

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 06/18/2026
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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to ensure the residents right to be informed of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers, for 6 resident (Resident #4, Resident #56, Resident #73, Resident #82, Resident #104, and Resident #109) of 17 residents reviewed for consent for antipsychotic medications.1. The facility failed to ensure Resident #4's Consent for Antipsychotic or Neuroleptic Medication Treatment HHSC Form 3713 was correctly completed for Seroquel (an antipsychotic) as evidenced by there was no date or signature for the practitioner and there was no date after the resident's signature. 2. The facility failed to ensure Resident #56's Consent for Antipsychotic (used to treat certain mental/mood disorders) or Neuroleptic (also known as Antipsychotic) Medication Treatment HHSC Form 3713 was correctly completed for Risperdal (antipsychotic medication used to treat certain mental/mood disorders) as evidenced by there was no practitioner's signature and date. 3. The facility failed to ensure Resident #73's Consent for Antipsychotic or Neuroleptic Medication Treatment HHSC Form 3713 was correctly completed for olanzapine (an antipsychotic) as evidenced by there was no date or signature for the practitioner. 4. The facility failed to ensure Resident #82's Consent for Antipsychotic or Neuroleptic Medication Treatment HHSC Form 3713 was correctly completed for Risperidone as evidenced by there was no date after the practitioner's signature and there was no date after the resident representative's signature. 5. The facility failed to ensure Resident #104's Consent for Antipsychotic or Neuroleptic Medication Treatment HHSC Form 3713 was correctly completed for Seroquel (an antipsychotic) as evidenced by there was no date or signature for the practitioner. 6. The facility failed to ensure Resident #109's Consent for Antipsychotic or Neuroleptic Medication Treatment HHSC Form 3713 was correctly completed for Risperidone as evidenced by there was no date or signature for the practitioner and there was no date after the resident's signature. These failures could affect the right to self-determination of all facility residents who receive medication by allowing them to receive medication without their prior knowledge or consent, or that of their responsible party or emergency contacts. Findings included: 1. Record review of Resident #4's face sheet, dated 06/17/26, reflected a [AGE] year-old male, admitted on [DATE], diagnoses included: type 2 diabetes mellitus (insulin resistance and high blood sugar levels), acute kidney failure (condition that affects the kidneys' ability to filter waste from the blood), generalized muscle weakness, heart failure, bipolar disorder (mental health condition characterized by significant mood changes), depression (persistent feeling of sadness and loss of interest), generalized anxiety disorder (excessive, uncontrollable worry about every day issues), and post-traumatic stress disorder (mental health condition that's caused by an extremely stressful or terrifying event). Record review of Resident #4's MDS assessment, dated 06/14/26, reflected a BIMS score of 15, which indicated intact cognition. The MDS assessment (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: 455423	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reflected Resident #4 had active diagnoses of anxiety disorder, depression, bipolar disorder, and post-traumatic stress disorder. Record review of Resident #4's care plan, dated 06/17/26, reflected [Resident #4] had a mood problem related to bipolar disorder, generalized anxiety, and PTSD. Date initiated: 04/07/26. Interventions included: administer medications as ordered, monitor/document for side effects and effectiveness, assist the resident/family/caregivers to identify positive coping skills, and educate resident/family/caregivers regarding expectations of treatment. [Resident #4] had depression. Date initiated: 04/07/26. Interventions included: administer medications as ordered, monitor/document for side effects and effectiveness, and pharmacy review monthly or per protocol. [Resident #4] used psychotropic medications related to disease process of bipolar disorder. Date initiated: 04/07/26. Interventions included: administer medications as ordered by physician, monitor for side effects and effectiveness, and consult with pharmacy/MD to consider dosage reduction when clinically appropriate. Record review of Resident #4's order summary, dated 06/17/26, reflected an active order of Quetiapine Fumarate (Seroquel) tablet 100 MG give 1 tablet by mouth at bedtime for bipolar disorder. Start date of 04/13/26. Record review of Resident #4's consent for antipsychotic medication treatment form 3713, undated, reflected Resident #4 had bipolar disorder and Seroquel was proposed as a course of therapy. There was a printed name for the MD prescriber but no signature or date. Resident #4 signed the form but there was no date for his signature. 2. Record review of Resident #56's face sheet, dated 6/18/2026, reflected a [AGE] year-old female admitted on [DATE]. Resident #56's diagnoses included Unspecified dementia, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (early-stage memory and thinking problems that interfere with daily life, but the cause isn't known), major depressive disorder (serious mental health condition that causes persistent feelings of sadness, hopelessness, and a loss of interests in activities once enjoyed), anxiety disorder (mental health condition where the brain's danger alarm gets stuck in the on position), major depressive disorder, recurrent, severe with psychotic symptoms (intense, repeated bouts of severe clinical depression paired with a temporary loss of touch with reality, such as seeing or hearing things that aren't there), and Alzheimer's disease (progressive brain disorder that slowly destroys memory and thinking skills). Record review of Residents #56's quarterly MDS assessment, dated 6/13/2026, reflected a BIMS score of 2, which indicated severe cognitive impairment. Resident #56 was coded as having diagnoses of Alzheimer's disease, non-Alzheimer's dementia, anxiety disorder, depression, and unspecified dementia, mild without behaviors/psychotic/mood disturbances/anxiety. Resident #56 was coded as taking an antipsychotic medication. Record review of Resident #56's Order Summary Report, dated 6/18/2026, reflected an order for Risperdal 0.5 mg (Risperidone)give 1 tablet by mouth one time a day for affective mood disorder with a start date of 10/05/2025. Record review of Resident #56's Medication Administration Record, dated 6/1/26-6/30/26, indicated she received Risperdal 0.5 mg give 1 tablet by mouth one time a day for affective mood disorder on 6/1/26-6/18/26. Record review of Resident #56's Consent for Antipsychotic or Neuroleptic Medication Treatment HHSC Form 3713 reflected no signature of person prescribing medication, or person's designee or the nursing facility's medical director and no date. 3. Record review of Resident #73's admission record dated 06/18/2026, revealed a [AGE] year-old female with an admission date of 10/08/2024. Resident #73's diagnoses included dementia (a decline in mental ability - such as memory, thinking, and reasoning - severe enough to interfere with daily life) with other behavioral disturbance, bipolar disorder (a mental health condition that causes extreme, cyclical shifts in mood energy, and activity levels), psychosis (a collection of symptoms rather than a single illness where a person experiences a loss of contact with reality) not due to a substance or known physiological condition, mood disorder (a broad category of mental (continued on next page)		

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 06/18/2026
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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	health conditions that primarily affect a person's persistent emotional state), schizoaffective disorder (a chronic mental health condition characterized by a combination of schizophrenia symptoms [like hallucinations or delusions] and mood disorder symptoms [like mania or depression]). Record review of Resident #73's Modification of Quarterly MDS, dated [DATE], revealed a BIMS score of 00, indicating severe cognitive impairment. Resident #73 had unclear speech, rarely/never understood others, and rarely/never was understood by others. There were psychiatric or mood disorders noted (Bipolar Disorder, Psychotic disorder other than schizophrenia, and schizophrenia). Resident #73 was dependent for showers and toileting requiring the assistance of two helpers. Resident #73 required substantial/maximal assistance for eating, toileting, and personal hygiene where the helpers provided 50% or more of the effort. Antipsychotics, antidepressants, and anticonvulsants were received on a routine basis. Record review of Resident #73's care plan, dated 04/11/2026, revealed, FOCUS: Antipsychotics: (Black Box Warning): Potential for side effects, complications or adverse reactions related to ordered use of drug, as noted by the FDA. *Adverse cardiovascular effects, risk for infections, respiratory and pneumonia, falls, blood glucose and lipid elevations, abnormal movement, stroke, sedation. Date Initiated: 06/11/2026 Revision on: 06/11/2026. GOAL: Side effects & adverse reactions will be minimized, recognized early, or prevented. Date Initiated: 06/11/2026 Target Date: 07/29/2026. INTERVENTIONS/TASKS: Administer medication/s as ordered Date Initiated: 06/11/2026 LPN LVN RN Observe for adverse effect/s (Black Box Warning) of drug therapy. BLACK BOX WARNING - Associated with increased mortality in older adult patients Date Initiated: 06/11/2026 LPN LVN RN Olanzapine Oral Tablet 2.5 MG Black Box Warning Warning: Increased mortality in elderly patients with dementia-related psychosis Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Analyses of 17 placebo-controlled trials (modal duration, 10 weeks), largely in patients taking atypical antipsychotic drugs, revealed a risk of death in drug-treated patients between 1.6 and 1.7 times the risk of death in placebo-treated patients. Over the course of a typical 10-week controlled trial, the rate of death in drug-treated patients was approximately 4.5%, compared with a rate of about 2.6% in the placebo group. Although the causes of death were varied, most of the deaths appeared to be either cardiovascular (eg, heart failure, sudden death). [sic] Record review of Resident #73's antipsychotic consent form for olanzapine (antipsychotic) dated 03/09/2026 was not signed or dated by physician. Record review of Resident #73's Physician's order dated 04/23/2026, revealed OLANZAPINE Oral Tablet 2.5 MG (Olanzapine) Give 1 tablet orally at bedtime for MOOD DISORDER DUE TO KNOWN PHYSIOLOGICAL CONDITION WITH MIXE related to MOOD DISORDER DUE TO KNOWN PHYSIOLOGICAL CONDITION WITH MIXED FEATURES. [sic] Record review of Resident #73's April 2026 MAR revealed Resident #73 was administered Olanzapine 2.5 mg at bedtime from 04/23/2026 through 04/30/2026 without consent signed or dated by the doctor. Record review of Resident #73's May 2026 MAR revealed Resident #73 was administered Olanzapine 2.5 mg at bedtime from 05/01/2026 through 05/31/2026 without consent signed or dated by the doctor. Record review of Resident #73's June 2026 MAR revealed Resident #73 was administered Olanzapine 2.5 mg at bedtime from 06/01/2026 through 06/18/2026 without consent signed or dated by the doctor. Record review of Resident #73's Order Summary dated 06/18/2026 revealed an order for OLANZAPINE Oral Tablet 2.5 MG (Olanzapine) Give 1 tablet orally at bedtime for MOOD DISORDER DUE TO KNOWN PHYSIOLOGICAL CONDITION WITH MIXE related to MOOD DISORDER DUE TO KNOWN PHYSIOLOGICAL CONDITION WITH MIXED FEATURES with an order date of 04/23/2026 and a start date of 04/23/2026. [sic] 4. Record review of Resident # 82's face sheet, dated 6/18/2026, reflected an [AGE] year-old female admitted on [DATE]. Resident #82's diagnoses included unspecified dementia, mild without behavioral (continued on next page)		

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 06/18/2026
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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	disturbance, psychotic disturbance, mood disturbance, and anxiety (early-stage memory and thinking problems that interfere with daily life, but the cause isn't known), major depressive disorder (serious mental health condition that causes persistent feelings of sadness, hopelessness, and a loss of interests in activities once enjoyed), persistent mood [affective] disorder (long-lasting, low-level type of sadness), and unspecified dementia, unspecified severity, with other behavioral disturbance (decline in brain function that affects daily life and thinking skills.). Record review of Resident #82's quarterly MDS assessment, dated 5/19/2026, reflected a BIMS score of 1, which indicated severe cognitive impairment. Resident #82 was coded as having diagnoses of non-Alzheimer's dementia, depression, persistent mood [affective] disorder, and unspecified dementia, mild, without behaviors/psychotic/mood/anxiety. Record review of Resident #82's Order Summary Report, dated 6/18/26, reflected an order for Risperdal 0.5 mg (Risperidone) give 0.25 mg by mouth at bedtime for affective mood disorders with a start date of 8/11/25. Record review of Resident #82's Medication Administration Record, dated 6/1/26-6/30/26, indicated she received Risperdal 0.5 mg (Risperidone) give 0.25 mg by mouth at bedtime for affective mood disorders on 6/1/26-6/17/26. Record review of Resident #82's Consent for Antipsychotic or Neuroleptic Medication Treatment HHSC Form 3713 reflected no date next to the person prescribing the medication and no date next to the Resident or Resident's Representative's signature. 5. Record review of Resident #104's admission record dated 06/15/2026, revealed an [AGE] year-old female with an admission date of 08/12/2024. Resident #104's diagnoses included Alzheimer's Disease (a progressive, irreversible brain disorder that slowly destroys memory and thinking skills), and anxiety disorder (a group of mental health conditions that cause intense, persistent, and excessive fear or worry in non-threatening situations). Record review of Resident #104's Quarterly MDS, dated [DATE], revealed a BIMS score of 03, indicating severe cognitive impairment. There were psychiatric or mood disorders noted (anxiety and depression). Resident #104 required substantial/maximal assistance for eating, toileting, showering, and personal hygiene where the helpers provided 50% or more of the effort. Antipsychotics, antidepressants, anticoagulants, and anticonvulsants were received on a routine basis. Record review of Resident #104's care plan, dated 06/08/2026, revealed, FOCUS: Antipsychotics: (Black Box Warning): Potential for side effects, complications or adverse reactions related to ordered use of drug, as noted by the FDA. *Adverse cardiovascular effects, risk for infections, respiratory and pneumonia, falls, blood glucose and lipid elevations, abnormal movement, stroke, sedation. Date Initiated: 06/11/2026 Revision on: 06/11/2026. GOAL: Side effects & adverse reactions will be minimized, recognized early, or prevented. Date Initiated: 06/11/2026 Target Date: 07/29/2026. INTERVENTIONS/TASKS: Administer medication/s as ordered Date Initiated: 06/11/2026 LPN LVN RN Observe for adverse effect/s (Black Box Warning) of drug therapy. BLACK BOX WARNING - Associated with increased mortality in older adult patients Date Initiated: 06/11/2026 LPN LVN RN OLANzapine Oral Tablet 2.5 MG Black Box Warning Warning: Increased mortality in elderly patients with dementia-related psychosis Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Analyses of 17 placebo-controlled trials (modal duration, 10 weeks), largely in patients taking atypical antipsychotic drugs, revealed a risk of death in drug-treated patients between 1.6 and 1.7 times the risk of death in placebo-treated patients. Over the course of a typical 10-week controlled trial, the rate of death in drug-treated patients was approximately 4.5%, compared with a rate of about 2.6% in the placebo group. Although the causes of death were varied, most of the deaths appeared to be either cardiovascular (eg, heart failure, sudden death). [sic] Record review of Resident #104's Physician's order dated 04/20/2026, revealed Seroquel Oral Tablet 25 MG Give 1 tablet one time a day for affective mood disorder. Record review of Resident #104's (continued on next page)		

