

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 07/03/2026
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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is a significant change in the resident's physical status for 1 (Resident #1) of 5 residents reviewed for resident rights. The facility failed to ensure LVN A and LVN B notified the physician and the resident representative when there were reported scratches to Resident #1's arm and face on [DATE]. This deficient practice could affect residents with a change of condition and result in not receiving adequate and timely invention and decline in condition. Findings included: Record review of Resident #1's face sheet, dated [DATE], reflected a [AGE] year-old female with an admission date of [DATE]. Her relevant diagnoses included severe intellectual disabilities (a person has major challenges learning, problem-solving, and managing daily life), cerebral palsy (lifelong condition that affects a person's ability to move, keep their balance, and control their posture), seborrheic dermatitis (chronic skin condition that causes itchy, greasy, and flaky patches of skin), psoriasis (chronic condition where the immune system mistakenly attacks healthy skin cells), enlarged hypertrophic nails (overgrown, thickened, or claw-like nails) and type 2 diabetes mellitus (body can't properly use or make the hormone insulin). Record review of Resident #1's comprehensive MDS assessment, dated [DATE], reflected her BIMS score of 00, which indicated severe cognitive impairment. Record review of Resident #1's care plan, dated [DATE], reflected Resident #1 has potential impairment to skin r/t psoriasis has potential to skin r/t psoriasis and seborrheic dermatitis. Goal: will maintain or develop clean and intact skin. Interventions: Educate resident/family/caregivers of causative factors and measures to prevent skin injury. Monitor /document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx of infection, maceration, etc. to MD. During an interview on [DATE] at 8:16 a.m., CNA C said she worked the 2 p.m.-10 p.m. shift on [DATE] and around 6 p.m., she took Resident #1 to the shower room and did not have marks or scratches on her arm and face. She said she returned to Resident #1's room at 7:30 p.m. and saw scant (barely sufficient or adequate) amount of smeared blood on the bed sheet that covered the resident's face. CNA C said she saw scratches on Resident #1. She said she saw dried blood under Resident #1's fingernails and immediately notified LVN A. During an interview on [DATE] at 9:16 a.m., LVN A said the incident regarding Resident #1 took place during the evening shift on [DATE]. He said he was informed by the CNA at 7:30 p.m. of scratches on Resident #1's face and arm. LVN A said he assessed Resident #1 and saw small amounts of dried smeared blood on the resident's face and small amount of dried smeared blood on the part of the bed sheet that covered her chin. He said he assumed she scratched herself because she is being seen by a dermatologist for a skin condition. LVN A said Resident #1 was not in distress and cleaned her wounds. He said he got busy with other residents and did not notify the RP and the (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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	doctor to inform them of the scratches. LVN A the process to follow for residents having had a change in condition included documenting in the EMR and notifying the physician, RP, and DON. He said negative outcomes from not having documented and notified the MD and RP were increasing the family's concerns and escalating issues with the residents. He said he received an in-service on documentation and notification for changes in condition on [DATE]. During an interview on [DATE] at 11:14 a.m., LVN B said he received report from LVN A in the morning on [DATE]. He said he was told by LVN A that Resident #1 had scratched herself during the evening shift. LVN B said he assumed LVN A had reported and documented the incident. He said he did not notify anyone about the incident and Resident #1 remained calm and had no further changes throughout the day. LVN B said not having made the proper notifications of change in condition might increase the residents' risk of infection. He said the nursing process for changes in condition included resident assessment, documentation, notification, and provided treatment as needed. LVN B said he received an in-service on documentation and notification of changes in condition on [DATE]. During an interview on [DATE] at 11:30 a.m., the DON said during the morning meeting on [DATE], he was informed of Resident #1 scratches. He said he immediately checked the resident and informed the MD and RP and began the investigative process. He said notifications were made to the state agency within two hours. He said Resident #1's physician was in-house and ordered treatment. The DON said he performed 1:1 counseling with both nurses regarding the process when there is a change in condition and provided all staff with ANE in-services on [DATE]. During an interview on [DATE] at 12:00 p.m., the Administrator said he and the leadership staff were made aware of the incident during the morning meeting on [DATE]. He said he immediately checked Resident #1 and reassigned the resident's roommate to ensure safety as the investigation proceeded. He said he directed the DON to complete a head-to-toe assessment on Resident #1 and to make the proper notifications. The Administrator said he immediately began the investigative process and notified the state agency within two hours on [DATE]. He said daily morning meetings were held with the IDT and discussed issues and resolutions, which included Resident #1's incident. Record review of facility policy titled Change in Condition, undated, stated The licensed nurse is responsible for: Notifying the physician or practitioner as required. Notifying the resident representative when appropriate. Documenting all findings and actions.