted that doctor to be arrested but that doctor had been hiding. Resident #1 stated he did not fight or argue with anyone else. Resident #1 stated that was all that happened. Resident #1 had pants on and he did not want to show the bandage on his left leg. Resident #1 stated it was fine. Record review of the facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy, undated, 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. 1. Protect residents from abuse, neglect, exploitation, or misappropriation of property by anyone (facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, and/or any other individual).2. Develop and implement policies and protocols to prevent and identify: a. abuse or mistreatment of residents;9. Investigate and report any allegations within timeframes required by federal requirements.

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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 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** Based on observation, interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, or mistreatment, were reported immediately to the State Survey Agency, within two hours if the events that cause the allegation involve abuse or result in serious bodily injury, for 2 of 4 residents (Resident #1 and Resident #2) reviewed for abuse/neglect. The facility failed to report an allegation of abuse to the State Survey Agency within two hours, when Resident #1 hit Resident #2 on 04/03/26. The facility failed to report an allegation of abuse to the State Survey Agency within two hours, when Resident #1 alleged a doctor or the DON hit his left leg on the bed frame on 04/03/26, resulting in a 1 centimeter skin tear. These failures could place all residents at increased risk for potential abuse due to unreported allegations of abuse and neglect.Findings included: 1. Record review of Resident #1's face sheet, dated 04/09/26, reflected a [AGE] year-old male, admitted on [DATE], diagnoses included: type 2 diabetes (high levels of sugar in blood), osteoporosis (weak and fragile bones), hepatic encephalopathy (brain dysfunction caused by liver failure), alcoholic cirrhosis of the liver (advanced scarring of the liver caused by long-term alcohol use), major depressive disorder (mental health condition with persistent feelings of sadness, loss of interest, various emotional/physical problems), adult failure to thrive (syndrome of weight loss, decreased appetite, functional decline, and social withdrawal), and personal history of other mental and behavioral disorders. Record review of Resident #1's MDS, dated [DATE], reflected a BIMS score of 12, indicating moderate cognitive impairment. The MDS reflected Resident #1 had no physical or verbal behavioral symptoms directed towards others. Record review of Resident #1's care plan, dated 04/09/26, reflected [Resident #1] was physically aggressive related to anger and poor impulse control. Date initiated: 03/03/26. Revised: 04/07/26. Interventions included when the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. Date initiated: 03/03/26. [Resident #1] has a behavior problem related to MDD (resident will have verbal outburst with staff and other residents). Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Resident on 30 minute behavior log, monitor resident behavior and document as necessary. Date initiated: 04/07/26. Record review of Resident #1's progress notes, dated 04/03/26 at 8:38 AM, revealed, [LVN A] witnessed [Resident #1] starting to verbally and physically getting aggressive with [Resident #2]. Both residents next to portable coffee stand. [Resident #1] was getting coffee. [Resident #2] asked to get a cup of coffee and [Resident #1] started yelling derogatory words towards [Resident #2]. [Resident #2] defended himself. [Resident #1] got up and started swatting [Resident #2]. This nurse and staff attempted to redirect [Resident #1]. [Resident #1] refused and kept yelling. The DON, ADM, and NP made aware. Documented by LVN A. At 12:15 PM, revealed, [Resident #1] was redirected to his room by the DON. While taking [Resident #1] back to his room, he was still yelling. Once inside his room [Resident #1] started throwing kicks and hit the frame of the bed with his left shin, as a result he had a skin tear about 1 cm long, edges well approximated. Documented by the DON. 2. Record review of Resident #2's face sheet, dated 04/09/26, reflected a [AGE] year-old male, admitted on [DATE], diagnoses included: type 2 diabetes (high levels of sugar in blood), major depressive disorder (mental health condition with persistent feelings of sadness, loss of interest, various emotional/physical problems), and unspecified dementia (decline in cognitive function, affecting memory, thinking, behavior, and ability to perform everyday activities). Record review of Resident #2's MDS, dated [DATE], reflected a BIMS score of 8, indicating moderate cognitive impairment. The MDS reflected Resident #2 had no physical or verbal behavioral symptoms directed towards others. Record review of Resident #2's care plan, (continued on next page)