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 06/18/2026
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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	antipsychotic consent form for Seroquel 25 mg (an antipsychotic) dated 04/28/2026 was not signed or dated by physician. Record review of Resident #104's April 2026 MAR revealed Resident #104 was administered Seroquel 25 mg one time a day from 04/21/2026 through 04/30/2026 without consent signed or dated by the doctor. Record review of Resident #104's May 2026 MAR revealed Resident #104 was administered Seroquel 25 mg one time a day from 05/01/2026 through 05/31/2026 without consent signed or dated by the doctor. Record review of Resident #104's June 2026 MAR revealed Resident #104 was administered Seroquel 25 mg one time a day from 06/01/2026 through 06/17/2026 without consent signed or dated by the doctor. Record review of Resident #104's Order Summary dated 06/15/2026 revealed Seroquel Oral Tablet 25 MG Give 1 tablet one time a day for affective mood disorder with an order dated of 04/20/2026 and a start date of 04/21/2026. 6. Record review of Resident #109's admission record dated 06/17/2026, revealed a [AGE] year-old male with an admission date of 08/29/2018. Resident #109's diagnoses included bipolar disorder (a chronic mental health condition characterized by intense, alternating mood swings between extreme highs (mania or hypomania) and lows (depression) and schizophrenia (a chronic and severe mental brain disorder that affects a person's ability to interpret reality, think logically, regulate emotions, and relate to others). Record review of Resident #109's Quarterly MDS dated [DATE] revealed a BIMS score of 11, indicating moderate cognitive impairment. There were psychiatric or mood disorders noted (anxiety, bipolar disorder, depression, and schizophrenia). Resident #109 required substantial/maximal assistance for toileting and personal hygiene where the helpers provided 50% or more of the effort. Antipsychotics, antidepressants, hypoglycemics (including insulin), and anticonvulsants were received on a routine basis. Record review of Resident #109's care plan, dated 04/12/2026, revealed, FOCUS: Antipsychotics: (Black Box Warning): Potential for side effects, complications or adverse reactions related to ordered use of drug, as noted by the FDA: ☐ Prolixin ☐ Risperdal ☐ Risperdal Consta ☐ Seroquel ☐ Stelazine ☐ Symbyax ☐ Thorazine ☐ Trilafone ☐ Zyprexa ☐ Zyprexa Zydis ☐ Other (RISPERIDONE). *Adverse cardiovascular effects, risk for infections, respiratory and pneumonia, falls, blood glucose and lipid elevations, abnormal movement, stroke, sedation. Date Initiated: 06/11/2026 Revision on: 06/11/2026 GOAL: Will be free from side effect from medication. Date Initiated: 06/11/2026 Target Date: 07/11/2026 INTERVENTIONS/TASKS: Administer medication/s as ordered Date Initiated: 06/11/2026 LPN LVN RN Attempt a gradual dose reduction as indicated/condition improves, as ordered Date Initiated: 06/11/2026 LPN LVN RN Labs as indicated, report abnormal results to physician. Date Initiated: 06/11/2026 LPN LVN RN Observe and report signs of hallucinations, headache, nervousness, talkativeness, apprehension, irritability, confusion, euphoria, relaxed feeling, weakness, tremor, lack of concentration, depression, dreaming/nightmares, insomnia, palpitations, chest pains, rapid heart rate, heartburn, nausea, vomiting, diarrhea, constipation, abdominal pain, loss of appetite, alterations in taste, difficulty urinating, dry mouth, excessive salivation, photosensitivity, tic-like movements Date Initiated: 06/11/2026 LPN LVN RN Observe for adverse effect/s (Black Box Warning) of drug therapy. BLACK BOX WARNING - Associated with increased mortality in older adult patients Date Initiated: 06/11/2026 LPN LVN RN Observe/record effectiveness of drug treatment as indicated LPN LVN. Record review of Resident #109's Physician's order dated 07/03/2024, revealed RisperIDONE Oral Tablet 1 MG Give 1 tablet by mouth two times a day for SCHIZOPHRENIA. Record review of Resident #109's antipsychotic consent form for risperidone 1 mg (an antipsychotic) not dated by the doctor or resident and was not signed by the physician. Record review of Resident #109's July 2024 MAR revealed Resident #109 was administered risperidone 1 mg two times a day from 07/01/2024 through 07/31/2024 without consent signed or dated by the doctor or dated by the resident. Record review of (continued on next page)		

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 06/18/2026
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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #109's Order Summary dated 06/17/2026 revealed RisperIDONE Oral Tablet 1 MG Give 1 tablet by mouth two times a day for SCHIZOPHRENIA with an order dated of 07/03/2024 and a start date of 07/03/2024. Record review of Resident #109's Care Plan dated 04/12/2026 revealed: FOCUS: Antipsychotics: (Black Box Warning): Potential for side effects, complications or adverse reactions related to ordered use of drug, as noted by the FDA: ☐ Prolixin ☐ Risperdal ☐ Risperdal Consta ☐ Risperdal M ☐ Seroquel ☐ Stelazine ☐ Symbyax ☐ Thorazine ☐ Trilafone ☐ Zyprexa ☐ Zyprexa Zydis ☒ Other (RISPERIDONE). *Adverse cardiovascular effects, risk for infections, respiratory and pneumonia, falls, blood glucose and lipid elevations, abnormal movement, stroke, sedation. Date Initiated: 06/11/2026 Revision on: 06/11/2026 GOAL: Will be free from side effect from medication. Date Initiated: 06/11/2026 Target Date: 07/11/2026 INTERVENTIONS/TASKS: Administer medication/s as ordered Date Initiated: 06/11/2026 LPN LVN RN Attempt a gradual dose reduction as indicated/condition improves, as ordered Date Initiated: 06/11/2026 LPN LVN RN Labs as indicated, report abnormal results to physician. Date Initiated: 06/11/2026 LPN LVN RN Observe and report signs of hallucinations, headache, nervousness, talkativeness, apprehension, irritability, confusion, euphoria, relaxed feeling, weakness, tremor, lack of concentration, depression, dreaming/nightmares, insomnia, palpitations, chest pains, rapid heart rate, heartburn, nausea, vomiting, diarrhea, constipation, abdominal pain, loss of appetite, alterations in taste, difficulty urinating, dry mouth, excessive salivation, photosensitivity, tic-like movements Date Initiated: 06/11/2026 LPN LVN RN Observe for adverse effect/s (Black Box Warning) of drug therapy. BLACK BOX WARNING - Associated with increased mortality in older adult patients Date Initiated: 06/11/2026 LPN LVN RN Observe/record effectiveness of drug treatment as indicated LPN LVN During an interview on 06/15/26 at 2:00 p.m., Resident #4 refused to speak to this surveyor. During an interview on 06/18/26 at 10:00 a.m., Resident #4 refused to speak to this surveyor and did not want this surveyor to return at a later time. During an interview on 06/18/2026 at 2:55 p.m., LVN D stated the nurse who took the order for an antipsychotic was the one responsible for getting the consent from the RP. She said the ADON oversaw the antipsychotics. She said the antipsychotic will be put on hold until consent was given. LVN D stated the antipsychotic consent sheets have the nurse's signature and RP/Resident and it would be dated. She said they would get a signature if the RP was at the facility. She said doctors/NPs do not sign the consent. She said she was not sure about signatures on the new 3713 Consent for Antipsychotics. She said the nurses were the ones who filled out the Consent for antipsychotics. She said they recently started the new 3713 Consent forms for antipsychotics. During an interview, on 06/18/26 at 3:00 p.m., the ADON stated Resident #4 was on Seroquel (Quetiapine Fumarate) since 04/13/26 and required a form 3713 (consent form) signed by the resident and physician. The ADON stated the Seroquel medication was for Resident #4's diagnosis of bipolar disorder and Seroquel was an antipsychotic medication. The ADON stated the consent form on file for the Seroquel was not signed or dated by the physician and was not dated by the resident. The ADON stated the form should have been signed and dated by both the resident and physician before administering the medication. The ADON stated the purpose of the form was so that the resident was aware of the medication, what it was for, what side effects were possible, and how it might make them feel. The ADON stated there was no negative outcome for Resident #4 as staff followed his orders, but the form was not official as it was not signed and dated by both the resident and physician. During an interview on 6/18/26 at 6:28 p.m., the ADON stated once an order for an antipsychotic medication was ordered, the nurses ensured the consent for the medication was completed. She stated consent form 3713 was completed once the MD or NP and the Resident or Resident Representative signed and dated the form. The ADON stated the DON checked the consent (continued on next page)		

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 06/18/2026
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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	forms for antipsychotic medication to ensure they were completed. During an interview on 06/18/2026 at 6:43 p.m., ADON stated the ADON and DON monitored antipsychotic orders. She said they made sure the consents were signed, RP was notified, behavior monitoring was in place, and nurses were monitoring resident for 14 days. She said an antipsychotic needed the RP/Resident's and doctor's signature and the consent was dated. She said the ADON and DON reviewed orders for antipsychotics at the morning meetings Monday through Friday. She stated they ensured the order was input properly, consent was complete, and documentation was in the computer. She said consents for antipsychotics needed to be completed with signature of the RP/resident and doctor and they needed to be dated before the medication could be administered. The antipsychotic would be held until the consent was completed with dates and signatures. During an interview, on 06/18/26 at 7:45 p.m., the DON stated the physician that prescribed the antipsychotic medication would have explained the risks, benefits, and black box warning to the resident or their RP. The DON stated the 3713 form for antipsychotic medication had to be signed and dated by resident or the RP and the physician before administration of the medication. The DON stated he was aware that there was lack of coordination between the team and the forms had not been completed as required. The DON stated if the form was not fully signed with a signature or date missing, then the form was not official based on the regulations. The DON stated he had been auditing the consent forms and in-service nurses on antipsychotics and consents. The DON stated he last in-service was no more than two months ago. During an interview on 6/18/2026 at 8:30 p.m., the DON stated he audited consent forms daily. He said the NP or MD were supposed to educate the family or residents and initiate the consent form for antipsychotic medication. The DON said there was no coordination between the NP, MD, nurses, and resident or resident representative to initiate consent. He stated psychotropic medications were given to residents with incomplete consent forms if signatures and dates were missing. The DON said the last in-service given to the nurse on antipsychotic medication and consents was no more than two months ago. Record review of the facility's policy Antipsychotics - Consent, not dated, revealed, 1. Policy Statement [Facility] will protect each resident's right to make informed decisions regarding treatment and will not administer antipsychotic or neuroleptic medication unless legally valid consent has been obtained and documented, except in a medication-related emergency as permitted by law. Consent will be obtained in a manner that is voluntary, informed, free from coercion or undue influence, and consistent with federal and Texas requirements. [Facility] will ensure that antipsychotic medications are used only when medically necessary to treat a specific, documented condition, are not used for staff convenience or discipline and are subject to ongoing review, monitoring, and attempts at reduction/discontinuation when clinically appropriate. 2. Purpose The purpose of this policy is to: 1.Ensure compliance with Texas Health and Safety Code 242.505, 26 TAC 554.1207, and HHSC requirements for consent to antipsychotic/neuroleptic medication treatment. 2.Support compliance with CMS resident-rights and psychotropic-medication guidance applicable to nursing facilities. 3.Protect resident autonomy, safety, dignity, and person-centered decision-making. 4.Standardize the facility process for obtaining, documenting, renewing, and monitoring consent related to antipsychotic use.5.1 The prescribing practitioner, the practitioner's designee, or the facility's medical director is responsible for providing the consent information required by state law and for completion of the clinical information section of the form 3713 for antipsychotic medication treatment. 5.3 Nursing staff are responsible for: verifying that valid consent is present before administration.		

