STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45F603	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mesa View Senior Living	106 Teas Circle Canadian, TX 79014

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents or their representative had properly completed Out-of-Hospital Do-Not-Resuscitate(OOH-DNR) form which requires the document to be properly completed and signed, including the notary's date of completion for 4 (Residents #2, # 4, #8, and #11) of 17 residents reviewed for advanced directives.Residents #2, # 4, #8, and #11's DNR form in their record was missing the date of when the notary signed the form.This failure could place residents at risk of receiving medical treatment inconsistent with their or their legal representatives expressed wishes.Findings included:Resident #2Record review of Resident #2's face sheet revealed she was a [AGE] year-old female resident admitted to the facility on [DATE] with diagnoses to included but not limited to epilepsy (seizure disorder), unspecified, chronic kidney disease (loss of kidney function) and essential hypertension (high blood pressure). Resident #2 was listed in Advance Directives as being a DNR. Record review of Resident #2's quarterly MDS was completed [DATE] listing her with a BIMS of 10 indicating her cognition was moderately impaired, and she had a functionality of being dependent with most of her ADL's Record review of Resident #2's care plan last revision dated [DATE] revealed the following: Focus:Resident #2 has the right to choose Advance Directives that reflect her personal values and beliefs with interventions for her preferences to be honored.Record review of the clinical record for Resident #2 revealed an Order Summary with Active Orders as of [DATE] with the following order: -DNR-Active [DATE] Record review of the clinical record for Resident #2 revealed a DNR dated [DATE] (signed by the physician) revealed with the following:Section - Two Witnesses - there was a signature for the notary, a printed name for the notary, but no date of when the notary completed the DNR form. Resident #4Record review of Resident #4's face sheet revealed she was an [AGE] year-old female resident admitted to the facility on [DATE] with diagnoses to included but not limited to heart failure, paroxysmal atrial fibrillation (irregular heartbeat), chronic combined systolic and diastolic heart failure (heart not pumping strong), chronic obstructive pulmonary disease (progressive lung condition that makes it difficult to breathe). Resident #4 was listed in Advance Directives as being a DNR. Record review of Resident #4's quarterly MDS was completed [DATE] listing her with a BIMS of 03 indicating her cognition was severely impaired, and she had a functionality of being dependent with most of her ADL's Record review of Resident #4's care plan and last revision dated [DATE] revealed the following: Focus:Resident #4 has the right to choose Advance Directives that reflect her personal values and beliefs with interventions for her preferences to be honored. Record review of the clinical record for Resident #4 revealed an Order Summary with Active Orders as of [DATE] with the following order: -DNR-Active [DATE] Record review of the clinical record for Resident #4 revealed a DNR dated [DATE] (signed by the physician) revealed with the following:Section - Two Witnesses - there was a signature for the notary, a printed name for the notary, but no date of when the notary completed the DNR form.Resident #8Record review of Resident #8's face sheet revealed he was a 74 -year-old male resident admitted to the facility on [DATE] with diagnoses to included but not limited to Heart failure, essential hypertension and benign prostatic hyperplasia (non-cancerous enlargement (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45F603	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mesa View Senior Living	106 Teas Circle Canadian, TX 79014

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of the prostate gland) with lower urinary tract symptoms. Resident #8 was listed in Advance Directives as being a DNR. Record review of Resident #8's quarterly MDS was completed [DATE] listing him with a BIMS of 08 indicating his cognition was severely impaired, and he had a functionality of set up/clean up assistance with eating, toileting, supper and lower body dressing.Record review of Resident #8's care plan last revision dated [DATE] revealed the following: Focus:Resident #8 has the right to choose Advance Directives that reflect his personal values and beliefs with interventions for her preferences to be honored. Record review of the clinical record for Resident #8 revealed an Order Summary with Active Orders as of [DATE] with the following order: -DNR-Active [DATE]Record review of the clinical record for Resident #8 revealed a DNR dated [DATE](signed by the physician) revealed with the following:Section - Two