STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676427	A. Building B. Wing	12/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skilled Care of Mexia	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)
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** 47772 Based on interviews and record review, the facility failed to ensure the residents' assessments accurately reflected the residents' statuses for 1 of 5 Resident (Resident#1) reviewed for accuracy of assessments. The facility failed to identify Resident #1's severe weight loss on a Quarterly MDS Assessment, dated [DATE], at 180 day look back increment. This failure could place residents at the facility at risk of malnutrition. Findings included: RR of Resident #1's AR, dated [DATE], reflected a [AGE] year-old female who admitted to the facility on [DATE]. She was diagnosed with diabetes mellitus type 2 with ketoacidosis (which was a life threatening condition of the body that disrupted how the body used sugar for fuel), pneumonia (which was an infection in the lungs caused by bacteria, viruses or fungi), acute respiratory failure (which was a life threatening that occurred with the body's lungs were not able to exchange gases with blood), and chronic respiratory failure (which was a condition that impeded the body's ability to effectively exchange oxygen and carbon dioxide). RR of Resident #1's Quarterly MDS Assessment, dated [DATE], reflected the resident had a BIMS Score of 10, which indicated the resident had moderate cognitive impairment. Resident weighed 132 pounds; Loss of 5% or more pounds in the last month, or 10% or more in the last 6 months was annotated with a 0, which indicated No or Unknown. RR of Resident #1's CCP reflected a Focus area, initiated [DATE], for potential risk for malnutrition. The Goal, initiated on [DATE], reflected Resident #1 was supposed to maintain stable weight and nutritional parameters. The Intervention, initiated [DATE], reflected nursing staff was supposed to monitor resident weights and notify the physician of any negative findings; a Focus, initiated on [DATE], for significant unplanned/unexpected weight loss for poor food intake. The Goal, initiated on [DATE], reflected Resident #1's weight would stabilize within 4 weeks. The Intervention, initiated on [DATE], reflected nursing staff was supposed to alert the DON if food consumption was poor for more than 48 hours, encourage food related activities, report results to physician, ensure dietician was aware, and monitor food intake at each meal. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RR of Resident #1's Death Certificate, dated [DATE], reflected the resident expired at the nursing facility by a natural manner of death. The immediate cause was sepsis (which was a serious condition in which the body responded improperly to an infection; the infection fighting process turned against the body causing organs to have functioned poorly.) RR of Resident #1's Nutritional Risk Assessment, dated [DATE] by the DTCN, reflected dietary risk were numerous food intolerance and limited food choice possible. RR of Resident #1's PN, dated [DATE] at 1:15 PM by the DTCN, reflected resident lost 30 pounds in the last 3 months. RR of the dietary consult reflected Resident #1 had lost 30 pounds in the last 3 months. Add supplements three times a day (360 calories.) RR of Resident #1's Dietary Consult, dated [DATE] by the DTCH, reflected resident lost 30 pounds in the last 3 months. RR of the dietary consult reflected Resident #1 had lost 30 pounds in the last 3 months. Add supplements three times a day (360 calories.) RR of an Intakes (Intake A), dated [DATE], reflected an allegation towards the facility for a failure to address Resident #1's weight loss. RR of an Intake (Intake B), dated [DATE], reflected an addendum to Intake A. Intake B reflected an allegation the facility failed to address Resident #1's rapid weight loss; and the facility staff killed Resident #1 through neglect. RR of the local hospital DC paperwork, dated [DATE] to [DATE] reflected Resident #1 presented to the emergency roiagnom on [DATE] at 4:58 PM. Chief complaint was the resident had critically low labs (hemoglobin), low O2 saturations (89%), and difficulty breathing. X-rays were consistent with bronchopneumonia (a respiratory illness with inflammation of the lung tissue). The lungs were stable. HDOC's notes reflected Resident #1 admitted to service from local nursing facility for altered mental status as well as shortness of breath was found to have aspiration pneumonia (a lung infection that occurred when something other than air, like food, liquid saliva, or stomach contents was inhaled into the lungs.) She also had significant /severe protein caloric malnutrition and failure to thrive. Patient was not responsive to therapy. Resident #1 was not doing very well at all. She was not able to eat or drink due to aspiration of everything she took in. After long discussion with responsible parties, it was decided to write a DNR and agreed hospice would be in line (appropriate). Resident #1 was placed on hospice care and would be transferred back to nursing facility later today, [DATE]. Interview on [DATE] at 1:40 PM with RP#2 revealed he had concerns about the nutritional assistance Resident #1 received while at the facility. He stated Resident #1 had food intolerance and did not get a sufficient diet. He claimed Resident #1 started to lose weight ,d+[DATE] months ago. He referenced Resident #1 having been diagnosed with malnutrition on the most recent hospital stay, [DATE] to [DATE]. He insinuated the facility neglected Resident #1's nutritional needs and her weight loss contributed to her death. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and RR on [DATE] at 11:00 AM with the ADON revealed Resident #1 was identified to have experienced Sev. WL on [DATE]. She received a CCP update, [DATE], and dietary consult, dated [DATE]. Resident #1 was supposed to maintain stable weight and nutritional parameters. Nursing staff was supposed to monitor resident weights and notify the physician of any negative findings. RR of the dietary consult reflected Resident #1 had lost 30 pounds in the last 3 months. Add supplements three times a day (360 calories.) RR reflected Resident #1 experienced Sev. WL prior to [DATE]. RR of Resident #1's weights indicated the resident was eligible for a nutritional intervention when she was weighed on [DATE]. She demonstrated Sev. WL at the 30, 90, and 180 day mark. On [DATE], she demonstrated Sev. WL at the 30, 90, and 180 day mark. On [DATE], she demonstrated Sev. WL at the 30, 90, and 180 day mark. On [DATE], she demonstrated Sev. WL at the 30, 90, and 180 day mark. Finally, on [DATE], she was found to have demonstrated Sev. WL at the 30, 90, and 180 day mark. On [DATE], Resident #1 was 115.3 pounds. On [DATE], Resident #1's weight was 135.4 pounds. Resident #1 continued to lose an additional 20.1 pounds (-14.84% loss in body weight) from [DATE] until [DATE]. RR of Resident #1's weights: Interval Significant Loss Severe Loss 1 month 5% Greater than 5% 3 months 7.5% Greater than 7.5% 6 months 10% Greater than 10% % Body Weight equation: 1st weight (higher) minus 2nd weight (lower) = difference. Example: ,d+[DATE].4=20.6 Difference / 1st weight (higher) = % of weight loss. Example: 20XXX,d+[DATE]= -13.20 % body weight loss. [DATE]-% of Gain/Loss percentages with weight taken of 135.4 pounds. On [DATE], the resident weighed 156 lbs. On [DATE], the resident weighed 135.4 which is a -13.20% Loss. Sev. WL On [DATE], the resident weighed 159 lbs. On [DATE], the resident weighed 135.4 which is a -14.84% Loss. Sev. WL On [DATE], the resident weighed 164 lbs. On [DATE], the resident weighed 135.4 which is a -17.44% Loss. Sev. WL On [DATE], the resident weighed 160 lbs. On [DATE], the resident weighed 135.4 which is a -15.38% Loss. Sev. WL [DATE]-% Gain/Loss percentages with weight taken of 135.00 pounds. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE], the resident weighed 160 lbs. On [DATE], the resident weighed 135 pounds which is a -15.63 % Loss. Sev. WL On [DATE], the resident weighed 160 lbs. On [DATE], the resident weighed 135 pounds which is a -15.63 % Loss. Sev. WL On [DATE], the resident weighed 158 lbs. On [DATE], the resident weighed 135 pounds which is a -14.56 % Loss. Sev. WL. [DATE]-% Gain/Loss percentages with weight taken of 132.00 pounds. On [DATE], the resident weighed 135 lbs. On [DATE], the resident weighed 132 pounds which is a -2.22 % Loss. WNL On [DATE], the resident weighed 159 lbs. On [DATE], the resident weighed 132 pounds which is a -16.98 % Loss. Sev. WL On [DATE], the resident weighed 157 lbs. On [DATE], the resident weighed 132 pounds which is a -15.92 % Loss. Sev. WL [DATE]- % Gain/Loss percentages with weight taken of 130 pounds. On [DATE], the resident weighed 132 lbs. On [DATE], the resident weighed 130 pounds which is a -1.52 % Loss. WNL On [DATE], the resident weighed 160 lbs. On [DATE], the resident weighed 130 pounds which is a -18.75 % Loss. Sev. WL On [DATE], the resident weighed 164 lbs. On [DATE], the resident weighed 130 pounds which is a -20.73 % Loss. Sev. WL [DATE]- % Gain/Loss percentages with weight taken of 115.3 pounds. On [DATE], the resident weighed 130 lbs. On [DATE], the resident weighed 115.3 pounds which is a -11.31 % Loss. Sev. WL On [DATE], the resident weighed 132 lbs. On [DATE], the resident weighed 115.3 pounds which is a -12.65 % Loss. Sev. WL On [DATE], the resident weighed 164 lbs. On [DATE], the resident weighed 115.3 pounds which is a -29.70 % Loss. Sev. WL Interview on [DATE] at 9:20 AM with the NP revealed Resident #1's weights were supposed to be monitored by the facility. There were missed opportunities for weight loss intervention, but the NP was not able to determine if keeping her weight up would have made much of a difference in her health. Resident #1 had often refused medications, refused treatments, and refused to eat; therefore, the resident's non-compliance was a large factor. Weight loss would have been hard to combat. The NP stated, Resident #1 was very ill. She thought the facility took good care of her. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 10:30 AM with the DTCN revealed she reviewed the residents' weights every month. She did not recall Resident #1's weight loss in August, September, or October. She reviewed monthly weight reviews and utilized a formula to determine weight loss/weight gain; however, she did not notice any weight loss for Resident #1 until [DATE]. The dietician stated, it was hard to keep her weight up because she did not feel like eating. Had Resident #1's Sev. WL been discovered prior to [DATE], she would have started the intervention on that date. The negative potential outcome for failing to intervene on [DATE] was hard to determine. A dietary intervention on [DATE] may not have slowed her health decline. Since the intervention never happened, we would not know. Resident #1's Sev. WL put her at risk for general weakness, dehydration, confusion, bed sores, muscle wasting, dry mouth, and stress on the immune system. Safeguards in place to discover residents' weight loss were the monthly weights in PCC, staff observations, and resident record reviews. The failure to address the Sev. WL for Resident #1 fell upon missing the weights in review of the documentation. Interview, observation, and RR on [DATE] at 12:25 PM with MDSC revealed she oversaw entering resident information in the MDS System. Resident #1's weight, entered on her Quarterly review date of [DATE], was 132 pounds (from [DATE].) K0300, Weight Loss: Asks if the Resident had loss of 5% or more in the last month or loss of 10% or more in last 6 months. MDSC entered a 0 for K0300, meaning No she had not. To determine the response for K0300, she only looked at the last months weight, not the 180 day mark. Observation of the MDSC utilizing a calculator, she calculated Resident #1's weights. Although the previous weight of [DATE] was WNL, 180 days out, [DATE], had the difference of -15.92 % Body Weight Loss. Sev. WL. She stated, I should have marked yes. She did not recall previous list for residents' weights, until she received one in [DATE]. Prior, she asked for more information. The facility was supposed to follow the RAI manual for date entry into the MDS. She did not recall having received specific instruction to calculate the weight differences with a calculator, or mathematical formula. Safeguards in place to combat data discrepancies were the RAI and corporate checks each quarter. The failure for the correct entry fell upon the MDSC and human error. Interview on [DATE] at 1:18 PM with the Med. Dir. revealed it would have been difficult to keep Resident #1's weight up at the end of life. There was no way to determine if earlier weight loss interventions would have helped with the resident's existing medical condition. It may have extended her life, but not necessarily increased quality. The Med. Dir. Med did not think Resident #1 was neglected in any way. Interview and RR on [DATE] at 2:44 PM with the DON revealed Resident #1 received a dietary intervention on [DATE] for weight loss. RR of Resident #1's weight indicated the facility missed opportunities to address Resident #1's weight loss on [DATE], [DATE], [DATE], and [DATE]. An earlier nutritional intervention could have helped Resident #1 with muscle mass, cognition, and more energy. Some negative results of her weight loss could have been skin breakdown, falls, and depressed mood. Given Resident #1's medical conditions, it would have been hard for her to maintain weight. However, the facility would not know because we did not put any dietary interventions in place. The resident went without diagnosis of weight loss due to a failure. The failure fell upon the facility. The facility should have been monitoring the weights per policy and per Resident #1's CCP. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 4:06 PM with the ADM revealed the facility staff was trained to monitor residents' weights through the facility policy. The ADON oversaw entering the weights, gauging the difference of loss/gain, and the ADON, or the DON, would tell the dietician about any changes. The DTCN had access to PCC, could remote access, address concerns, and implement intervention from other locations. The facility did miss opportunities for intervention on ,d+[DATE], ,d+[DATE], ,d+[DATE], and ,d+[DATE]. The MDSC missed an opportunity on [DATE]. Based on resident's medical conditions, increasing Resident #1's weight would have been difficult, but we would not know, because there was no intervention put in place. The failure resulted from how the facility was monitoring weights. The facility should have been monitoring the weights per policy and per Resident #1's CCP. RR of the facility Resident Weight Policy, dated [DATE], reflected the facility reviewed residents' monthly weights to determine residents with significant weight change. Significant weight change will be defined as 5% or greater in one month (30 days,) 7.5% or greater in three months (90 days,) 10% or greater in 6 months (180 days.) Weights will be recorded, along with interventions. Follow up will be recorded in the designated location. The physician, and the family will be notified. In addition, in acute care plan for weight loss will be initiated and the clinical record would have been reviewed for significant change of condition. All significant weight changes would have been referred to the DTCN on the next visit. The DTCN could generate a copy of the report and can review the weight record on PCC. The DTCN will complete assessment also significant weight losses. DTCN will review all facility interventions, formulate appropriate recommendations. RR of the RAI Chapter 3, dated [DATE], reflected weight loss may be an important indicator of a change in the president's health status or environment. If significant weight loss is noted, the interdisciplinary team should review for possible causes of changed intake, changed caloric need, change in medication (e.g., diuretics), or changed fluid volume status. From the medical record, compare the resident's weight in the current observation period to their weight in the observation period 30 days ago. If the current weight is less than the weight in the observation period 30 days ago, calculate the percentage of weight loss. From the medical record, compare the resident's weight in the current observation period to their weight in the observation period 180 days ago. If the current weight is less than the weight in the observation period 180 days ago, calculate the percentage of weight loss. RR of the facility's Comprehensive Care Planning, undated, reflected the facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and times to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The facility will establish, document, and implement the care and services to be provided to each resident to assist in attaining or maintaining his or her highest practicable quality of life. Care planning drives the type of care and services that a resident receives. The comprehensive care plan will reflect interventions to enable each resident to meet his/her objectives. Interventions are the specific care and services that will be implemented. When developing the comprehensive care plan, facility staff will, at a minimum, use the Minimum Data Set (MDS) to assess the resident's clinical condition, cognitive and functional status, and use of services. If a Care Area Assessment (CAA) is triggered, the facility will further assess the resident to determine whether the resident is at risk of developing, or currently has a weakness or need associated with that CAA, and how the risk, weakness or need affects the resident. Documentation regarding these assessments and the facility's rationale for deciding whether or not to proceed with care planning for each area triggered will be recorded in the medical record.