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 06/18/2026
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 - Some	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 interview and record review, the facility failed to ensure that the residents were free from chemical restraints not required to treat the resident's medical symptoms for 5 (Resident #9, Resident #56, Resident #73, Resident #82, and Resident #104) of 11 residents reviewed for unnecessary medications. 1.The facility failed to have an adequate indication for the use of the medication olanzapine (Zyprexa) (an antipsychotic) for Resident #9 with a diagnosis of dementia.2.The facility failed to have an adequate indication for the use of the medication risperidone (Risperdal) (an antipsychotic) for Resident #56 with a diagnosis of dementia.3.The facility failed to have an adequate indication for the use of the medication olanzapine (Zyprexa) (an antipsychotic) for Resident #73 with a diagnosis of dementia.4.The facility failed to have an adequate indication for the use of the medication risperidone (Risperdal) (an antipsychotic) for Resident #82 with a diagnosis of dementia.5.The facility failed to have an adequate indication for the use of the medication Seroquel (an antipsychotic) for Resident #104 with a diagnosis of dementia. This failure could put residents at risk of harm from adverse reactions or harmful side effects. The findings included: 1. Record review of Resident # 9's face sheet, dated 6/17/26, reflected an [AGE] year-old female admitted on [DATE]. Resident #9's diagnoses include unspecified dementia, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (early-stage memory and thinking problems that interfere with daily life, but the cause isn't known), major depressive disorder (serious mental health condition that causes persistent feelings of sadness, hopelessness, and a loss of interests in activities once enjoyed), anxiety disorder (mental health condition where the brain's danger alarm gets stuck in the on position), and unspecified psychosis not due to a substance or known physiological condition (experiencing a loss of touch with reality, but doctors have not yet determined the exact mental health cause). Record review of Resident #9's quarterly MDS assessment, dated 5/13/26, reflected a BIMS score of 02, which indicated severe cognitive impairment. Resident #9 was coded as having non-Alzheimer's dementia, anxiety disorder, depression, and psychotic disorder. Section N indicated Resident #9 received antipsychotics on a routine basis. Record review of Resident #9's care plan, dated 6/02/2026, revealed, FOCUS: Resident #9 uses psychotropic medications r/t dementia. Date initiated: 4/30/24 Revision on: 4/30/24. GOAL: The Resident will be/remain free of psychotropic drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction, or cognitive/behavior impairment through review date. Date initiated 8/19/24 Revision on 8/19/24 Target date: 7/29/26 Intervention/Tasks: Zyprexa Black Box Warning. Warning: Increased mortality in elderly patients with dementia-related psychosis.Olanzapine is not approved for treatment of patients with dementia-related psychosis. Date initiated: 8/4/25. Record review of Resident #9's Order Summary Report, dated 6/17/26, reflected an order for Zyprexa 5 mg (olanzapine) give one tablet by mouth two times a day for unspecified psychosis. Start date: 5/7/26 Record review of Resident #9's Medication Administration Record, dated 6/1/26-6/30/26, indicated she received Zyprexa 5 mg (olanzapine) give one tablet by mouth two times a day for unspecified psychosis on 6/1/26-6/17/26. 2. Record review of Resident #56's face sheet, dated 6/18/2026, reflected a [AGE] year-old female admitted on [DATE]. Resident #56's diagnoses included Unspecified dementia, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (early-stage memory and thinking problems that interfere with daily life, but the cause isn't known), major depressive disorder (serious mental health condition (continued on next page)		

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 06/18/2026
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 - Some	that causes persistent feelings of sadness, hopelessness, and a loss of interests in activities once enjoyed), anxiety disorder (mental health condition where the brain's danger alarm gets stuck in the on position), major depressive disorder, recurrent, severe with psychotic symptoms (intense, repeated bouts of severe clinical depression paired with a temporary loss of touch with reality, such as seeing or hearing things that aren't there), and Alzheimer's disease (progressive brain disorder that slowly destroys memory and thinking skills). Record review of Residents #56's quarterly MDS assessment, dated 6/13/2026, reflected a BIMS score of 2, which indicated severe cognitive impairment. Resident #56 was coded as having diagnoses of Alzheimer's disease, non-Alzheimer's dementia, anxiety disorder, depression, and unspecified dementia, mild without behaviors/psychotic/mood disturbances/anxiety. Resident #56 was coded as taking an antipsychotic medication. Record review of Resident #56's care plan, dated 4/12/26, revealed, FOCUS: Antipsychotics: (Black Box Warning): Potential for side effects, complications or adverse reactions related to ordered use of drug as noted by the FDA: Risperdal. *Adverse cardiovascular effects, risk for infections, respiratory and pneumonia, falls, blood glucose and lipid elevations, abnormal movement, stroke sedation. Date initiated: 8/13/24 Revision on: 6/11/26. GOAL: Side effects & adverse reactions will be minimized, recognized early, or prevented. Date initiated 6/11/26 Target date: 7/11/26. Record review of Resident #56's Order Summary Report, dated 6/18/2026, reflected an order for Risperdal 0.5 mg (Risperidone)give 1 tablet by mouth one time a day for affective mood disorder (an inappropriate indication for a resident with Alzheimer's/Dementia to receive an antipsychotic) with a start date of 10/05/2025. Record review of Resident #56's Medication Administration Record, dated 6/1/26-6/30/26, indicated she received Risperdal 0.5 mg give 1 tablet by mouth one time a day for affective mood disorder on 6/1/26-6/18/26. 3.Record review of Resident #73's admission record dated 06/18/2026, revealed a [AGE] year-old female with an admission date of 10/08/2024. Resident #73's diagnoses included dementia (a decline in mental ability - such as memory, thinking, and reasoning - severe enough to interfere with daily life) with other behavioral disturbance, bipolar disorder (a mental health condition that causes extreme, cyclical shifts in mood energy, and activity levels), psychosis (a collection of symptoms rather than a single illness where a person experiences a loss of contact with reality) not due to a substance or known physiological condition, mood disorder (a broad category of mental health conditions that primarily affect a person's persistent emotional state), schizoaffective disorder (a chronic mental health condition characterized by a combination of schizophrenia symptoms [like hallucinations or delusions] and mood disorder symptoms [like mania or depression]). Record review of Resident #73's Modification of Quarterly MDS, dated [DATE], revealed a BIMS score of 00, indicating severe cognitive impairment. Resident #73 had unclear speech, rarely/never understood others, and rarely/never was understood by others. There were psychiatric or mood disorders noted (Bipolar Disorder, Psychotic disorder other than schizophrenia, and schizophrenia). Resident #73 was dependent for showers and toileting requiring the assistance of two helpers. Resident #73 required substantial/maximal assistance for eating, toileting, and personal hygiene where the helpers provided 50% or more of the effort. Antipsychotics, antidepressants, and anticonvulsants were received on a routine basis. Record review of Resident #73's care plan, dated 04/11/2026, revealed FOCUS: [Resident #73] has a communication problem and is at risk for delirium or an acute confusional episode r/t Acute disease process Dementia. Resident exhibits cognitive loss related to dementia. Resident is provide low stimulation activities in security unit. Sometimes [Resident #73] will carry a baby doll for a while if offered. [Resident #73] do not follow even simple directions She just stares at you and rarely follows simple instructions but she can't do any activity most of the time. Activities will continue provide with daily low stimulation activities in security unit (continued on next page)		

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 06/18/2026
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 - Some	through the next review date. Date Initiated: 04/07/2026 Revision on: 05/25/2026. [sic] FOCUS: [Resident #73] has impaired cognitive function/dementia or impaired thought processes r/t Dementia Date Initiated: 10/09/2024 Revision on: 10/09/2024. INTERVENTIONS/TASKS: Administer medications as ordered. Monitor/document for side effects and effectiveness. Date Initiated: 10/09/2024 LPN RN. FOCUS: [Resident #73] is at risk for delirium or an acute confusional episode r/t Acute disease process Dementia Date Initiated: 11/01/2024 Revision on: 11/01/2024. FOCUS: [Resident #73] is at risk for a mood problem r/t Dementia with behaviors and psychosis Date Initiated: 10/09/2024 Revision on: 10/09/2024. INTERVENTIONS/TASKS: Administer medications as ordered. Monitor/document for side effects and effectiveness. Date Initiated: 10/09/2024 LPN RN Behavioral health consults as needed (psycho-geriatric team, psychiatrist etc.) Date Initiated: 10/09/2024 LPN RN. Record review of Resident #73's Physician's order dated 04/23/2026, revealed OLANzapine Oral Tablet 2.5 MG (Olanzapine) Give 1 tablet orally at bedtime for MOOD DISORDER DUE TO KNOWN PHYSIOLOGICAL CONDITION WITH MIXE related to MOOD DISORDER DUE TO KNOWN PHYSIOLOGICAL CONDITION WITH MIXED FEATURES. [sic] Record review of Resident #73's April 2026 MAR revealed Resident #73 was administered Olanzapine 2.5 mg at bedtime from 04/23/2026 through 04/30/2026 without consent signed or dated by the doctor. Record review of Resident #73's May 2026 MAR revealed Resident #73 was administered Olanzapine 2.5 mg at bedtime from 05/01/2026 through 05/31/2026. Record review of Resident #73's June 2026 MAR revealed Resident #73 was administered Olanzapine 2.5 mg at bedtime from 06/01/2026 through 06/18/2026. 4. Record review of Resident # 82's face sheet, dated 6/18/2026, reflected an [AGE] year-old female admitted on [DATE]. Resident #82's diagnoses included unspecified dementia, mild without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (early-stage memory and thinking problems that interfere with daily life, but the cause isn't known), major depressive disorder (serious mental health condition that causes persistent feelings of sadness, hopelessness, and a loss of interests in activities once enjoyed), persistent mood [affective] disorder (long-lasting, low-level type of sadness), and unspecified dementia, unspecified severity, with other behavioral disturbance (decline in brain function that affects daily life and thinking skills.). Record review of Resident #82's quarterly MDS assessment, dated 5/19/2026, reflected a BIMS score of 1, which indicated severe cognitive impairment. Resident #82 was coded as having diagnoses of non-Alzheimer's dementia, depression, persistent mood [affective] disorder, and unspecified dementia, mild, without behaviors/psychotic/mood/anxiety. Record review of Resident #82's Order Summary Report, dated 6/18/26, reflected an order for Risperdal 0.5 mg (Risperidone) give 0.25 mg by mouth at bedtime for affective mood disorders (an inappropriate indication for a resident with Alzheimer's/Dementia to receive an antipsychotic) with a start date of 8/11/25. Record review of Resident #82's Medication Administration Record, dated 6/1/26-6/30/26, indicated she received Risperdal 0.5 mg (Risperidone) give 0.25 mg by mouth at bedtime for affective mood disorders on 6/1/26-6/17/26. Record review of Resident #82's care plan, dated 6/2/26, revealed, FOCUS: Antipsychotics: (Black Box Warning): Potential for side effects, complications or adverse reactions related to ordered use of drug as noted by the FDA: Risperdal. *Adverse cardiovascular effects, risk for infections, respiratory and pneumonia, falls, blood glucose and lipid elevations, abnormal movement, stroke sedation. Date initiated: 6/11/26 Revision on: 6/11/26. GOAL: Side effects & adverse reactions will be minimized, recognized early, or prevented. Date initiated 6/11/26 Target date: 7/29/26. 5. Record review of Resident #104's admission record dated 06/15/2026, revealed an [AGE] year-old female with an admission date of 08/12/2024. Resident #104's diagnoses included Alzheimer's Disease (a progressive, irreversible brain disorder that slowly destroys memory and thinking skills), and anxiety (continued on next page)		