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	455423	A. Building B. Wing	04/10/2026

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated 04/09/26, reflected [Resident #2] had impaired cognitive function/dementia or impaired thought processes related to dementia. Date initiated: 03/03/26. Record review of Resident #2's progress note, dated 04/03/26 at 2:49 PM, revealed Gave report to charge nurse of 100 hall (room change). Resident at this time has no acute distress noted and no abnormalities. Plan of care ongoing. Documented by LVN A. During an interview and observation, on 04/09/26 at 10:00 AM, Resident #1 did not wish to speak. Resident #1 was observed self-propelling in his wheelchair in the hallways and then went outside. Resident #1 had a bandage on his left shin area. During an interview, on 04/09/26 at 1:10 PM, CNA B stated she witnessed Resident #1 become aggressive towards Resident #2 when they were getting coffee. CNA B stated she assisted LVN A to intervene but Resident #1 was able to sort of push Resident #2 on his chest. CNA B stated they separated the residents and moved them away from each other. CNA B stated later on that day, Resident #1 was wheeled to his room by the DON. CNA B said she could see the doorway but did not see what happened inside the room. CNA B stated Resident #1 yelled and said he wanted the doctor to be arrested for abuse. CNA B stated Resident #1 was referring to the DON when he said the doctor. CNA B stated the ADM was aware of these incidents and spoke to the residents. During an interview, on 04/09/26 at 3:00 PM, MA D stated he saw when Resident #1 yelled at Resident #2 and called him names. MA D stated he intervened right away along with CNA B and LVN A. MA D stated later that day or the next day, Resident #1 had a bandage on his left shin area. MA D stated Resident #1 told him that he had a cut on his leg that he obtained when a doctor rolled him in a chair and banged him on the bed. MA D stated he told LVN A about what Resident #1 was saying but she was already aware because Resident #1 was telling everyone about that incident with the doctor. MA D stated the ADM already knew about what Resident #1 alleged about being banged on the bed by a doctor. During an interview, on 04/09/26 at 3:15 PM, LVN A stated on 04/03/26 in the morning, Resident #1 and Resident #2 were getting coffee and Resident #1 started cussing at Resident #2, saying that Resident #2 hated him. LVN A stated she tried to redirect them immediately and got in the middle of the residents. LVN A stated Resident #1 started swatting, trying to hit Resident #2. LVN A stated Resident #1 was able to hit Resident #2 on the arm even though she was in between them. LVN A stated she moved her arms higher so Resident #1 could not reach Resident #2 again. LVN A stated MA D and CNA B moved the residents away. LVN A stated Resident #1 and Resident #2 were not injured from the incident. LVN A stated the ADM was notified and he went to speak to the residents. LVN A stated later on that day, around lunch time, the DON took Resident #1 to his room. LVN A stated she saw the DON take Resident #1 to his room and walked away. LVN A stated she did not see the DON hurt Resident #1's leg or bang him into the bed. LVN A stated Resident #1 had a cut on his left shin after that and Resident #1 said that it was the doctor that hit him with the bed. LVN A stated there was no doctor in the facility and she did not know if Resident #1 meant the DON. LVN A stated Resident #1 had a skin tear on his left shin that was bleeding minimally and only required first aid. LVN A stated Resident #1 said that the doctor pushed him to the bed, the doctor hurt him, and that's how he got the skin tear on his leg. LVN A stated that incident was also reported to the ADM and the ADM spoke to Resident #1. During an interview, on 04/09/26 at 4:15 PM, the DON stated he was aware of the incident with Resident #1 and Resident #2 on 04/03/26 but he did not witness it. The DON stated as far as he knew, the staff intervened and separated the residents. The DON stated the residents did not hit or make any physical contact at all. The DON stated on 04/03/26 around lunch time, he wheeled Resident #1 to his room. The DON stated once in the room, Resident #1 turned his wheelchair on his own and then said, Oh my leg, my leg. The DON stated Resident #1 had a skin tear on his left leg and blamed the DON. The DON stated Resident #1 said that he pushed him into the room and pushed him against the bed. The DON stated that did not happen as he only wheeled Resident #1 into his room and left him by the bed in front of the nightstand. The DON stated when Resident #1 turned himself in the wheelchair, Resident #1 had kicked his leg and that's when he said, My leg, my leg. The DON stated when Resident #1 blamed him, LVN A and the ADON arrived to the room. The DON stated the ADM was notified and the ADM spoke to (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 on his own. The DON stated Resident #1 was changing his mind and going back and forth about what he