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	05/06/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49301 Based on interview and record review, the facility failed to ensure residents had the right to formulate an advance directive for 1 (Resident #62) of 8 residents reviewed for Advance Directives. The facility failed to ensure Resident #62's OOH-DNR was completed. The OOH-DNR form did not have the physician's signature. This failure could affect all residents who have implemented Advance Directives and established their choice not to be resuscitated at risk of receiving CPR against their wishes. The findings were: Record review of Resident #62's electronic face sheet dated [DATE] reflected he was admitted to the facility on [DATE] and was [AGE] years old. His diagnoses included: Metabolic Encephalopathy (any disease or disorder of the brain, characterized by changes in brain function or structure), Unspecified Dementia (a group of symptoms caused by disorders that affect the brain in which a person loses the ability to think, remember, learn, make decisions, and solve problems), muscle weakness, and bipolar disorder (mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration. Resident #62's electronic face sheet reflected he was Code Status: DNR. Record review of Resident #62's quarterly MDS assessment dated [DATE] reflected he scored an 11 on his BIMS which reflected moderate cognitive impairment. Resident #62 was independent with eating, oral hygiene, and upper body dressing ADLs, and required supervision or touching assistance with toileting hygiene, shower/bathing, lower body dressing, putting on/taking off footwear, and personal hygiene. Record review of Resident #62's undated comprehensive care plan revealed, Resident #62's Advanced Directive: Resident: Has Advanced Directive for Do Not Resuscitate (DNR) Date Initiated: [DATE]. o Advance Directives and Code Status will be honored. Date Initiated: [DATE]. o Review with resident/responsible party current Advance Directives and Code Status. Notify physician of expressed desire for changes as indicated. Date Initiated: [DATE]. o Staff will notify the hospital/ambulance/care provider of Advanced Directives and Code Status as indicated within HIPAA policy and procedure. Date Initiated: [DATE]. (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
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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #62's physician order dated [DATE] reflected ***Code Status: ***DNR*** .Active [DATE]. Record review of Resident #62's OOH-DNR form dated [DATE] revealed the form was signed in section C. Declaration by a qualified relative of the adult person who is incompetent or otherwise incapable of communication: I am the above person's: spouse. The OOH-DNR revealed the form was not signed by the attending physician below section E, Physician's Statement: I am the attending physician of the above noted person and have noted the existence of this order in the person's medical records. I direct health care professionals acting in our-of-hospital settings, including a hospital emergency department, not to initiate or continue for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation. It also revealed the physician did not sign below section F, All persons who have signed above must sign below, acknowledging that this document has been properly completed. In an interview on [DATE] at 12:45 pm Social Services said upon admission, she informed the resident and/or family of their rights regarding the DNR status. If it was requested for the resident to be a DNR, she provided them with the form, helped them complete the form, and obtained their signatures. She then sends the form to Medical Records, who was responsible to get the form signed by the Physician. She said once the form was signed, she uploaded the form into PCC under the miscellaneous tab. She said she uploaded the form into PCC but saw that it was not signed. She said that she did not recall why she uploaded the form not signed. In an interview on [DATE] at 3:00 pm the Medical Records said she had the signed DNR form and that it was already scanned into PCC. She provided me a copy of the DNR, and it revealed the MD signed it today, [DATE]. I asked Medical Records if she just got the DNR form signed today, and she said yes, she had it signed today. She said usually when a resident came out of the hospital with a DNR, the social worker would provide her the documentation through email, and she would be responsible to get them signed right away by the physician. She said since the form was received last year and she started working in January of 2025, she had to look for Resident #62's DNR and got it signed today. She said since she started working this job in January, she ensured the DNR forms were signed immediately because DNRs were very important. She said if the DNR was not signed by the physician, then the resident was considered a full code and could potentially not get the appropriate care. In an interview on [DATE] at 4:14 pm CNA P said she knew the resident's DNRs showed on PCC. She said they were not allowed to resuscitate a resident. She said they must call the nurses and they should know if a resident was a DNR. She said if a DNR was not complete, it could make a resident receive resuscitation and it was not what was wanted. In an interview on [DATE] at 11:20 am LVN A said a resident who was a DNR should have a completed and signed by all parties and the DNR on file. She said if a DNR was not signed by the MD, it would affect the care for the resident if they coded because they would not know if they could provide resuscitation or not. She said if the DNR was not signed by the MD, then it was not valid. She said they would not be able to respect the resident's wishes of the DNR. They would have to provide CPR causing the resident harm. She said the DNR status of a resident was located on PCC. She said if it showed DNR on PCC that meant it had been verified and completed. