STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676163	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mesquite Post Acute Care	4510 27th St Lubbock, TX 79410

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 - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, 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 for 3 (Resident #1, Resident #2, and Resident #3) of 9 residents reviewed for comprehensive care plans. The facility failed to update or add interventions to Resident #1's care plan regarding aggressive and physical behaviors toward one other resident that occurred on 09/03/25.The facility failed to update or add interventions to Resident #2's care plan regarding aggressive and physical behaviors toward one other resident that occurred on 09/06/25.The facility failed to update or add interventions to Resident #3's care plan regarding aggressive and physical behaviors toward other resident that occurred on 09/07/25.These failures could result in residents not receiving the care that they need to prevent further incidents of aggression.Findings Included: Resident #1Record review of Resident #1's face sheet, dated 09/24/25, revealed an [AGE] year-old-male was admitted to the facility on [DATE] with diagnoses to include cognitive communication deficit (difficulty communicating), dementia (memory loss), and intermittent explosive disorder (mental disorder characterized by sudden intense outburst of anger). Record review of Resident #1's Comprehensive Minimum Data Set, dated [DATE], revealed the following: *Section A indicated the assessment was his first assessment. *Section C Brief Interview for Mental Status score revealed a score of 00, which indicated the resident's cognition was severely impaired.*Section E did not reveal any coded behaviors that included behaviors directed towards others.*Section V revealed that Resident #1 triggered for CAA #9 Behavioral Symptoms and should have been care planned.Record review of Resident #1's Change of Condition Evaluation, dated 09/03/25 revealed:The change of condition identified was behavioral symptoms (agitation, psychosis).Findings: Resident redirected with no continued behaviors.Skin Status Evaluation: No change of condition reported.Vitals Signs were evaluated.Provider Notification and Feedback: clinician notified on 09/03/25 at 5:00 PM, and recommendation of the clinician was to monitor. Resident Representative Notified on 09/03/25 at 5:00 PM. Record review of Resident #1's progress notes, dated 06/23/25-09/24/25, revealed:*09/3/25 at 5:54 PM LVN A documented Resident (unidentified in the progress note) yelled out and it was witnessed that Resident #1 hit another resident. The DON, resident representative and the doctor were notified. Further review of Resident #1's progress notes did not reveal any further incidents of aggression after 09/03/25. Record review of the facility's incident and accident report, dated 09/24/25 revealed:Resident #1 had an incident of resident-to-resident aggression that occurred on 09/03/25. Record review of Resident #1's Q15 minute rounds documentation indicated that he was on 15 minute checks from 09/03/25-09/06/25. Record review of Resident #1's care plan, dated 9/2/25 revealed the following:*Resident #1 had a focus behavior that addressed his risk for wandering and elopement (initiated 09/04/25).*Resident #1's care plan dated 09/2/25 did not address the incident of aggression from 09/03/25 by way of goals and interventions. During an interview on 09/24/25 at 6:57 PM, Resident #1 was unable to participate in an interview as he did not answer any questions related to the incident that occurred on 09/03/25. Resident #2Record review of Resident #2's face sheet, dated 09/24/25, revealed a [AGE] year-old-male was admitted to the facility on [DATE] with diagnoses to include Alzheimer's (memory loss), anxiety (increased worry) and major depressive disorder (mood disorder characterized by persistent feelings of sadness). Record review of Resident #2's Comprehensive Minimum Data Set, dated [DATE], revealed the following: *Section C Brief Interview for Mental Status score revealed a score of 03, which indicated the resident's cognition was severely impaired.*Section E did not reveal any coded behaviors.*Section V revealed that Resident #2 did not trigger for CAA #9 Behavioral Symptoms.Record review of Resident #2's Change of Condition Evaluation, dated 09/06/25 revealed:The change of condition identified was other (resident to resident- hit another resident).Findings: No changes noted and the incident had not occurred before.Skin Status Evaluation: No change of condition reported.Vitals Signs were evaluated.Provider Notification and Feedback: clinician notified on 09/06/25 at 11:45 PM, and recommendation of the clinician was to monitor.Resident Representative Notified on 09/06/25 at 11:45 PM. Record review of Resident #2's progress notes, dated 06/23/25-09/24/25, revealed:*09/7/25 at 3:11 AM the ADON documented Resident #2 hit another resident that was watching TV in the dining room. Resident #2 hit another resident twice on the back of the neck and upper back. Both of the residents were separated. Further review of Resident #2's