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for one (Resident #1) of five residents reviewed for ADL care. The facility failed to ensure Resident #1's nails were cleaned and did not have rough edges on 7/01/2026. These failures could place residents at risk of not receiving services or care, diminishing quality of life, and decreased self-esteem. Findings included: Record review of Resident #1's face sheet, dated 7/3/26, reflected a [AGE] year-old female with an admission date of 4/02/24. Her relevant diagnoses included severe intellectual disabilities (a person has major challenges learning, problem-solving, and managing daily life), cerebral palsy (lifelong condition that affects a person's ability to move, keep their balance, and control their posture), seborrheic dermatitis (chronic skin condition that causes itchy, greasy, and flaky patches of skin), psoriasis (chronic condition where the immune system mistakenly attacks healthy skin cells), enlarged hypertrophic nails (overgrown, thickened, or claw-like nails) and type 2 diabetes mellitus (body can't properly use or make the hormone insulin). Record review of Resident #1's comprehensive MDS assessment, dated 4/13/26, reflected her BIMS score of 00, which indicated severe cognitive impairment. Section GG- functional abilities for personal hygiene was coded at 2, which indicated the resident needed substantial/maximal assistance. Record review of Resident #1's care plan, dated 5/25/2026, reflected Resident #1 has potential impairment to skin r/t psoriasis has potential to skin r/t psoriasis and seborrheic dermatitis. Goal: will maintain or develop clean and intact skin. Interventions: Educate resident/family/caregivers of causative factors and measures to prevent skin injury. Monitor /document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx of infection, maceration, etc. to MD. Resident #1 has an ADL self-care performance deficit r/t impaired balance, limited mobility, unsteadiness on feet, difficulty in walking, lack of coordination. Goal: will maintain current level of function through the review date. Interventions: Personal Hygiene: The resident requires substantial/maximal assistance by one staff member with personal hygiene. During an observation on 7/03/2026 at 6:03 p.m., revealed Resident #1 was in her room eating dinner, assisted by therapy personnel. Resident #1 had brownish and whitish/yellowish substances underneath her fingernails (thumb, index finger, middle finger, and ring finger) on her left hand. She had blackish/brownish substances under her fingernail to her middle finger, yellowish substance under her fingernails (index finger, middle finger, pinky, and ring finger). The edges to all her fingernails on both hands were uneven. During an interview on 7/02/2026 at 4:15 p.m., the Activity director said nail trimming was a task she would carry out for residents that did not have a diagnosis of diabetes. She said she had not trimmed Resident #1's nails and that was a task that was carried out by the nurses. During an interview on 7/03/2026 at 11:40 a.m., The DON said it was part of activities to perform manicures and involve residents in the process. He said residents that have specific diagnoses, such as diabetes, were done by the nursing staff excluding CNAs. He said residents that had long and unkept nails were at risk of scratching themselves and could cause skin tears. The DON said the CNAs were to inquire if a resident had a diagnosis of DM before they trimmed the resident's fingernails. He said Resident #1 was calm and allowed the nurses to trim her fingernails but became easily startled when she felt the clippers on her nails. The DON said in-services for ADLs were done with the CNAs yearly and quarterly. Record review of facility policy titled Infection Control Standard Precautions, undated, stated .g. Personnel assist the residents with hand hygiene before meals, after toileting and when indicated.