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 11:40 am the ADON said if a resident was out of hospital DNR, they must verify that the form was current and ensure the MD signed the form in case the resident coded, to ensure they did not go against the resident's wishes. She said if the DNR was not signed by the physician, it was an incomplete DNR. The ADON said to her knowledge a DNR must be signed by the physician. She said the floor nurse receiving the order would update it in PCC. She said if PCC showed the resident in DNR status, it could have been that the resident went out to the hospital and the receiving nurse received report from hospital nurse that the resident was a DNR. She said if the RP requested a change, the nurse may also update PCC at that time. The ADON said PCC should not be updated until the completed DNR form was received and uploaded into PCC. The ADON said the negative outcome of the MD not signing the DNR could be causing the facility staff to provide resuscitation against the resident's wishes or not resuscitating a resident when the resident wanted to be. In an interview on [DATE] at 1:46 pm the DON said best practice was upon admission they talk to the resident and the family about code status. He said they must explain what a DNR was so they could decide. If they say yes, they want to be DNR, the facility started the document and explained what it entailed. The facility would obtain the resident/RP, witnesses, and the MD signatures. The DON said once everything was completed, they uploaded the document and then changed the code status on PCC. According to the DON, we explain to the resident / family that until the DNR was completed they were full code. The DON said that he did not know if the facility had a policy that stated one or the other was correct. The DON said they did not tell staff to place the DNR status until they received the DNR. He said they tell staff if PCC says DNR, they must check the form to ensure it was completed. The DON said legally if the MD did not sign, the DNR was not complete. He said if the DNR was not complete, they could not resuscitate a resident. He said if the legal document did not have the signatures in place, they would not be respecting the resident's wishes or not saving a resident's life. In an interview on [DATE] at 2:30 pm the ADM said his understanding regarding the DNR status of a resident was if the resident/family decided they wanted the resident to be a DNR, that should suffice. The ADM said they would get the resident/family signatures on the form. He said it was his understanding that they only need a physician's signature if the resident/family could not decide. He said if they had 2 family members sign and the resident/RP, then that was a valid DNR. The ADM said if the MD signature was required, then they would have an incomplete DNR, and the resident would be a full code and the full code would be against their wishes. The ADM provided me with a copy of the Physician's Order and said that since Resident #62 showed on the orders as a DNR status, that showed the DNR was ordered by the MD. Record review of the facility's Advance Directives policy dated 2001, revealed the Policy Statement The resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy. Policy Interpretation and Implementation 1. The facility defines the following in accordance with current OBRA definitions and guidelines: . (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Advance Directive - a written instruction, such as a living will or durable power of attorney for health care, recognized by state law (whether statutory or as recognized by the courts of the state), relating to the provisions of health care when the individual is incapacitated . (3) Do Not Resuscitate (DNR) - indicates that, in case of respiratory or cardiac failure, the resident, legal guardian, health care proxy, or representative (sponsor) has directed that no cardiopulmonary resuscitation (CPR) or other life-sustaining treatments or methods are to be used. Record review of the OOH DNR Order instructions for issuing and OOH-DNR Order revealed the Purpose: The Out-of-Hospital Do-Not-Resuscitate (OOH-DNR) Order on reverse side complies with Health and Safety Code (HSC), Chapter 166 for use by qualified persons or their authorized representatives to direct health care professionals to forgo resuscitation attempts and to permit the person to have a natural death with peace and dignity. Applicability: This OOH-DNR Order applies to health care professions in out-of-hospital settings, including physicians' offices, hospital clinics and emergency departments. Implementation: A competent adult person at least [AGE] years of age, or the person's authorized representative or qualified relative may execute or issue an OOH-DNR Order. The person's attending physician will document existence of the Order in the person's permanent medical record. The OOH-DNR Order may be executed as follows: . In addition: the OOH-DNR Order must be signed and dated by two competent adult witnesses, who have witnessed either the competent adult person making his/her signature in section A, or authorized declarant making his/her signature in either sections B, C, or E, and if applicable, have witnessed a competent adult person making and OOH-DNR Order by nonwritten communication to the attending physician, who must sign in Section D and also the physician's statement section.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49301 Based on observation, interview, and record review the facility failed to ensure the assessment accurately reflected the resident's status for 1 (Resident #36) of 8 residents reviewed for accuracy of assessments. The facility failed to ensure Resident #36 was coded in the MDS for falls. This failure could place residents at risk of improper or incorrect care and services necessary for their physical, mental, and psychosocial well-being. The findings included: Record review of Resident #36's face sheet dated 05/06/25 revealed Resident #36 was admitted on [DATE] and was [AGE] years old. Resident #36 had diagnoses of Alzheimer's Disease (a progressive disease that affects memory, thinking, and behavior), muscle weakness, lack of coordination, and hemiplegia (paralysis or severe weakness on one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body) affecting left and right side. Record review of Resident #36's comprehensive care plan reflected: Resident #36 is at risk for falls r/t Psychoactive drug use, Unaware of safety needs Date Initiated: 02/28/2024 Revision on: 02/28/2024. Interventions: o Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Date Initiated: 02/28/2024 o bilateral floor mats as needed Date Initiated: 02/22/2025 Revision on: 03/23/2025 o Fall occurs; 72 hours documentation of; injuries and neuro checks as indicated Date Initiated: 02/28/2024 o Get resident up to wheelchair if restless in bed. Date Initiated: 03/10/2025 o Pt evaluate and treat as ordered or PRN. Date Initiated: 02/28/2024 o Replace bed to low bed to lowest position Date Initiated: 03/11/2025 o tent call light as tolerated Date Initiated: 03/25/2024 Revision on: 02/23/2025. Unwitnessed fall resident noted laying on mat by bed on floor, no injury Date Initiated: 03/10/2025 Revision on: 03/23/2025. Interventions: o For no apparent acute injury, determine and address causative factors of the fall. Date Initiated: 03/10/2025 o Get resident up to wheelchair if restless in bed. Date Initiated: 03/10/2025 o Monitor/document /report PRN x 72h to MD for s/sx: Pain, bruises, Change in mental status, New onset: confusion, sleepiness, inability to maintain posture, agitation. Date Initiated: 03/10/2025 o Neuro-checks Date Initiated: 03/10/2025 Revision on: 03/23/2025 o Pharmacy consult to evaluate medications. Date Initiated: 03/10/2025. Resident #36 was found lying PRONE ON THE FLOOR MAT BETWEEN BOTH BEDS, Date Initiated: 03/11/2025 Revision on: 03/23/2025. Interventions: o For no apparent acute injury, determine and address causative factors of the fall. Date Initiated: 03/11/2025 o Monitor/document /report PRN x 72h to MD for s/sx: Pain, bruises, Change in mental status, New onset: confusion, sleepiness, inability to maintain posture, agitation. Date Initiated: 03/11/2025 o Neuro-checks Date Initiated: 03/11/2025 Revision on: 03/23/2025 o Pharmacy consult to evaluate medications. Date Initiated: 03/11/2025 o Replace bed to low bed Date Initiated: 03/11/2025. