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	04/30/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents had the right to be free from abuse for one (Resident #2) of 5 residents reviewed for abuse. The facility failed to protect Resident #2 from Resident #1's physical abuse on 04/13/26 at around 11:00 PM. This failure could lead to residents suffering physical injuries and fear.The findings included:Record review of Resident #1's face sheet dated 04/30/26 revealed a [AGE] year-old male with an original admission date of 02/18/26 and a current admission date of 04/06/26. Pertinent diagnoses included Personal History of Other Mental and Behavioral Disorders. Record review of Resident #1's admission MDS assessment dated [DATE] revealed a BIMS score of 12 indicating moderate cognitive impairment. Further review revealed Resident #1 had not displayed any physical or verbal behaviors towards others. Record review of Resident #1's Comprehensive Care Plan dated 04/30/26 revealed the focus [Resident #1] is physically aggressive r/t Anger, Poor impulse control. He throws items at dietary staff, etc initiated on 03/03/26 and revised on 04/07/26. An intervention listed for the focus 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 initiated on 03/03/26. Further review revealed another focus [Resident #1 has a behavior problem r/t MDD (resident will have verbal outburst with staff, and other residents initiated and revised on 04/07/26. An intervention listed for the focus included 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 initiated on 04/07/26. Record review of Resident #2's face sheet dated 04/30/26 revealed a [AGE] year-old male with an admission date of 03/09/26. Pertinent diagnosis included bipolar disorder (chronic mental health condition characterized by intense, fluctuating mood shifts, ranging from high-energy, euphoric, or irritable manic/hypomanic episodes to deep depressive episodes.) Record review of Resident #2's Comprehensive MDS assessment dated [DATE] revealed a BIMS score of 15 indicating his cognition was intact. Further review revealed Resident #2 had not displayed any physical or verbal behaviors towards others. Record review of Resident #2's Comprehensive Care Plan dated 04/30/26 revealed the focus [Resident #2] is verbally aggressive r/t Ineffective coping skills, Poor impulse control, dx: anxiety, bipolar disorder initiated on 03/16/26 and revised on 04/07/26. An intervention listed for the focus 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 initiated on 03/16/26. Record review of nurse's progress notes on 04/30/26 revealed a progress note written on 04/14/26 at 3:19 AM stated [Resident #1] was seen talking to [Resident #2] in hallway in front of his room in normal tone of voice. Both residents went into 213 and [Resident #2] exited [Resident #1's] room and loud voices heard in hallway from both residents. [Resident #2] went to the patio. SN went in to talk to resident, very upset. [Resident #1] got long grabber tool and wheeled himself to hallway between Unit 200 and 300. Being loud, angry toward [Resident #2](.) [Resident #2] heard him and came into hallway and started being loud and using profanity and [Resident #1] got (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	04/30/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	long grabber tool and hit [Resident #2] on his left forearm, causing a bruise. SN called [ADM] and made aware of situation. [ADM] informed me to call police. Both residents kept apart. [ADM] and police arrived at facility. PCP was informed of incident. In an interview with Resident #1 at 9:25 AM on 04/29/26, Resident #1 stated Resident #2 was very argumentative. Resident #1 stated he did not hit Resident #2 with the reaching aid. Resident #1 stated Resident #2 tried to take his reaching aid from him, and in the scuffle, he may have bumped Resident #2 with the reaching aid. Resident #1 stated he was defending himself. Resident #1 stated Resident #2 had never hit him before, but he had called him a faggot and a cripple. Resident #1 stated he made amends with Resident #2, and they were back to being friends. During an observation in Resident #1's room at 9:25 AM on 04/29/26, a reaching aid was seen on a table near his bed. In an interview with Resident #2 at 10:21 AM on 04/29/26, Resident #2 stated Resident #1 swung his reaching aid at him. Resident #2 stated he blocked the blow with his forearm. Resident #2 stated he had a bruise from the blow after the incident. Resident #2 stated his arm had healed and the bruise was now gone. Resident #2 stated Resident #1 threatened to hit him before with the reaching aid, but this was the first time he followed through with the threat. Resident #2 stated he made peace with Resident #1, and they were fine at this point. In an interview with the ADON at 3:41 PM on 04/29/26, the ADON stated she was familiar with Resident #1. The ADON stated Resident #1 had a short