STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675645	A. Building B. Wing	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mesa Springs Healthcare Center	7171 Buffalo Gap Rd Abilene, TX 79606

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44766 Based on interviews and record reviews, the facility failed to thoroughly investigate allegations of abuse and neglect for 1 (Resident #1) of 7 residents reviewed. The facility did not have evidence that a thorough investigation was completed for Resident #1 allegation of being verbally abused. This failure could place residents at risk of incidents not being thoroughly investigated and subject to further abuse. The findings included: 1.Record review of Resident'#1's Admission Record, dated 6/25/2024, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included cerebral infarction due to embolism of right cerebellar artery (a cerebrovascular event involving the posterior cranial fossa, specifically targeting the cerebellum), type 2 diabetes, and hypertension. Record review of Resident #1's State Optional MDS, dated [DATE], revealed the resident had a BIMS score of 10, which indicated the resident was mildly cognitively impaired for daily decision-making skills. 2.Record review of Resident'#2's Admission Record, dated 6/25/2024, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included cerebral infarction (a condition that occurs when blood flow to the brain is disrupted, causing brain cells to die due to lack of oxygen and nutrients), Neuralgia (a sharp, shocking pain that follows the path of a nerve and is due to irritation or damage to the nerve), and Depression. Record review of Resident #2's State Optional MDS, dated [DATE], revealed the resident had a BIMS score of 15, which indicated the resident was not cognitively impaired for daily decision-making skills. (continued on next page)

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
	675645	A. Building B. Wing	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mesa Springs Healthcare Center	7171 Buffalo Gap Rd Abilene, TX 79606

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/24/24 at 2:40 PM Resident #1 stated Resident #2 used to be mean to her. She stated that she would just say awful things to her. She stated she never was physically abusive towards her but was verbally abusive every day. She stated she was only her roommate for a month or so. She stated she did not say anything to anybody because she had concerns on what the roommate would do to her. She stated but next thing she knew she was interviewed and told the truth. She stated she feels so much better in her new room. She stated Resident #1 would call her names or make fun of her. During an interview on 6/25/24 at 9:25 AM Resident #2 stated that she did have a roommate. She stated her and the roommate did not get along. She stated the roommate wanted to go to bed at certain times and wanted to do things in the room and wanted her to agree and do what she did. She stated she did not remember being rude or mean to her but knew they had many disagreements. She stated she was much happier now that she was gone, and she has the room to herself. During an interview on 6/24/24 at 12:40 PM CNA A stated she was working on 4/20/24 and overheard Resident #2 calling Resident #1, nasty and an idiot. She stated she went into the room and removed Resident #1 because she was crying and sat with her a little bit until she calmed down. She stated she reported what she heard to her charge nurse for the day. She stated she has no idea from there what occurred. During an interview on 6/24/24 at 1:40 PM LVN B stated she was working on 4/20/24 and does remember the incident that was brought to her attention by CNA A. She stated she reached out to the administrator because he was the abuse coordinator even if an incident occurs on a weekend. She stated she does not have anything written down that a call was made on 4/20/24 from her to the administrator but does remember calling the administrator on 4/20/24. During an interview on 6/24/24 at 1:15 PM Administrator stated that he was called on 4/20/24 and came up to the facility. He stated as he was walking in Resident #1 family member A was walking out. He stated he spoke with the family member A and asked her if there was any arguing or raised voices between her and Resident #1. He stated that she replied, no. He stated that he felt after the interview with the family member A he had no other concerns with the incident. Record review of Resident #1's progress notes dated 4/25/24 submitted by DON indicated: staff reported that resident was in her room crying, she stated that family member B was upset with her because her roommate called him and told him things, he came in and talked to the resident, upon investigation, it was reported that the roommate had been saying mean things to the resident telling her that she could make her move out because she smells, was dirty and that she was not nice to her family. During an attempted interview with the DON on 6/24/24 and 6/25/24, no answer, left message. Messages were not returned. During an interview on 6/25/24 at 10:45 AM the Administrator stated he should have further investigated the incident. He stated by doing so he would have found that the incident involved a resident-to-resident abuse allegation, not resident to family abuse allegation. He stated upon finding it was resident to resident he would have started the process of asking residents if they wanted to move rooms and figured out better placement for both residents. He stated the investigation should have been done in full on 4/20/24 because it would have removed Resident #1 from the verbal abuse. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675645	A. Building B. Wing	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mesa Springs Healthcare Center	7171 Buffalo Gap Rd Abilene, TX 79606