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #36's quarterly MDS dated [DATE] reflected he scored a 04 on his BIMS which reflected a severe cognitive impairment. Required Supervision or touching assistance with eating, substantial/maximal assistance with shower/bathing and oral hygiene and dependent for toileting hygiene, upper and lower body dressing, putting on/taking off footwear and personal hygiene. Reflected no falls since admission/entry or reentry or the prior assessment, whichever was more recent. Record review of facility's incident log dated 5/4/25 revealed that on Resident #36 had falls on 2/22/25, 3/10/25 and 3/11/25. In an interview on 5/6/25 at 11:40 am the ADON said if a resident had a fall and the MDS did not accurately update on the MDS the resident had repeated falls, it would not trigger the interventions for those falls. She said the negative outcomes could be to cause a lack of attention to the care the resident needed or not changing a previous intervention that was not working to something new that would help. In an interview on 5/6/25 at 1:46 pm the DON said if a resident had any falls since the last MDS assessment, it should be captured on the next quarterly assessment. The DON said the MDS should review the incident log to see if there have been any changes. He said for him, the MDS at times failed to capture falls, so he would review incidents and would have contacted the therapist to inform, the resident needed a PT assessment. He said if the resident required a low bed, he would have informed his nurses. The DON said if the MDS failed to capture falls on the assessments, it did not reflect what was actually going on with the resident. It would show he was not having falls, when in reality he was. He said at some level, it could affect the type of care the resident would receive. The DON said they review reports and if those reports were not reflecting the correct information, it could affect his decision of what interventions to take. He said it could cause the resident to fall again because the assessment did not reflect what was exactly going on with the resident. In an interview on 5/6/25 at 2:23 pm MDS Q, she looked at Resident #36's most recent quarterly MDS and said it was coded inaccurately. She said the MDS Nurse who completed the assessment no longer worked at the facility. She said not capturing the falls on the MDS assessment was just an inaccuracy of the MDS itself. She looked at the care plan and said it looked like the interventions were updated for the falls, they were just not captured on the MDS. She said not capturing the falls accurately could affect for quality measures because it was not reflecting accurately but it would not have any affect for anything else negatively or positively. In an interview on 5/6/25 at 2:30 pm the ADM said as long as there were interventions in the care plan, the resident should have no negative effects for any falls not captured on the MDS. He said the facility goes over falls in the morning meetings, so the residents' needs should be met. Record review of the facility's Resident Assessments policy dated 2001 revealed the Policy Statement - A comprehensive assessment of each resident is completed at intervals designated by OBRA regulations and PPS requirements. Data from the Minimum Data Set (MDS) is submitted to the Internet Quality Improvement Evaluation System iQIES as required. Policy Interpretation and Implementation . (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12. Information in the MDS assessments will consistently reflect information in the progress notes, plans of care, and resident observations/interviews. Record review of CMS's RAI Version 3.0 Manual dated 10/2024 reflected section: J1800: Any falls since admission/entry or reentry or Prior to Assessment. Coding instructions: Code 1, yes if the resident has fallen since the last assessment. Continue to number of falls since admission/entry or reentry or prior to assessment . J1900: Any falls since admission/entry or reentry or Prior to Assessment. Coding instructions: Code 2, two or more: if the resident had two or more non-injurious falls since admission/entry or reentry or prior assessment.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 40872 49301 Based on interviews, and record review, the facility failed to develop a comprehensive care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment and described the services that were to be furnished to attain or maintain the resident's medical, nursing, and mental and psychosocial needs for 3 (Resident #252, Resident #97 and Resident #72) of 8 residents reviewed for comprehensive care plans. 1. Resident #72's comprehensive care plan was not revised after he returned from being hospitalized on [DATE] for a recurrence of pneumonia. 2. The facility failed to develop a comprehensive person-centered care plan to address Resident #252's antibiotics for positive sputum culture. 3. The facility failed to develop a comprehensive person-centered care plan for Resident #97's cigarette use. These failures could place residents at risk for not receiving the appropriate care, services or treatments needed and place at risk for re-hospitalization . The findings included: 1. Record review of Resident #72's face sheet dated 05/5/25 reflected a [AGE] year-old-male with an original admitted [DATE]. Diagnoses included End Stage Renal Disease (condition in which the kidneys lose the ability to remove waste and balance fluids), metabolic encephalopathy (change in how the brain works due to underlying condition that can cause confusion, and muscle weakness. Record review of Resident #72's Change of Condition Evaluation dated 2/20/25 reflected the resident had SOB, oxygen level 95-97 room air, heart rate within normal limits. Resident stated the SOB happened only during transfers. Reported to the MD on call and ordered a chest x-ray. Attempted to report to the RP but no answer. Standing orders for SOB were being carried out. Will report to oncoming nurse. Record review of Resident #72's progress notes revealed on: 2/20/25 at 7:05 pm, Resident was c/o SOB during transfers. Oxygen level 95-97 room air, heart rate withing normal limits. Respiration 22. Resident states SOB only happens during transfers. Called Dr on call service. Informed them of standing orders for SOB are being carried out. Attempted to call responsible party but no answer. Will inform oncoming nurse. 