Witnesses - there was a signature for the notary, a printed name for the notary, but no date of when the notary completed the DNR form.Resident #11Record review of Resident #11's face sheet revealed she was an 83 -year-old female resident admitted to the facility on [DATE] with diagnoses to included but not limited to Parkinson's Disease with dyskinesia (erratic movement), essential hypertension (high blood pressure) and personal history of other circulatory system. Resident #11 was listed in Advance Directives as being a DNR. Record review of Resident #11's admission MDS was completed [DATE] listing her with a BIMS of 15 indicating her cognition was intact, and she had a functionality of independence in eating, toileting, upper and lower body dressing.Record review of Resident 11's care plan last revision dated [DATE] revealed the following: Focus:Resident #11 has the right to choose Advance Directives that reflect her personal values and beliefs with interventions for her preferences to be honored. Record review of the clinical record for Resident #11 revealed an Order Summary with Active Orders as of [DATE] with the following order: -DNR-Active [DATE] Record review of the clinical record for Resident 11 revealed a DNR dated [DATE](signed by the physician) revealed with the following:Section - Two Witnesses-- there was a signature for the notary, a printed name for the notary, but no date of when the notary completed the DNR form.During an observation and interview on [DATE] at 2:10 PM LVN E who worked in House A and B where #2, # 8 and #11 resided. She stated if a DNR was not completely correct or accurately the staff would be required to provide CPR. LVN E reviewed Resident #8's DNR who resided in House A and stated she did not observe anything incorrect with the form and would honor the DNR as written.During an observation and interview on [DATE] at 2:47 PM the ADM stated that a DNR that was not completed correctly could not be honored. The ADM pulled up Resident #8's DNR and said she was not sure if it was correct or not. The ADM said that the administrative personnel were responsible for ensuring DNRs was completed correctly and a possible negative outcome for not having a completed DNR in the file would be that a resident would not have their wishes followed.During an interview on [DATE] at 9:24 AM, the DON stated she was aware that some DNR forms were incomplete and would not be valid because the notary did not sign the form at the time the signatures were witnessed. The DON stated the facility uses various notaries from the community and believed the notary may have missed dating the form. The DON further stated that a possible negative outcome of not having a properly completed DNR would be a resident's wishes might not be honored.During an interview on [DATE] at 9:45 AM, LVN D, who worked in House C where #4 Resident resided stated if a DNR form was not completed correctly with accurate dates and signatures, the DNR would be invalid. She stated that in such a case, staff would be required to initiate CPR, which would go against the resident's expressed wishes. LVN D stated she believed it was the social worker's responsibility to ensure DNR forms were completed accurately and in accordance with requirements.During an interview on [DATE] at 9:54 AM, the SW stated that many residents were admitted to the facility with their DNR forms already completed. The SW stated that the facility uses various notaries from the community, or the resident or resident's Power of attorney may obtain a notary from outside the facility. The SW stated she was responsible for reviewing and verifying that DNR forms were completed accurately. She further stated that if a DNR form was not completed correctly, the resident's wishes might not be followed.Record review of (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45F603	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mesa View Senior Living	106 Teas Circle Canadian, TX 79014

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Advanced Directives (no date) did not have any information regarding OOH-DNRs.Record review of the undated OUT-OF-HOSPITAL DO-NOT-RESUSCITATE (OOH-DNR) ORDER-TEXAS DEPARTMENT OF STATE HEALTH SERVICES form that was in the admission Packet revealed the following: The original or a copy of a fully and properly completed OOH-DNR Order or the presence of an OOH-DNR device on a person is sufficient evidence of the existence of the original OOH-DNR Order and either one shall be honored by responding health care professional.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45F603	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mesa View Senior Living	106 Teas Circle Canadian, TX 79014