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 06/18/2026
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 - Some	disorder (a group of mental health conditions that cause intense, persistent, and excessive fear or worry in non-threatening situations). Record review of Resident #104's Quarterly MDS, dated [DATE], revealed a BIMS score of 03, indicating severe cognitive impairment. There were psychiatric or mood disorders noted (anxiety and depression). Resident #104 required substantial/maximal assistance for eating, toileting, showering, and personal hygiene where the helpers provided 50% or more of the effort. Antipsychotics, antidepressants, anticoagulants, and anticonvulsants were received on a routine basis. Record review of Resident #104's care plan, dated 06/08/2026, revealed FOCUS: [Resident #104] has a potential behavior problem r/t depression, anxiety and Alzheimer's Date Initiated: 06/15/2026 Revision on: 06/15/2026. INTERVENTIONS/TASKS: Administer medications as ordered. Monitor/document for side effects and effectiveness. Date Initiated: 06/15/2026 LPN RN. FOCUS: [Resident #104] has impaired cognitive function/dementia and impaired thought processes r/t Dementia Date Initiated: 03/10/2026 Revision on: 06/15/2026. INTERVENTIONS/TASKS: Administer medications as ordered. Monitor/document for side effects and effectiveness. Date Initiated: 03/10/2026 LPN RN. FOCUS: [Resident #104] has inattention and disorganized thinking related to Alzheimer's and Dementia Date Initiated: 08/30/2024 Revision on: 08/30/2024. FOCUS: [Resident #104] has depression/anxiety r/t Dementia Date Initiated: 08/30/2024 Revision on: 08/30/2024. INTERVENTIONS/TASKS: Administer medications as ordered. Monitor/document for side effects and effectiveness. Date Initiated: 08/30/2024 LPN RN . Record review of Resident #104's Physician's order dated 04/20/2026, revealed Seroquel Oral Tablet 25 MG Give 1 tablet one time a day for affective mood disorder (an inappropriate indication for a resident with a diagnosis of Alzheimer's Disease/dementia to receive an antipsychotic). Record review of Resident #104's April 2026 MAR revealed Resident #104 was administered Seroquel 25 mg one time a day from 04/21/2026 through 04/30/2026. Record review of Resident #104's May 2026 MAR revealed Resident #104 was administered Seroquel 25 mg one time a day from 05/01/2026 through 05/31/2026 without consent signed or dated by the doctor. Record review of Resident #104's June 2026 MAR revealed Resident #104 was administered Seroquel 25 mg one time a day from 06/01/2026 through 06/17/2026 without consent signed or dated by the doctor. During an interview on 06/17/2026 at 12:17 p.m., Resident #104 stated she did not want to talk. In an interview on 6/18/26 at 3:20 p.m., LVN D stated the nurse was responsible for receiving and writing the order for a psychotropic medication. She said she would carry out the order for antipsychotics for a resident with the diagnosis of Alzheimer's Disease/Dementia unless the family did not agree with the antipsychotic and then the doctor would be notified. LVN D stated she did not question the doctor or the NP on the indication given for an antipsychotic even if the resident had a diagnosis of Alzheimer's Disease/Dementia. She stated if a resident showed signs of aggression, a antipsychotic medication was ordered with a diagnosis of psychosis. LVN D stated she would question the provider if the resident had not shown signs of aggression or other behaviors. In an interview on 6/18/26 at 6:28 p.m., the ADON stated the indications for an antipsychotic were checked and the nurses go by the doctor's diagnosis. She stated that an improper diagnosis for an antipsychotic medication was a diagnosis not listed in the residents' EMR. She said there would need to be documentation with a reason for giving the antipsychotic. The ADON stated she and the DON reviewed new order for antipsychotic medication to ensure the order was properly entered in the EMR and they reviewed the diagnosis used for the medication. She stated a negative outcome for a resident that had a diagnosis of Alzheimer's or dementia and was receiving an antipsychotic medication was worsening their behavior or dementia. During an interview on 06/18/2026 at 7:45 p.m., the DON stated an antipsychotic medication was ordered using a specific diagnosis and a specific behavior. He said when reviewing he looked specifically at the diagnosis. He (continued on next page)		

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 06/18/2026
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 - Some	said a specific diagnosis was important. He said they should start with nonpharmacological interventions that should be documented and care planned (before starting an antipsychotic). The DON stated mood disorder or affective mood disorder was not an appropriate diagnosis/indication for an antipsychotic to be given to a resident with Alzheimer's Disease or dementia because they were broad terms. He said psychosis was not an appropriate indication for an antipsychotic to be given to a resident with Alzheimer's Disease or dementia because a diagnosis of psychosis was an acute (sudden and for a short time) episode. The DON stated psychosis was not an appropriate diagnosis for Resident #9 because she had a diagnosis of dementia. The DON said there was a risk of increased mortality for a resident using an antipsychotic medication with a diagnosis of dementia. He stated the nurses were in-serviced on antipsychotics. He said the last in-service on antipsychotics was no more than two months ago. Record review of the facility's undated policy titled, Antipsychotic- Consent, reflected in part: 1. Policy Statement- The nursing facility will ensure that antipsychotic medications are used only when medically necessary to treat a specific, documented condition, are not used for staff convenience or discipline, and are subject to ongoing review, monitoring, and attempts at reduction/discontinuation when clinically appropriate. 2. Purpose- 2. Support compliance with CMS resident-rights and psychotropic-medication guidance applicable to nursing facilities. Record review of the facility's Antipsychotic Medication Use policy not dated reflected: Policy StatementAntipsychotic medications will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and re-review. Policy Interpretation and Implementation 1.Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. 2. The attending physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others. 3.The attending physician will identify, evaluate and document, with input from other disciplines and consultants as needed, symptoms that may warrant the use of antipsychotic medications. 4.The attending physician will and facility staff will identify acute psychiatric episodes, and will differentiate them from enduring psychiatric conditions. 6.Diagnosis of a specific condition for which antipsychotic medications are necessary to treat will be based on comprehensive assessment of the resident.		

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 06/18/2026
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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to coordinate assessments with the Pre-admission Screening and Resident Review (PASSR) program to the maximum extent practicable to avoid duplicative testing and effort for 4 (Resident #4, Resident #9, Resident #13, and Resident #28) of 12 residents reviewed for PASSR. 1. The facility failed to refer Resident #4 and Resident #28 for PASSR Level I when the facility incorrectly completed Form 1012. 2. The facility failed to refer Resident #9 and Resident #13 for PASRR Level II assessment when the resident were newly diagnosed with a mental illness. These failures could place residents at risk of not receiving a needed assessment, individualized care, or specialized services to meet their needs. Findings included: 1. Record review of Resident #4's face sheet, dated 06/17/26, reflected a [AGE] year-old male, admitted on [DATE], diagnoses included: type 2 diabetes mellitus (insulin resistance and high blood sugar levels), acute kidney failure (condition that affects the kidneys' ability to filter waste from the blood), generalized muscle weakness, heart failure, bipolar disorder (mental health condition characterized by significant mood changes), depression (persistent feeling of sadness and loss of interest), generalized anxiety disorder (excessive, uncontrollable worry about every day issues), and post-traumatic stress disorder (mental health condition that's caused by an extremely stressful or terrifying event). Record review of Resident #4's MDS assessment, dated 06/14/26, reflected a BIMS score of 15, which indicated intact cognition. The MDS assessment reflected Resident #4 had active diagnoses of anxiety disorder, depression, bipolar disorder, and post-traumatic stress disorder. Record review of Resident #4's care plan, dated 06/17/26, reflected [Resident #4] had a mood problem related to bipolar disorder, generalized anxiety, and PTSD. Date initiated: 04/07/26. Interventions included: administer medications as ordered, monitor/document for side effects and effectiveness, assist the resident/family/caregivers to identify positive coping skills, and educate resident/family/caregivers regarding expectations of treatment. [Resident #4] had depression. Date initiated: 04/07/26. Interventions included: administer medications as ordered, monitor/document for side effects and effectiveness, and pharmacy review monthly or per protocol. [Resident #4] used psychotropic medications related to disease process of bipolar disorder. Date initiated: 04/07/26. Interventions included: administer medications as ordered by physician, monitor for side effects and effectiveness, and consult with pharmacy/MD to consider dosage reduction when clinically appropriate. Record review of Resident #4's PASRR level 1 screening, dated 03/09/26, reflected a negative PL1 as there was no diagnosis of mental disorder indicated on the screening. Record review of Resident #4's Form 1012, dated 03/11/26, section C was incorrectly filled out. Form 1012 indicated if any responses were YES, the facility had to complete a new PL 1. Section C was marked as YES for number two, Mood disorder (bipolar disorder, major depression, or other mood disorder) with date of onset: 03/11/26. Section D was marked with the option the PL1 remained negative and no new PL1 needed to be completed. 2. Record review of Resident # 28's face sheet, dated 6/18/2026, reflected a [AGE] year-old female admitted on [DATE]. Resident #28's diagnoses included major depressive disorder (serious mental health condition that causes persistent feelings of sadness, hopelessness, and a loss of interests in activities once enjoyed), bipolar disorder (a mental health condition that causes extreme, uncontrollable shifts in mood, energy, and activity levels), obsessive-compulsive disorder (a mental health condition where a person gets stuck in a cycle of uncontrollable, distressing thoughts [obsession] and repetitive behaviors [compulsions] they feel (continued on next page)		

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 06/18/2026
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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	driven to do to relieve the anxiety), unspecified dementia, mild, without behavioral disturbances, psychotic disturbance, mood disturbance, and anxiety (early-stage memory and thinking problems that interfere with daily life, but the cause isn't known), and dementia in other disease classified elsewhere, moderate with psychotic disturbance (moderate-stage mental decline caused by psychotic symptoms like hallucinations [seeing or hearing things that aren't real] or delusions [strong, false beliefs like paranoia]). Record review of Resident #28's quarterly MDS assessment, dated 5/12/2026, reflected a BIMS score of 12, which indicated moderate cognitive impairment. Resident #28 was coded as having non-Alzheimer's dementia, depression, bipolar disorder, major depressive disorder, and obsessive-compulsive disorder. Record review of Resident #28's care plan, dated 4/11/2026, indicated in part, Resident has potential for behavior problems r/t dementia and mdd. Interventions: anticipate and meet resident's needs, explain all procedures to the resident and allow resident to adjust to changes. Resident is at risk for decreased psychosocial well-being and adjustment issues, emotional distress and ineffective coping skills poor impulse related to bipolar disorder. Interventions include encourage to voice feelings and frustrations as indicated, encourage family and friends support visits, administer meds as ordered. Resident uses antidepressant and psychotropic medication r/t behavior management. Interventions include monitor/document/report PRN adverse reactions of psychotropic and antidepressant medication. Record review of Resident #28's PASRR Level 1 screening, dated 9/29/25, reflected a negative PL 1 as there was no diagnosis of mental disorder indicated on the screening. Record review of Resident #28's Form 1012, dated 9/30/25, section C was incorrectly filled. Form 1012 indicated if any responses were YES, the facility had to complete a new PL 1. Section C was marked as YES for number two, Mood disorder (bipolar disorder, major depression, or other mood disorder) with date of onset: 09/30/25. Section D was marked with the option the PL1 remained negative and no new PL1 needed to be completed. 3. Record review of Resident #9's face sheet, dated 6/17/26, reflected an [AGE] year-old female admitted on [DATE]. Resident #9's diagnoses include unspecified dementia, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (early-stage memory and thinking problems that interfere with daily life, but the cause isn't known), major depressive disorder (serious mental health condition that causes persistent feelings of sadness, hopelessness, and a loss of interests in activities once enjoyed), anxiety disorder (mental health condition where the brain's danger alarm gets stuck in the on position), and unspecified psychosis not due to a substance or known physiological condition (experiencing a loss of touch with reality, but doctors have not yet determined the exact mental health cause). Record review of Resident #9's quarterly MDS assessment, dated 5/13/26, reflected a BIMS score of 02, which indicated severe cognitive impairment. Resident #9 was coded as having non-Alzheimer's dementia, anxiety disorder, depression, and psychotic disorder. Record review of Resident #9's care plan, dated 6/02/2026, indicated in part, Resident has depression and anxiety r/t depression. Interventions include administer medications as ordered, arrange for psych consult, and monitor/document/report PRN s/sx of depression. Record review of Resident #9's recent psychiatric subsequent assessment, dated 5/10/2026, reflected a diagnosis of unspecified psychosis. 4. Record review of Resident #13's face sheet, dated 06/17/26, reflected a [AGE] year-old female, admitted on [DATE], diagnoses included: unspecified dementia (decline in cognitive function severe enough to interfere with daily life affecting memory loss, language, problem solving, and other cognitive abilities), type 2 diabetes mellitus (insulin resistance and high blood sugar levels), generalized muscle weakness, hallucinations, and other schizoaffective disorders (mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression and mania). Other schizoaffective disorders had an (continued on next page)		

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 06/18/2026
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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	onset date of 02/16/25. Record review of Resident #13's MDS assessment, dated 06/09/26, reflected a BIMS score of 01, which indicated severe cognitive impairment. The MDS assessment reflected Resident #13 had an active diagnosis of schizophrenia (e.g., schizoaffective disorders). Record review of Resident #13's care plan, dated 06/17/26, reflected [Resident #13] had a mood problem related to schizoaffective disorder. Date initiated: 05/25/26. Interventions included: administer medications as ordered, monitor/document for side effects and effectiveness, assist the resident/family/caregivers to identify positive coping skills, and educate resident/family/caregivers regarding expectations of treatment. [Resident #13] used psychotropic medications related to behavior management. Date initiated: 02/27/25. Interventions included: administer medications as ordered by physician, monitor for side effects and effectiveness, and consult with pharmacy/MD to consider dosage reduction when clinically appropriate. [Resident #13] had an aggressive behavior and mood problem due to dementia and mood affective disorders. Date initiated: 09/04/24. Interventions included: administer medications as ordered by physician, anticipate needs, provide opportunity for positive interaction, and monitor behaviors. Record review of Resident #13's PASRR level 1 screening, dated 08/20/24, reflected a negative PL1 as there was no diagnosis of mental illness indicated on the screening. The screening reflected Resident #13 had a primary diagnosis of dementia. Record review of Resident #13's psychiatric note, dated 02/22/25, reflected a diagnosis of schizoaffective disorder, bipolar type. During an attempted interview and observation, on 06/15/26 at 2:00 PM, Resident #4 refused to speak to this surveyor. Resident #4 was observed with no visible bruises, skin tears, or injury. During an interview and observation, on 06/15/26 at 2:35 PM, Resident #13 stated she was doing well and had no issues. Resident #13 stated the staff gave her medications and took care of her. Resident #13 stated she was not sure what she took medications for and she only remembered she had medications for diabetes. Resident #13 stated she was not injured or in pain. Resident #13 was observed with no visible bruises, skin tears, or injury. During an attempted interview, on 06/18/26 at 10:00 AM, Resident #4 refused to speak to this surveyor and did not want this surveyor to return at a later time. In an interview on 06/18/2026 at 5:30 p.m., the MDS nurse stated she reviewed and inputted the information from the PL1 when she received the PL1s from the hospital or the facility the resident was being admitted from. The MDS Nurse stated there were discrepancies on the 1012 forms that were incorrect. The MDS Nurse stated Resident #4 had a diagnosis of bipolar disorder and PTSD since admission. The MDS Nurse stated the form 1012 indicated yes on section C so then there should have been another PL1 submitted for Resident #4, but she did not submit another PL1 for him and could not explain why. The MDS Nurse stated Resident #13 initially had a negative PL1 because her primary diagnosis was dementia. The MDS Nurse stated she was unsure when Resident #13 was diagnosed with schizoaffective disorders but it was later after admission. The MDS Nurse stated it did not matter if Resident #13 had a primary diagnosis of dementia, Resident #13 should have had a new PL1 completed once she had the new diagnosis of schizoaffective disorders. The MDS Nurse stated Resident #28's form 1012 was also marked incorrectly and did not know why a new PL1 was not submitted. The MDS Nurse stated she would submit a new PL1 for Resident #28 but she knew Resident #28 was receiving services from a local counseling entity. The MDS Nurse stated she was going to follow up and review Resident #9's PL1 and the diagnosis of psychosis as she was unsure of when this change occurred. The MDS Nurse stated Resident #9 should have also had a new PL1 submitted with the new diagnosis of psychosis. The MDS Nurse stated audits were done annually, quarterly and as needed of residents which had a positive PASSR screening and were receiving services at the facility. The MDS Nurse stated the discrepancies on the forms resulted in the residents possibly not receiving additional services from (continued on next page)		