2/20/25 at 7:05 pm Chest xrays 2 views orders. Will inform oncoming nurse. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2/24/25 at 8:00 pm Upon administering scheduled medications, resident c/o SOB. Resident had scheduled neb treatment and medications due. Administered as ordered. Nurse reassessed resident SPO2 was 83%. Pulse was 128. Patient was diaphoretic (excessively sweating) and in respiratory distress. Notified respiratory therapist who then placed patient on nonrebreather. Patient had improvement in O2. Resident placed on 4LPM via nasal cannula O2 sat 95%. Resident continued to be in distress with elevated heart sustaining between 118-120. Notified physician. Order to send patient to hospital to evaluate/treat. Nurse called 911 to transport patient and will call hospital to notify/report patients arrival. RP family member notified of change of condition and transfer. 2/25/25 at 2:29 am nurse called hospital for update: patient to be admitted admitting dx: pneumonia, flu ache. 3/2/2025 at 9:11 pm Resident is alert and oriented to self and situation. Able to follow simple commands. No visual signs of pain or discomfort. Calm and cooperative.As per Dr. standing order continue all medication. Record review of Resident #72's comprehensive care plan reflected: The resident has a Respiratory Infection r/t pneumonia Date Initiated: 01/22/2025 Revision on: 01/22/2025. The resident will be free of symptoms of respiratory distress through the review date. Date Initiated: 01/22/2025 Target Date: 02/19/2025. Interventions: o Antibiotic therapy as ordered by the physician. Date Initiated: 01/22/2025 o Bronchodilators via nebulizer as ordered by the physician. Monitor/document side effects and effectiveness. Record BP, pulse, and respiration rate. Date Initiated: 01/22/2025 o Document response to treatment. Date Initiated: 01/22/2025 o Encourage coughing, deep breathing. Date Initiated: 01/22/2025 o Encourage fluid intake. Date Initiated: 01/22/2025 o Give antipyretics as ordered. Monitor/document side effects and effectiveness. Record temperature. Date Initiated: 01/22/2025 o Give cough suppressant or expectorant as ordered. Monitor/document for side effects and effectiveness. Date Initiated: 01/22/2025 o Monitor/document and document level of consciousness and any changes. Date Initiated: 01/22/2025 o Monitor/document breath sounds, document rate, rhythm, and the use of any accessory muscles. Date Initiated: 01/22/2025 o Monitor/document/report to MD PRN for s/sx of dehydration: dry skin and mucous membranes, poor skin turgor, weight loss, anorexia, malaise, hypotension, increased heart rate (Tachycardia), fever, abnormal electrolyte levels. Date Initiated: 01/22/2025. The resident is on antibiotic therapy r/t pneumonia Date Initiated: 01/27/2025 Revision on: 01/27/2025 o The resident will be free of any discomfort or adverse side effects of antibiotic therapy through the review date. Date Initiated: 01/27/2025 Target Date: 02/19/2025 o Administer ANTIBIOTIC medications as ordered by physician. Monitor/document side effects and effectiveness Q-SHIFT. Date Initiated: 01/27/2025 o Monitor/document/report PRN adverse reactions to ANTIBIOTIC therapy: diarrhea, nausea, vomiting, anorexia, and hypersensitivity/allergic reactions (rashes, welts, hives, swelling face/throat). Date Initiated: 01/27/2025 o Monitor/document/report PRN s/sx of secondary infection r//t ANTIBIOTIC therapy: oral thrush (white coating in mouth, tongue), persistent diarrhea, and vaginitis/itchy (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	perineum (area between anus and genitals)/whitish discharge/coating of the vulva/anus. Date Initiated: 01/27/2025 o Report pertinent lab results to MD Date Initiated: 01/27/2025. In an interview on 5/6/25 at 11:20 am LVN A said the floor nurse, ADONs or DONs update the care plans. She said the CNAs learn about changes when they came in and got report from the previous shift CNA or would get report from the nurses. She said if interventions were not updated in the care plan, it could affect the resident's care. She said they would not know how to properly take care of the resident because they would not know what new interventions to provide. She said a bad outcome for someone who returned from the hospital with pneumonia and the care plan was not updated could be that the resident could get pneumonia again, go into respiratory distress if not monitoring properly, or could go septic (life-threatening caused by the body's extreme response to infection) and back in the hospital. She said Resident # 72 was on nebulizer treatments, O2 saturations checked, lung sounds checked, and respirations checked. She said she was not sure if those interventions were there prior to his most recent hospitalization . She said the ADON or DON would update care plans when a resident returned from a hospital stay. In an interview on 5/6/25 at 11:40 am the ADON said if a resident was hospitalized and returned with a diagnosis of pneumonia, they should update the care plan. She said if pneumonia was previously care planned, then they would add to that care plan. She said they usually did new interventions and added any new medications. She said the care plan would have to be revised with a date. She said the MDS nurse, receiving nurse or DON were responsible for updating the care plans. She said the ADONs only updated if asked to do it if for some reason. In an interview on 5/6/25 at 1:46 pm the DON said care plans were updated on a case-by-case basis, because the resident went to the hospital for a reason. He said the care plan should be updated if a resident went to the hospital for pneumonia even if it was care planned previously. He said he would ensure there was a change in condition. He said a resident who had pneumonia would be sent to the hospital. He said for best practice yes, they needed to update the care plan because it needed to be documented somewhere. He said the IP would update the care plan if the resident was started on antibiotics, the floor nurse should update the care plan upon a resident's arrival. He said if pneumonia was care planned for a resident and still active, and he received a change in medication then it should be updated. The DON said if there was no new problem, for example the problem was resolved while the resident was in the hospital, they would not update the care plan. He said the floor nurse should have updated that care plan if it was active. He said the negative outcome would be the resident being at risk for the problem to happen again was increased. In an interview on 5/6/25 at 2:30 pm the ADM said for a care plan to be updated for pneumonia, he thought they got MD orders. He said he knew they sent residents out to the hospital with a diagnosis that had already been care planned. He said it could be that the admitting dx was already care planned and did not need to be updated. Record review of the facility's policy on Care Plans, Comprehensive Person-Centered with a revision date of March 2022, reflected the Policy Statement (continued on next page)

