STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676480	A. Building B. Wing	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mesquite Village Wellness & Rehabilitation	825 W. Kearney Street Mesquite, TX 75149

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for two of seven residents (Resident #1, Resident #2) reviewed for abuse, neglect, and exploitation. The facility failed to ensure Resident #2 was free from abuse by Resident #1. This failure could place residents at risk for abuse or neglect that could lead to serious harm.Findings included: Record review of Resident #1's face sheet, dated 05/05/26, reflected a [AGE] year-old male was admitted to the facility on [DATE]. Resident #1 had diagnoses which included: acute osteomyelitis (severe bone infection), non-pressure chronic ulcer of unspecified heel and midfoot, type 2 diabetes (high blood sugar), protein-calorie malnutrition (a severe nutritional deficiency resulting from inadequate intake of protein and calories), schizoaffective disorder (a chronic mental health condition that combines symptoms of schizophrenia (such as hallucinations, delusions, or disorganized thinking) with a major mood disorder, such as bipolar or unipolar (depressive) disorder), muscle weakness (a reduction in physical strength), end stage renal disease (final, irreversible state of kidney failure), dysphagia (pain, choking, or food feeling stuck in the throat), lack of coordination (clumsy, unsteady, and uncoordinated muscle movements), abnormal posture and cognitive communication deficit (impairment in communication). Record review of Resident #1's Quarterly MDS assessment, dated 03/17/26, reflected BIMS score of 11, which indicated moderate cognitive impairment. The MDS assessment under Section GG-Functional Abilities, reflected Resident #1 needed setup or clean-up assistance with eating and oral hygiene, substantial assistance with toileting, partial assistance with shower and bathing, and supervision with dressing and hygiene. The MDS assessment under Section E-Behaviors, reflected Resident #1 did not exhibit any physical, verbal or other behavioral symptoms towards others. Record review of Resident #1's care plan, revised 04/01/26, reflected Resident #1 at risk for physical behavior related to dementia by evidence of hitting another resident in the face/eye. Interventions included: sending to psych ED for evaluation and treatment, analyzing key times, places circumstances, triggers, and what de-escalates behavior and document, assessing and addressing contributing sensory deficits, assessing and anticipating resident's needs, cognitive assessment, providing physical and verbal cues to alleviate anxiety; giving positive feedback back, assisting verbalization of source of agitation, assisting to set goals for more pleasant behavior, encourage seeking out staff member when agitated, evaluating side effects of medications, giving resident as many choices as possible about care and activities. Record review of Resident #1's progress note LVN B, dated 03/30/26 at 2:45 PM, reflected the following: The writer was at the nurse station, when another staff member drew attention to [Resident #1] in the hallway who was about hit [Resident #2]. [Housekeeper A] ran to the hallway. Immediate intervention was initiated to prevent further physical contact and ensure the safety of both residents. [This writer] after separated both patients, I asked him what happened, [Resident #1] bust out laughing, He said Oh I hit [Resident #2], and nothing can be done about it. Both [residents] were separated immediately. Skin assessment was completed. [Resident #2] he had no skin issue vitals were B/P 129/84, P 79, 02 97 room air, pain 0, (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	temperature 97.8. Administrator, DON, ADON, MD, POA were notified. [Resident #1] was placed on 1 on 1. We continued to follow the plan of care. [sic] Record review of Resident #1's progress note by RN A, dated 05/04/26 at 3:00 PM, reflected the following: Resident witnessed [Resident #1] hit another resident in the back while looking out the door in the TV room. [Resident #1] hit the other resident twice in his back and threatened to hit another resident. Resident #1 stated, ?Yeah, I hit him'. Residents separated immediately. Administrator notified immediately, DON, MD and RP notified, one on one initiated. Skin assessment completed, no new skin issues noted, continue plan of care. Record review of Resident #2's face sheet, dated 05/05/26, reflected a [AGE] year-old male that was admitted to the facility on [DATE]. Resident #2 had diagnoses which included: type 2 diabetes (body resists insulin or fails to produce enough), chronic pulmonary edema (gradual accumulation of fluid in the lung's air sacs), dementia (decline in mental ability), major depressive disorder (a