was saying. The DON stated the ADM was the abuse coordinator and he determined if something was abuse or not. The DON stated the incident with Resident #1 and Resident #2, and the incident of Resident #1 alleging he caused the skin tear to his leg were not reported to the State Survey Agency. During an interview and observation, on 04/09/26 at 6:00 PM, Resident #2 stated he was doing well. Resident #2 stated he did not have any problems. Resident #2 stated he tried to be respectful and the staff treated him with the same respect. Resident #2 stated the staff provided him with anything he needed. Resident #2 did not recall the alleged incident with Resident #1 and did not know who Resident #1 was. Resident #2 was able to communicate his needs/wants. Resident #2 was not injured or in distress. During the interview, Resident #1 passed by Resident #2 and neither reacted to one another in any way. During an interview, on 04/10/26 at 10:00 AM, the ADON stated she went to Resident #1's room on 04/03/26 and the DON was in the room with LVN A and Resident #1. The ADON stated she saw Resident #1 had a skin tear on his leg and it was bleeding slightly, well approximated, where the skin flaps were together. The ADON stated Resident #1 calmed down and he allowed them to take care of the cut. The ADON stated Resident #1 said that the DON had taken him to his room and that he hit his leg. The ADON stated Resident #1 did not directly say that the DON hurt his leg as she understood it as Resident #1 hit his leg on his own. The ADON stated the ADM was notified either way and arrived to speak to Resident #1. During an interview, on 04/10/26 at 10:35 AM, the ADM stated on 04/03/26 in the morning, there was an incident where Resident #1 was yelling at Resident #2. The ADM stated he was not sure what was said but the staff intervened immediately and separated the residents. The ADM stated he did not witness the incident but from what staff told him, there was no physical contact between the residents. The ADM stated the staff did not tell him that Resident #1 hit or made any contact with Resident #2. The ADM stated if he had known that there was a physical altercation or that Resident #1 was able to hit Resident #2, he would have reported the incident to the State Survey Agency, even though there was no injury. The ADM stated there was another incident that day on 04/03/26 where Resident #1 alleged the DON had hurt his leg. The ADM stated he arrived to Resident #1's room and asked the DON to step out. The ADM stated he tried to redirect Resident #1 to calm down so he could explain to him what happened. The ADM stated Resident #1's comments were back and forth. The ADM stated he asked Resident #1 if he wanted to call the police and he said no. The ADM stated he told Resident #1 that he needed to interview him, to assess if there was abuse or not, and that he had 2 hours to report. The ADM stated Resident #1 said to just let the time lapse, that he did not want to get anyone in trouble. The ADM stated he told Resident #1 he could not do that. The ADM stated Resident #1 said that the DON had rammed him into the bed which caused the cut on his leg, but then he said that maybe he kicked the bed frame himself. The ADM stated that was why he did not report it to the State Survey Agency because Resident #1 had changed his statement. The ADM stated on 04/03/26, after Resident #1 alleged that the DON rammed him into the bed frame, he did not recall the time, but Resident #1 called the police. The ADM stated he was still at the facility and spoke to the police after they spoke to Resident #1. The ADM stated the police told him that Resident #1 said somebody had pushed him into the bed frame causing the cut on his leg. The ADM stated the police did not specify who somebody was. The ADM stated he explained to the police the version of events Resident #1 had told him earlier. The ADM stated at that point, Resident #1 was again alleging that somebody had hurt him and he should have reported it to the State Survey Agency. The ADM stated the facility's policy indicated to report allegations of abuse within 2 hours and to protect the residents. The ADM stated he believed they did enough to protect the residents in the facility and they were not at risk of negative outcomes. During an interview and observation, on 04/10/26 at 11:45 AM, Resident #1 stated the other day, a doctor (did not know which doctor) brought him to his room and banged his leg into the bed frame. Resident #1 stated this bed frame that he was laying on which was made of metal and it hurt. Resident #1 stated he got a cut on his leg and it was bleeding. Resident #1 stated the nurses took care of the cut. Resident #1 stated he (continued on next page)

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	04/10/2026

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