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 06/18/2026
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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASRR screenings not submitted appropriately. The MDS Nurse stated she had not received training on PASRR services from the facility. In an interview on 6/18/2026 at 8:35 p.m., the DON stated a PASRR positive was when a resident had a mental disorder or intellectual disorder and qualified for services through the local community mental health service provider. The DON stated if residents were not screened appropriately, residents could potentially miss out on services. The DON stated the MDS Nurse completed PASRR screenings and coordinated assessments with the local community mental health service provider for additional services for the residents. Record review of the facility's undated policy titled, PASRR (Pre-admission Screening & Resident Review) reflected in part: Policy Statement- To ensure each patient in the facility is screened for a mental disorder (MD) or intellectual disability prior to admission and that individuals identified with MD or ID are evaluated and receive care and services in the most integrated setting appropriate to their needs. Policy Interpretation and Implementation- 3. A negative Level 1 screen permits admission to proceed and ends the pre-screening process unless possible serious mental disorder or intellectual disability arises later.		

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 06/18/2026
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, 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 1 (Resident #23) of 5 residents and 1 (100 hall medication room) of 2 medications storage rooms reviewed for infection control.1. The facility failed to ensure RN C disinfected the blood pressure cuff before use for Resident #23 on [DATE].2. The facility failed to ensure RN C wore a gown to give gastric tube medications to Resident #23 on [DATE].3. The facility failed to dispose of an expired COVID test that was in a cabinet in the medication room. 4. The facility failed to dispose of expired IV supplies stored on the counter and in cabinet in the medication room. 5. The facility failed to dispose of an enteral feeding pump administration set that was not in a protective wrapper in a drawer in the medication room. 6. The facility failed to ensure a soiled baby monitor type camera and screen were not stored in the medication room cabinet. 7. The facility failed to ensure a soiled enteral feeding pump was not stored in the medication room. These failures could place residents at risk of infection and receiving medications and supplies which were expired and possibly cross contaminated.The findings included:Record review of Resident #23's admission record reviewed on [DATE] reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included nontraumatic intracerebral hemorrhage in cerebellum (brain bleed not caused from trauma), essential hypertension (high blood pressure), tracheostomy (a hole made through the front of the neck into the windpipe when medical conditions make the use of a breathing machine, also known as a ventilator, necessary for an extended period of time), gastrostomy (a tube surgically implanted through the abdomen into the stomach used to provide nutrition, hydration, and medication), and persistent vegetative state (after a brain injury, a person may appear awake but is unaware of their surroundings and unable to respond to any stimulus). Record review of Resident #23's quarterly MDS dated [DATE] reflected a BIMS score of 6 which indicated severe cognitive impairment. The MDS also reflected Resident #23 received 51% or more calories and 501cc/day or more fluid intake by tube feeding.Record review of Resident #23's order summary report on [DATE] reflected the following phone order dated [DATE]: Enhanced barrier precautions during high contact resident care activities secondary to gastric tube, foley catheter every shift.During an observation on [DATE] at 8:18 am, RN C did not wipe down the blood pressure cuff between resident use before he checked Resident #23's blood pressure. During an observation on [DATE] at 8:18 am, RN C did not wear a gown during gastric tube medication administration for Resident #23. During an inspection of the facility's 100 hall medication room on [DATE] at 1:00 pm, the following were found: 1. An at home COVID test with an expiration date of [DATE] was found on the top shelf of a cabinet containing oral medications, inhalation medications and IV fluids. 2a. 1 of 15 7- inch IV extension sets with an expiration date 05/2026 was found in a bin labeled luer locks on the counter. 2b. 3 of 3 20 gauge IV catheters with an expiration date of [DATE] were found in a bin on the counter labeled 22G PIV. 2c. 17 of 27 7-inch expired IV extensions sets were found in a bag that was in a cabinet marked IV supplies. 5 had an expiration date of 01/2025, 5 had an expiration date of 03/2026, and 7 had an expiration date of 05/2026. 3. In a drawer labeled enteral administration kit, 1 of 8 enteral feeding pump administration sets was not in a protective wrapper. 4. In a cabinet labeled ostomy supplies, a baby monitor type camera, screen, and power cord were in a soiled, crumpled up bag on the top shelf. The camera, screen, and power cord all had brownish colored stains on them. 5. On the bottom shelf of a 3-shelf cart inside and to the right of the (continued on next page)		

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 06/18/2026
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	door of the medication room, there was an enteral feeding pump with tan colored spot type stains on the back of it and a long approximately 4 inch long by 1-inch-wide tan colored streak type stain down the front of it. In an interview on [DATE] at 8:37 am, RN C stated he was nervous and forgot to wipe down the blood pressure cuff or put a gown on before he checked Resident #23's blood pressure and administered his medications. RN C stated it was important to disinfect equipment between resident use because of cross contamination. He stated wiping down the blood pressure cuff was important because it touched the residents skin and if a resident had some type of skin infection, it could spread to other residents. RN C stated it was important to wear a gown when he administered medications to a resident with a gastric tube or when he did any kind of care for residents with indwelling devices because he did not want to risk spreading infection to or from those residents. In an interview with the DON on [DATE] at 2:33 pm, the DON stated EBP was used to protect staff and residents. He stated when a resident had EBPs, staff was to wear gown and gloves for any care that involved contact with the resident such as trach care, gastric tube care or feeding, and medication administration through a gastric tube. The DON stated any equipment that was used for more than one resident was to be wiped down between resident use with disinfectant wipes. The DON stated he did not know why the expired COVID test was in the storage room because they used a different test now when testing for COVID or flu. The DON stated the expired IV supplies should have been disposed of and if they were used it could cause infection or contamination, or the IVs or extension sets could fail and lead to injury to a resident. He stated the enteral feeding pump administration set should have been thrown away after it was opened and not put back into the drawer. He stated it could be contaminated and if it was used, could cause a resident to get sick. The DON stated he did not know why the baby monitor type system had been in the cabinet or how long it had been there. He stated he also did not know why the soiled enteral feeding pump was in the medication room. He stated when a resident left it was the charge nurse's responsibility to remove the equipment from a resident's room and she was supposed to give equipment to the central supply person to clean and store. The DON stated he did not know how long the pump had been in the medication room. The DON stated infection control in-services were monthly and the last one was in May. In an interview on [DATE] at 3:52 pm, LVN B stated the CS/MDS nurse was responsible for ensuring that all supplies and over the counter medications in the medication rooms were up to date. She stated when a resident was discharged, she would let the CS/MDS nurse know about it and the CS/MDS nurse would tell her where to put the equipment or what to do about. LVN B stated the nurse for the resident was responsible for cleaning equipment such as a feeding pump. In an interview on [DATE] at 4:29 pm, the CS/MDS nurse stated she did not go into the medication supply rooms; only the nurses went into them. She stated when a resident was discharged, the nurse cleaned the equipment and let her know about it. She stated the feeding pump should not have been in the medication room and should not have been dirty. She stated all enteral feeding equipment was wiped down every day by the nurses. In an interview on [DATE] at 6:42 pm, the ADON stated the nurses, ADONs and pharmacy were responsible for ensuring that medications and supplies in the medication storage rooms were not expired. She stated the nurses were supposed to clean the feeding pumps when a resident was discharged then put them in the appropriate storage area. The ADON stated if dirty equipment was stored in the medication room it could cause cross contamination. She stated they had several brands of COVID tests in the medication room, but she thought they got all of them out when they expired. The ADON stated she was unaware that test was on the top shelf. She stated she did not know how long the baby monitor had been there, but it should not have been there. The ADON stated medication room checks were done weekly by the nurses, every two weeks by the ADONs, sporadically by the DON, and once a (continued on next page)		

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 06/18/2026
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	month by the pharmacist. Record review of the facility's undated policy: Administering Medications reflected in part: 22. Staff follows established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable. Record review of the facility's undated policy: Enhanced Barrier Precautions reflected in part: Policy Statement Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents. Policy Interpretation and Implementation 1. Enhanced barrier precautions (EBPs) refer to infection prevention and control interventions designed to reduce the transmission of multi-drug-resistant organisms (MDROs) during high contact resident care activities. 2. Enhanced barrier precautions apply when: b. A resident is NOT known to be infected or colonized with any MDRO, has a wound or indwelling medical devices, and does not have secretions or excretions that are unable to be covered or contained; and c. Contact precautions do not otherwise apply. 5. Indwelling medical devices include central lines, urinary catheters, feeding tubes, and tracheotomies. 7. EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). 8. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: i. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.) Record review of the facility's undated policy titled Medication Labeling and Storage reflected in part: Medication Storage 2. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Record review of the facility's undated policy titled Infection Control Standard Precautions reflected in part: 5. Resident-Care Equipment b. Reusable equipment is not used for the care of more than one resident until it has been appropriately cleaned and reprocessed. 6. Environmental Control a. Environmental surfaces, beds, bedrails, bedside equipment and other frequently touched surfaces are appropriately cleaned.		

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 06/18/2026
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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure a PASRR evaluation was completed on newly admitted residents prior to admission or after admission for 1 resident (Resident #25) out of 6 residents reviewed for Preadmission Screening and Resident Review screenings. The facility failed to ensure Resident #25's PASRR L1 screening dated 03/07/25 accurately reflected her diagnoses of mental illness. There was no evidence that Resident #25 was referred to a Level 2 PASRR Screening and Evaluation having a primary diagnosis of mental illness. This failure could affect residents by placing them at risk for not receiving needed treatments and services. Findings included: Record review of Resident 25's admission record revealed a [AGE] year-old female with an initial admission date of 03/07/2025. Resident #25's diagnoses included schizophrenia (a chronic severe brain disorder that affects how a person thinks, feels, and acts) (primary diagnosis), dementia (a decline in mental ability - such as memory, thinking, and reasoning - severe enough to interfere with daily life) without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, anxiety disorder (a group of mental health conditions characterized by intense, excessive, and persistent fear or worry about everyday situations), and paranoid schizophrenia (a chronic mental health disorder characterized by intense, irrational suspicions, auditory hallucinations, and persecutory or grandiose delusions). Record review of Resident #25's Quarterly MDS report dated 06/15/2026 revealed a BIMS score of 12 indicating moderate cognitive impairment. No mood or behaviors were noted. A psychiatric disorder of schizophrenia was noted. Antidepressants were received on a routine basis. Record review of Resident #25's PL1 from the facility dated 03/07/2025 was negative for MI (mental illness), ID (intellectual disability), and DD (developmental disability). Resident #25's PL1 documented primary diagnosis as dementia. There were no other PL1 screenings for Resident #25. Record review of Resident #25's Form 1012 (Mental Illness/Dementia Resident Review) dated 03/07/2025 revealed No, the individual does not have a dementia diagnosis or has a dementia diagnosis, but it is not primary. Complete Section C. The physician does not need to sign Section B.1. The Form 1012 Indicated the PL1 was dated 03/07/2025. Section C. of the Form 1012 was not completed by the physician. Resident #25's Form 1012 was signed by the MDS nurse on 03/07/2025. Record review of Resident #25's Care Plan dated 04/11/2026 revealed FOCUS: [Resident #25] uses psychotropic medications (Haldol) r/t Behavior management, Dx: Schizophrenia 6/3/25 Resident has long history of having auditory hallucinations and paranoid delusions. 8/11/25 Resident has delusions and visual hallucinations. She voices seeing things that are not there. Date Initiated: 03/10/2025 Revision on: 08/11/2025. In an interview on 06/18/2026 at 5:17 p.m., the MDS nurse stated Resident #25 had dementia as her primary diagnosis on her PL1. She said the Form 1012 Review shows no diagnosis of dementia or dementia was not the primary diagnosis. The MDS nurse stated, I see the error. I will have to notify [behavioral testing facility] for a new PL1 and 1012 to correct it. The MDS nurse stated the negative effect was due to the discrepancy on the PL1 and 1012, it could change services for the resident. The MDS nurse stated she had not received training on PASRRs. During an interview on 06/18/2026 at 7:45 p.m., the DON stated if a resident was not screened properly for PASRRs, residents could be missing services. Record review of the facility's undated policy titled, PASRR (Pre-admission Screening & Resident Review) reflected in part: Policy Statement- To ensure each patient in the facility is screened for a mental disorder (MD) or intellectual disability prior to admission and that individuals identified with MD or ID are evaluated and receive care and services in the most integrated setting appropriate to their needs. Policy Interpretation and Implementation- 3. A (continued on next page)		

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 06/18/2026
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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	negative Level 1 screen permits admission to proceed and ends the pre-screening process unless possible serious mental disorder or intellectual disability arises later.		

