

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676480	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/08/2026
NAME OF PROVIDER OR SUPPLIER Mesquite Village Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 825 W Kearney St 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that the residents' environment remained free of hazards as was possible for three of eight Residents (Resident #2, #3 and #4) reviewed for accident hazard. The facility failed to ensure that Resident #4 did not have a container of disinfectant wipes on his bedside table on 07/08/26. The facility failed to ensure that Resident #2 did not have a container of Clorox disinfectant wipes, Fantastik Disinfectant multipurpose cleaner spray, and a bottle of Fabuloso cleaning liquid on his bedside table on 07/08/26. The facility failed to ensure that Resident #3 did not have Lysol air sanitizer aerosol can and a bottle of nail polish remover on her bedside table 07/08/26. These deficient practices placed the residents at risk for accidental injury, misuse and, exposure to hazardous chemicals. Findings included: Record review of Resident #4's Face Sheet, dated 07/08/26, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. She had diagnoses of Schizoaffective Disorder, Bipolar Type, Violent Behavior. Record review of Resident #4's Significant change in condition MDS Assessment, dated 05/28/26, revealed the resident had a BIMS score of 15 (indicating no cognitive decline). The MDS Assessment indicated that he had medically complex conditions, and was mostly independent with ADL's and functional ability. During an observation and interview on 07/08/26 at 9:50 a.m. with Resident #4, it was observed that she had a container of disinfecting wipes. She stated she ordered and used the wipes to sanitize her surroundings. Record review of Resident #2's Face Sheet, dated 07/08/26, reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnosis of Schizoaffective Disorder, Bipolar Type (breaks from reality with extreme mood swings) Record review of Resident #2's admission MDS Assessment, dated 06/16/26 revealed a BIMS score of 14 (cognitively intact). The admission MDS Assessment indicated that he had medically complex conditions and was primarily independent. During an observation and interview on 07/08/26 at 9:55 a.m. with the Housekeeping Supervisor, a container of Clorox wipes, bottle of Fabuloso cleaning liquid, and Fantastik disinfectant cleaner were noted on Resident #2's bedside table. He stated that the items should not be in the resident's room. He stated that the facility policy was that no hazardous items should be stored in the residents' rooms. He stated that they should be locked in designated areas out of reach of the residents. He stated that the reason for keeping them away from the residents was to make sure they did not swallow harmful chemicals and cause harm to themselves. He stated that it could mess up their intestines if swallowed or make a wound worse if it got on their skin. He stated that he had not noticed the items in Resident #2's room before now. He stated that if any housekeeping staff found any hazardous substances, they will usually reported to him. Record review of Resident #3's Face Sheet, dated 07/08/26, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. She had diagnoses of mild cognitive impairment (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(transitional stage between normal age-related memory loss and more serious conditions like dementia) and Type 2 Diabetes (high blood sugar). Record review of Resident #3's Quarterly MDS Assessment, dated 05/13/26, revealed the resident had a BIMS score of 15 (indicating no cognitive impairment). The MDS Assessment indicated he had medically complex conditions. Record review of Resident #3's Comprehensive Care Plan, dated 12/21/25, revealed the resident has an ADL self-care performance deficit. During an observation on 07/08/26 at 10:20 a.m. it was observed that Resident #3 had Lysol air sanitizer, and Equate nail polish remover on her bedside table. During an interview on 07/08/26 at 10:25 a.m. with Housekeeper M, she stated that the facility policy was that no hazardous items should be stored in the resident's room. She stated that she had not noticed any hazardous items in Resident #3's room. She stated that she reported any items not allowed in the rooms to her supervisor who took care of it. She stated that the residents could inhale or drink the items especially if they were confused. She stated that the chemicals could cause neurological issues, stomach issues or burn the resident's skin. During an interview on 07/08/26 at 12:47 p.m. with the ADON, she stated that the residents should not have any hazardous items in their rooms. She stated that they removed them and labeled them with the resident's name and returned the items to their family and educated them to not bring those items. She stated that it could be ingested by the residents or other residents who wander. She stated that the chemicals could be poisonous and interact with their medications and could land the resident