

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675903	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER Mexia Ltc Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 601 Terrace LN Mexia, TX 76667	
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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to maintain medical records on each resident that were complete, accurately documented, readily accessible, and were systematically organized, for 3 of 5 residents (Residents #23, Resident #29 and Resident #44) reviewed for consents for accurate medical records.1. The facility failed to document on Resident #23's smoking assessment dated [DATE] Resident #23's ability to smoke unsupervised.2. The facility failed to document on Resident #29's smoking assessment dated [DATE] Resident #29's ability to smoke unsupervised.3. The facility failed to document on Resident #44's smoking assessment dated [DATE] Resident #44's ability to smoke unsupervised. This failure could place residents at risk of harm due to not having supervision when needed while the residents are smoking.Findings included:1. Record review of Resident #23's face sheet, dated 12/17/2025, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #23 had a diagnosis which included colon cancer, need for assistance with personal care, anemia (not enough healthy red blood cells), type 2 diabetes mellitus with diabetic neuropathy (nerve damage due to diabetes), repeated falls, retention of urine and lack of coordination.Record review of Resident #23's annual MDS, dated [DATE], revealed Resident #23 had a BIMS of 15, which indicated intact cognitive response. The MDS also revealed current tobacco use was marked as yes. Record review of Resident #23's Smoking Assessment, dated 09/29/2025, revealed Resident #23 was oriented according to BIMS review and aware of safety associated with smoking. The box that said This resident is safe to smoke unsupervised was not checked. Also, the box that said This resident requires direct supervision while smoking was not checked.Record review of Resident #23's care plan, dated 10/15/2025, revealed Resident #23 was a smoker. Resident passes safe smoking evaluation. Resident is deemed to be a safe smoker. The goal in place was that the resident will be free from injury related to smoking through the review. Interventions were Resident will be offered smoking cessation programs as needed, notify physician if resident requests programs. 2. Record review of Resident #29's face sheet, dated 12/17/2025, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #29 had a diagnosis which included epilepsy (seizure disorder), anxiety (feeling of uneasiness or worry), muscle wasting, lack of coordination, cognitive communication deficit (problems with communication), and abnormalities of gait and mobility.Record review of Resident #29's annual MDS, dated [DATE], revealed Resident #29 had a BIMS of 15, which indicated intact cognitive response. The MDS also revealed, current tobacco use was marked as yes. Record review of Resident #29's Smoking Assessment, dated 09/29/2025, revealed Resident #29 was oriented according to BIMS review and aware of safety associated with smoking. The box that said This resident is safe to smoke unsupervised was not checked. Also, the box that said This resident requires direct supervision while smoking was not checked.Record review of Resident #29's care plan, dated 11/25/2025, revealed Resident #23 was a smoker. Resident is safe to smoke unsupervised. The goal in place was that the resident will be free from injury related to smoking through the review. Interventions were: Resident will be offered smoking cessation programs as needed, notify physician if resident requests programs. 3. Record review of Resident #44's face (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sheet, dated 12/17/2025, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #44 had a diagnosis which included heart disease, repeated falls, need for assistance with personal care, hyperlipidemia (high cholesterol), polyneuropathy (damage affecting the nerves roughly the same area on both sides of the body), and lack of coordination. Record review of Resident #44's annual MDS, dated [DATE], revealed Resident #44 had a BIMS of 14, which indicated intact cognitive response. The MDS also revealed, current tobacco use was marked as yes. Record review of Resident #44's Smoking Assessment, dated 11/03/2025, revealed Resident #44 was oriented according to BIMS review and aware of safety associated with smoking. The box that said This resident is safe to smoke unsupervised was not checked. Also, the box that said, This resident requires direct supervision while smoking was not checked. Record review of Resident #44's care plan, dated 12/13/2025, revealed Resident #44 was a smoker. Resident is considered a safe smoker per safe smoking assessment. The goal in place was that the resident will be free from injury related to smoking through the review. Interventions were: Resident will be offered smoking cessation programs as needed, notify physician if resident requests programs. During an interview with LVN A on 12/18/2025 at 12:38 p.m. revealed, she had been trained on completing the smoking assessments. She said the smoking assessment contained information regarding whether the resident was a safe smoker or needed to be supervised. She said the smoking assessment was done quarterly or if there was a change in the resident's smoking status. She said the nurses were responsible for filling out the smoking assessments. She said if the smoking assessment was not completed correctly the staff would not know if the residents needed to be supervised while smoking. She said the DON monitored to ensure the smoking assessments were completed correctly. She said she did not know how the DON monitored the smoking assessments. She said she did not know why Resident #23, Resident #29 and Resident #44 did not have their smoking assessment completed correctly. During an interview the DON on 12/18/2025 at 12:51 p.m. revealed, the DON had been trained on completing the smoking assessments. She said the smoking assessment contained information regarding whether the resident could hold a cigarette themselves and if they were cognitive to smoke. She said if the resident started smoking after quitting the nurse must do another smoking assessment. She said the smoking assessment was done quarterly or if there was a change in the resident's smoking status. She said the nurses were responsible for feeling out the smoking assessments. She said if the smoking assessment was not completed correctly the staff could miss that a resident needed supervision while smoking and the resident could get burned or hurt. She said the DON monitored to ensure the smoking assessments were completed correctly. She said