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 06/18/2026
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a comprehensive care plan for each resident, consistent with the resident's rights, that includes measurable short-term and long-term objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment for 2 (Resident #7 and Resident #116) of 5 residents reviewed for care plans. 1. The facility failed to ensure Resident #7's comprehensive care plan was updated to reflect he was on hemodialysis. 2. The facility failed to ensure Resident #116's comprehensive care plan was completed. These failures could place residents at risk of not receiving individualized care and services to attain or maintain the residents' highest practicable physical, mental, and psychosocial wellbeing. The findings included: 1. Record review of Resident #7's admission record on 06/16/26 reflected a [AGE] year-old male who was originally admitted to the facility on [DATE] and most recently admitted on [DATE]. His diagnoses included end stage renal disease (when the kidneys lose the ability to remove waste and balance fluids), dependence on renal dialysis (process of filtering blood through a machine to remove excess water and toxins in the blood when the kidneys no longer function), Guillain-Barre syndrome (a rare condition where the immune system attacks the nerves, causing muscle weakness and potential paralysis), quadriplegia (total or partial loss of movement and feeling in both arms, both legs, and the torso), tracheostomy (a hole made through the front of the neck into the windpipe when medical conditions make the use of a breathing machine, also known as a ventilator, necessary for an extended period of time), type 2 diabetes (chronic condition that happens when blood sugar levels are persistently high which can lead to heart disease, kidney disease, and stroke), and hypertension (high blood pressure). Record review of Resident #7's admission MDS dated [DATE] reflected a BIMS score of 13 which indicated he was cognitively intact. Section O- Special Treatments, Procedures, and Programs reflected Resident #7 was on hemodialysis on admission and while a resident. Record review of Resident #7's care plan dated 05/06/26 reflected a focus of, (chronic) renal failure r/t kidney disease (stage 4) (severe loss of kidney function), initiated and revised on 06/02/26. The goal was Resident #7 would be able to resume normal daily activities of daily living by the review date, initiated on 06/02/26 with target date 08/02/26. The interventions included assist with ADLs, dietary consult to regulate protein and potassium intake, give medications as ordered by physician, monitor/document/report for s/sx of acute failure, all initiated on 06/02/26. 2. Record review of Resident #116's admission record, dated 6/17/2026, reflected an [AGE] year-old female admitted on [DATE]. Resident #116's diagnoses included malignant neoplasm of pancreas (tumor in the pancreas), non-Hodgkin lymphoma (type of blood cancer that starts in the lymphatic system), hypertension (high blood pressure), anemia, thrombocytopenic purpura (blood disorder where low number of platelets cause purple bruises and tiny red spots on the skin), adrenocortical insufficiency (two small organs above the kidneys not producing enough vital hormones), and automatic (implantable) cardiac defibrillator (small device placed under the skin in the chest, continuously monitoring heartbeat, and immediately sends an electrical jolt to reset the heart). Record review of Resident #116's PPS MDS assessment, dated 5/5/2026, reflected a BIMS score of 12 which indicated moderate cognitive impairment. Record review of resident #116's comprehensive care plan, updated 4/12/2026, revealed the only areas addressed were preferences in activities, discharge/transfer preferences, witnessed fall, and code status. Record review of Resident #116's care plan, dated 6/17/2026, revealed a comprehensive care (continued on next page)		

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 06/18/2026
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	plan was reviewed and closed on 4/12/2026 due to discharge. In an interview on 06/18/26 at 2:51 pm, LVN D stated care plans could be updated by nurses, and it was the whole team's responsibility to ensure they were up to date. She stated she did not recall if she had looked at Resident #7's care plan in the last 2 months. LVN D stated when a resident was a new admission or re-admission, the assessment form did not include information on dialysis. LVN D stated she did not review Resident #116's care plan and that the IDT was responsible for implementing changes in the resident's care plan. She stated the changes in the care plan were reported to the DON, ADON, MD, and RP. LVN D stated the baseline care plan was re-triggered anytime the resident was re-admitted to the facility from the hospital. In an interview on 06/18/26 at 4:29 pm, the CS/MDS nurse stated the MDS nurse did care plans and nursing helped. She stated the MDS nurse revised, changed, or updated the care plans. The CS/MDS nurse stated Resident #7's dialysis should have been care planned and as of 06/18/26 it still was not on the care plan. The CS/MDS nurse stated she was not sure why Resident #7's dialysis was not care planned. She stated care plans told the story of the residents and their plan of care; what, who, how, when, why things were done. She stated care plans were to be seen daily and not having a completed care plan could affect resident care by causing delays or mistakes in the care being rendered by the nurses and CNAs. The CS/MDS nurse stated Resident #116 was sent to the hospital frequently and the resident care plan did not reflect the resident's care and medical needs. She stated Resident #116 was able to make her needs known but was dependent on the staff for care. The CS/MDS nurse stated she had not had a care plan in service, but she knew the facility had them. In an interview on 06/18/26 at 5:22 pm, the MDS nurse stated she was responsible for keeping care plans up to date. She stated any acute changes, such as falls, were changed and updated by the DON and/or the ADON. The MDS nurse stated unless she audited a chart or a progress note was available, no update was made to the resident's care plan. She stated Resident #7's dialysis was supposed to be care planned. The MDS nurse stated when a resident was admitted or readmitted, she went through the orders to pull her information for the care plan. She stated she must have missed the dialysis order for Resident #7 and that was why it was not on his care plan. She stated she had not completed the care plan for Resident #116. The MDS nurse stated nursing did a baseline care plan within 48 hours; the admitting nurse started it and the DON looked over it and signed off on it within 48 hours of resident entry. She stated 3 sets of eyes missed that he was a dialysis patient. The MDS nurse stated it was important to have a complete and accurate care plan, so all nursing staff were aware of interventions and monitoring that needed to be done. She stated the DON and ADONs did in-services on care plans with the nursing staff. The MDS nurses stated she had not been in-serviced on care plans, but the DON audited care plans and discussed any issues with her. The MDS nurse stated at least 6 care plans were audited weekly for the last 4 months. In an interview on 06/18/26 at 7:45 pm, the DON stated the MDS nurses were responsible for care plans. He stated he reviewed the care plan only for acute (sudden) incidents such as falls. The DON stated care plans were reviewed upon admission and during care plan meetings. He stated he could not explain why Resident #7's dialysis was not care planned for 2 months. The DON stated usually with readmitted residents, the MDS nurse activated the previous care plan and modified it as needed. He stated Resident #7's care plan should have been reviewed. He said Resident #116's care plan might not have been reviewed after re-admission to the facility. The DON stated there were no negative outcomes due to Resident #116 not having a completed care plan. The DON stated in the nurse meeting in the mornings, they discussed new orders and things that needed to be care planned and passed that information to the MDS nurse. He stated they also printed a report that was specifically for the MDS nurse to use for care plans that contained any information such as new orders or new residents. He (continued on next page)		

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 06/18/2026
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated the MDS nurse was the only person who reviewed care plans. He stated the MDS nurse had an assistant, but that person was part-time. He stated the nurses provided care based on the orders. The DON said he did not review care plans, and the nurses did not receive in-services or training on care plans at the facility. The DON stated the only training from corporate for RNs was whatever was online, and it did not contain care plan training. He stated, I'm pretty sure she (the MDS nurse) got training on care plans, but not from the facility. He stated the regional MDS nurse provided support for care plans that were reviewed. Record review of the facility's undated policy: Care Plans, Comprehensive Person-Centered reflected in part: Policy Statement 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 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: (3) which professional services are responsible for each element of care; 9. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. 11. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. 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;		

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 06/18/2026
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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team, for 2 (Resident #11 and Resident #104) of 12 residents reviewed for comprehensive care plan revisions. 1. The facility failed to review and revise Resident #11's care plan to reflect his current diet (regular texture with thin liquids) and to reflect he had weight gain. 2. The facility failed to review and revise Resident #104's care plan to reflect eating with her fingers and refusing assistance with eating. These failures could place the residents at risk of not receiving appropriate interventions and care to meet their current needs. Findings included: 1. Record review of Resident #11's face sheet, dated 06/17/26, reflected a [AGE] year-old male, admitted on [DATE], diagnoses included: Autism disorder (condition related to brain development that impacts how a person perceives and socializes with others), type 2 diabetes mellitus (insulin resistance and high blood sugar levels), adult failure to thrive (syndrome of progressive decline in weight, nutrition, physical function, and cognitive or emotional health), dysphagia (trouble swallowing), generalized muscle weakness, unspecified protein-calorie malnutrition (condition characterized by inadequate intake of protein and calories), and other reduced mobility. Record review of Resident #11's MDS assessment, dated 04/16/26, reflected a BIMS score of 10, which indicated moderate cognitive impairment. The MDS assessment reflected Resident #11 had weight gain and was not on a physician prescribed weight gain regimen. The MDS assessment reflected Resident #11 was on a therapeutic diet (e.g., low salt, diabetic, low cholesterol). Record review of Resident #11's care plan, dated 06/17/26, reflected [Resident #11] was at risk for nutritional problem or potential nutritional problem related to risk for malnutrition and weight loss. Date initiated: 02/21/25. Interventions included: monitor weight loss, provide diet as ordered, and RD to evaluate and make diet change recommendations PRN. [Resident #11] had a nutritional risk related to malnutrition and limited concentrated sweets, no added salt diet, mechanical soft texture, and thin liquids consistency. Date initiated: 07/14/25. Interventions included: encourage dietary compliance, monitor tolerance to mechanical soft texture, monitor weight and report significant changes to MD. Resident #11's care plan did not reflect the current diet of limited concentrated sweets, no added salt diet with regular texture and thin liquids consistency. Resident #11's care plan did not reflect his weight gain. Record review of Resident #11's order summary, dated 06/17/26, reflected diet order of limited concentrated sweets, no added salt diet, regular texture, thin liquids consistency. Start date of 01/06/26. Record review of Resident #11's nutritional risk assessment, dated 01/26/26, reflected Resident #11 weighed 200 pounds and triggered for weight gain related to excessive energy intake and lifestyle choices. Encourage healthy food choices, consider weight loss regimen, encourage good oral intake, and RD to remain available for further assessments as needed. 2. Record review of Resident #104's admission record dated 06/15/2026, revealed an [AGE] year-old female with an admission date of 08/12/2024. Resident #104's diagnoses included Alzheimer's Disease (a progressive, irreversible brain disorder that slowly destroys memory and thinking skills), and anxiety disorder (a group of mental health conditions that cause intense, persistent, and excessive fear or worry in non-threatening situations). Record review of Resident #104's Quarterly MDS, dated [DATE], revealed a BIMS score of 03, indicating severe cognitive impairment. Resident #104 required substantial/maximal assistance for eating where the helpers provided 50% or more of the effort. Record review of Resident #104's care plan, dated 06/08/2026, revealed FOCUS: [Resident #104] has (continued on next page)		