in the hospital for poisoning. She stated that all staff were responsible for making sure the hazardous items were not in the residents' rooms. During an interview on 07/08/26 at 1:26 p.m. with CNA R, she stated that the facility policy as that hazardous items should not be in the residents' room. She stated that if she notices any hazardous items she reports it to the nurse in charge. She stated that she has not noticed any harmful items in Resident #3's room. She stated the resident went out shopping yesterday and may have bought the items. She stated that any hazardous items can harm the residents. She stated that ingesting any chemicals will land the resident in the hospital. She stated that all staff are responsible for making sure there are no harmful items in the residents' rooms. During an interview on 07/08/26 at 1:50 p.m. with CNA C, she stated that the facility policy is that no hazardous items should be in the residents' room, she stated that the residents go out to the store to buy them, she stated she is supposed to notify the nurse when she finds them. She stated that she had not noticed any such items in any residents' rooms. She stated that inhaling the fumes or drinking any hazardous chemicals can cause harm or induce an allergic reaction for the resident or roommate. During an interview on 07/08/26 at 2:11 p.m. with RN M, she stated that the facility policy is that no harmful chemicals should be allowed in the resident's room. She stated that all nurses, CNAs, and housekeeping staff are responsible for making sure that no harmful chemicals are stored in the residents' room. She stated that some of the chemicals may be flammable and since they have residents that are cognitively impaired, they might get a hold of it and drink the chemicals. She stated that the chemicals can cause breathing issues, burns, allergic reactions and even death. During an interview on 07/08/26 at 2:32 p.m. with the DON, he stated that the facility policy is that all cleaning material should have an MSDS (medical safety data sheet) and the sheets should specify what chemicals are contained in the cleaning chemicals and how to treat them. He stated that they remove any hazardous chemicals from the residents room and notify the family to come get them. He stated that he has not noticed any of the chemicals observed in any residents' rooms. He stated that the residents can accidentally ingest the chemicals which can make them sick. He stated that all staff are responsible for making sure that no dangerous chemicals are stored in the residents' rooms. The facility did not supply any hazardous items storage policy as requested during the investigation on 07/08/2026 at 11:40 a.m.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one of eight residents (Resident #5) reviewed for respiratory care. The facility failed to ensure Resident #5's oxygen nasal canula and BIPAP mask were properly stored on 07/08/26. These failures could place residents at risk of respiratory infection, respiratory complications, and not having their respiratory needs met. Findings Include 1. Record review of Resident #5's face sheet, dated 07/08/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with the following: Chronic Respiratory Failure (when the lungs cannot adequately supply oxygen or take out carbon dioxide from the blood) and Obstructive Sleep Apnea (collapse of upper airway during sleep) Record review of Resident #5's admission MDS Assessment, dated 06/15/26, reflected moderately impaired cognition with a BIMS of 14 (cognitively intact). The MDS Assessment indicated that he had medically complex conditions. Record review of Resident #5's Comprehensive Care Plan, dated 06/16/26, reflected that the resident had oxygen therapy related to CHF and one of the interventions was: The resident has O2 via nasal 2 Liters per minute continuously and as needed. The care plan dated 06/18/26 revealed the resident is resistive to care and refuses to use BIPAP at night with interventions to Allow to make decisions about treatment regime, to provide sense of control. Record review of Resident #5's Physician's Order, dated 06/09/26, revealed BiPAP Settings (IPAP-18: EPAP 6:fi02%-35) at bedtime for Sleep Apnea as needed, order dated 06/11/26 revealed O2 3 liters per minute via nasal cannula every shift related to CONGESTIVE HEART FAILURE, Change Respiratory Tubing, Mask, Bottled Water, clean filter every 7 days continuous related to CONGESTIVE HEART FAILURE check O2 daily and change tubing every 7 days. During an observation and interview on 07/08/26 at 10:00 a.m. with Resident #5, revealed his oxygen tube was lying on the oxygen concentrator and the BIPAP mask was in an open drawer. Both items were observed open to air and not bagged. Resident #5 was unable to verbalize when asked if he knew it should be bagged, he only nodded his head. During an interview on 07/08/26 at 12:47 p.m. with the ADON, she stated that the BIPAP should be washed, wiped and stored in a bag when not in use and the bag was changed weekly and dated. She stated the oxygen tubing is changed weekly and should