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	called the cops because he wanted that doctor to be arrested but that doctor had been hiding. Resident #1 stated he did not fight or argue with anyone else. Resident #1 stated that was all that happened. Resident #1 had pants on and he did not want to show the bandage on his left leg. Resident #1 stated it was fine. Record review of the facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy, undated, 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. 1. Protect residents from abuse, neglect, exploitation, or misappropriation of property by anyone (facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, and/or any other individual).2. Develop and implement policies and protocols to prevent and identify: a. abuse or mistreatment of residents;9. Investigate and report any allegations within timeframes required by federal requirements.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to have evidence that all alleged violations involving abuse, neglect, or mistreatment, were thoroughly investigated for 2 of 4 residents (Resident #1 and Resident #2) reviewed for abuse/neglect. The facility failed to have evidence of a thorough investigation regarding an allegation of abuse when Resident #1 hit Resident #2 on 04/03/26. The facility failed to have evidence of a thorough investigation regarding an allegation of abuse when Resident #1 alleged a doctor or the DON hit his left leg on the bed frame on 04/03/26, resulting in a 1 centimeter skin tear. These failures could place all residents at increased risk for potential abuse due to uninvestigated allegations of abuse and neglect.Findings included: 1. Record review of Resident #1's face sheet, dated 04/09/26, reflected a [AGE] year-old male, admitted on [DATE], diagnoses included: type 2 diabetes (high levels of sugar in blood), osteoporosis (weak and fragile bones), hepatic encephalopathy (brain dysfunction caused by liver failure), alcoholic cirrhosis of the liver (advanced scarring of the liver caused by long-term alcohol use), major depressive disorder (mental health condition with persistent feelings of sadness, loss of interest, various emotional/physical problems), adult failure to thrive (syndrome of weight loss, decreased appetite, functional decline, and social withdrawal), and personal history of other mental and behavioral disorders. Record review of Resident #1's MDS, dated [DATE], reflected a BIMS score of 12, indicating moderate cognitive impairment. The MDS reflected Resident #1 had no physical or verbal behavioral symptoms directed towards others. Record review of Resident #1's care plan, dated 04/09/26, reflected [Resident #1] was physically aggressive related to anger and poor impulse control. Date initiated: 03/03/26. Revised: 04/07/26. Interventions included when the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. Date initiated: 03/03/26. [Resident #1] has a behavior problem related to MDD (resident will have verbal outburst with staff and other residents). Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Resident on 30 minute behavior log, monitor resident behavior and document as necessary. Date initiated: 04/07/26. Record review of Resident #1's progress notes, dated 04/03/26 at 8:38 AM, revealed, [LVN A] witnessed [Resident #1] starting to verbally and physically getting aggressive with [Resident #2]. Both residents next to portable coffee stand. [Resident #1] was getting coffee. [Resident #2] asked to get a cup of coffee and [Resident #1] started yelling derogatory words towards [Resident #2]. [Resident #2] defended himself. [Resident #1] got up and started swatting [Resident #2]. This nurse and staff attempted to redirect [Resident #1]. [Resident #1] refused and kept yelling. The DON, ADM, and NP made aware. Documented by LVN A. At 12:15 PM, revealed, [Resident #1] was redirected to his room by the DON. While taking [Resident #1] back to his room, he was still yelling. Once inside his room [Resident #1] started throwing kicks and hit the frame of the bed with his left shin, as a result he had a skin tear about 1 cm long, edges well approximated. Documented by the DON. 2. Record review of Resident #2's face sheet, dated 04/09/26, reflected a [AGE] year-old male, admitted on [DATE], diagnoses included: type 2 diabetes (high levels of sugar in blood), major depressive disorder (mental health condition with persistent feelings of sadness, loss of interest, various emotional/physical problems), and unspecified dementia (decline in cognitive function, affecting memory, thinking, behavior, and ability to perform everyday activities). Record review of Resident #2's MDS, dated [DATE], reflected a BIMS score of 8, indicating moderate cognitive impairment. The MDS reflected Resident #2 had no physical or verbal behavioral symptoms directed towards others. Record review of Resident #2's care plan, dated 04/09/26, reflected [Resident #2] had impaired cognitive function/dementia or impaired thought processes related to dementia. Date initiated: 03/03/26. Record review of Resident #2's (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	progress note, dated 04/03/26 at 2:49 PM, revealed, Gave report to charge nurse of 100 hall (room change). Resident at this time has no acute distress noted and no