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	04/15/2026

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to implement their written policies and procedures regarding allegations of abuse/neglect for one (Resident #1) of seven residents reviewed for abuse/neglect. The facility did not report an incident of neglect to the state agency within the given time frame. These failures could place all residents that access the facility van. The findings included:Record review of Resident #1's Face Sheet, dated April 14, 2026, revealed a [AGE] year-old female with the latest admission date of 08/24/2025. Her diagnoses included Hemiplegia, unspecified affecting right dominant side (a type of paralysis that affects one side of the body, often resulting from brain damage due to conditions such as a stroke or injury); and ataxic gate (an unsteady, irregular walking pattern caused by cerebellar dysfunction, leading to poor coordination and balance); and cognitive communication deficit (difficulty in communications that arise from impaired cognitive functions). Record review of Resident #1 Quarterly MDS, dated [DATE], revealed Resident #1 had a BIMS score of 99 (unable to access cognitive impairment). Section GG revealed Resident #1 required the use of a wheelchair for ambulation. Record review of nursing progress note, dated 3/27/26 at 1515 revealed facility van driver reported that resident fell out from her wheelchair and rolled over near driver's seat. Resident did not have seat belt on at the time van stopped suddenly.In an interview on 04/14/2026 at 12:54 pm, Nurse A said she assessed Resident #1 when she returned to the facility. She was not injured but complained of generalized body pain and was given pain medication which was effective. Post-fall interventions were put into place with no reports of any further effects from the incident. Record review of Resident #1's Medication Administration Record revealed she received Acetaminophen-Codeine Tablet on 3/27/26 at 1510. In an interview on 04/14/2026 at 1:00 pm, Resident #1 stated she was on her way back from a dental appointment and was not buckled in. The van driver was not driving fast but had to stop suddenly and she fell out of her wheelchair and onto the floor of the van. There were no other residents in the van. She said the van driver accessed her and helped her back into her wheelchair and strapped her in. She said she was not injured just some general body pain and was assessed and given pain medication when she returned to the facility. She said, it was just an accident. She said she had always been buckled in before. In interviews with the sampled residents on 4/14/26 the following were revealed: Resident #2 said she rides on the facility van for appointments and outings and has always been buckled in. Resident #3 said she goes to activities and appointments in the van and was always buckled in. Resident #4 said she goes to appointments in the van and was always buckled in. Resident #5 said she goes to doctor's appointments and outings such as going to Wal-Mart was always buckled in. Resident #6 said she goes to outings in the van and was always buckled in. Resident #7 said she rides in the van for appointments and outings and was always buckled in. In an interview on 04/14/26 at 1:15 pm, the Maintenance Director said he is the current van driver for the facility. He had received training on transporting residents and how to secure a resident in the van. He said he recently completed an in-service training with demonstration on how to secure a resident in the van. In an interview on 04/15/26 at 9:35 am, the Administrator said after the incident, an investigation was completed by the facility. She said the van driver admitted he failed to buckle the resident in. When the incident (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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	happened, the van driver immediately assessed the resident with no injury, buckled her in her wheelchair, and called and notified the facility of the incident. He was placed on suspended leave, received a final written warning, and he resigned on 03/31/26. In-services with the van drivers were completed with demonstration. She said the Maintenance Manager was currently the van driver for the facility. The Administrator said she did not report the event outside of the facility to the state because she felt like at the time of incident it was not a reportable event as she did not consider the incident as resident neglect. A record review of the van driver employee file on 4/15/26 revealed the van driver received a counseling note on 3/27/26 concerning the failure to buckle in the resident with a final written warning. He resigned on 03/31/26. A record review on 04/15/26 of the investigation and training/in-service titled Annual Fleet Safety Re-Evaluation with a checklist with demonstration that was completed on 3/27/26 for residents to be bucked in at all times. Record review of the facility policy Abuse: Prevention of and Prohibition Against, dated as revised 12.2023, revealed the following [in part]: Policy: It is the policy of this Facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, exploitation and mistreatment.The Facility will provide oversight and monitoring to ensure that its staff, who are agents of the Facility, deliver care and services in a way that promotes and respects the rights of the residents to be from abuse, neglect, misappropriation of resident property, exploitation, or use of technology that would infringe on the resident's right to personal privacy.Definitions:*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 includes cases where the facility's indifferent or disregard for resident care, comfort, or safety, resulted in or could have resulted in physical harm, pain, mental anguish, or emotional distress.Procedure:H. Reporting/Response2. Allegations of abuse, neglect, misappropriation of resident property, or exploitation will be reported outside the Facility and to the appropriate State or Federal agencies in the applicable timeframes, as per this policy and applicable regulations. The facility provided the policy Transportation to Diagnostic Appointment, not dated, did not address the need to buckle/secure residents while they are using the van for transportation.