

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675645	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2025
NAME OF PROVIDER OR SUPPLIER Mesa Springs Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record reviews, the facility failed to ensure residents had the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal for 1 of 5 residents (Resident #312) reviewed for grievances.</p> <p>The facility failed to ensure a grievance was completed for Resident #312's complaint of LVN A.</p> <p>This failure could place residents at risk for not having their grievances resolved.</p> <p>The findings included:</p> <p>Record review of Resident #312's electronic face sheet indicated a [AGE] year-old female, who was initially admitted to the facility on [DATE] with a current admission date of 05/31/25. Resident #312's medical diagnoses included dementia, asthma, weakness, chronic kidney disease, stage 4 severe, pressure ulcer on left buttock, difficulty swallowing, type 2 diabetes mellitus, Parkinson's disease, heart failure, anemia, high blood cholesterol, high blood pressure, gout, cognitive communication deficit, and nausea with vomiting.</p> <p>Record review of Resident #312's quarterly MDS assessment, dated 05/18/25, Section C - Cognitive Patterns, subsection C0500. BIMS Summary Score was not completed. Subsection C0600 - Should the Staff Assessment for Mental Status (C0700-C1000) be Conducted? 1. Yes (resident was unable to complete Brief Interview of Mental Status) - Continue to C0700 Short-Term Memory OK was entered. Subsection 0700. Short-term Memory OK 1. Memory problem was entered. Subsection C0800. Long-term Memory OK 1. Memory problem was entered. Subsection C0900. Memory/Recall Ability B. Location of own room and D. That they are in a nursing home/hospital swing bed were entered. Subsection C1000. Cognitive Skills for Daily Decision Making 2. Modified independence - some difficulty in new situations only was entered.</p> <p>Record review of Resident #312's care plan revised on 05/08/25 indicated Resident #312 had an actual impairment to her skin integrity to the unstageable of Left Gluteal Fold/Interior Ischial Tuberosity (a large bone commonly referred to as sit bone protected by the gluteus maximus or buttock). Interventions included Cleanse wound with wound cleanser, pat dry, apply [medical honey], cover with border dressing 3x (times) weekly and PRN,</p> <p>Record review of Resident #312's physician's orders dated 05/08/25, indicated, Cleanse wound on Left interior ischial tuberosity with wound cleanser, pat dry then skin prep, apply [medical honey], cover with Border foam. 3 times weekly and as needed.</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 675645
		If continuation sheet Page 1 of 7

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #312's electronic treatment record for May 2025 revealed the dressing change was performed every Monday, Wednesday, and Friday as ordered.</p> <p>During an interview on 05/31/2025 at 06:30 PM, the Administrator stated she was not sure what the grievance policy was and if it was different from the previous state she had come from. She stated after a conversation with Resident #312's family member on Friday (05/30/25) she did not complete a grievance form or begin investigating staff because the family member stated she was going to call State. The DON stated she did not remember the family member saying she did not want LVN A to work with her family. She remembered the family member making comments such as she did not like LVN A and was disappointed in the care, but the DON did not think that warranted an investigation. The DON stated the Administrator was responsible for monitoring the grievance procedure.</p> <p>During an interview on 06/03/25 at 10:43 AM, the Marketer stated the family member told the Marketer that her family members residing in the facility were being neglected by LVN A. The Marketer stated the family member and LVN A did not get along. The family member told the Marketer on 05/29/25 that she met with the DON and requested LVN A not provide care to her family members anymore. The Marketer could not recall the DON stating when the meeting was or the DON's response to the family member's request. The Marketer stated the family member did not state any other staff member names during the conversation. The Marketer stated she reported the family member's concern to the Administrator.</p> <p>During an interview on 06/03/25 at 12:18 PM, the family member stated she blamed LVN A for the Resident #312's wound and decline. The family member did not explain why she blamed LVN A. The family member reported her grievance verbally to the Marketer who then reported to the Administrator.</p> <p>During a follow-up interview on 06/05/25 at 02:23 PM, the Marketer clarified the date and time she reported the allegation of neglect to the Administrator. She explained during the visit to the hospital Resident #312's family member stated [the facility] neglected my [Resident #312]and continues to neglect my [Resident #312]. The Marketer stated she called the Administrator right away. Review of a screenshot of the call revealed the call was made at 05/07/25 at 04:17 PM.</p> <p>During a follow-up interview on 06/06/25 at 09:16 AM, the family member confirmed the date, approximate time, and conversation she had with the Marketer at the hospital. She stated she was angry about the situation. The family member stated she did not feel LVN A performed dressing changes on her family member's pressure ulcer as ordered causing the wound to worsen.</p> <p>During an interview on 06/06/25 at 09:43 AM, the Administrator stated she would have started the grievance process immediately if the grievance was about alleged abuse or neglect.</p> <p>During an interview on 06/06/25 at 10:08 AM, the DON stated she did not recall knowing about the Administrator being notified of the family member's concerns on 05/27/25. She stated the timeframe to report a grievance was immediately and it was the Administrator's responsibility to report to State if necessary.