serious, common mental health condition characterized by persistent, severe low mood, loss of interest in activities and physical/cognitive symptoms lasting at least two weeks), fracture of neck of right femur, abnormal posture, protein-calorie malnutrition (a severe nutritional deficiency resulting from inadequate intake of protein and calories), vitamin b deficiency (body lacks sufficient levels of B vitamins), age related osteoporosis (a condition where bones lose density and strength, accelerating after age [AGE] as bone breakdown outpaces formation), lack of coordination (muscle movements are clumsy or unsteady), impulse disorders (mental health conditions characterized by an inability to resist urges, behaviors, or impulses that may harm oneself or others), depression (a common, serious medical illness causing persistent sadness, loss of interest, and physical symptoms that interfere with daily life), cognitive communication deficit (difficulty with verbal or non-verbal communication), delusional disorder (a serious mental health condition characterized by the presence of one or more non-bizarre delusions-false, fixed beliefs-lasting for at least one month), acute kidney failure (a sudden, rapid loss of kidney function-often within hours or days-leading to waste, toxin, and fluid buildup in the body), congestive heart failure (a chronic, progressive condition where the heart muscle is too weak or stiff to pump blood efficiently), muscle weakness, hyperlipidemia (high levels of fats) and weakness. Record review of Resident #2's Quarterly MDS assessment, dated 03/07/26, reflected a BIMS score of 4 which indicated severely impaired cognition. The MDS assessment under Section GG-Functional Abilities, reflected Resident #2 needed clean-up assistance with eating, supervision with oral hygiene and upper body dressing, partial assistance with toileting hygiene, showering, and lower body dressing and substantial assistance with putting and taking off footwear and personal hygiene. The MDS assessment under Section E-Behaviors, reflected Resident #2 did not exhibit any physical, verbal or other behavioral symptoms towards others. Record review of Resident #2's care plan, revised 04/01/26, reflected Resident #2 had a risk of redness with puffiness to left eye due to another resident hitting him in his eye. Interventions included: Identifying potential causative factors and eliminating/resolving when possible, informing/instructing staff of causative factors and measures to prevent bruises, monitoring location, size of redness with puffiness and reporting to MD. Record review of Resident #2's progress note by RN A, dated 03/30/26 at 3:12 PM, reflected the following: Resident Nurse was informed by another employee that [Resident #2] was about to be hit by [Resident #1]. Nurse went there quickly to prevent it immediately. Intervention was initiated to separate both [residents] to prevent any physical contact. [Resident #2] said, He swung his hand and hit my face, I was about to swing mine but missed it. I was on the hallway, he was saying bitch words to me on the hallway, I told him, I don't like it, that's when he started to swing his hand. Nurse separated both residents. Immediately we noticed redness on the left eye and slide [sic] swelling noted under the left eyelid. [Resident #2] was assisted to his room. Skin assessment was completed, we only saw the redness in the eye, and swelling under his eyelid. MD, Administrator, DON, POA were notified. MD gave a new order for Skull series to assess for possible fracture. Xray order was placed. Vital signs were B/P 132/80, P 73, 02 98 room air, pain 0, temp 97.7. We placed iced pad on the left eyelid, [there] was no bleeding. [Resident #2] was asked if he wanted to go to his room. [Resident (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#2] denied and assisted to the nurse's station. We continued to follow the plan of care. [sic] Record review of Resident #2's progress note by LVN B, dated 05/04/26 at 5:00 PM, reflected the following: [Resident #2] noted in wheelchair in TV room looking out of the doors, when [Resident #1] in a wheelchair hit [Resident #2] in his back 2 times, residents immediately separated. [Resident #2] was unable to verbalize what happened. Administrator notified, skin assessment completed, no skin issues noted. DON, MD and RP notified, continue plan of care. Record review of Resident #2's radiology results report, examination date 03/30/26, reflected the following in part: Procedure: SkullInterpretation:Reason for Study: Localized swelling, mass and lump, headFindings: The visualized skull and facial bone demonstrate no acute fracture. No joint dislocation. Unremarkable soft tissues. The nasal bone appears intact. Conclusion: 1. No obvious or acutely displaced fracture. 