

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 07/30/2026
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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that the residents were free from chemical restraints not required to treat the residents' medical symptoms for 1 of 3 residents (Resident #1) reviewed for unnecessary medications. The facility failed to ensure LVN A correctly documented Resident #1's ordered medications outcome for Haloperidol and Invega on July 20, 21, 24, 25, 26, 2026 during the 7:00 a.m. to 7:00 p.m. shift. This failure could place residents at risk for adverse reactions and negative side effects from the administration of medication and dependence on unnecessary medications. Findings included: Record review of Resident #1's admission record, dated 07/29/26, reflected a [AGE] year-old male readmitted on [DATE] and initially admitted on [DATE]. His relevant diagnoses included schizophrenia (mental illness defined by delusions, hallucinations, and disorganized thinking), bipolar disorder (mental health condition defined by extreme shifts in mood, energy, and activity levels, moving between highs (mania) to lows (depression), severe intellectual disabilities (IQ score between 20 and 35, major developmental delays and a need for daily supervision and assistance), and ataxia (lack of order, poor muscle control, clumsy movements, and balance issues). Record review of Resident #1's quarterly MDS assessment, dated 05/18/26, reflected a BIMS score of 05, which indicated his cognition was severely impacted. Record review of Resident #1's quarterly care plan assessment, dated 07/26/26, reflected: Focus: [Resident #1] uses psychotropic medications r/t behavior management. Date initiated 09/08/2025 and revised on 04/11/2026. Interventions included to administer psychotropic medications as ordered by physician. Monitor for side effects and effectiveness Q-SHIFT. Date Initiated: 09/08/2025 Record review of Resident #1's physician's order summary, dated 07/29/26, reflected: An order for Haloperidol, Invega outcome codes: I=Improved, S=Same, W=Worsened. Every shift, active 07/15/2026. Record review of Resident #1's July 2026 MAR reflected: Haloperidol, Invega outcome codes: I=Improved, S=Same, W=Worsened. Every shift, start date 07/15/2026 reflected a code of 0 (zero) on July 20, 21, 24, 25, and 26 for the 7:00 a.m. to 7:00 p.m. shift. During an observation on 07/29/26 at 10:04 a.m., Resident #1 was observed lying in bed asleep. He was on a 1:1 supervision. During an interview on 07/29/29 at 4:26 p.m., LVN A said had been Resident #1's charge nurse on July 20-21, 24-26, 2026. He was observed as he reviewed Resident #1's medical electronic record and said he had entered 0 (zero) in error. LVN D said a code 0 (zero) to him meant same. LVN D said he must have gotten confused because Resident #1 also had an order to monitor his side effects of haloperidol and Invega that required a numerical code. LVN A said he understood his error and said, I need to pay more attention. LVN A said he was regularly in-serviced on medication administration. LVN A said a negative outcome to Resident #1 not having the correct cods for his haloperidol, Invega outcome order would be that his behaviors would not be able to be monitored. During an interview on 07/29/26 at 4:36 p.m., ADON B (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said it was her responsibility to ensure all nursing staff entered the correct codes on a resident's MAR. She said she was part of the IDT team who reviewed all resident's MAR during their morning daily meetings. She said Resident #1 had an order to be monitored for the outcomes of haloperidol and Invega per shift and the codes required to enter were I=improved, S=same, and W=worsened. She said a code 0 (zero) entered by LVN A on July 20, 21, 24, 25, 26, 2026 was not correct and that the order required an alphabetical code. ADON B said she and the IDT must have missed it, when reviewing Resident #1's July 2026 MAR. She said all nursing staff are in-serviced on the topic of medication administration on a regular basis. She was observed as she reviewed Resident #1's electronic medical record. She said a negative outcome for Resident #1 not having the correct codes entered on his MAR would be we would not monitor his behaviors correctly and not know if the mediation(s) were working. During an interview on 07/29/26 at 5:00 p.m., the DON was observed as he reviewed Resident #1's electronic medical record. He said Resident #1 had an order Haloperidol, Invega outcome codes: I=Improved, S=Same, W=Worsened. Every shift. He said the order required an alphabetical code and not a numerical code entered by LVN A on July 20, 21, 24, 25, 26, 2026. The DON said it was the responsibility of his ADONs and himself to ensure all nursing staff and medication aides enter the appropriate monitoring codes according to their orders. He said during their morning meetings, he and his ADONs would review all resident's orders to ensure they were being followed correctly. The DON said he and the facility's ADONs in-serviced nursing staff on the topic of medication administration. The DON said a negative outcome to Resident #1 not having his haloperidol and Invega outcome codes entered as ordered would be that we would not be able to monitor Resident #1's behaviors and not know if they have improved, stayed the same or worsened. Record review of the facility's Administering Medications policy, undated reflected: Policy Statement: Medications are administered in a safe and timely manner, and as prescribed. Policy Statement: .4. Medications are administered in accordance with prescriber orders, including any required time frame. Record review of the facility's Charting and Documentation policy, undated reflected: Policy Statement: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, function or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Policy Interpretation and Implementation .2. The following information is to be documented in the resident medical record .b. Medications administered.		