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 06/18/2026
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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an ADL self-care performance deficit r/t Confusion, Dementia, Impaired balance, hip fracture Date Initiated: 08/30/2024 Revision on: 01/16/2025. INTERVENTIONS/TASKS: EATING: The resident is dependent on 1 staff member to eat. Date Initiated: 08/30/2024 Revision on: 06/02/2026. During an observation on 06/15/2026 at 12:05 p.m., Resident #104 was observed in the dining room eating lunch with her fingers. Resident #104 was seen emptying her bowl onto the table and scooping the food with her fingers and putting it in her mouth. During an observation and interview on 06/17/2026 at 12:17 p.m., Resident #104 was sitting at a table in the dining room. LVN F stated Resident #104 had already eaten. LVN F stated Resident #104 was assisted with eating. LVN F stated if Resident #104 was not assisted with eating, she would just play with her food. Resident #104 was clean and the table was cleaned. Resident #104 did not want to talk. During an interview and observation, on 06/18/26 at 11:30 AM, Resident #11 stated he was doing well and had no issues. Resident #11 stated he ate well, he ate on his own and he ate regular foods. Resident #11 stated he knew he could not eat too much and only ate 1 plate for breakfast, lunch, and dinner. Resident #11 stated he was told by staff to try to make healthier choices, but it was up to him what he ate. Resident #11 was observed with no visible bruises, skin tears, or injury. Resident #11 was observed to be served his lunch meal and had a regular texture meal on the tray. During an observation on 06/18/2026 at 11:47 a.m., Resident #104 was sitting at a table by herself at a dining room table. When she received her lunch tray, she used her left fingers to put food on the spoon in her right hand, alternating between her spoon and her fingers to eat. Resident #104 was observed eating pudding with her fingers only. Resident #104 would not speak. During an interview on 06/18/2026 at 12:10 p.m., LVN E stated Resident #104 could eat by herself. LVN E said she can check residents' charts to see if they needed assistance with eating. LVN E stated most the residents in the dining room were on her hall. She said they were her residents so she knew them and did not need to check their care plans. She said she made sure they were eating. During an interview on 06/18/2026 at 12:22 p.m., CNA H was assisting residents with eating in the dining room. CNA H stated she assisted residents who needed help eating. She said she knew which residents needed assistance with eating. CNA H stated Resident #104 ate by herself. She said Resident #104 was supposed to be assisted with eating but she refused to be assisted. CNA H stated she would let Resident #104 eat by herself when she refused help. She said she would notify the nurse when a resident refused help eating when they were supposed to be assisted. During an interview on 06/18/2026 at 2:55 p.m., LVN D stated a person who was care planned as a 1-person assist for eating, a CNA would feed them. She said it should be care planned if a resident ate with their fingers / refused to be assisted with eating. LVN D stated it was everyone's responsibility to ensure Care Plans were updated. She said the nurse can update, but IDT was responsible for Care Plans. During an interview, on 06/18/26 at 3:00 PM, the ADON stated she updated care plans for weight loss and weight gain. The ADON stated she or the MDS Nurse updated care plans for diet changes. The ADON stated she reviewed Resident #11's care plan and his care plan did not reflect weight gain or his current diet. The ADON stated Resident #11's care plan should have been updated to reflect his current diet of regular texture and should have also been updated from weight loss to weight gain. The ADON stated there was no negative outcome for Resident #11 as staff followed his orders, provided him with his current diet, and encouraged him to follow his diet. The ADON stated it was important to ensure the care plans were revised as needed to ensure everyone was aware of how to care for the resident. During an interview on 06/18/2026 at 4:34 p.m., CS/MDS stated the MDS Nurse handled care plans and the nurses help with the care plans. She said if any changes or updating are needed, the MDS Nurse and nurse will update the care plan. She said Resident #104 was a 1-person assist for eating. She said the care plan was there for anyone taking (continued on next page)		

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 06/18/2026
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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care of the resident. She said Resident #104 would have to be fed. CS/MDS stated if Resident #104 refused assistance with feeding, it would need to be care planned. She said the nurse or CNA would report the refusal to MDS. She said if the resident would eat with her fingers, it should be care planned as a preference. CS/MDS stated once the care plan was updated, MDS will notify the nurse. She said there was also the daily meeting where they were notified (the nurses) about care plans that had been updated. CS/MDS stated the care plans should be checked every day by the nurses especially for Resident #104, if eating with her fingers or refusal of assistance to eat was not care planned she might not be eating. She said the negative effect could be miscommunication and if the resident was eating with her fingers and it had not been care planned, the resident's preferences may not happen. During an interview on 06/18/2026 at 5:00 p.m., LVN E stated she did not look at the residents' care plans. She said she looks at the Tasks tab (CNAs). LVN E stated she did not look at the residents' MDS. She said Resident #104 eating with her fingers and refusal of assistance to eat should be care planned. During an interview on 06/18/2026 at 5:17 p.m., MDS Nurse stated she was responsible for care plan updates. She said if there were behaviors or falls, the ADON or DON would update the care plan. MDS stated Resident #104 was a 1-staff assist in the care plan and on MDS she was a substantial/maximal assist for eating needing 1 staff to assist her. She said that Resident #104 would be a 1-person task for feeding her. She said if a resident refused assistance with eating when they were a 1-person assist, the refusal should be care planned. MDS stated Resident #104's eating with her fingers was not care planned and it should be. She said anything like eating with fingers or refusal for assistance to eat, she would be notified by the ADON or DON when they had their Stand-up Meeting with nurses. She said if it was not reported to her, she would be unaware and could not update the care plan. MDS stated the negative effects could be not all staff would be aware of interventions that were to be done or monitoring of residents that should be done. She stated she had not been in-serviced on care plans. During an interview, on 06/18/26 at 5:20 PM, the MDS Nurse stated she or the ADON were responsible for updating care plans, depending on the change. The MDS Nurse stated diet changes and weight loss/weight gain should have been care planned and updated as needed. The MDS Nurse stated she had not been made aware that Resident #11's diet was changed from mechanical soft to regular texture, so it was not updated on his care plan. The MDS Nurse stated weight gain should have been updated by the ADON, but it was not updated. The MDS Nurse stated there was no negative outcome for Resident #11 as staff followed his diet orders and encouraged him to make good choices. The MDS Nurse stated it was important for the care plan to be updated accurately to ensure all staff was aware of the resident's current needs and how to care for him. During an interview, on 06/18/26 at 7:45 PM, the DON stated the MDS Nurse was responsible for developing and revising care plans. The DON stated care plans should have been updated for weight gain and diet changes such as texture upgrades. The DON stated Resident #11's diet was changed from mechanical soft to regular texture on 01/06/26. The DON stated Resident #11 was noted with weight gain on 01/26/26. The DON stated those changes should have been updated on the care plan. The DON stated there was no negative outcome for Resident #11 as staff followed the orders and interventions. The DON stated it was important for the care plan to be revised to ensure everyone was aware of changes in care. The DON stated Resident #104 was a 1-person assist for eating, her refusals for assistance should be care planned, and her eating with her fingers should be care planned. The DON stated if refusals and finger eating were not care planned, the task would not be generated on the tasks and they (nurses and CNAs) would not know the interventions. Record review of the facility's Care Plans, Comprehensive Person-Centered policy, undated, reflected - Policy: A comprehensive, person-centered care plan that includes measurable objectives and timetables to (continued on next page)		

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 06/18/2026
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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.		

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 06/18/2026
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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews the facility failed to ensure that a resident who was fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding for 1 of 5 residents (Resident #23) reviewed for enteral feeding tubes. The facility failed to ensure RN C followed physician ordered water flushes before and after medication administration given via the enteral feeding tube for Resident #23 on 06/17/26. This failure could place residents at risk of feeding tube obstruction and a decrease in nutrition and hydration. The findings included: Record review of Resident #23's admission record reviewed on 06/17/26 reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included nontraumatic intracerebral hemorrhage in cerebellum (brain bleed not caused from trauma), essential hypertension (high blood pressure), tracheostomy (a hole made through the front of the neck into the windpipe when medical conditions make the use of a breathing machine, also known as a ventilator, necessary for an extended period of time), gastrostomy (a tube surgically implanted through the abdomen into the stomach used to provide nutrition, hydration, and medication), and persistent vegetative state (after a brain injury, a person may appear awake but is unaware of their surroundings and unable to respond to any stimulus). Record review of Resident #23's quarterly MDS dated [DATE] reflected a BIMS score of 6 which indicated severe cognitive impairment. The MDS also reflected Resident #23 received 51% or more calories and 501cc/day or more fluid intake by tube feeding. Record review of Resident #23's care plan dated 03/04/26 reflected he had potential fluid deficit, initiated on 04/14/26 and revised on 04/28/26. The goal was Resident #23 would be free of symptoms of dehydration and maintain moist mucous membranes and good skin turgor with interventions that included medications administered as ordered. Resident #23's care plan also reflected he required tube feeding, initiated on 03/10/26 with an intervention that stated, the resident was dependent with tube feeding and water flushes. See MD orders for current feeding orders. Record review of Resident #23's order summary report on 06/17/26 reflected a phone order on 02/26/26 that stated to flush gastric tube with 30ml of water before and after medication administration every shift. During an observation on 06/17/26 at 8:18am, RN C did not flush Resident #23's gastric tube with 30ml of water before or after medication administration. In an interview on 06/17/26 at 8:37am, RN C stated he forgot to flush Resident #23's gastric tube with 30ml of water before he started medication administration and after he completed medication administration. He stated it was important to flush the gastric tube to prevent the medications from clogging the tube which could cause the resident to have to go to the hospital to have the gastric tube changed out. In an interview on 06/17/26 at 2:23pm, the DON stated if there was a specific order to flush the gastric tube before and after medication administration, then it was to be flushed with the ordered amount of water. He stated if the tube was not flushed, it would cause the tube to clog. He stated a physician could change the gastric tube at the bedside, but most of the time, the resident was sent to the ER for it to be changed. The DON stated if the gastric tube clogged, it could cause the resident to not receive their prescribed nutrition or medications. He stated a clogged gastric tube could also cause leakage of tube feed outside of the tube or tube rupture if a nurse used too much pressure when they tried to give medication, nutrition, or unclog the tube. The DON stated gastric tube in-services were done annually and as needed. The DON stated the last in-service on medication administration was in March and the pharmacist also came in monthly and observed 2 medication passes each time. Record review of the facility's undated policy: Administering (continued on next page)		

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 06/18/2026
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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medications reflected in part: Policy Statement Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation 4. Medications are administered in accordance with prescriber orders, including any required time frame. Record review of the facility's undated policy: Enteral Nutrition reflected in part: 12. The provider will consider the need for supplemental orders, including: i. flushing the tube before and after medications are administered.		

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 06/18/2026
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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews, the facility failed to ensure residents were free of significant medication errors for 1 (Resident #76) of 5 residents reviewed for medication errors. 1. The facility failed to ensure LVN A did not administer Resident #76's 9:00 pm dose of Diltiazem (blood pressure lowering medication) on 06/09/26 when her blood pressure was not within parameters for administration. The facility failed to ensure LVN A did not administer Resident #76's 9:00 pm dose of Metoprolol Tartrate (blood pressure lowering medication) on 06/09/26 when her blood pressure was not within parameters for administration. The facility failed to ensure LVN B did not administer Resident #76's 3:00 pm dose of Diltiazem (blood pressure lowering medication) on 06/14/26 when her blood pressure was not within parameters for administration. The facility failed to ensure LVN B did not administer Resident #76's 3:00 pm dose of Metoprolol Tartrate (blood pressure lowering medication) on 06/14/26 when her blood pressure was not within parameters for administration. The facility failed to ensure LVN B administered Resident #76's Midodrine (blood pressure raising medication) on 06/14/26 at 3:00 pm when her blood pressure was within parameters for administration. The facility failed to ensure LVN A administered Resident #76's Midodrine (blood pressure raising medication) on 06/14/26 at 9:00 pm when her blood pressure was within parameters for administration. These failures could place residents at an increased risk for complications, exacerbation of symptoms and disease process, and potential hospitalization. The findings included: Record review of Resident #76's admission record on 06/16/26 reflected a [AGE] year-old female admitted to the facility on [DATE]. Her pertinent diagnoses included metabolic encephalopathy (a chemical, or metabolic, problem in the body that can cause brain dysfunctions such as confusion, memory loss, and/or personality changes), essential hypertension (high blood pressure), end stage renal disease (when the kidneys lose the ability to remove waste and balance fluids), dependence on renal dialysis (process of filtering blood through a machine to remove excess water and toxins in the blood when the kidneys no longer function), quadriplegia (total or partial loss of movement and feeling in both arms, both legs, and the torso), and aphonia (loss of voice, unable to speak). Record review of Resident #76's admission MDS dated [DATE] reflected a cognitive skills for daily decision making score of 3 (severely impaired) which indicated she rarely or never made decisions. Record review of Resident #76's physician order summary on 06/16/26 reflected the following orders: Diltiazem HCl Oral Tablet 90 mg. Give 1 tablet via PEG-Tube (feeding tube) three times a day for HTN/AFIB. Do not administer if BP is <100/60 and HR <60. Ordered on 06/04/26. Metoprolol Tartrate Oral Tablet 25 mg. Give 1 tablet via PEG-Tube three times a day for HTN. Hold if BP is <100/60 and/or HR is <60. Ordered on 06/04/26. Midodrine HCl Oral Tablet 10 mg. Give 1 tablet via PEG-Tube every 6 hours as needed for Hypotension (low blood pressure). Hold if SBP >110. Ordered on 06/11/26. Record review of Resident #76's June 2026 MAR reflected the following: On 06/09/26 at 9:00 pm LVN A documented Resident #76's blood pressure as 98/50. LVN A documented Resident #76's Diltiazem and Metoprolol were both administered outside of parameters for administration per the physician's orders. On 06/14/26 at 3:00 pm, LVN B documented Resident #76's blood pressure as 93/58 and pulse 117 for Resident #76's Diltiazem and blood pressure 93/58 and pulse 76 for her Metoprolol. LVN B documented Resident #76's Diltiazem and Metoprolol were both administered outside of parameters for administration per the physician's orders. LVN B did not administer Resident #76's Midodrine when her blood pressure was within the parameters for admission per the physician's orders. On 06/14/26 at 9:00 pm, LVN A documented Resident #76's (continued on next page)		