she monitored the smoking assessments by doing chart audits and reviewing the smoking assessments when they are completed. She said Resident #23, Resident #29, and Resident #44's smoking assessments was an oversight on her part. During an interview with the ADM on 12/18/2025 at 1:15 p.m., she said she had been training on completing the smoking assessments. She said the information in the smoking assessment was whether the resident could handle their smoking material. She said the smoking assessment also had weather or not the resident was safe to smoke unsupervised. She said the smoking assessment should be done upon admission, quarterly, or if there was a change in the resident's smoking status. She said the staff needed to do a new smoking assessment if the resident stopped smoking and then started back up smoking. She said the nurses were responsible for filling out the smoking assessments. She said if not filled out correctly or completely there could be a safety issue with the resident. She said the DON monitors to ensure the smoking assessments were filled out correctly. She said she was not sure how the DON monitored the smoking assessments. She said she did not know why Resident #23, Resident #29, and Resident #44's smoking assessment did not have if the resident needed to be supervised or not when smoking. She said it was just an oversight by the facility. Record review of Resident Assessment Policy not dated revealed A comprehensive assessment of each resident is completed at intervals.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure assessments accurately reflected the resident's status for 2 of 5 residents (Resident #23 and Resident #38) reviewed for accuracy of assessments. 1. The facility failed to ensure Resident #23's annual MDS, dated [DATE], accurately reflected her smoking status. 2. The facility failed to ensure Resident #38's annual MDS, dated [DATE], accurately reflected her smoking status. These failures could place residents at risk of inadequate supervision due to an inaccurate assessment of smoking status. Findings included: 1. Record review of Resident #23's face sheet, dated 12/17/2025, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #23 had a diagnosis which included colon cancer, need for assistance with personal care, anemia (not enough healthy red blood cells), type 2 diabetes mellitus with diabetic neuropathy (nerve damage due to diabetes), repeated falls, retention of urine and lack of coordination. Record review of Resident #23's annual MDS, dated [DATE], revealed Resident #23 had a BIMS of 15, which indicated intact cognitive response. The MDS also revealed current tobacco use was marked as no. Record review of Resident #23's Smoking Assessment, dated 09/29/2025, revealed Resident #23 was oriented according to BIMS review and aware of safety associated with smoking. Record review of Resident #23's care plan, dated 10/15/2025, revealed Resident #23 was a smoker. Resident passes safe smoking evaluation. Resident is deemed to be a safe smoker. The goal in place was that the resident will be free from injury related to smoking through the review. Interventions were; Resident will be offered smoking cessation programs as needed, notify physician if resident requests programs. 2. Record review of Resident #38's face sheet, dated 12/17/2025, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #38 had diagnoses which included obstructive pulmonary disease (chronic progressive lung disease), lack of coordination, repeated falls, dependent on oxygen, muscle weakness, and hemiplegia and hemiparesis following cerebral infraction affecting right dominant side (paralysis and weakness on right side after stroke). Record review of Resident #38's care plan, dated 07/29/2025, revealed Resident #38 was a smoker. The care plan also revealed Resident passed safe smoking evaluation, she is deemed to be a safe smoker. The goal in place was that the resident will be free from injury related to smoking through the review. Interventions were Resident will be offered smoking cessation programs as needed, notify physician if resident requests programs. Record review of Resident #38's annual MDS, dated [DATE], revealed Resident #38 had a BIMS of 15, which indicated intact cognitive response. The MDS also revealed current tobacco use was marked as no. Record review of Resident #38's Smoking Assessment, dated 10/19/2025, revealed Resident #38 was orientated according to BIMS review and aware of safety associated with smoking. These resident wears oxygen and requires removal during smoking. This resident is safe to smoke unsupervised, at this time. During an interview with the MDSN on 12/18/2025 at 2:02 p.m., stated she was trained on the MDS. She said the MDS nurse was responsible for completing the MDS. She said information that was on the MDS were assessments, pain, and dietary information from a resident's medical records. She said the MDS should be updated when there was a quarterly, annually and if there was a significant change in the resident. She said she had fourteen days from admission to complete the MDS. She said the resident's smoking status was supposed to be on the MDS. She said if the resident's smoking status was not coded correctly it would not affect the resident's care. She said the reason Resident #23's MDS was marked no on smoking was because Resident #23 had stopped smoking at one point and started back. She said Resident #23's smoking status should have been added when the MDS was done. She said she did not know why Resident #38's smoking status was not on the MDS. During an interview with the ADM on 12/18/2025 at 1:09 p.m., stated she had not been trained on MDS's. She said the MDS nurse was responsible for doing the MDS. She said the resident's smoking status was to be on the MDS. She said the MDS was done quarterly, annually, and (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	if a significate change. She said the MDS nurse was notified of the resident's smoking status from the admission packet, and the smoking assessment done by the nurse if the resident was a smoker. She said if the resident's smoking status was not on the MDS there could be a change with the resident's smoking status, and the staff would not know and could possibly harm the resident. She said she did not know why Resident #23, and Resident #38's smoking status was not on the MDS. She said it was an oversight on the facility's part. Record review of the Smoking Residents list provided on 12/16/2025 revealed Resident #23, and Resident #38 were smokers. Record review of Resident Assessment Policy dated 10/2023 revealed The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments. Information in the MDS assessments will consistently reflect information in the progress notes, plans of care and resident observations/interviews.		