abnormalities. Plan of care ongoing. Documented by LVN A. During an interview and observation, on 04/09/26 at 10:00 AM, Resident #1 did not wish to speak. Resident #1 was observed self-propelling in his wheelchair in the hallways and then went outside. Resident #1 had a bandage on his left shin area. During an interview, on 04/09/26 at 1:10 PM, CNA B stated she witnessed Resident #1 become aggressive towards Resident #2 when they were getting coffee. CNA B stated she assisted LVN A to intervene but Resident #1 was able to sort of push Resident #2 on his chest. CNA B stated they separated the residents and moved them away from each other. CNA B stated later on that day, Resident #1 was wheeled to his room by the DON. CNA B said she could see the doorway but did not see what happened inside the room. CNA B stated Resident #1 yelled and said he wanted the doctor to be arrested for abuse. CNA B stated Resident #1 was referring to the DON when he said the doctor. CNA B stated the ADM was aware of these incidents and spoke to the residents. During an interview, on 04/09/26 at 3:00 PM, MA D stated he saw when Resident #1 yelled at Resident #2 and called him names. MA D stated he intervened right away along with CNA B and LVN A. MA D stated later that day or the next day, Resident #1 had a bandage on his left shin area. MA D stated Resident #1 told him that he had a cut on his leg that he obtained when a doctor rolled him in a chair and banged him on the bed. MA D stated he told LVN A about what Resident #1 was saying but she was already aware because Resident #1 was telling everyone about that incident with the doctor. MA D stated the ADM already knew about what Resident #1 alleged about being banged on the bed by a doctor. During an interview, on 04/09/26 at 3:15 PM, LVN A stated on 04/03/26 in the morning, Resident #1 and Resident #2 were getting coffee and Resident #1 started cussing at Resident #2, saying that Resident #2 hated him. LVN A stated she tried to redirect them immediately and got in the middle of the residents. LVN A stated Resident #1 started swatting, trying to hit Resident #2. LVN A stated Resident #1 was able to hit Resident #2 on the arm even though she was in between them. LVN A stated she moved her arms higher so Resident #1 could not reach Resident #2 again. LVN A stated MA D and CNA B moved the residents away. LVN A stated Resident #1 and Resident #2 were not injured from the incident. LVN A stated the ADM was notified and he went to speak to the residents. LVN A stated later on that day, around lunch time, the DON took Resident #1 to his room. LVN A stated she saw the DON take Resident #1 to his room and walked away. LVN A stated she did not see the DON hurt Resident #1's leg or bang him into the bed. LVN A stated Resident #1 had a cut on his left shin after that, and Resident #1 said that it was the doctor that hit him with the bed. LVN A stated there was no doctor in the facility and she did not know if Resident #1 meant the DON. LVN A stated Resident #1 had a skin tear on his left shin that was bleeding minimally and only required first aid. LVN A stated Resident #1 said that the doctor pushed him to the bed, the doctor hurt him, and that's how he got the skin tear on his leg. LVN A stated that incident was also reported to the ADM and the ADM spoke to Resident #1. During an interview, on 04/09/26 at 4:15 PM, the DON stated he was aware of the incident with Resident #1 and Resident #2 on 04/03/26 but he did not witness it. The DON stated as far as he knew, the staff intervened and separated the residents. The DON stated the residents did not hit or make any physical contact at all. The DON stated on 04/03/26 around lunch time, he wheeled Resident #1 to his room. The DON stated once in the room, Resident #1 turned his wheelchair on his own and then said, Oh my leg, my leg. The DON stated Resident #1 had a skin tear on his left leg and blamed the DON. The DON stated Resident #1 said that he pushed him into the room and pushed him against the bed. The DON stated that did not happen as he only wheeled Resident #1 into his room and left him by the bed in front of the nightstand. The DON stated when Resident #1 turned himself in the wheelchair, Resident #1 had kicked his leg and that's when he said, My leg, my leg. The DON stated when Resident #1 blamed him, LVN A and the ADON arrived to the room. The DON stated the ADM was notified and the ADM spoke to Resident #1 on his own. The DON stated Resident #1 was changing his mind and going back and forth about what he was saying. The DON stated the ADM was the abuse coordinator and he determined if (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	something was abuse or not. The DON stated the ADM would have been the one to investigate. During an interview and observation, on 04/09/26 at 6:00 PM, Resident #2 stated he was doing well. Resident #2 stated he did not have any problems. Resident #2 stated he tried to be respectful and the staff treated him with the same respect. Resident #2 stated the staff provided him with anything he needed. Resident #2 did not recall the alleged incident with Resident #1 and did not know who Resident #1 was. Resident #2 was able to communicate his needs/wants. Resident #2 was not injured or in distress. During the interview, Resident #1 passed by Resident #2 and neither reacted to one another in any way. During an interview, on 04/10/26 at 10:00 AM, the ADON stated she went to Resident #1's room on 04/03/26 and the DON was in the room with LVN A and Resident #1. The ADON stated she saw Resident #1 had a skin tear on his leg and it was bleeding slightly, well approximated, where the skin flaps were together. The ADON stated Resident #1 calmed down and he allowed them to take care of the cut. The ADON stated Resident #1 said that the DON had taken him to his room and that he hit his leg. The ADON stated Resident #1 did not directly say that the DON hurt his leg, as she understood it as Resident #1 hit his leg on his own. The ADON stated the ADM was notified either way and arrived to speak to Resident #1. During an interview, on 04/10/26 at 10:35 AM, the ADM stated on 04/03/26 in the morning, there was an incident where Resident #1 was yelling at Resident #2. The ADM stated he was not sure what was said but the staff intervened immediately and separated the residents. The ADM stated he did not witness the incident but from what staff told him, there was no physical contact between the residents. The ADM stated the staff did not tell him that Resident #1 hit or made any contact with Resident #2. The ADM stated he investigated the incident and based on what the staff said to him, he did not report it. The ADM stated the progress notes documented by LVN A reflected his investigation for the incident between Resident #1 and Resident #2. The ADM stated he interviewed staff and obtained their statements but he did not have records to show. The ADM stated the progress notes did not really show his investigation process. The ADM stated he had nothing else to show he thoroughly investigated. The ADM stated there was another incident that day on 04/03/26 where Resident #1 alleged the DON had hurt his leg. The ADM stated he arrived to Resident #1's room and asked the DON to step out. The ADM stated he tried to redirect Resident #1 to calm down so he could explain to him what happened. The ADM stated Resident #1's comments were back and forth. The ADM stated he asked Resident #1 if he wanted to call the police and he said no. The ADM stated he told Resident #1 that he needed to interview him, to assess if there was abuse or not, and that he had 2 hours to report. The ADM stated Resident #1 said to just let the time lapse, that he did not want to get anyone in trouble. The ADM stated he told Resident #1 he could not do that. The ADM stated Resident #1 said that the DON had rammed him into the bed which caused the cut on his leg, but then he said that maybe he kicked the bed frame himself. The ADM stated that was why he did not report it to the State Survey Agency because Resident #1 had changed his statement. The ADM stated on 04/03/26, after Resident #1 alleged that the DON rammed him into the bed frame, he did not recall the time, but Resident #1 called the police. The ADM stated he was still at the facility and spoke to the police after they spoke to Resident #1. The ADM stated the police told him that Resident #1 said somebody had pushed him into the bed frame causing the cut on his leg. The ADM stated the police did not specify who somebody was. The ADM stated he explained to the police the version of events Resident #1 had told him earlier. The ADM stated he did not further investigate when Resident #1 voiced that the DON hit his leg because he went to Resident #1's room as soon as it happened and he did not see any other staff around. The ADM stated had he seen other staff around he would have asked them about the incident. The ADM stated the facility's policy indicated to investigate allegations of abuse and to protect the residents. The ADM stated he did what he could within the regulations to protect the residents. The ADM stated Resident #1 had behaviors but all the residents still had rights. The ADM stated he believed they did enough to protect the residents in the facility and they were not at risk of negative outcomes. The ADM stated he could have done a better job in investigating. During an interview and observation, on 04/10/26 at 11:45 AM, Resident #1 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated the other day, a doctor (did not know which doctor) brought him to his room and banged his leg into the bed frame. Resident #1 stated this bed frame that he was laying on which was made of metal and it hurt. Resident #1 stated he got a cut on his leg and it was bleeding. Resident #1 stated the nurses took care of the cut. Resident #1 stated he called the cops because he wanted that doctor to be arrested but that doctor had been hiding. Resident #1 stated he did not fight or argue with anyone else. Resident #1 stated that was all that happened. Resident #1 had pants on and he did not want to show the bandage on his left leg. Resident #1 stated it was fine. Record review of the facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy, undated, 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. 