</p> <p>(continued on next page)</p>		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy titled Grievances, revised 11/23/2016 revealed under Procedures: 1. The facility's grievance official is responsible for overseeing the grievance process, receiving, and tracking grievances; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances; issuing written grievance decisions to the resident, if requested; and coordinating with state and federal agencies as necessary. 2. Resident and/or Resident Representatives have the right to file grievances orally or in writing, the right to file grievances anonymously, and obtain a written decision regarding his or her grievance as requested. Copies of the Grievance Resolution Forms are available from the Social Services Designee or Grievance official and at the nursing stations. These forms are to be initiated when concerns are made. 4. The Grievance Official evaluates and investigates the concern and takes immediate action to resolve the concern and prevent further potential violations of any resident's right while the alleged violation is being investigated.		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to implement written policies and procedures to prohibit and prevent abuse, neglect, and misappropriation for 1 of 5 residents (Resident #312) reviewed for developing and implementing neglect policies.</p> <p>The facility failed to follow its policy to investigate and report to the Texas Health and Human Services Commission (HHSC) when Resident #312's family member alleged that LVN A neglected Resident #312.</p> <p>This failure could place residents at risk of not having allegations thoroughly investigated per policy.</p> <p>Findings included:</p> <p>Record review of Resident #312's electronic face sheet indicated a [AGE] year-old female, who was initially admitted to the facility on [DATE] with a current admission date of 05/31/25. Resident #312's medical diagnoses included dementia, asthma, weakness, chronic kidney disease, stage 4 severe, pressure ulcer on left buttock, difficulty swallowing, type 2 diabetes mellitus, Parkinson's disease, heart failure, anemia, high blood cholesterol, high blood pressure, gout, cognitive communication deficit, and nausea with vomiting.</p> <p>Record review of Resident #312's quarterly MDS assessment, dated 05/18/25, section C - Cognitive Patterns, subsection C0500. BIMS Summary Score was not completed. Subsection C0600 - Should the Staff Assessment for Mental Status (C0700-C1000) be Conducted? 1. Yes (resident was unable to complete Brief Interview of Mental Status) - Continue to C0700 Short-Term Memory OK was entered. Subsection 0700. Short-term Memory OK 1. Memory problem was entered. Subsection C0800. Long-term Memory OK 1. Memory problem was entered. Subsection C0900. Memory/Recall Ability B. Location of own room and D. That they are in a nursing home/hospital swing bed were entered. Subsection C1000. Cognitive Skills for Daily Decision Making 2. Modified independence - some difficulty in new situations only was entered.</p> <p>Record review of Resident #312's care plan revised on 05/08/25 indicated Resident #312 had an actual impairment to her skin integrity to the unstageable of Left Gluteal Fold/Interior Ischial Tuberosity (a large bone commonly referred to as sit bone protected by the gluteus maximus or buttock). Interventions included Cleanse wound with wound cleanser, pat dry, apply [medical honey], cover with border dressing 3x (times) weekly and PRN,</p> <p>Record review of Resident #312's physician's orders dated 05/08/25, indicated, Cleanse wound on Left interior ischial tuberosity with wound cleanser, pat dry then skin prep, apply [medical honey], cover with Border foam. 3times weekly and as needed.</p> <p>Record review of Resident #312's electronic treatment record for May 2025 revealed the dressing change was performed every Monday, Wednesday, and Friday as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a phone interview on 06/03/25 at 01:03 PM, Resident #12's primary physician stated the resident had a fall and hit her head in April which he attributed to the resident's decline. He stated when the wound developed, he wanted to send the resident to the local wound care clinic. The physician stated the family declined due to the resident's status. He stated the family told him the wound care could be done in the facility. The physician stated his assessment revealed a necrotic wound (a wound containing dead tissue), no evidence of infection, no tunneling (formation of channels or tunnels under the skin extending from the main wound to deeper tissues), no abscesses. He stated he did not feel the resident had been neglected.</p> <p>During an interview on 06/03/25 at 10:43 AM, the Marketer stated the family member told the Marketer that her family members residing in the facility were being neglected by LVN A. The Marketer stated the family member and LVN A did not get along. The family member told the Marketer she met with the DON and requested LVN A not provide care to her family members anymore. The Marketer could not recall the DON stating when the meeting was or the DON's response to the family member's request. The Marketer stated the family member did not state any other staff member names during the conversation. The Marketer stated she reported the family member's concern to the Administrator via phone call.</p> <p>During a phone interview on 06/03/25 at 12:38 PM, the wound care specialist stated services began on 04/22/25. He stated on 05/13/25 the wound was looking better, necrotic tissue had improved, and the surface area of the wound had decreased. He stated LVN A, the facility treatment nurse, was very involved in resident's care. He stated he had every confidence in her ability to manage the wounds in the facility.