

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676427	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2024
NAME OF PROVIDER OR SUPPLIER Skilled Care of Mexia		STREET ADDRESS, CITY, STATE, ZIP CODE 501 E Sumpter St 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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44526</p> <p>Based on interview, and record review the facility failed to ensure residents had right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other resident for 1 of 5 residents (Resident #1) reviewed for resonable accommodations.</p> <p>The facility failed to ensure CNA A did not remove Resident #1's call light and beside table from within her reach which prevented the resident from calling for assistance when needed.</p> <p>This failure could place residents at risk of being neglected by staff if they were unable to call for assistance when needed.</p> <p>The noncompliance was identified as PNC. The noncompliance began on 3/20/2024 and ended on 3/27/2024. The facility had corrected the noncompliance before the survey began.</p> <p>Findings included:</p> <p>Record Review of Resident #1's face sheet, dated 12/5/2022, reflected an 82- year- old female who was, admitted to the facility on [DATE]. Resident # 1 had diagnoses which included exudative age-related macular degeneration (progressive blurring of the of the central visual which can be acute), left eye, Difficulty walking, / major depressive disorder (a persistently low mood an decreased interest in activities, and feelings of guilt) and insomnia (persistent problems falling and staying asleep).</p> <p>Record Review of Resident # 1's care plan, dated 2/15/2024, reflected Resident # 1 was at risk for Falls and had gait balance problems. The following interventions to help prevent falls were documented: ensure resident's call light is within reach an encourage the resident to call for assistance as needed, keep items water within reach. The care plan also reflected Resident #1 had a ADL self-Care performance deficit. Interventions included: assist with personal hygiene as required, bathing 1x staff assist, mobility 1x staff assist, and dressing required 1x staff assist.</p> <p>Record Review of Resident # 1's quarterly MDS dated [DATE], reflected a BIMS of 11, which indicated moderate cognitive impairment. Section GG, functional section, reflected Resident # 1 required extensive assistance with bed mobility, transfers and toileting.</p> <p>(continued on next page)</p>

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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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/30/2024 at 1:23 p.m., LVN 1 stated on 3/20/2024, CNA A stated Resident #1 was banging on her bedside table with her silverware. LVN 1 stated CNA A went into the room and removed the bedside table and call light out of Resident #1's reach so she would not wake the other residents. LVN 1 stated she advised CNA A she could not do that, and she and LVN 2 went down to resident #1's room and placed the call light and beside table back within her reach. LVN 1 stated she did report the incident to the DON, she stated they were in-serviced after the incident on abuse/ neglect, resident rights, answering call lights and falls.</p> <p>During an interview via phone on 4/30/2024 at 1:34 p.m. LVN 2 stated on 3/20/2024, CNA A stated she was not going back in Resident #1's room because she continued to bang on her bedside table and push her call light. LVN 2 stated CNA A went into Resident #1's room and moved her bedside table and call light out of her reach so she would stop banging on the table. LVN 2 stated she advised CNA A she could not do that, and the resident's should always have their call light and beside table within reach. LVN 2 stated she and LVN 1 went into Resident #1's room and Resident #1 was trying to get out of her bed with no assistance. She stated they assisted Resident #1 back into her bed and placed her bedside table and call light back within her reach. LVN 2 stated she and LVN 1 reported the incident to the DON. LVN 2 stated they were in-serviced after the incident on abuse/ neglect, resident rights, answering call lights and falls.</p> <p>During an interview on 4/30/2024 at 1:45pm with the DON revealed, on 3/21/2024 she was advised by LVN 1 that CNA A took Resident #1's call light and beside table and placed them out of her reach to stop her from waking the other residents. She stated she immediately advised the Admin. and CNA A was suspended pending investigation and later terminated. She stated they completed an in-service on Abuse/Neglect, resident rights, answering call lights, and falls and stated all staff were trained. She stated the residents should always have their call lights and beside tables within their reach. The DON stated all staff were responsible or responding to call lights and at no time should a residents call light be removed from within their reach.</p> <p>During an interview on 4/30/2024 at 3:50 p.m. with the Admin. revealed he was advised on 3/21/2024 by the DON that CNA A removed Resident #1 call light and bedside table from within her reach. The Admin. stated CNA A was immediately suspended pending an investigation. The Admin. stated after speaking with Resident # 1 and his staff CNA A was confirmed and she was terminated on 3/26/2024. He stated they completed the following after the incident:</p> <p>Suspended the staff pending investigation.</p> <p>Call in a report to HHSC regarding the incident.</p> <p>Conducted an investigation at facility.</p> <p>At the conclusion of the facility investigation terminated the staff</p> <p>In-Serviced all staff on Abuse/Neglect, Resident rights, Call lights, and Falls.</p> <p>Completed Safe surveys with residents throughout the facility.</p> <p>Followed back up with Resident #1 to ensure that she felt safe at facility.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility investigation, dated 3/21/2024 reflected an investigation was completed and the facility confirmed abuse by CNA A</p> <p>Record review of CNA A written statement dated 3/20/2024 reflected she responded to Resident #1's room when she heard her banging on her bedside table and moved the table of her reach so she would not disturb the other residents.</p> <p>Record review of CNA A's disciplinary action, dated 3/21/2024, reflected she was suspended pending investigation. Review of disciplinary action dated 3/26/2024 reflected CNA A was terminated from employment.</p> <p>Record review of Safe surveys, dated 3/27/2024, reflected they were completed on 10 residents from all four halls with no concerns noted.</p> <p>Record review of in-services dated 3/26/2024 for abuse/neglect, resident rights, call lights, and falls reflected it was completed by all staff.</p> <p>Record review of the facility's Abuse/Neglect policy, dated 3/29/2018, reflected residents had a right to be free from Neglect.</p> <p>Record review of the facility's resident rights policy, undated, reflected the resident had a right to a dignified existence, self -determination, and communication with and access to persons and services inside and outside the facility, including those specified in this policy.</p>		