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 - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with the professional standards for food service safety for 1 of 4 kitchens reviewed for kitchen sanitation. 1. The facility failed to ensure freezer items were properly stored, labeled, and dated in House A kitchen. These failures could place residents who ate food served by the kitchen at risk of food-borne illness. Findings included: Observation of the freezer in House A on 10/13/25 at 10:30 AM revealed the following:1. (1) pie shell, open to air, with no label or date, not in original box.2. (1) package of diced potatoes, not labeled and open to air. 3. (1) Ziplock baggie of frozen cookie dough, no label, not in original box. 4. (1) brown bag of unknown food item, open to air, not labeled, not in original box5. (1) brown bag of unknown food item, not labeled, not in original box 6. (1) Ziplock bag of onions, not labeled, not in original box.7. (1) Ziplock bag of pastry sheets, open to air, not labeled, not in original box8. (3) Ziplock bags of breadsticks, not labeled, not in original box, one of the bags was slimy and greasy to the touch9. (1) Ziplock bag of a meat product, frost in the bag covering all the food, no label, not in original package10. (1) large package of bacon, no label or date, not in original box.11. (1) Ziplock bags of cheese cubes, not labeled, not in original box, one bag was open to air. Observation of the freezer in House A on 10/13/25 at 2:00 pm revealed the following: 1. (1) pie shell, open to air, with no label or date, not in original box.2. (1) package of diced potatoes, not labeled and open to air. 3. (1) Ziplock baggie of frozen cookie dough, no label, not in original box. 4. (1) brown bag of unknown food item, open to air, not labeled, not in original box5. (1) brown bag of unknown food item, not labeled, not in original box 6. (1) Ziplock bag of onions, not labeled, not in original box.7. (1) Ziplock bag of pastry sheets, open to air, not labeled, not in original box8. (3) Ziplock bags of breadsticks, not labeled, not in original box, one of the bags was slimy and greasy to the touch9. (1) Ziplock bag of a possibly meat product, frost in the bag covering all the food, no label, not in original package10. (1) large package of bacon, no label or date, not in original box. 11. (2) Ziplock bags of cheese cubes, not labeled, not in original box, one bag was open to air.12. (1) large Ziplock bag of turkey or chicken strips, open to air, no label not in original box. In an interview on 10/13/25 at 2:15 pm, [NAME] F stated all foods in the freezer should be labeled and dated. She stated she did not know what the unlabeled foods in the brown bags and the Ziplock bag of meat with frost were. She stated she had been trained by the DM from the hospital on how to label and date foods.She stated she did not know why the foods had been open to air and not labeled. She stated the food issues could cause food borne illnesses in the residents. In an interview on 08/21/23 at 2:30 pm with the DM, she stated she had been supervising all the kitchens in the facility. She stated the expectation was all foods needed to be dated with the receiving date. She stated each cook in each house had been responsible for dating the food. She stated all foods should be closed to air. When asked about labeling the foods she stated the cooks do not have to label the food because they know what it is. She stated the brown bags of food and meats, should be labeled as you cannot tell what had been in the brown bag and you might not be able to tell what kind of meat may have been in the package. She stated all other food items did not have to be labeled with a name. She stated the food had been kept in the original boxes it was packed in and the box had a name on the box. She stated she had trained the staff in their job duties and had held in-services as needed. She stated she spot-checked the kitchens when she had been in the facility. The DM stated the consequences of unlabeled, undated food would be food borne illness. The DM stated they follow the TFER (Texas Food Establishment Rules) in the kitchen.Record review of the undated facility policy titled Sanitary Food Handling, revealed the facility will prepare store and serve food under sanitary conditions using the most recent version of the Texas Food Establishment Rules and the Texas State Department of State Health Food Services food sanitation requirements as a guide.They will meet the standards imposed by local, state and federal codes regarding food and food handling.Record review of the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45F603	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mesa View Senior Living	106 Teas Circle Canadian, TX 79014