fuse. The ADON stated Resident #1 made racist comments to staff. The ADON stated she had seen Resident #1 be physically aggressive with another resident one time before the incident between Resident #1 and Resident #2. The ADON stated she witnessed Resident #1 shake another resident's wheelchair after he thought the other resident called him a name. The ADON stated the incident between Resident #1 and Resident #2 was the first time she had heard of Resident #1 using the reaching aid as a weapon. The ADON stated it would not surprise her if Resident #1 was involved in another physical altercation with a resident in the future. The ADON stated every resident had the right to be free from abuse at the facility. In an interview with LVN A at 5:04 PM on 04/29/26, LVN A stated Resident #1 had been very edgy, had no patience, and was verbally aggressive towards staff and residents. LVN A stated Resident #1 had a short fuse. LVN A stated Resident #1 told her to get off her lazy ass before and check his glucose or blood pressure. LVN A stated Resident #1 calmed down since he first arrived at the facility. LVN A stated Resident #1 threatened to get her fired. LVN A stated it did not surprise her when she learned that Resident #1 had hit another resident. LVN A stated every resident had the right to be free from abuse. In an interview with the DON at 8:57 AM on 04/30/26, the DON stated he witnessed Resident #1 be physically aggressive with another resident one time. The DON stated he saw Resident #1 grab onto another resident's wheelchair and shake it. The DON stated he would describe Resident #1 as having a short fuse. The DON stated Resident #1 generally behaved better now than when he first arrived at the facility. The DON stated after the incident between Resident #1 and Resident #2, they placed Resident #1 on a one-to-one and had psychiatry evaluate him. The DON stated Resident #1 was no longer on a one-to-one and was back to normal rounding times. The DON stated they did lab tests, but they did not reveal any infection in Resident #1. The DON stated Resident #2 moved rooms to be further away from Resident #1 for a few days, but then he moved back. The DON stated he did believe it was abuse when Resident #1 hit Resident #2 with the reaching aid. The DON stated all residents at the facility had the right to be free from abuse. In an interview with LVN B at 10:12 AM on 04/30/26, LVN B stated he witnessed the incident between Resident #1 and Resident #2. LVN B stated the incident occurred at around 11:00 PM on 04/13/26. LVN B stated both residents yelled profanities at each other in the hall. LVN B stated Resident #1 claimed Resident #2 shook his chair. LVN B stated both residents stated fuck you to each other. LVN B stated Resident #1 grabbed the reaching aid on the back of his wheelchair and swung it at Resident #2. LVN B stated Resident #2 blocked the blow with his left arm. LVN B stated Resident #2 took the reaching aid and tried to break it. LVN B stated he took the reaching aid from Resident #2. LVN B stated he performed the skin assessment on Resident #2 after the incident and discovered a minor bruise less than an inch in diameter to his (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	04/30/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	posterior left forearm. LVN B stated the incident he witnessed was physical abuse. LVN B stated every resident in the facility had the right to be free from abuse. In an interview with the ADM at 12:26 PM on 04/30/26, the ADM stated he first learned about the incident between Resident #1 and Resident #2 at around 11:00 or 11:30 PM on 04/13/26. The ADM stated he came up to the facility and arrived at about the same time the police did. The ADM stated he spoke to both residents after the incident. The ADM stated they implemented a one-to-one on Resident #1. The ADM stated they took the reaching aid from Resident #1 after the incident, but he ordered a new one that they had not taken from him. The ADM stated they had a discussion on whether to take the new reaching aid or not, but since Resident #1 had not displayed any behaviors since the incident, they decided to let him keep it. The ADM stated they ordered psychiatric consultations for both residents and moved Resident #2 to a different hall to separate them further. The ADM stated Resident #1 had been physically aggressive with another resident before this incident. The ADM stated he believed this incident was physical abuse. The ADM stated he felt they had put in sufficient interventions to successfully limit his future behaviors moving forward. The ADM stated every resident had the right to be free from abuse at the facility. Record review of the undated facility policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program revealed the following: Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives:Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to:.b. other residents;