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	455423	A. Building B. Wing	05/06/2025

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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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Policy Interpretation and Implementation . 12. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition; . c. when the resident has been readmitted to the facility from a hospital stay; . 2. Review of Resident #252's Admission Record dated 05/5/2025 revealed an admitted [DATE]. The Resident's diagnoses included chronic obstructive pulmonary disease (a progressive lung disease that makes it difficult to breath) and tracheostomy status (whether an individual has a tracheostomy tube, a surgical procedure where a hole is made in the windpipe to create an airway). Review of the Resident #252's physician orders dated 05/5/2025 revealed Resident #252 received Meropenem solution reconstituted 1 gram, administer 1 gram via intravenously every 12 hours for positive sputum culture for 14 days with a start day on 4/30/2025 and end date 5/14/2025. Review of Resident #252's most recent comprehensive MDS assessment dated [DATE], revealed the resident received tracheostomy care while a resident. Review of the Resident #252's Care Plan, dated 04/7/2025, revealed the care plan did not identify the resident's treatment for positive sputum culture. During an observation on 5/4/25 at 1:15 p.m. Resident #252 was in her room, she was laying on her bed, she was watching television. Call light was within reach from Resident #252. Resident #252 had a tracheostomy, she was not able to talk. During an interview on 05/5/25 at 1:44 p.m. the MDS nurse stated the care plan should have been updated when and by whomever received the order for the antibiotic. The MDS nurse stated if the care plan was not updated it could affect the nurses by not being able to give the care that Resident #252 needed. During an interview on 05/6/25 at 10:50 p.m. with DON stated the care plan had to be updated to give the resident the best care and to verify if the interventions were effective. The DON stated care plans were created upon admission within 48 hours, updated 14 days after admission, quarterly, and upon change of condition. The DON stated Resident #252 was at risk of not receiving a proper care that she required. DON said that the nurse that got the new order was responsible to start updating the care plan. Review of the facility Care planning - Interdisciplinary Team policy revised March 2022, reflected A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional need is developed and implemented for each resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Record review of Resident #97's face sheet dated 05/04/25 indicated Resident #97 was a [AGE] year old male admitted on [DATE] with diagnoses of Type 2 Diabetes Mellitus (body's inability to use insulin properly, leading to high blood sugar levels requiring insulin injections to manage) without Complications, Essential (Primary) Hypertension (type of high blood pressure where no underlying cause is identified), Alcohol Abuse, uncomplicated, Other Abnormalities of Gait and Mobility (deviations from normal walking patterns and movement capabilities). Record review of Resident #97's MDS dated [DATE] revealed Resident #97's BIMS of 11 indicating moderate cognitive impairment suggesting need for increased assistance with daily tasks. Record review of Resident #97's comprehensive care plan dated 03/31/25 revealed no documentation of Resident #97's use of cigarettes. Observation conducted on 05/04/25 at 9:38 a.m. revealed Resident #97 was observed laying down in bed in his room. It was observed next to his bed was a box of cigarettes. During an interview on 05/04/25 at 9:38 a.m. Resident #97 stated he had the cigarettes in his jacket and did not tell the staff that he had them. He said he knew he was not supposed to have them in his room. During an interview on 05/06/25 at 4:39 p.m. LVN X said the nurses and MDS nurses were supposed do care plans for residents. She said on the initial admission assessment it stated no to uses tobacco. She said it should have been care planned because although he wasn't a regular smoker because he didn't always have money for cigarettes, he did smoke. During an interview on 05/06/25 at 4:39 p.m. the DON stated if a resident is a smoker, it should be documented in the care plan. He said if Resident #97 did not mention that he was or was not a smoker when he was admitted then it would not be care planned. He said he was not working at the facility at the time Resident #97 was admitted and did not know if he was a smoker prior to admission. During an interview on 05/06/25 at 5:37 p.m. the Administrator stated that Resident #97 was not a smoker when he came in. He said he probably picked up the habit from others while staying at this facility. When asked about negative outcomes, the Administrator said the resident is alert and oriented and able to smoke on his own. Review of facility Care planning - Interdisciplinary Team policy revised March 2022, reflected A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional need is developed and implemented for each resident. 50487

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26141 Based on observations, interviews, and record review, the facility failed to ensure residents received proper treatment and care to maintain mobility and good foot health for 1 Resident (Resident #91) of 8 residents reviewed for foot care. The facility did not provide adequate foot care for Resident #91. Resident #91's nails were greyish/black, thick, and long. The nail of her right big toe was curving and growing toward her second toe. This failure could put residents at risk for infection, impaired mobility, and poor foot health as well as a decline in their quality of life. The findings were: Record review of Resident #91's Admission Record indicated Resident #91 was admitted to the facility on [DATE] with diagnoses including unspecified dementia, unspecified severity, with other behavioral disturbance (the loss of cognitive function that interferes with daily life and activities), type 2 diabetes mellitus (a disease in which your blood glucose, or blood sugar, levels are too high), muscle weakness, and difficulty in walking and other lack of coordination. Record review of Resident #91's Order Summary Report for May 2025 revealed may consult with podiatrist for evaluation and treatment, order dated 01/14/2025 and podiatry care PRN, order dated 01/01/25. Record review of Resident #91's MDS quarterly assessment, dated 04/01/25 revealed Resident #91 would understand