2. A CT is recommended for better sensitivity if symptoms persist or worsen. In an interview on 05/05/26 at 11:21 AM, Resident #1 stated he and Resident #2 were watching tv in the tv common area. Resident #1 stated he rolled up on Resident #2 and punched Resident #2 in the face with a closed fist. Resident #1 stated after he punched Resident #2, Resident #2 put up his hands. Resident #1 stated Resident #2 stated he did not hit back. Resident #1 also stated staff were passing lunch trays during that time. Resident #1 stated he did not know how staff found out, but staff separated them. Resident #1 stated he hit Resident #2 because he felt Resident #2 was a child molester. Resident #1 stated he seen it in his file but did not identify what file. In an interview on 05/05/26 at 11:33 AM, Resident #2 stated he was trying to remember the incident. He stated he did not remember. Resident #2 then stated he had been hit with a fist in his chest. Resident #2 stated he did not know who the other resident was that hit him. Resident #2 stated he did not have any marks. Resident #2 stated he felt safe and was not afraid of anyone at the facility. On 05/05/26 at 1:46 PM, an attempt call to Housekeeper C but no answer. The operator stated mailbox was full and unable to leave a message. Housekeeper A had not called back by exit. In an interview on 05/05/26 at 3:04 PM, the Administrator stated Resident #1 and Resident #2 had not previously had any altercations prior to 03/03/26. She stated she received information about the incident while still in the building. The Administrator stated the residents were separated, assessed and notified RP's, MD and PD. The Administrator stated the facility was currently working on transferring Resident #1 to a group home. The Administrator stated Resident #1 would be transferred on 05/06/26. She also stated additional training was done with staff regarding resident to resident altercations, abuse and neglect, and how to handle residents with schizophrenia and dementia. In an interview on 05/05/26 at 4:38 PM, Resident #3 stated on 05/04/26 around lunchtime, he was sitting facing the tv and Resident #2 was facing outside. He stated Resident #1 went up and hit Resident #2 on his back two times. He stated Resident #2 told Resident #1 that he better be glad he did not hit him back. Resident #3 stated there were no words exchanged between the residents prior to the incident. Resident #3 stated there was no staff in the tv room at the time. He stated staff were walking around. He stated when he called there were 3 or 4 staff that came to assist. Resident #3 stated staff separated Resident #1 and Resident #2, then took Resident #1 out of the room. In an interview on 05/05/26 at 4:55 PM, the DON stated he was in the building during the incident but received the information afterwards. The DON stated Resident #1 was the aggressor. The DON stated Resident #1 felt like he knew Resident #2 from out in the community. Resident #1 alleged Resident #2 was a child molester and that was why he hit him. The DON stated he spoke to Resident #1 about keeping his hands to himself. The DON also stated the residents were separated immediately and assessed Resident #2. The DON stated Resident #2's eye had some redness as if it was irritated but not swollen. The DON stated that the redness was gone within 48 hours. The DON stated they were in the process of having Resident #1 transferred to a group home. Record review if the facility's policy titled, Abuse Prevention and Prohibition Program, revised 08/2020, reflected in part the following: Purpose: To ensure the Facility establishes, operationalizes, and maintains an Abuse Prevention and Prohibition Program designed to screen and train employees, protect residents, and to ensure a standardized methodology for the prevention, identification, investigation, and reporting of (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	abuse, neglect, mistreatment, misappropriation of property, and crime in accordance with federal and state requirements.Policy:Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property. The Facility has zero tolerance for abuse, neglect, mistreatment, and/or misappropriation of resident property. Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment, or misappropriation of resident property.A. Definitions for the meaning of key terms used in this policy.II. The Facility is committed to protecting residents from abuse by anyone, including but not limited to Facility Staff, other residents, consultants, volunteers, staff from other agencies serving residents, family members, legal guardians, surrogates, sponsors, friends, and visitors. This policy statement also includes deprivation by any individual, including a caretaker, of goods, services or rights that are necessary for a resident to attain or maintain physical, mental, and psychosocial wellbeing.