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 - Some	facility provided policy titled Serve Safe Essentials, page 7-4, documented if you take food out of its original package, put it in a clean sanitized container and cover it. The new container must be labeled with the name of the food being stored and its original use by or expiration date.Record review of the facility provided untitled, undated policy, stated food labels should include the common name or a food statement that clearly and accurately identifies the food. If the food is unlabeled, then dispose in trash due to unknown age. Record review of the 2021 US Food Code revealed the following: 3-302.12 Food Storage Containers, Identified with Common Name of Food.Except for containers holding FOOD that can be readily and unmistakably recognized such as dry pasta, working containers holding FOOD or FOOD ingredients that are removed from their original packages for use in the FOOD ESTABLISHMENT, shall be identified with the common name of the FOOD. Record review of the 2015 TFER (Texas Food Establishment Rules) revealed: S228.79. Labeling. (a) Food labels. (1) Food packaged in a food establishment, shall be labeled as specified in law, including 21 CFR 101, Food Labeling, 9 CFR 317, Labeling, Marking Devices, and Containers, and 9 CFR 381, Subpart N, Labeling and Containers. Pf [24] (2) Label information shall include: (A) the common name of the food, or absent a common name, an adequately descriptive identity statement. (b) Food storage containers, identified with common name of food. Except for containers holding food that can be readily and unmistakably recognized such as dry pasta, working containers holding food or food ingredients that are removed from their original packages for use in the food establishment, shall be identified with the common name of the food.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45F603	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mesa View Senior Living	106 Teas Circle Canadian, TX 79014

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 observation, interview and record review, the facility failed to implement a comprehensive care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 2 (Resident #4 and #32) of 17 Residents reviewed for comprehensive care plans. -The facility failed to address the use of oxygen in Resident #4 and Resident #32's care plans. This failure could result in residents not being able to attain or maintain their highest practicable physical, mental, and psychosocial well-being.Findings included: Resident #4: Record review of Resident #4's face sheet dated 10/13/2025 revealed an [AGE] year-old female resident admitted to the facility originally on 1/27/2025 and readmitted on [DATE] with diagnoses to include Alzheimer's (a progressive disease that destroys memory and other important mental functions), congestive heart failure (a chronic condition in which the heart dose not pump blood as well as it should), and chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breath). Record review of Resident #4's quarterly MDS completed 8/05/25 listed her with a BIMS of 03 indicating she was severely cognitively impaired, and she had a functionality of being dependent on staff for most of her activities of daily living. Resident #4 was listed as on oxygen therapy while a resident. Record review of Resident #4's order summary reports revealed the following:- O2 at 2-5 liters PRN for shortness of breath. - Verbal Active 01/27/2025. Record review of Resident #4's care plan with date of initiation 1/27/2025 revealed no care plan for oxygen use. During an observation on 10/13/2025 at 10:22 AM Resident #4 was in bed sleeping with her oxygen tubing rolled up next to her head. Resident #4's oxygen concentrator was on. Resident #4 awoke to knocking. Resident #4 was confused and did not respond appropriately to questions. Resident #4 did appear in good condition. Resident #32: Record review of Resident #32's face sheet dated 10/13/2025 revealed an [AGE] year-old female resident admitted to the facility originally on 3/06/2019 and readmitted on [DATE] with diagnoses to include Alzheimer's (a progressive disease that destroys memory and other important mental functions), chronic kidney disease (longstanding disease of the kidneys leading to kidney failure), Bipolar disorder (a disorder associated with episode of mood swings ranging from depressive lows to manic highs), epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures), left ventricular failure (a condition where the left side of the heart's main pumping chamber, the left ventricle, cannot pump enough oxygenated blood to the body), and rheumatoid arthritis (autoimmune inflammation of the joints). Record review of Resident #32's quarterly MDS completed 7/15/25 listed her with a BIMS of 99 indicating she was unable to complete the interview due to memory problems, and she had a functionality of being dependent on staff for most of her activities of daily living. Resident #32 was listed as on oxygen therapy while a resident. Record review of Resident #32's order summary reports revealed the following:- O2 at 2-5 liters QHS for shortness of breath at bedtime related to HEART FAILURE, UNSPECIFIED (I50.9) - Verbal Active 12/20/2021 Record review of Resident #32's care plan with date of initiation 10/06/2020 and last revision date of 4/27/2025 revealed no care plan for oxygen use. During an observation on 10/13/2025 at 10:32 AM Resident #32 was in bed awake but unable to respond effectively to any questions. Resident #32 was wearing O2 via a NC. Resident #32 appeared in good condition. During an observation on 10/14/2025 at 8:18 AM Resident #32 was in bed sleeping peacefully with her oxygen on via NC. During an interview on 10/14/2025 at 3:11 PM MDS C confirmed she was responsible for completing all care plans for residents. MDS C reviewed Resident #32 chart, verified Resident #32 had orders for oxygen, had a diagnosis of sarcoidosis (a chronic inflammatory disease characterized by the formation of non-caseating granulomas in various organs, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45F603	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mesa View Senior Living	106 Teas Circle Canadian, TX 79014

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	most commonly in the lungs) which would require oxygen, and that Resident #32 had orders for oxygen at 2-5L/min via NC at HS and PRN for SOB. MDS C verified that Resident #32 did not have oxygen use addressed in her care plans and has not had it addressed for a while. MDS C reported I just missed it. I am not sure what happened. MDS C reported that oxygen should be care planned, especially if it has orders. MDS C reported that not addressing a resident's needs in their care plans such as oxygen use could be detrimental to their health. It could result in impaired oxygen exchange and affect that resident's condition. MDS C was unavailable for comment on 10/15/2025 when Resident #4 was discovered to have no care plans for her oxygen therapy. During an interview on 10/15/2025 at 8:55 AM the DON reported we really don't know why the oxygen was missing on the care plans. When asked if the care plan not addressing the residents need for oxygen was an issue the DON reported, I don't know. The order was in the chart so the residents need for oxygen was addressed. No further comment was given. Record review of the facility provided policy titled Care Plans reviewed annually, revealed the following: Baseline:3. The care plan will include at the minimum the following information:b. Physician orders. Comprehensive:Policy Statement - An individualize comprehensive care plan that includes measurable objectives and timetables to meet the residents' medical, nursing, mental and psychological needs is developed for each resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45F603	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mesa View Senior Living	106 Teas Circle Canadian, TX 79014

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents who need respiratory care were provided such care consistent with professional standards of practice for 1 (Resident #32) of 17 residents reviewed for respiratory care. -Resident #32 was not receiving oxygen at the correct dose. This failure could affect residents by placing them at risk for respiratory compromise and associated complications such as shortness of breath, confusion, respiratory failure, infection, and exacerbation of their condition. Findings included: Record review of Resident #32's face sheet dated 10/13/2025 revealed an [AGE] year-old female resident admitted to the facility originally on 3/06/2019 and readmitted on [DATE] with diagnoses to include Alzheimer's (a progressive disease that destroys memory and other important mental functions), chronic kidney disease (longstanding disease of the kidneys leading to kidney failure), Bipolar disorder (a disorder associated with episode of mood swings ranging from depressive lows to manic highs), epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures), left ventricular failure (a condition where the left side of the heart's main pumping chamber, the left ventricle, cannot pump enough oxygenated blood to the body), and rheumatoid arthritis (autoimmune inflammation of the joints). Record review of Resident #32's quarterly MDS completed 7/15/25 listed her with a BIMS of 99 indicating she was unable to complete the interview due to memory problems, and she had a functionality of being dependent on staff for most of her activities of daily living. Resident #32 was listed as on oxygen therapy while a resident. Record review of Resident #32's order summary reports revealed the following:- O2 at 2-5 liters QHS for shortness of breath as needed - Verbal Active 12/20/2021. - O2 at 2-5 liters QHS for shortness of breath at bedtime related to HEART FAILURE, UNSPECIFIED (I50.9) - Verbal Active 12/20/2021. Record review of Resident #32's care plan with date of initiation 10/06/2020 and last revision date of 4/27/2025 revealed no care plan for oxygen use. During an observation on 10/13/2025 at 