others and was understood by others, had severe cognitive impairment, and did not trigger for rejection of care, and required substantial assistance for personal hygiene and put on/off footwear. Record review of Resident #91's Comprehensive Care Plan dated 01/21/25 revealed Resident #91 had an ADL Self-Care deficit and the resident had diabetes mellitus. Interventions included refer to podiatrist /foot care nurse to monitor/document foot care needs and to cut long nails. Record review of Resident #91's Comprehensive Care Plan dated 02/18/25 revealed the resident had a behavior problem. Refused to allow toenails to be trimmed r/t dementia with aggression with interventions to anticipate and meet resident needs and Podiatrist to continue attempts. Record review of Nurse's Progress Notes dated 02/18/25 revealed the Podiatrist at bedside unable to trim her toenails. The Resident became combative, patient refused. Record review of progress notes from 02/18/25 through 05/06/25 did not reveal any further attempts by staff to trim Resident #91's toenails. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 05/04/25 at 10:23 a.m., revealed Resident #91 was sitting on the bed. Greeted Resident #91 and she asked who was calling her Senora. She got up, walked toward the door, said yo me siento [NAME] (I sit over there) and walked out of her room. The Resident had on red non-skid socks and the right foot sock was torn at the toes. The State Surveyor observed the resident's right toenail was long, discolored, crooked, and curved toward her second toe. Interview on 05/05/25 at 03:02 PM CNA D said Resident #91 had long toenails and the nurses knew about it, but Resident #91 would not allow the staff to touch her or change her. Resident #91 would hit and scratch staff when they tried to provide care. CNA D said it took three people to shower the resident because she would hit, kick, scratch, and spit at staff. CNA D said she did not know how they could cut her nails because she would not allow it. CNA D said perhaps Resident #91 would allow the doctor, but she did not think so. Resident #91 was confused and disoriented and even if they asked her if she wanted her nails cut, she would not answer correctly. In an interview via phone on 05/06/25 at 8:41 a.m., Resident #91's FM said she was aware of Resident #91's behavior of not allowing the staff or the Podiatrist to trim her nails. The FM said Resident #91 had the same behavior at home. The FM said she would try to visit on the weekend and hoped the Podiatrist would be able to see Resident #91 on the weekend. The FM said she was aware it was necessary for the Podiatrist to provide care to Resident #91 to prevent complications to her health. The FM said the resident was diabetic. Observation on 05/06/25 at 10:28 AM revealed Resident #91 was in her room. The resident was lying down in bed. The State Surveyor and LVN C were there to observe the resident's toenails. LVN C asked Resident #91 if he could see her right root and the resident stuck her foot out of the blanket and then quickly tucked it back in. LVN C asked Resident #91 if he could take off her sock so he could see her nails and Resident #91 declined. The resident asked to be left alone and for LVN C and the State Surveyor to leave her room. In an interview on 05/06/25 at 10:32 AM LVN C said Resident #91 had fungal infection in her nails because they were discolored and thick. LVN C said they have clipped some of the toenails, but the staff were not able to clip the big toes. LVN C said he had not measured the nails, but the nail of the big toe was over the nailbed. LVN C said it could be an inch or inch and a half over the nailbed. LVN C said by not allowing staff to cut her nails, it could put the resident at risk of pain or difficulty walking. LVN C said the Responsible Party was aware of the status of the nails. LVN said he had not attempted other methods for the resident to consent to care. LVN C said he could ask the doctor to prescribe Resident #91 a one-time dose of Ativan if the Responsible Party gave consent. In an interview via phone on 05/06/25 at 12:21 p.m., the Podiatrist said he had attempted two times in January and once in February to provide care to Resident #91, but she refused to allow him to trim her toenails. The Podiatrist said he was able to cut two of her toenails but then the resident became combative, and he had to stop. The Podiatrist said it was important for Resident #91 to receive treatment for her feet to prevent an infection or end up in the hospital due to complications. The Podiatrist said he would be willing to go this weekend if the FM would be there. The Podiatrist said he could prescribe a one-time dose of a medication to calm the resident so she could allow him to be able to trim her nails. The Podiatrist said he did not usually like to medicate his patients, but he could order some Benadryl for Resident #91. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/06/25 at 03:33 p.m., the DON said he tried to get a care plan meeting for the family so they could hear the facility's concerns and what they needed to do to get results for Resident #91. The DON said it was a bit difficult to get residents with dementia to agree to care. The staff tried to get the family to be present when they were providing the care to Resident #91. The DON said sometimes doctors required a resident to be sedated while providing the care, but he did not feel that Ativan would be a proper medication to administer to Resident #91. The DON said they could try the Benadryl, but it was not strong. They would have to ask the family to give consent for the medication. The DON said the negative outcome for Resident #91 not having her toenails cut could be the resident would have pain, or it could affect her ability to walk if she had pain. There was a risk the nail could cut into the skin of her second toe. The DON said LVN C had a good rapport with residents and perhaps he and the doctor could provide the nail care to Resident #91. In an interview on 05/06/25 at 04:02 p.m., the Administrator said they had morning meetings every day to go over any grievances and concerns. The Administrator said he was not aware Resident #91 had issues with her nails. The Administrator said the staff had tried to provide nail care to residents, but she had refused. The Administrator said the podiatrist had come to provide care to Resident #91, but she refused to have her toenails trimmed. The Administrator said it was a resident's right to refuse care. The Administrator said he had not seen resident 91's toenails. The Administrator said Resident #91 had refused requests to trim her toenails and the staff can't force her to accept the care. Record review of the facility's policy on Activities of Daily Living (ADL), Supporting dated 2001 indicated: Policy Statement Residents will be provided with care, treatment, and services as appropriate to maintain, improve their ability to carry out activities of daily living (ADLs). Resident who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. Policy Interpretation and Implementation 1. Residents will be provided with care, treatment, and services to ensure that their activities of daily living (ADLs) do not diminish unless circumstances of their clinical condition(s) demonstrate that diminishing ADLs are unavoidable. 