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47772 Based on interviews and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and times to meet a resident's need for 1 of 5 residents (Resident #1) reviewed for comprehensive care plans. 1. The facility failed monitor Resident #1's monthly weights. 2. The facility failed to develop, and implement, a person-centered intervention for Resident #1's severe weight loss that began on [DATE]. The noncompliance was identified as PNC IJ. The IJ began on [DATE] and ended on [DATE]. The facility had implemented actions that corrected the deficient practice prior to the beginning of the investigation. This failure could place residents at the facility at risk of malnutrition. Findings included: RR of Resident #1's AR, dated [DATE], reflected a [AGE] year-old female who admitted to the facility on [DATE]. She was diagnosed with diabetes mellitus type 2 with ketoacidosis (which was a life threatening condition of the body that disrupted how the body used sugar for fuel), pneumonia (which was an infection in the lungs caused by bacteria, viruses or fungi), acute respiratory failure (which was a life threatening that occurred with the body's lungs were not able to exchange gases with blood), and chronic respiratory failure (which was a condition that impeded the body's ability to effectively exchange oxygen and carbon dioxide). RR of Resident #1's Quarterly MDS Assessment, dated [DATE], reflected the resident had a BIMS Score of 10, which indicated the resident had moderate cognitive impairment. Resident weighed 132 pounds; Loss of 5% or more pounds in the last month, or 10% or more in the last 6 months was annotated with a 0, which indicated No or Unknown. RR of Resident #1's CCP reflected a Focus area, initiated [DATE], for potential risk for malnutrition. The Goal, initiated on [DATE], reflected Resident #1 was supposed to maintain stable weight and nutritional parameters. The Intervention, initiated [DATE], reflected nursing staff was supposed to monitor resident weights and notify the physician of any negative findings; a Focus, initiated on [DATE], for significant unplanned/unexpected weight loss for poor food intake. The Goal, initiated on [DATE], reflected Resident #1's weight would stabilize within 4 weeks. The Intervention, initiated on [DATE], reflected nursing staff was supposed to alert the DON if food consumption was poor for more than 48 hours, encourage food related activities, report results to physician, ensure dietician was aware, and monitor food intake at each meal. (continued on next page)

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(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 - Immediate jeopardy to resident health or safety Residents Affected - Some	RR of Resident #1's Death Certificate, dated [DATE], reflected the resident expired at the nursing facility by a natural manner of death. The immediate cause was sepsis (which was a serious condition in which the body responded improperly to an infection; the infection fighting process turned against the body causing organs to have functioned poorly.) RR of Resident #1's Nutritional Risk Assessment, dated [DATE] by the DTCN, reflected dietary risk were numerous food intolerance and very limited food choice possible. RR of Resident #1's PN, dated [DATE] at 1:15 PM by the DTCN, reflected resident lost 30 pounds in the last 3 months. RR of the dietary consult reflected Resident #1 had lost 30 pounds in the last 3 months. Add supplements three times a day (360 calories.) RR of Resident #1's Dietary Consult, dated [DATE] by the DTCH, reflected resident lost 30 pounds in the last 3 months. RR of the dietary consult reflected Resident #1 had lost 30 pounds in the last 3 months. Add supplements three times a day (360 calories.) RR of an Intakes (Intake A), dated [DATE], reflected an allegation towards the facility for a failure to address Resident #1's weight loss. RR of an Intake (Intake B), dated [DATE], reflected an addendum to Intake A. Intake B reflected an allegation the facility failed to address Resident #1's rapid weight loss; and the facility staff killed Resident #1 through neglect. RR of the local hospital DC paperwork, dated [DATE] to [DATE] reflected Resident #1 presented to the emergency roiagnom on [DATE] at 4:58 PM. Chief complaint was the resident had critically low labs (hemoglobin), low O2 saturations (89%), and difficulty breathing. X-rays were consistent with bronchopneumonia (a respiratory illness with inflammation of the lung tissue). The lungs were stable. HDOC's notes reflected Resident #1 admitted to service from local nursing facility for altered mental status as well as shortness of breath was found to have aspiration pneumonia (a lung infection that occurred when something other than air, like food, liquid saliva, or stomach contents was inhaled into the lungs.) She also had significant /severe protein caloric malnutrition and failure to thrive. Patient was not responsive to therapy. Resident #1 was not doing very well at all. She was not able to eat or drink due to aspiration of everything she took in. After long discussion with responsible parties, it was decided to write a DNR and agreed hospice would be in line (appropriate). Resident #1 was placed on hospice care and would be transferred back to nursing facility later today, [DATE]. Interview on [DATE] at 1:40 PM with RP#2 revealed he had concerns about the nutritional assistance Resident #1 received while at the facility. He stated Resident #1 had food intolerance and did not get a sufficient diet. He claimed Resident #1 started to lose weight ,d+[DATE] months ago. He referenced Resident #1 having been diagnosed with malnutrition on the most recent hospital stay, [DATE] to [DATE]. He insinuated the facility neglected Resident #1's nutritional needs and her weight loss contributed to her death. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on [DATE] at 10:30 AM with the ADM revealed the facility had recent discrepancies with resident's weights. RR of an email, dated [DATE] from CRN reflected instructions to the facility for consistency in monitoring resident's weights. The email instructed the facility to ensure monthly weights were accurate upon admittance and readmittance; enter weights into the facility's computer program by the 10th day of each month; use the same scale, use the same staff, weigh each resident, and review the weights prior to entering them into the facilities computer program; the DON or the ADON should be entering the weights into the facility's computer program. Residents who had unstable weights, brought upon by new admission, readmission, significant weight loss, change the condition, or alternate feeding situations were weighed weekly until stable. The ADM stated a corporate compliance office presented to the facility in the month of [DATE], for an audit with resulted discrepancies with resident's weights. In turn, the facility initiated a PIP. RR of the PIP reflected [weights] were the area of concern; Improvement goal was to implement weight system for facility to ensure weights are monitored, obtained, correctly and interventions put into place. The internal CAP to fix discrepancies with residents' weights was assigned to the ADON. When asked, the ADM would not provide more specific information related to the PIP. She stated she was only allowed to provide the PIP and the CAP. She stated that every resident in the facility had been weighed and that all weight loss had been addressed. Resident # 1 was a resident identified to have had weight loss. She stated all other residents' weight were stable. The ADM produced a list of residents' names on reviewed for weight loss. Interview and observation on [DATE] at 10:47 AM with Resident #2 revealed he in her room sitting on her bed. She did not appear to be overly skinny or malnourished. She was not worried that she was losing weight. She stated, I have gained some weight since my arrival, on [DATE]. Interview and observation on [DATE] at 10:53 AM revealed a member of nursing staff taking Resident #3 from the common area to the dining room. He appeared in good spirits and ad an appropriate body shape and size. He did not appear to be malnourished. He voiced, and displayed in body language, that he got enough food to eat. Interview and observation on [DATE] at 1:35 PM with Resident #4 revealed her in a wheelchair at the nurse's station. She was smiling and engaging with staff. She did not appear to be underweight or malnourished. She voiced, and displayed in body language, that she got enough food to eat. Interview and observation on [DATE] at 1:50 PM with Resident #5 and RP #5 revealed the resident sleeping in bed, sitting up. She was of appropriate size and shape. She did not appear to be underweight. The RP stated he did not have any issues of concerns with the resident's weight loss. He thought the facility was taking good care of the resident. Interview and observation on [DATE] at 2:15 PM with the Resident #6 revealed him in bed watching television. He was a large man and appeared to be well nourished. It was true he lost some weight, but he liked the fact he was losing unwanted belly fat. He was in good spirits. He denied complaints with the facility. Interview and observation on [DATE] at 2:59 PM with Resident #7 revealed he in her room laying on her bed. She did not appear to be underweight. She stated the facility had been checking her weights and that she, her weight, was stable. She did not have any issues or concerns with her weight. (continued on next page)

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	676427	A. Building B. Wing	12/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skilled Care of Mexia	501 E Sumpter St Mexia, TX 76667

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(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 - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview and RR on [DATE] at 11:00 AM with the ADON revealed the facility implemented a weight watchers' program, the facility's PIP, on [DATE] for residents who reflected Sig. WL or Sev. WL. All residents were weighed, and the start date of the PIP was [DATE]. RR of the CAP reflected the ADON was responsible for: 1. Immediately begin to coordinate residents' weights, using the same staff to obtain weight every month; 2. Immediately begin reviewing weights before entering them into the facilities computer program and reweigh as identified; 3. Identify how each resident is supposed to be weighed and ensure the same method is used monthly; 4. Identify weight loss/weight gain under the weights and vital section in the facilities computer program. Create progress notes for weight loss; 5. Immediately begin to create a weekly red glass list (a list of residents flagged for weight loss; placed a red glass on their meal tray to alert staff to help provide nutrition) and provide copies to dietary, MDS, and DON no later than each Monday at 10:00 AM. The internal CAP started on [DATE]. It was signed by the ADM, DON, and the ADON. The ADON stated, every resident in the facility had been weighed. All residents who were outside of parameters were placed on a weight watchers plan. That meant they were weighed each week until stable. All resident identified have stabilized. Resident #1 was identified to have experienced Sev. WL on [DATE]. She received a CCP update, [DATE], and dietary consult, dated [DATE]. Resident #1 was supposed to maintain stable weight and nutritional parameters. Nursing staff was supposed to monitor resident weights and notify the physician of any negative findings. RR of the dietary consult reflected Resident #1 had lost 30 pounds in the last 3 months. Add supplements three times a day (360 calories.) RR reflected Resident #1 experienced Sev. WL prior to [DATE]. RR of Resident #1's weights indicated the resident was eligible for a nutritional intervention when she was weighed on [DATE]. She demonstrated Sev. WL at the 30, 90, and 180 day mark. On [DATE], she demonstrated Sev. WL at the 30, 90, and 180 day mark. On [DATE], she