be bagged when not in use. She stated that bagging the oxygen tube and BIPAP mask prevents infection. She stated that if not bagged dust particles or bacteria can get in their nasal tracks and cause pneumonia or other respiratory infection. She stated that the nursing staff, including the CNAs, are responsible for making sure the oxygen tube and CPAP mask are stored correctly when not in use. During an interview on 07/08/26 at 1:26 p.m. with CNA R, she stated that oxygen tubes and CPAP masks should be bagged when not in use. She stated that if it's found exposed or on the floor the nurse is notified to make sure it is changed. She stated that not bagging the oxygen tube and the CPAP mask could be a cause of infection or make an already infection worse for the residents. During an interview on 07/08/26 at 1:50 p.m. with CNA C, she stated that the facility policy is that the oxygen tube and the BIPAP mask should be bagged when not in use. She stated that they need to be bagged for infection control and prevent dirt, debris or insects from getting into them. She stated that they could breathe germs in their lungs and cause respiratory problems long-term. During an interview on 07/08/26 at 2:11 p.m. with RN M, she stated that stated that the oxygen tube and the CPAP mask should always be bagged, she stated that any respiratory apparatus should always be bagged when not in use. She stated that (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they should be bagged for infection control. She stated that the nurses are responsible for making sure that respiratory apparatus are bagged when not in use. She stated that if the if the resident uses a contaminated breathing apparatus, it could cause allergies or worsen their respiratory issues. During an interview on 07/08/26 at 2:32 p.m. with the DON, he stated that all oxygen tubes and BIPAP mask should be store in a bag when not in use. He stated that the nursing staff is responsible for making sure they are bagged and they make rounds for the residents that are independent to make sure they are putting their oxygen tubes in a bag when they are not in use. He stated that bagging the oxygen tubes prevents and decreases any incidents of infection. Record review of the facility's policy / procedure titled, Oxygen Administration Nursing Manual dated 06/2020 reflected: Infection ControlB. Oxygen items will be stored in a plastic bag at the resident's bedside to protect theequipment from dust and dirt when not in use.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure, in accordance with State and Federal laws, store all drugs and biologicals in locked compartments under proper temperature controls, and permitted only authorized personnel to have access to the keys for two of eight residents (Residents #4, and #3) reviewed for medication storage. 1.The facility failed to ensure Resident #4's Trimicolone ointment 0.5% was not on top of the resident's side table on 07/08/26. 2.The facility failed to ensure Resident #3's melatonin gummies, melatonin tablets and Asper cream lidocaine cream were not on her bedside table on 07/08/26 These failures could place residents at risk of misuse of medications and possible adverse reactions.Findings included: Record review of Resident #4's Face Sheet, dated 07/08/26, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. She had diagnoses of Schizoaffective Disorder, Bipolar Type, Violent Behavior. Record review of Resident #4's Significant change in condition MDS Assessment, dated 05/28/26, revealed the resident had a BIMS score of 15 (indicating no cognitive decline). The MDS Assessment indicated that he has medically complex conditions, and mostly independent with ADL's and functional ability. Record review of Resident #4's physician's order date 04/06/26 revealed and order for Triamcinolone Acetonide External Cream 0.5 % (Triamcinolone Acetonide (Topical)) Apply to affected areas topically two times a day for rash on feet, leg, and back. During an observation and interview on 07/08/26 at 9:50 a.m. with Resident #4, it was observed that she had a tube of Trimicolone ointment 0.5% on her nightstand. She stated that the ointment was in the same place, and no one had told her it should not be on her table. She stated that the cream was prescribed for her and the nurse was the one who applied the cream on her and left it on her nightstand. She stated it had always been done that way. She stated she was not able to recall which nurse, that it was a few of them who tended to her at different times. Record review of Resident #3's Face Sheet, dated 07/08/26, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. She had diagnosed of mild cognitive impairment (transitional stage between normal age-related memory loss and more serious conditions like dementia) and Type 2 Diabetes (high blood sugar). Record review of Resident #3's Quarterly MDS Assessment, dated 05/13/26, revealed the resident had a BIMS score of 15 (indicating no cognitive impairment). The MDS Assessment indicated that he has medically complex conditions. Record review of Resident #3's Comprehensive