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care) 4. If a resident with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. Approaching the resident in a different way or at a different time or having another staff member speak with the resident may be appropriate.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40872 Based on observation, interview, and record review the facility failed to ensure residents received adequate supervision to prevent accidents and failed to ensure the resident environment remained as free of accident hazards as possible for 1 of 3 residents reviewed for accidents (Resident #97). The facility failed to provide adequate supervision to ensure Resident #97 did not obtain and keep cigarettes at his bedside. This failure could place residents who require supervision to prevent accidents and ensure their environment remains as free of accident hazards as possible, at risk for decreased quality of life or injury that could result in unnecessary hospitalization . Findings included: Record review of Resident #97's face sheet dated 05/04/25 indicated Resident #97 was a [AGE] year old male admitted on [DATE] with diagnoses of Type 2 Diabetes Mellitus (body's inability to use insulin properly, leading to high blood sugar levels requiring insulin injections to manage) without Complications, Essential (Primary) Hypertension (type of high blood pressure where no underlying cause is identified), Alcohol Abuse, uncomplicated, Other Abnormalities of Gait and Mobility (deviations from normal walking patterns and movement capabilities). Record review of Resident #97's MDS dated [DATE] revealed Resident #97's BIMS of 11 indicating moderate cognitive impairment suggesting need for increased assistance with daily tasks. Observation conducted on 05/04/25 at 9:38 a.m. revealed Resident #97 was observed lying down in bed in his room. It was observed next to his bed was a box of cigarettes. In an interview on 05/04/25 at 9:38 a.m. with Resident #97 stated he had the cigarettes in his jacket and did not tell the staff that he had them. He said he knew he was not supposed to have them in his room. In an interview on 05/04/25 at 9:46 a.m. with CNA O who stated she picked up Resident #97's food tray earlier and did not see the cigarettes in his room. She said residents were not supposed to have cigarettes in their room. She said they kept them locked at the nurses' station or cart. CNA O took the cigarettes to the nurse's station. In an interview on 05/04/25 at 9:48 a.m. LVN K stated she gave Resident #97 his medication at around 9:00 a.m. this morning and did not see the cigarettes on his nightstand. She said residents were not supposed to keep cigarettes in their room. She said nurses kept them in their carts locked and they gave them to the residents when they go outside to smoke at the designated times. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/06/25 at 4:29 p.m. the DON stated residents were not supposed to have any smoking items or paraphernalia in their rooms. He said that they were supposed to be kept in nurse's carts locked or in nurses medication room locked. The DON said he didn't know why the Resident #97 had cigarettes in his room. He said what can possibly happen was the resident can burn or die. The DON said all staff were inserviced on the smoking policy. He said he had done 2 inservices on smoking since he started working at this facility about a month ago. In an interview on 05/06/25 at 5:19 p.m. with the Administrator stated residents were not supposed to have cigarettes in their room. He said they were kept in the medication room locked. He said residents knew they were supposed to give them to staff and could not have them in their rooms. He said if cigarettes were kept in a resident's room, other residents could take them and may be a danger to others. He said Resident #97 went out on pass and maybe brought some back and didn't tell the staff. Record review of facility's policy on Smoking, dated: Revised October 2023, reflected: This facility has established and maintains safe resident smoking practices. 15. Residents without independent smoking privileges may not have or keep any smoking items, including cigarettes, tabaco, etc., except under direct supervision.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40872 Based on observation, interviews and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for storage, preparation and sanitation. The facility failed to ensure all food products in walk-in freezer were labeled and dated. The facility failed to ensure employee medication and a soft drink cup were not stored in refrigerated. The facility failed to properly thaw raw chicken that was observed in the sink designated for vegetables only. The chicken was not under running water. There was raw ground beef on the sink counter next to the sink that contained the raw chicken. These failures could place residents at risk for food contamination and food-borne illnesses. Findings included: Observation and initial tour of the kitchen on 05/04/25 at 8:50 a.m. revealed raw chicken in a 2-compartment sink labeled Vegetables only with no water running as well as raw ground beef on the counter of the sink. Inside the reach-in refrigerator was a small box labeled as medication belonging to an employee as well as a large soft drink cup labeled big gulp. Inside the walk-in freezer were 3 clear bags containing meat that were not labeled or dated. During an interview on 05/04/25 at 9:02 p.m. the DD stated the meat in the freezer was chicken and it should have been labeled and dated. He said the medication belonged to an employee and it was not supposed to be kept in the facility refrigerator he said he will speak with the employee and counsel him on it. DD said the chicken and the beef on the sink that was labeled for vegetables only should not have been there. He said that could contaminate the vegetables and cause resident to become sick. He said staff gets in serviced on this and on labeling on a weekly basis he didn't know why staff did not do what they were supposed to but would be in servicing them again on it. the DD said the medication along with the soft drink that were found in the refrigerator should not have been in there. He said staff were told not to put personal items in there and were in serviced as well. He said anyone could grab the medication. During an interview on 05/04/25 at 3:40 p.m. DA Q stated the medication was supposed to be refrigerated and was supposed be taken once a week. He