demonstrated Sev. WL at the 30, 90, and 180 day mark. On [DATE], she demonstrated Sev. WL at the 30, 90, and 180 day mark. Finally, on [DATE], she was found to have demonstrated Sev. WL at the 30, 90, and 180 day mark. On [DATE], Resident #1 was 115.3 pounds. On [DATE], Resident #1's weight was 135.4 pounds. Resident #1 continued to lose an additional 20.1 pounds (-14.84% loss in body weight) from [DATE] until [DATE]. RR of Resident #1's weights: Interval Significant Loss Severe Loss 1 month 5% Greater than 5% 3 months 7.5% Greater than 7.5% 6 months 10% Greater than 10% % Body Weight equation: 1st weight (higher) minus 2nd weight (lower) = difference. Example: ,d+[DATE].4=20.6 Difference / 1st weight (higher) = % of weight loss. Example: 20XXX,d+[DATE]= -13.20 % body weight loss. [DATE]-% of Gain/Loss percentages with weight taken of 135.4 pounds. On [DATE], the resident weighed 156 lbs. On [DATE], the resident weighed 135.4 which is a -13.20% Loss. Sev. WL (continued on next page)

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Skilled Care of Mexia	501 E Sumpter St Mexia, TX 76667

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(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 - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE], the resident weighed 159 lbs. On [DATE], the resident weighed 135.4 which is a -14.84% Loss. Sev. WL On [DATE], the resident weighed 164 lbs. On [DATE], the resident weighed 135.4 which is a -17.44% Loss. Sev. WL On [DATE], the resident weighed 160 lbs. On [DATE], the resident weighed 135.4 which is a -15.38% Loss. Sev. WL [DATE]-% Gain/Loss percentages with weight taken of 135.00 pounds. On [DATE], the resident weighed 160 lbs. On [DATE], the resident weighed 135 pounds which is a -15.63 % Loss. Sev. WL On [DATE], the resident weighed 160 lbs. On [DATE], the resident weighed 135 pounds which is a -15.63 % Loss. Sev. WL On [DATE], the resident weighed 158 lbs. On [DATE], the resident weighed 135 pounds which is a -14.56 % Loss. Sev. WL. [DATE]-% Gain/Loss percentages with weight taken of 132.00 pounds. On [DATE], the resident weighed 135 lbs. On [DATE], the resident weighed 132 pounds which is a -2.22 % Loss. WNL On [DATE], the resident weighed 159 lbs. On [DATE], the resident weighed 132 pounds which is a -16.98 % Loss. Sev. WL On [DATE], the resident weighed 157 lbs. On [DATE], the resident weighed 132 pounds which is a -15.92 % Loss. Sev. WL [DATE]- % Gain/Loss percentages with weight taken of 130 pounds. On [DATE], the resident weighed 132 lbs. On [DATE], the resident weighed 130 pounds which is a -1.52 % Loss. WNL On [DATE], the resident weighed 160 lbs. On [DATE], the resident weighed 130 pounds which is a -18.75 % Loss. Sev. WL On [DATE], the resident weighed 164 lbs. On [DATE], the resident weighed 130 pounds which is a -20.73 % Loss. Sev. WL [DATE]- % Gain/Loss percentages with weight taken of 115.3 pounds. On [DATE], the resident weighed 130 lbs. On [DATE], the resident weighed 115.3 pounds which is a -11.31 % Loss. Sev. WL (continued on next page)

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(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 - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE], the resident weighed 132 lbs. On [DATE], the resident weighed 115.3 pounds which is a -12.65 % Loss. Sev. WL On [DATE], the resident weighed 164 lbs. On [DATE], the resident weighed 115.3 pounds which is a -29.70 % Loss. Sev. WL Interview on [DATE] at 9:20 AM with the NP revealed Resident #1's weights were supposed to be monitored by the facility. There were missed opportunities for weight loss intervention, but the NP was not able to determine if keeping her weight up would have made much of a difference in her health. Resident #1 had often refused medications, refused treatments, and refused to eat; therefore, the resident's non-compliance was a large factor. Weight loss would have been hard to combat. The NP stated, Resident #1 was very ill. She thought the facility took good care of her. Interview on [DATE] at 10:30 AM with the DTCN revealed she reviewed the residents' weights every month. She did not recall Resident #1's weight loss in August, September, or October. She reviewed monthly weight reviews and utilized a formula to determine weight loss/weight gain; however, she did not notice any weight loss for Resident #1 until [DATE]. The dietician stated, it was hard to keep her weight up because she did not feel like eating. Had Resident #1's Sev. WL been discovered prior to [DATE], she would have started the intervention on that date. The negative potential outcome for failing to intervene on [DATE] was hard to determine. A dietary intervention on [DATE] may not have slowed her health decline. Since the intervention never happened, we would not know. Resident #1's Sev. WL put her at risk for general weakness, dehydration, confusion, bed sores, muscle wasting, dry mouth, and stress on the immune system. Safeguards in place to discover residents' weight loss were the monthly weights in PCC, staff observations, and resident record reviews. The failure to address the Sev. WL for Resident #1 fell upon missing the weights in review of the documentation. Interview and RR on [DATE] at 11:30 AM with the SW revealed Resident #1 started to decline over the past few months. She lost a lot of weight. The facility tried to accommodate her, but she often just did not have an appetite. RR of dental notes reflected the dentist on [DATE] and [DATE]. RR of Resident #1's OSR report indicated an order for a mechanical soft diet having begun on [DATE]. Interview, observation, and RR on [DATE] at 12:25 PM with MDSC revealed she oversaw entering resident information in the MDS System. Resident #1's weight, entered on her Quarterly review date of [DATE], was 132 pounds (from [DATE]). K0300, Weight Loss: Asks if the Resident had loss of 5% or more in the last month or loss of 10% or more in last 6 months. MDSC entered a 0 for K0300, meaning No she had not. To determine the response for K0300, she only looked at the last months weight, not the 180 day mark. Observation of the MDSC utilizing a calculator, she calculated Resident #1's weights. Although the previous weight of [DATE] was WNL, 180 days out, [DATE], had the difference of -15.92 % Body Weight Loss. Sev. WL. She stated, I should have marked yes. She did not recall the previous list for residents' weights, until she received it in [DATE]. Prior, she asked for more information. The facility was supposed to follow the RAI manual for date entry into the MDS. She did not recall having received specific instruction to calculate the weight differences with a calculator, or mathematical formula. Safeguards in place to combat data discrepancies were the RAI and corporate checks each quarter. The failure for the correct entry fell upon the MDSC and human error. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on [DATE] at 1:18 PM with the Med. Dir. revealed it would have been difficult to keep Resident #1's weight up at the end of life. There was no way to determine if earlier weight loss interventions would have helped with the resident's existing medical condition. It may have extended her life, but not necessarily increased quality. The Med. Dir. did not think Resident #1 was neglected in any way. Interview and record review with the DOR, and the OT revealed, revealed Resident #1 had occupational therapy for independent eating from [DATE] to [DATE], which she was successful. The OT stated, I observed her in the dining room eating with RP #2, and she did not demonstrate the need for further intervention, she could eat on her own. Interview and RR on [DATE] at 2:44 PM with the DON revealed Resident #1 received a dietary intervention on [DATE] for weight loss. RR of Resident #1's weight indicated the facility missed opportunities to address Resident #1's weight loss on [DATE], [DATE], [DATE], and [DATE]. An earlier nutritional intervention could have helped Resident #1 with muscle mass, cognition, and more energy. Some negative results of her weight loss could have been skin breakdown, falls, and depressed mood. Given Resident #1's medical conditions, it would have been hard for her to maintain weight. However, the facility would not know because we did not put any dietary interventions in place. The resident went without diagnosis of weight loss due to a failure. The failure fell upon the facility. The facility should have been monitoring the weights per policy and per Resident #1's CCP. All other residents at the facility were weighed. Any residents that were found out of ranges were under dietary supervision. Interview on [DATE] at 4:06 PM with the ADM revealed the facility staff was trained to monitor residents' weights through the facility policy. The ADON oversaw entering the weights, gauging the difference of loss/gain, and the ADON, or the DON, would tell the dietician about any changes. The DTCN had access to PCC, could remote access, address concerns, and implement intervention from other locations. The facility did miss opportunities for intervention on ,d+[DATE], ,d+[DATE], ,d+[DATE], and ,d+[DATE]. The MDSC missed an opportunity on [DATE]. Based on resident's medical conditions, increasing Resident #1's weight would have been difficult, but we would not know, because there was no intervention put in place. The failure resulted from how the facility was monitoring weights. The facility should have been monitoring the weights per policy and per Resident #1's CCP. The current PIP and the CAP have addressed all weight loss at the facility. All other residents at the facility were weighed. No resident was at risk for harm due to weight loss. Monitoring weights. The facility should have been monitoring the weights per policy and per Resident #1's CCP. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	RR of the facility's Comprehensive Care Planning, undated, reflected the facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and times to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The facility will establish, document, and implement the care and services to be provided to each resident to assist in attaining or maintaining his or her highest practicable quality of life. Care planning drives the type of care and services that a resident receives. The comprehensive care plan will reflect interventions to enable each resident to meet his/her objectives. Interventions are the specific care and services that will be implemented. When developing the comprehensive care plan, facility staff will, at a minimum, use the Minimum Data Set (MDS) to assess the resident's clinical condition, cognitive and functional status, and use of services. If a CAA is triggered, the facility will further assess the resident to determine whether the resident is at risk of developing, or currently has a weakness or need associated with that CAA, and how the risk, weakness or need affects the resident. Documentation regarding these assessments and the facility's rationale for deciding whether or not to proceed with care planning for each area triggered will be recorded in the medical record. RR of the facility Resident Weight Policy, dated [DATE], reflected the facility reviewed residents' monthly weights to determine residents with significant weight change. Significant weight change will be defined as 5% or greater in one month (30 days,) 7.5% or greater in three months (90 days,) 10% or greater in 6 months (180 days.) Weights will be recorded, along with interventions. Follow up will be recorded in the designated location. The physician, and the family will be notified. In addition, in acute care plan for weight loss will be initiated and the clinical record would have been reviewed for significant change of condition. All significant weight changes would have been referred to the DTCN on the next visit. The DTCN could generate a copy of the report and can review the weight record on PCC. The DTCN will complete assessment also significant weight losses. DTCN will review all facility interventions, formulate appropriate recommendations.