Care Plan, dated 12/21/25, revealed the resident has an ADL self-care performance deficit. Record review of Resident #3's physician order date 10/04/25 revealed an order for Salopas External Patch 3.1-6-10 % (Camphor-Menthol-Methyl Salicylate) Apply to lower back topically as needed for pain. During an observation on 07/08/26 at 10:20 a.m. it was observed that Resident #3 had melatonin gummies, melatonin tablets, Asper cream lidocaine cream on her bedside table. During an interview on 07/08/26 at 12:47 p.m. with the ADON, she stated that the residents should not have medications in their rooms. She stated that no resident in the facility is assessed to self-administer medications at this time. She stated that the residents can overdose if they have an order from the physician already and that the medications can interact with other medications they are taking. She stated that they can overdose or have an allergic reaction which can lead to hospitalization or even death. She stated that the nursing staff are responsible for making sure that the residents do not have medications in their rooms by checking daily and doing an inventory during admission, educate the family and residents (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	about why they should not have medications on them. During an interview on 07/08/26 at 1:26 p.m. with CNA R, she stated that no medication should be in the residents' rooms. She stated that if the residents brought a medication in it should be given to the nurse and have it labeled with the resident's name. She stated that all medication should be ordered by the physician even for over the counter. She stated that taking medication unsupervised could harm the residents. She stated that all medications should be documented by the nurse. She stated that if she found medication in a resident room, she reported it to the nurse. During an interview on 07/08/26 at 1:50 p.m. with CNA C, she stated that no medication should be stored in the residents' rooms. She stated that she had not noticed any medication in Resident #4's room. She stated that self-administering medication by residents can be hazardous especially if they have dementia. She stated they could get sick, have an allergic reaction or even be sent to the hospital if the resident takes medications inappropriately. During an interview on 07/08/26 at 2:11 p.m. with RN M, she stated that no residents should have medications in their rooms, and if medications are found during rounds, they are removed. She stated that if the resident wants to have a medication, they are assessed for self-medication and notify the physician to get an order if approved. She stated that the assessment is to make sure that the resident is alert and oriented and understands the dosing and side effects of the medication they are taking. She stated that if an assessment is not done, the residents can overdose themselves with the medication. She stated that neither Resident #3 and Resident #4 have had an assessment for self-administration of medication. During an interview on 07/08/26 at 2:32 p.m. with the DON, he stated that no medication should be at the resident's bedside, except those who have been assessed to self-administer medication and have a physician order. He stated that if the staff is not aware of the medication the resident is taking, it cannot be recorded and they could double dose them. He stated that overdose could decrease the resident's level of consciousness and make them lethargic. Record review of the facility's policy Medication Administration Policy/Procedure - Nursing Clinical, revised May 2025, reflected POLICY: It is the policy of this Facility, medication shall be administered as prescribed by the resident's physician, nurse practitioner, or physician's assistant . procedure . 1. Only licensed medical and nursing personnel or other lawfully authorized staff members may prepare, administer, and record medication administration. Record review of the facility's policy titled, Medication Storage in the Facility P & P, dated March 2025 reflected, Policy: Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations . 2. Only licensed nurses, the Consultant Pharmacist, and those lawfully authorized to administer medications. Record review of the facility's policy / procedure titled, Medication Storage Nursing Manual-Nursing Care dated 01/2026 reflected: PurposeTo establish standards that safeguard residents by preventing unauthorized access to medications and ensuring compliance with applicable federal and state pharmacy regulations.Policy1. Medications must be stored securely to prevent unauthorized access, diversion, loss, contamination, or misuse.2. All medications will be stored in accordance with physician orders, pharmacy labeling, manufacturer recommendations, and applicable federal and state regulations.3. Medication carts, rooms, cabinets, and controlled substance compartments must remain locked at all times unless under direct and continuous supervision of authorized personnel.4. Only authorized, licensed staff may access medication storage areas.		