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one (Resident #2) of six residents reviewed for infection control practices. The facility failed to ensure isolation protocols were followed when Resident #2 was newly admitted to the facility and roomed with a resident who was under droplet precautions. This failure could place residents at risk for the transmission of communicable diseases and infections. Findings included: Record review of Resident #2's face sheet, dated 7/2/26, reflected a [AGE] year-old male with an admission date of 6/24/26. His diagnoses included Alzheimer's disease (progressive brain disorder that gradually destroys memory and thinking skills), chronic kidney disease stage 3 (kidneys sustained moderate damage and filtering 30% to 59% of their normal capacity), osteoarthritis (cartilage that cushions the ends of bones gradually wears away), and peripheral vascular disease (poor blood circulation). Record review of Resident #2's Nursing Home Discharge MDS assessment, dated 6/29/2026, reflected his BIMS score was left blank. Record review of Resident #2's care plan, dated 6/25/26, reflected Resident #2 has an ADL self-care performance deficit r/t Alzheimer's, stroke. Goal: will maintain current level of function through the review date. Interventions: requires substantial/maximal assistance by staff 1-2 staff members for bathing/showering, bed mobility, and personal hygiene. Record review of Resident #2's, physician orders, dated 7/2/26, reflected orders to admit to skilled services. No order for isolation precautions. Record review of Resident #3's face sheet, dated 7/2/26, reflected a [AGE] year-old male with an admission date of 6/19/26. His pertinent diagnoses included pneumonia due to staphylococcus (lung infection caused by staphylococcus bacteria), personal history of other infections and parasitic diseases, and persistent vegetative state. Record review of Resident #3's comprehensive MDS assessment, dated 6/25/26, reflected hid BIMS score was left blank. Section GG indicated he was dependent on staff for ADLs. Record review of Resident #3's order summary, dated 7/2/26, indicated Resident #3 was transferred to the hospital for evaluation and treatment as ordered by the physician. During an interview on 7/02/2026 at 10:18 a.m., the ADON/IP said She said Resident #2 was admitted on [DATE] and was admitted to room [ROOM NUMBER]-A. She said he was not supposed to be in the same room with Resident #3 because Resident #3 was under droplet precautions. The ADON/IP said Resident #3 was admitted [DATE] and there was an order for droplet precautions on 6/21/26. She said the resident was under droplet precautions d/t MRSA. The ADON/IP said if he was under contact or droplet precautions there shouldn't have been another resident in the same room. She said if a resident was already in the room and the roommate was diagnosed with MRSA; the roommate would not be moved because he had already been exposed. The ADON/IP said Resident #2 could have been exposed to the MRSA by being in the same room with Resident #3. She said the staff wore their PPE while working with Resident #3 but, Resident #2 could have still been exposed. She said there were no negative outcomes for Resident #2 being in the same room as Resident #3. She said they were roomed together for one day because Resident #3 was sent to the hospital and Resident #2 was at the facility for a few days due to respite care and was discharged on 6/29/26. She said the last in-service on TBP was on 6/17/2026. She said annual clinics were done on infection control and TBP. She said the admissions coordinator assigned the rooms for newly admitted residents and she coordinated with admissions and informed them which rooms were under TBP precautions. She said she gave admission and dietary a list of residents under TBP. She said she (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	could not explain why Resident #2 was admitted to the same room as Resident #3. During an interview on 7/02/2026 at 10:42 a.m., the Admissions Coordinator said rooms were assigned by the IDT. She said during morning meetings, new admissions were discussed and rooms were assigned for new residents. She said the team agreed to admit Resident #2 with Resident #3. She said she knew ahead of time which rooms were under isolation precautions. She said she was not aware Resident #3 was under droplet precautions and was not marked as isolation precautions on her roster dated 6/25/26. She said the staff discussed Resident #2's admission but somehow the isolation precaution was missed for Resident #3. During an interview on 7/03/2026 at 11:07 a.m., The DON said he did not know why Resident #2 was placed in the same room with Resident #3. He said whenever a resident was under TBP, the resident was roomed alone unless both residents had the same infection. He said the census sheet was highlighted to ensure all staff were aware of which residents were under isolation precautions. He said there was a follow up after Resident #2 was discharged and there was no negative outcome for Resident #2. He said there was ongoing in-services and training for the staff on infection control and infection control transfer sheets. Record review of facility policy untitled, undated, stated, Policy Statement- Transmission-Based Precautions shall be based upon the mode of transmission and may include: .2. Droplet precautions. 4. Droplet precautions shall be used for infections spread through respiratory droplets. Required measures- Staff and visitors shall: wear a surgical mask when entering the room, perform hand hygiene before and after contact, limit resident movement outside the room unless medically necessary, and place mask on the resident during transport when tolerated.		