said he didn't have another refrigerator to put it in. DA Q also said he hadn't told his manager that he had been putting it in the refrigerator. He said he knew he wasn't supposed to be putting it there. (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/06/25 at 5:28 p.m. the Administrator stated the staff were in serviced on kitchen policies by the DD and the DD also has huddles daily to remind staff on those policies. He said they shouldn't be putting meat to thaw on areas that were designated for something else. He said it could contaminate other food. Administrator also said that staff aren't supposed to be putting any medication or any personal items in the facility refrigerator. he said employees have lockers and they have employee lounge which has a refrigerator where staff can put their personal items. He said he didn't know why DA Q hadn't put the medication in those places. He said a negative outcome could be that it falls or touches food, it can possibly contaminate it but it was in a box so I don't think anything could happen unless its opened. Record review of facility's policy: Food Receiving and Storage, not dated, states, Policy Statement: Foods shall be received and stored in a manner that complies with safe food handling practices. 7. All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date). Reference FDA Food Code 2022 Ch. 3-307 Preventing Contamination from Other Sources 3-307.11 Miscellaneous Sources of Contamination. FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306 3-501.13 Thawing Except as specified in (D) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be thawed: (B) Completely submerged under running water: (1) At a water temperature of 21oC (70oF) or below Pf, (2) With sufficient water velocity to agitate and float off loose particles in an overflow Pf. 6-305.11 Designation. (B) Lockers or other suitable facilities shall be provided for the orderly storage of EMPLOYEES' clothing and other possessions. 6-305.11 Designation. Street clothing and personal belongings can contaminate food, food equipment, and food-contact surfaces. Proper storage facilities are required for articles such as purses, coats, shoes, and personal medications.

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	05/06/2025

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 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** 50487 Based on observations, interviews, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 1 Resident out of 5 (Resident #42) reviewed for Enhanced Barrier Protections (EBP) for infection control practices. LVN A failed to follow Enhanced Barrier Precautions for an indwelling medical device (gastrostomy tube) for Resident #42. This failure could place residents at risk for cross contamination and the spread of infection. Findings included: Review of Resident #42's Admission Record, dated 5/5/25, revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (a condition that affects one side of the body, usually caused by a stroke or other brain injury) and gastrostomy status (is the presence of a gastrostomy, which is a surgical opening in the stomach that can be used for nutritional support or to decompress the stomach). Review of Resident #42's Care Plan dated 7/20/2019 revealed: Revised on 1/24/25 Focus: The resident required enhanced barrier precautions during high-contact resident care activities due to the presence of indwelling device, gastrostomy status. Goal: Enhanced barrier precautions will be followed during high-contact resident care activities. Interventions included: assess the ongoing need for enhanced barrier precautions, ensure items for following enhanced barrier precaution were in place, hand hygiene utilizing alcohol-based hand rub, and utilize PPE during high-contact resident care activities (dressing, bathing/showering, transferring, hygiene, linin changes, brief changes, toileting assistance, device care, and wound care). Review of Resident #42's quarterly MDS Assessment, dated 4/4/25 revealed her BIMS score was 2, meaning she was severely cognitive impaired. Further review revealed she had a diagnosis of a cerebral infarction. Resident #42 had a feeding tube while a resident and while not a resident marked. Resident was total dependent on staff for nutrition. Review of Resident #42's Order Summary Report, dated 5/5/24, revealed active enteral feedings (Isosource 1.5 at 60 Milliliters per hour times 22 hours via peg tube). There were no orders about enhanced barrier precautions. An observation on 5/5/25 at 7:00 a.m. of G-Tube medication administration revealed LVN A prepared medication for Resident #142. LVN A placed the medication cups and a cup filled with approximately 8 ounces of water on a tray and entered the resident's room. LVN A performed hand hygiene and put on gloves but did not put on a gown. LVN A turned off the feeding pump, checked for residual, administered the medication, reconnected the feeding tube, and turned the pump back on. LVN A removed her gloves and performed hand hygiene and left the room. (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	05/06/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with LVN A on 05/5/25 at 07:25 a.m. she stated any resident with a G-tube was required to be on enhanced barrier precautions. She stated she should have worn a gown and just overlooked it when she entered the room. She stated the risk of not following enhanced barrier precautions was the spread of infection. Interview on 5/5/25 at 7:50AM LVN B said it was important to use the EBP to protect residents from whatever microorganisms she could carry. LVN B said residents could be at risk of infection. LVN B said the nurses were responsible to make sure the PPE is available. Interview on 5/5/25 at 1:00 p.m. the ADON said he was the ICP. The ADON stated for EBP, there was PPE on the linen carts. The ADON said staff were supposed to wear them for chronic wounds, catheter, and ostomy care. The ADON stated the staff knew and had been in-serviced, the gowns were on the linen carts. The ADON stated it was important to use PPE to prevent any infection to the body through the open wounds or the ostomy. ADON was all staff responsibility to use PPE. In an interview on 5/6/25 at 10:45 a.m., the DON stated for EBP the staff needed to wear gowns and gloves for individuals with a catheter, feeding tube, or wounds. The DON said it was important to use PPE to prevent introducing any kind of infection to residents. The DON said that by not using EBP, it could put residents at higher risk for infection. DON was all staff responsibility to use PPE. Review of the facility's policy and procedure on Enhanced Barrier Precautions, revision date December 2024, revealed: Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug-resistant organisms (Multi Drug Resistant Organisms). Indwelling medical devices include central lines, urinary catheters, feeding tubes, and tracheotomies.