10:32 AM Resident #32 was in bed awake but unable to respond effectively to any questions. Resident #32 was wearing O2 via NC at 0.5L/min. Resident #32 appeared in good condition. During an observation on 10/14/2025 at 8:18 AM Resident #32 was in bed sleeping peacefully her oxygen on at 0.5L/min via NC. During an interview on 10/14/2025 at 9:22 AM MA B (the skilled staff member responsible for Resident #32 this shift) checked Resident #32's oxygen and verified that the current dose Resident #32 was receiving 0.5L/min via her NC. MA B then checked Resident #32's orders and noted Resident #32 ordered for 2-5L/min via NC prn and at HS. MA B reported, her dose is not correct. We need to up her dose. MA B reported that a resident not receiving enough oxygen could have increased SOB, they would not get enough oxygen, and that could increase their confusion. MA B reported that when a resident was not getting enough oxygen then the first sign could be increased confusion. MA B checked Resident #32's O2 saturation with a level of 95% noted. MA B reported that the nurses were responsible for making sure the oxygen was set at the right level. Ma B reported that the nurse responsible for this unit left this shift to take care of a sick family member and she (MA B) was her replacement. During an interview on 10/15/2025 at 8:51 AM the DON reported that staff were not following the physicians' order when they administered Resident #32s oxygen at 0.5L/min and that the nurses or the medications aide's responsibility to check the oxygen to ensure the correct dose was administered. The DON reported that not administering oxygen per the physicians' orders at the correct dose could result in impaired oxygen exchange for the resident. Record review of the facility provided policy titled, Oxygen Policy undated, revealed the following: Policy:.appropriately, trained staff may assist the resident with oxygen administration per physicians' orders. 1) Any resident using oxygen must have a current physician order.Oxygen Orders and Administration:1) Oxygen administration per the residents' physicians' orders.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45F603	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mesa View Senior Living	106 Teas Circle Canadian, TX 79014

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical service to include accurate dispensing and administering of biologicals for 1 of 7 insulins reviewed to meet the needs of each resident. The House B medication cart had an inulin bottle that expired according to the date documented on the bottle of when it was opened. This failure could result in ineffective treatment resulting in exacerbation of residents' disease processes.Findings included: During an observation on [DATE] at 11:27 AM the House B medication cart revealed 1 [NAME] insulin marked with opened/access date of [DATE] (35 days from [DATE]). RN A reported the insulin pen marked opened/access [DATE] expired, that an insulin should be discarded 28 days after it was opened/accessed, and that the resident involved receives a scheduled dose every evening. RN A immediately discarded the insulin pen and opened a new one. RN A marked the new insulin pen with the opened/accessed date. RN A reported that using an expired medication such as this insulin on a resident could result in the medication losing its effectiveness and could affect the residents hyper or hypoglycemic (high/low blood sugar) reactions. During an interview on [DATE] at 8:48 AM the DON reported that all insulins should be labeled with required information such as the resident's name and dose. The DON reported that a multidose vial should be labeled when pulled out of the box for the first time. When asked what information the insulin should be labeled with the DON stated, the residents name and such. When asked what information staff should put on the label when an insulin was opened/accessed and the DON stated, I am not sure what you are asking. When asked if an insulin could be used for 60 days after it was opened the DON stated, Yes. During an interview on [DATE] at 9:22 AM the DON reported that administering an insulin that expired could result in the resident not receiving the appropriate dose of medication. Record review of the facility provided Insulin Administration reviewed annually, revealed the following: Purpose: To provide guidelines for the safe administration of insulin to resident with diabetes.Insulin Delivery.Procedure:4. Check expiration date, if drawing from an open multidose vial. If opening a new vial, record expiration date and time on the vial (follow manufacturer recommendations for expiration after opening). Record review of manufacturer recommendation for Lantus Insulin at lantus.com revealed the following instructions:- How to store your opened Lantus Solostar Pen:After 28 days, throw your opened Lantus pen away-even if it still had insulin in it.