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 06/18/2026
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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	blood pressure as 101/59. LVN A documented Resident #76's Diltiazem and Metoprolol were not administered due to her blood pressure was outside of parameters for administration per the physician's orders. LVN A did not administer Resident #76's Midodrine when her blood pressure was within the parameters for admission per the physician's orders. In an interview on 06/17/26 at 8:47 am, LVN B stated she spoke to the NP about Resident #76's blood pressure and heart rate and was told to give the Diltiazem if the pulse was over 100, so she gave the Diltiazem on 06/14/26 at 3:00 pm. LVN B stated she documented 114 for Resident #76's pulse on the MAR for her Diltiazem but documented 76 for her pulse on the MAR because that was the last one that was recorded and she did not change it. She stated she did not think to give the Midodrine. LVN B stated it was important to not give blood pressure lowering medications if the blood pressure was below parameters because it could cause the resident to be hypotensive (low blood pressure) and go to the hospital. She stated it was important to give Midodrine to raise the blood pressure to prevent complications from hypotension. LVN B stated check offs for medication administration were every 6 months and the last one was about a month ago. She stated the last in-service on medication administration was about a month ago also. In an interview on 06/17/26 at 2:23pm, the DON stated he would clarify the Diltiazem order with the physician because that medication was only to control heart rate. He stated because it only affected heart rate, LVN A was right to give the Diltiazem on 06/09/26 because Resident #76's heart rate was 68 and LVN B was right to give it on 06/14/26 because Resident #76's heart rate was 117. The DON stated Resident #76's Metoprolol should have been held on both dates because Metoprolol affected both blood pressure and heart rate. He stated the Midodrine should have been given on both 06/09/26 and 06/14/26 when Resident #76's blood pressure was low. The DON stated if antihypertensive (blood pressure lowering) medications were given outside of parameters, it could lower the blood pressure more and lead to hypotensive (low blood pressure) complications and the same was true for Midodrine not being given when the resident was hypotensive. The DON stated the last in-service on medication administration was in March and the pharmacist also came in monthly and observed 2 medication passes each time. Record review of the facility's undated policy: Administering Medications reflected in part: Policy Statement Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation 4. Medications are administered in accordance with prescriber orders, including any required time frame.		

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 06/18/2026
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews and record review, the facility failed to store, prepare, distribute, and serve food additives in accordance with professional standards for food service safety for 1 of 2 medication storage rooms (100 hall medication room) reviewed for storage of medications and food additives. The facility failed to label an opened container of food thickener stored in a cabinet with the date it was opened. This failure could place residents at risk of receiving medications and food additives that were expired. The findings included: During an inspection of the facility's 100 hall medication room on 06/17/26 at 1:00 pm, the following was found: 1 of 2 containers of food thickener stored on a shelf in a cabinet labeled enteral and milks was opened and did not have an open date on the container. In an interview on 06/17/26 at 2:23 pm, the DON stated he was not sure how long the container of food thickener had been in the cabinet, as they did not even use it anymore because only dietary was trained and allowed to thicken foods and drinks. In an interview on 06/18/26 at 3:52 pm, LVN B stated the CS/MDS nurse was responsible for ensuring that all supplies and over the counter medications in the medication rooms were up to date. In an interview on 06/18/26 at 4:29 pm, the CS/MDS nurse stated she did not go into the medication supply rooms; only the nurses went into them. In an interview on 06/18/26 at 6:42 pm, the ADON stated the nurses, ADONs and pharmacy were responsible for ensuring that medications and supplies in the medication storage rooms were not expired. The ADON stated medication room checks were done weekly by the nurses, every two weeks by the ADONs, sporadically by the DON, and once a month by the pharmacist. Record review of the facility's undated policy titled Medication Labeling and Storage reflected in part: Medication Storage 2. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.		

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 06/18/2026
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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain medical records on each resident that were complete and accurately documented in accordance with accepted professional standards and practices for 2 of 6 residents (Resident #6 and Resident #76) reviewed for medical records. 1. The facility failed to ensure RN C failed to remove contact precautions from the MAR for Resident #6 after receiving verbal orders from the physician to discontinue contact precautions. 2. The facility failed to ensure LVN B and LVN D documented Resident #76's information accurately on her pre-dialysis forms in the facility's electronic medical record. This failure could place residents at risk of errors in care and treatment. The findings included: 1. Record review of Resident #6's admission record, dated 06/17/26, reflected a [AGE] year-old male admitted on [DATE]. Resident #6's diagnoses included tracheostomy status (surgically created hole in the neck that leads directly to the windpipe [trachea]), severe sepsis without septic shock (body overreacts to a common infection, causing widespread inflammation leading to organ failure), pneumonia (infection of the lung causing air sacs to swell and fill with fluid or pus), and persistent vegetative state (awake but completely unaware), Record review of Resident #6's quarterly MDS assessment, dated 04/29/26, reflected a BIMS score was left blank which indicated it could not be completed. Record review of Resident #6's nursing progress note, dated 05/11/26 at 12:05 pm, indicated, discontinue contact precautions due to ATB completed. Record review of Resident # 6's MAR, dated 05/01/26-05/31/26, reflected, Isolation with: contact precautions related to e. Coli and ESBL to urine. Every shift start date 04/27/26 D/C date 05/11/26 and indicated check marks by the nurses for 7A-7P and 7P-7A shifts, from 05/01/26-05/11/2026. Record review of Resident #6's MAR, dated 05/01/26-05/31/26, reflected, Isolation with: contact precautions related to ESBL to urine. May cohort. Every shift start date 04/24/26 and indicated check marks by the nurses for 7A-7P and 7P-7A shifts, from 05/01/26-05/31/26. Record review of Resident #6's MAR, dated 06/01/26-06/30/26, reflected, Isolation with: contact precautions related to ESBL to urine. May cohort. Every shift start date 04/24/26 and indicated check marks by the nurses for 7A-7P and 7P-7A shifts, from 06/01/26-06/15/26. 2. Record review of Resident #76's admission record on 06/16/26 reflected a [AGE] year-old female admitted to the facility on [DATE]. Her pertinent diagnoses included metabolic encephalopathy (a chemical, or metabolic, problem in the body that can cause brain dysfunctions such as confusion, memory loss, and/or personality changes), essential hypertension (high blood pressure), end stage renal disease (when the kidneys lose the ability to remove waste and balance fluids), dependence on renal dialysis (process of filtering blood through a machine to remove excess water and toxins in the blood when the kidneys no longer function), quadriplegia (total or partial loss of movement and feeling in both arms, both legs, and the torso), and aphonia (loss of voice, unable to speak). Record review of Resident #76's admission MDS dated [DATE] reflected a cognitive skills for daily decision making score of 3 (severely impaired) which indicated she rarely or never made decisions. Record review of Resident #76's order summary report reflected the following telephone order dated 06/10/26: Avoid taking blood pressure, performing venipuncture (blood draw), giving injections, strenuous activity, or applying restrictive clothing or restraints on the AV site extremity. (Left Upper Extremity) every shift. Record review of Resident #76's pre-dialysis forms in the facility's electronic medical records reflected the following: On 06/05/26 at 10:26 am, LVN D documented Resident #76's most recent blood pressure: 110/59 on 06/04/26 at 8:36 pm (continued on next page)		

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 06/18/2026
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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(approximately 14 hours before the documented assessment time), most recent temperature: 97.8 on 06/04/26 at 4:43 pm (approximately 17 hours before the documented assessment time), and most recent pulse: 128 on 06/05/26 at 8:12 am. On 06/08/26 at 10:09 am, LVN B documented Resident #76's most recent temperature: 97.6 on 06/08/26 at 5:57 am (approximately 4 hours before the documented assessment time), most recent pulse: 107 on 06/08/26 at 7:17 am (approximately 3 hours before the documented assessment time), and most recent oxygen saturation: 97% on 06/08/26 at 7:17 am. LVN B also documented she checked Resident #76's blood pressure on her left arm. On 06/09/26 at 9:44 am LVN B documented Resident #76's most recent blood pressure: 110/61 on 06/09/26 at 3:08 pm (approximately 5 hours AFTER the documented assessment time), most recent temperature: 97.6 on 06/08/26 at 5:57 am (approximately 3.5 hours before the documented assessment time), most recent pulse: 88 on 06/09/26 at 4:13 pm (approximately 6 hours AFTER the documented assessment time), most recent respiration: 18 on 06/09/26 at 4:13 pm, and most recent oxygen saturation: 98% on 06/09/26 at 4:13 pm. LVN B also documented she checked Resident #76's blood pressure on her left arm. On 06/16/26 at 10:11 am, LVN D documented Resident #76's most recent blood pressure: 126/65 on 06/15/26 at 9:36 pm (approximately 12.5 hours before the documented assessment time), most recent temperature: 97.6 on 06/12/26 at 9:40 am (4 days before the documented assessment time), most recent pulse: 86 on 06/16/26 at 4:02 am (approximately 6 hours before the documented assessment time), most recent respiration: 06/15/26 at 7:15pm (approximately 15 hours before the documented assessment time), and most recent oxygen saturation: 98% on 06/16/26 at 4:01 am. On 06/17/26 at 9:46 am, LVN B documented Resident #76's most recent blood pressure: 96/60 on 06/17/26 at 3:18 pm (approximately 6.5 hours AFTER the documented assessment time), most recent temperature: 97.6 on 06/12/26 at 9:40 am (5 days before the documented assessment time), most recent pulse: 103 on 06/17/26 at 3:18 pm, most recent respirations: 18 on 06/17/26 at 1:52 pm (approximately 3 hours AFTER the documented assessment time), and most recent oxygen saturation: 98% on 06/17/26 at 1:52 pm. LVN B also documented she checked Resident #76's blood pressure on her left arm. In an interview on 06/15/26 at 3:16 pm, LVN G said he had been signing the MAR for contact precautions for May and June. He said the resident had an order to discontinue contact precautions from 05/11/26, and that he and the nurses were made aware of it. He said the order for contact precautions was not removed from the EMR and the nurses continued signing for contact precautions after the order was discontinued. In an interview on 06/17/26 at 4:11 pm, RN C said he had received a verbal order from the NP to discontinue contact precautions for Resident #6 in May. He said once he received the order to discontinue contact precautions, he was supposed to remove the order from the EMR but did not. He said the MAR indicating contact precautions continued to be checked off by the nurses. RN C said he had an in-service for documentation upon hire, but no recent education or in-services were received. He said inaccurate documentation could have caused a negative outcome for the resident; the resident would have not been able to room with another resident due to contact precautions. In an interview on 06/18/26 at 2:51 pm, LVN D stated Resident #76 was supposed to have a pre-dialysis form completed in the EMR every time she went to dialysis. She stated the pre-dialysis form in the EMR would automatically add the most recently documented vital signs and she would have to put in the new vital signs. She stated she was not sure why she did not put the correct vital signs in that form. She stated she filled out the handwritten paper dialysis communication form every morning and that was the form to go by. LVN D stated she was not sure why the facility did both the electronic and paper forms. She stated it was important that vital signs matched on both the handwritten form and the electronic form and were most recent to paint a complete picture of the resident and to avoid (continued on next page)		

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 06/18/2026
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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confusion. LVN D stated she was not sure if anyone looked at the electronic pre-dialysis forms, but she thought the DON might. She stated if the vital signs were not accurate the resident possibly would not receive accurate treatment. LVN D stated it had been a while since the last in-service on documentation. In an interview on 06/18/26 at 3:52 pm, LVN B stated when Resident #76 went to dialysis, they checked her vital signs, disconnected her tube feeding, moved her bed and vent over to the dialysis area, then hooked her back up to everything. She stated the nurses filled out the pre and post dialysis forms in the EMR as well as on the handwritten paper dialysis communication form. She stated the pre-dialysis forms were completed right before the resident went to dialysis. LVN B stated if the form was completed after the resident returned, the documentation would not be accurate. She stated the handwritten dialysis communication form was the most accurate form. LVN B stated she thought they used the electronic dialysis forms because it was company policy. She stated medical records and the ADONs looked at those forms and they were supposed to be accurately documented. LVN B stated she documented she checked the blood pressure on Resident #76's left arm by accident. She stated it was important not to check a blood pressure on the same arm as the fistula (the site used for dialysis) because it could damage the fistula. LVN B stated if inaccurate information was documented it could cause the resident to not receive appropriate care and confusion between staff members and other entities. She stated they received in-services on documentation about once a month and it was mostly about resident behavioral documentation. In an interview on 6/18/2026 at 8:50 pm, the DON stated the expectation was accurate and timely documentation from the nurses. He stated he constantly provided guidance and education to the nurses regarding documentation and described timely as documentation within one hour. The DON stated the negative outcome from inaccurate documentation was not rendering proper care to the residents. Record review of the facility's undated policy titled Charting and Documentation reflected in part: Policy Statement All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional 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: a. Objective observations; c. Treatments or services performed; 3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. 7. Documentation of procedures and treatments will include care-specific details, including: a. the date and time the procedure/treatment was provided; 8. Timeliness Standards a. Documentation must be completed: 3. Treatment records: At the time of treatment or immediately after.		