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement Federal, State, and local laws and regulations regarding smoking, smoking areas, and smoking safety and their own smoking policy for one (Resident #1) of 8 residents reviewed for smoking and compliance. The facility failed to implement their smoking policy regarding Resident #1's noncompliance with smoking on 07/08/26. Resident #1 had smoking paraphernalia in his possession. This failure could affect residents' safety by smoking in other areas than the designated area which could lead to an unsafe smoking environment. Findings included: Review of Resident #1's Face Sheet dated 07/08/26 revealed the resident was a [AGE] year-old male, admitted to the facility on [DATE] with diagnoses of Mild cognitive impairment (intermediate stage of memory and thinking decline), and Tobacco use. Record review of Resident #1's Quarterly MDS Assessment, dated 07/26/26, revealed the resident had a BIMS score of 14 (indicating no cognitive impairment). The MDS Assessment indicated that he has medically complex conditions. Record review of Resident #1's Comprehensive Care Plan, dated 01/08/26, revealed I use of tobacco products, smoking, chewing, or snuff, with goal I will be free of tobacco related injuries through next review and intervention of: 1) I will be supervised by a nursing facility staff member when I smoke, 2) I will smoke only during the designated times determined by the facility when supervision will be provided, 3) I will smoke only in designated smoking areas, 4) Me/ my RP will be provided with the facility's smoking policy and will demonstrate understanding of consequences of any non-adherence to the facility's smoking policy(which could even result in my discharge from the facility for continued nonadherence to facility's smoking policy.), 5) My smoking /tobacco supplies are to be kept in the smoking supply box at the nurse's station/med room, 6) My smoking/tobacco supplies will be returned to the smoking supply box at the nurse's station/med room at the end of each smoke break, 7) Staff will assist in notifying my family when I need smoking supplies. During an observation and interview on 07/08/26 at 10:05 a.m. with Resident #1, 3 cigarette packs were observed on his bedside table. There was 2 empty cigarette packs and 1 full pack of cigarettes, he stated that he usually had his cigarettes on his table and no one had an issue with it. He stated he got them from the store when he goes out of the facility. During an interview on 07/08/26 at 12:47 p.m. with ADON, she stated that residents who smoke are not allowed to have any cigarettes in their possession, all cigarettes are supposed to be in a locked box and smoking is at designated times. She stated that all staff are responsible for making sure that no residents have cigarettes in their rooms. If noticed they are removed and stored in the appropriate lockbox, notify the RP and educate the residents. She stated that it is a hazard and could start a fire, they could burn themselves or other residents. During an interview on 07/08/26 at 1:26 p.m. with CNA R, she stated that residents are not allowed to have cigarettes or lighters in their rooms. She stated that the items should be stored in a locked box with the residents' names and made available during designated smoke times. She stated that if the residents light a cigarette in their room, it could be a fire hazard and if they have oxygen, it could cause an explosion that can harm him and other residents. During an interview on 07/08/26 at 1:50 p.m. with CNA C, she stated that no residents should have cigarettes in their rooms. She stated they are usually locked in a secure box till supervised smoking times by staff. She stated that she notifies the nurse if she finds any cigarette in the resident's room. She stated that is a fire hazard if they light the cigarette, if they drop cigarette or fall asleep while smoking. During an interview on 07/08/26 at 2:11 p.m. with RN M, she stated that no residents are allowed to have cigarettes in their rooms, she stated that they should be in a lock box located at the nursing (continued on next page)		

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	station. She stated that all staff are responsible for making sure the residents don't have cigarettes in their rooms. She stated that if the residents have cigarettes in their rooms, it could be a hazard, they can burn themselves or others. During an interview on 07/08/26 at 2:32 p.m. with the DON, he stated that no resident should have cigarettes on their person, cigarettes were always stored in a lockbox behind the nurses' station where the nurses can monitor. He stated that the residents having cigarettes in their rooms is a fire hazard. He stated that the residents have access to their individual lockboxes with keys and are supervised by the nurses during smoke times posted at the nurses' station. He stated that all staff should report to the charge nurse if they find cigarettes in the resident's room. He stated he is not sure how Resident #1 got the cigarettes in his room. Record review of the facility's policy / procedure titled, Smoking by Residents Nursing Manua-Nursing Administration dated 06/2020 reflected: PurposeTo respect resident choice to smoke and to maintain a safe healthy environment for both smokersand non-smokers.PolicyI. Smoking is not allowed anywhere inside the Facility.II. The Facility permits smoking only in the area(s) designated by the Facility's Safety Committee.III. The Facility discourages smoking by residents and ensures that those residents who choose tosmoke do so safely.IV. Residents who want to smoke will be assessed for their ability to smoke safely prior to beingallowed to smoke in these areas.V. Residents who are not able to smoke safely will be accompanied by Facility Staff while smoking.VI. This policy applies to the use of both cigarettes and e-cigarettes.IX. All smoking materials will be stored in a secure area to ensure they are kept safe.		