</p> <p>During an interview on 06/03/25 at 12:18 PM, the Resident #312's family member stated she was still angry about the wound. She stated she blamed LVN A for Resident #312's wound and decline. The family member did not explain why she blamed LVN A.</p> <p>During a follow-up interview on 06/05/25 at 02:23 PM, the Marketer clarified the date and time she reported the allegation of neglect to the Administrator. She explained during the visit to the hospital Resident #312's family member stated [the facility] neglected my [Resident #312]and continues to neglect my [Resident 312]. The Marketer stated she called the Administrator right away. Review of a screenshot of the call revealed the call was made at 05/07/25 at 04:17 PM.</p> <p>During a follow-up interview on 06/06/25 at 09:16 AM, the family member confirmed the date, approximate time, and conversation she had with the Marketer at the hospital. She stated she was angry about the situation. The family member stated she did not feel LVN A performed dressing changes on her family member's pressure ulcer as ordered causing the wound to worsen.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/06/25 at 09:43 AM, the Administrator stated she was the Abuse Coordinator. She stated her expectations of staff reporting abuse, neglect or exploitation was for staff to report any suspected or witnessed ANE immediately. She explained, once reported, her first action was to ensure resident safety, then report to State and begin an investigation. She stated the timeline to report to State was within 2 hours of being aware of the situation. The Administrator stated the failure to report could be due to staff making a judgement call and deciding to not report to her. She explained she did not feel in this instance that an error was made due to the report made to her on 05/27/25 only stated that family member was angry. She stated she remembered being told the family member was upset, especially at LVN A. She stated she felt that she would have started the investigation and reporting process per the facility policy immediately if the report stated abuse or neglect was alleged. The Administrator stated consequences to a resident or residents of staff failing to report, or administration failing to report and investigate an allegation, would be based on the situation. The Administrator stated ANE training was done at least annually for all staff members, in-services were conducted after an incident involving ANE, and ANE was discussed at all staff meetings. She stated she was ultimately the person responsible for monitoring that staff was in compliance with training requirements.</p> <p>During an interview on 06/06/25 at 10:08 AM, the DON stated she did not recall knowing about the Administrator being notified of the family member's concerns on 05/27/25. She stated her expectations of reporting suspected or witnessed ANE was for a report be made to herself and the Administrator/Abuse Coordinator. She stated if report was made to her, she would tell the reporter to contact the Administrator then follow up to make sure the Administrator was notified. The DON explained failure by the facility to report an allegation of ANE was because it was her understanding that the complaint involved a family member blaming LVN A for her family member's wound and subsequent admission to the hospital. She stated the words abuse and/or neglect were not used. She stated the family member was upset about the whole situation. The DON stated she was notified that the family member was going to report to State. She stated the timeframe to report an incident was immediately and it was the Administrator's responsibility to report to State. The DON explained the consequences to a resident or residents of failing to report would be a problem because staff was frequently trained on reporting. She stated training consisted of reviewing the policy during every staff meeting, reminders of who the Abuse Coordinator was, routine face-to-face and written in-services and online training. She stated training compliance was monitored by corporate. The DON stated a report was sent by corporate to HR twice a month listing training modules due. She stated nursing staff out of compliance was taken off the schedule until training was up to date.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of facility policy titled Alleged Violations of Abuse, Neglect, Exploitation or Mistreatment, reviewed/revised 12/2023 revealed under Definitions: Alleged violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor, another health care provider, or others but has not yet been investigated and, if verified, could be noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property. Neglect is the failure of the Facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Neglect occurs when the facility is aware of, or should have been aware of, goods or services that a resident(s) required but the facility fails to provide them to the resident(s), that has resulted in or may result in physical harm, pain, mental anguish, or emotional distress. Under Procedure: 1. In response to allegations of abuse, neglect, exploitation, or mistreatment, the Facility will: a. Ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment including injuries of unknown source and misappropriation of resident property, are reported immediately but: . Not later than twenty-four (24) hours if the events that cause the allegation does not involve abuse and does not result in serious bodily injury. 2. Ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported to: a. b. The State Survey Agency. 6. Guidelines for Facility Compliance: In order to comply with the Facility's obligations as set forth in 42 CFR 483.12, it will: e. Conduct a prompt, thorough and complete investigation in response to reportable allegations of abuse, neglect, mistreatment, exploitation, or misappropriation of resident property.</p>		