1. Protect residents from abuse, neglect, exploitation, or misappropriation of property by anyone (facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, and/or any other individual).2. Develop and implement policies and protocols to prevent and identify: a. abuse or mistreatment of residents;9. Investigate and report any allegations within timeframes required by federal requirements.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident needs, that included measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs, for 1 of 4 residents (Resident #2) reviewed for care plans. The facility failed to ensure Resident #2's care plan reflected his diagnosis of diabetes, major depressive disorder, and ADLs with assistance needed.This failure could place the residents at risk of not receiving appropriate interventions and care to meet their needs.Findings included:Record review of Resident #2's face sheet, dated 04/09/26, reflected a [AGE] year-old male, admitted on [DATE], diagnoses included: type 2 diabetes (high levels of sugar in blood), major depressive disorder (mental health condition with persistent feelings of sadness, loss of interest, various emotional/physical problems), and unspecified dementia (decline in cognitive function, affecting memory, thinking, behavior, and ability to perform everyday activities). Record review of Resident #2's MDS, dated [DATE], reflected a BIMS score of 8, indicating moderate cognitive impairment. The MDS reflected diagnosis of diabetes and depression. The MDS reflected Resident #2 was independent for eating, oral hygiene, upper body dressing, personal hygiene, rolling left to right, sitting to lying, and lying to sitting. Resident #2 required supervision or touching assistance for toileting hygiene, shower/bathe self, lower body dressing, putting on /taking off footwear, sitting to standing, and walking 10 feet, 50 feet, 150 feet. Record review of Resident #2's care plan, dated 04/09/26, reflected [Resident #2] had impaired cognitive function/dementia or impaired thought processes related to dementia. Date initiated: 03/03/26. The care plan did not reflect diabetes or major depressive disorder diagnoses and did not reflect the ADLs with assistance needed. During an interview, on 04/09/26 at 3:50 PM, the MDS Nurse stated Resident #2 had diagnoses of diabetes and major depressive disorder which should have been care planned. The MDS Nurse stated Resident #2's ADL dependence should have also been care planned. The MDS Nurse stated she reviewed Resident #2's care plan and verified that his diagnoses and ADLs were not care planned. The MDS Nurse stated she had been backed up with care plans and was trying to catch up which was the reason why Resident #2's care plan did not reflect the information needed. The MDS Nurse stated it was important to care plan the diagnoses of diabetes and major depressive disorder, as well as the ADLs and assistance needed, because the care plan was personalized to each resident and informed staff on how to care for him. The MDS Nurse stated the staff were still able to care for Resident #2 by checking the Kardex and following the orders so there was no negative outcome for Resident #2. During an interview, on 04/09/26 at 4:15 PM, the DON stated Resident #2 had a diagnosis of diabetes and major depressive disorder. The DON stated the diagnoses should have been care planned. The DON stated Resident #2's ADLs should have been in the care plan even if the resident was more independent like Resident #2. The DON stated there were no negative outcomes for Resident #2 because he was independent, but staff were still aware of how to care for him because they were familiar with him. The DON stated the CNAs had tasks to follow and know how to care for Resident #2. The DON stated the nurses also followed the orders. The DON stated care plans were developed and updated by the MDS nurse. The DON stated it was important for the care plan to be individualized and developed accurately so staff knew how to care for the residents. During an interview and observation, on 04/09/26 at 6:00 PM, Resident #2 stated he was doing well. Resident #2 stated he did not have any problems. Resident #2 stated he tried to be respectful and the staff treated him with the same respect. Resident #2 stated the staff provided him with anything he needed. Resident #2 was sitting and stood up without assistance and was ambulating without assistance. Resident #2 was able to communicate his needs/wants. Resident #2 was not injured or in distress. Record review of the facility's Care Plans, Comprehensive (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Person-Centered policy, undated, reflected - Policy: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes;b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being;e. reflects currently recognized standards of practice for problem areas and conditions.