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised February 2022, revealed: 3. Ensure that, after receipt of a report of possible abuse, neglect, mistreatment, exploitation, or misappropriation of resident property, steps are immediately taken to protect the identified resident. 6. Guidelines for facility Compliance: in order to comply with the facility's obligations as set for in 42 CFR 483. 12, it will: e. conduct a prompt, through and complete investigation in response to reportable allegations of abuse, neglect, mistreatment, exploitation, or misappropriation of resident proper.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675645	A. Building B. Wing	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mesa Springs Healthcare Center	7171 Buffalo Gap Rd Abilene, TX 79606

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** 44766 Based on interview, and record review the facility failed review and revise the comprehensive plan of care to meet a resident's needs that were identified in the comprehensive assessment for 1 of 6 residents (Resident #3) reviewed for comprehensive person-centered care plans. The facility failed to address Resident #3's 04/29/24 fall in her plan of care. This deficient practice could place residents at risk for injury with falls and not having personalized plans developed to address their needs. Findings include: Record review of Resident #3's electronic facility face sheet, dated 6/25/24, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #3 had diagnoses which included Alzheimer's Disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to conduct the simplest tasks), muscle weakness, unspecified lack of coordination, and Dementia. Record review of Resident #3's quarterly MDS assessment, dated 3/31/24, reflected she scored a 3 on his BIMS, which indicated she was severely cognitively impaired. Record review of Resident #3's care plan, dated 6/25/24, indicated to Monitor/document for risk of falls. Educate resident, family /caregivers on safety measures that need to be taken to reduce risk of falls. (If resident has a care plan for falls, refer to this). Date Initiated: 06/05/2018 Created on: 06/05/2018. The care plan did not address the resident's incident on 4/30/24. Record review of facility Description of allegation dated 5/1/24 indicated: On April 30, 2024, at approximately 9:00 AM, facility administrator is notified that Resident #3 fell in her room at approximately 11:40 PM on April 29 and received an injury requiring emergency treatment. CNA A stated Resident #3 is last checked at 10:30 PM during rounds and is still in bed at that time, and stated the bed is in the lowest, locked position at that time. CNA A stated she is starting her midnight round when she heard Resident #3 yelling and went into the room to find her on floor near the bed. A moderate amount of blood is noted on the floor, and a laceration to the resident's middle forehead is noted. CNA A notified LVN C who responded and applied pressure with gauze. Resident #3 is described as awake and alert but disoriented and confused (which is her baseline due to cognitive status). A 911 call is initiated, and LVN C continued to apply pressure to Resident #3's forehead until EMS arrived. Resident #3 is transported to local hospital for assessment and treatment and received 7 sutures to her forehead. Resident #3 is released to return to the building at approximately 4 AM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675645	A. Building B. Wing	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mesa Springs Healthcare Center	7171 Buffalo Gap Rd Abilene, TX 79606

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	During an interview on 6/25/24 at 10:45 AM MDS stated that the normal process was at morning meeting every morning there should be updates from staff/ADON on any change in condition or anything that flags for a change in care plan for a resident. She stated that Resident #3 did have a fall with a laceration to the forehead. She stated this should have flagged for an incident and should have been care planned. She stated however Resident #3 fall incident fell through the cracks and the incident was not care planned. She stated with care plans not up to date the residents are at risk of preventatives not being in place that protect the residents from injury or harm. During an interview on 6/25/24 at 11:15 AM ADON stated that the process for care plans was doing them annually, quarterly, and change in condition. She stated for example a fall with injury should have been notated and then brought to morning meeting to discuss with everyone. She stated at morning meeting the MDS coordinator would be the one to take was change in condition or incident and put it into the resident's care plan. She stated however was did not happen with resident price but should have been. Record review of the facility's Comprehensive Person-Centered Care Planning Policy, dated February 2023, reflected the following: It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. The IDT team will also develop and implement a baseline care plan for each resident, within 48 hours of admission, which includes minimum healthcare information necessary to properly care for each resident and instructions needed to provide effective and person-centered care that meet professional standards of quality care.