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47772 Based on interviews and record review, the facility failed to unsure residents maintained acceptable parameters of nutritional status, such as usual body weight, for 1 of 5 residents (Resident #1) reviewed for nutritional status. The facility failed to identify Resident #1's severe weight loss at a 30-day, 90-day, and 180-day increment on [DATE], [DATE], [DATE], and [DATE]. The noncompliance was identified as PNC IJ. The IJ began on [DATE] and ended on [DATE]. The facility had implemented actions that corrected the deficient practice prior to the beginning of the investigation. This failure could place residents at the facility at risk of malnutrition. Findings included: RR of Resident #1's AR, dated [DATE], reflected a [AGE] year-old female who admitted to the facility on [DATE]. She was diagnosed with diabetes mellitus type 2 with ketoacidosis (which was a life threatening condition of the body that disrupted how the body used sugar for fuel), pneumonia (which was an infection in the lungs caused by bacteria, viruses or fungi), acute respiratory failure (which was a life threatening that occurred with the body's lungs were not able to exchange gases with blood), and chronic respiratory failure (which was a condition that impeded the body's ability to effectively exchange oxygen and carbon dioxide). RR of Resident #1's Quarterly MDS Assessment, dated [DATE], reflected the resident had a BIMS Score of 10, which indicated the resident had moderate cognitive impairment. Resident weighed 132 pounds; Loss of 5% or more pounds in the last month, or 10% or more in the last 6 months was annotated with a 0, which indicated No or Unknown. RR of Resident #1's CCP reflected a Focus area, initiated [DATE], for potential risk for malnutrition. The Goal, initiated on [DATE], reflected Resident #1 was supposed to maintain stable weight and nutritional parameters. The Intervention, initiated [DATE], reflected nursing staff was supposed to monitor resident weights and notify the physician of any negative findings; a Focus, initiated on [DATE], for significant unplanned/unexpected weight loss for poor food intake. The Goal, initiated on [DATE], reflected Resident #1's weight would stabilize within 4 weeks. The Intervention, initiated on [DATE], reflected nursing staff was supposed to alert the DON if food consumption was poor for more than 48 hours, encourage food related activities, report results to physician, ensure dietician was aware, and monitor food intake at each meal. RR of Resident #1's Death Certificate, dated [DATE], reflected the resident expired at the nursing facility by a natural manner of death. The immediate cause was sepsis (which was a serious condition in which the body responded improperly to an infection; the infection fighting process turned against the body causing organs to have functioned poorly.) (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	RR of Resident #1's Nutritional Risk Assessment, dated [DATE] by the DTCN, reflected dietary risk were numerous food intolerance and very limited food choice possible. RR of Resident #1's PN, dated [DATE] at 1:15 PM by the DTCN, reflected resident lost 30 pounds in the last 3 months. RR of the dietary consult reflected Resident #1 had lost 30 pounds in the last 3 months. Add supplements three times a day (360 calories.) RR of Resident #1's Dietary Consult, dated [DATE] by the DTCH, reflected resident lost 30 pounds in the last 3 months. RR of the dietary consult reflected Resident #1 had lost 30 pounds in the last 3 months. Add supplements three times a day (360 calories.) RR of an Intakes (Intake A), dated [DATE], reflected an allegation towards the facility for a failure to address Resident #1's weight loss. RR of an Intake (Intake B), dated [DATE], reflected an addendum to Intake A. Intake B reflected an allegation the facility failed to address Resident #1's rapid weight loss; and the facility staff killed Resident #1 through neglect. RR of the local hospital DC paperwork, dated [DATE] to [DATE] reflected Resident #1 presented to the emergency roiagnom on [DATE] at 4:58 PM. Chief complaint was the resident had critically low labs (hemoglobin), low O2 saturations (89%), and difficulty breathing. X-rays were consistent with bronchopneumonia (a respiratory illness with inflammation of the lung tissue). The lungs were stable. HDOC's notes reflected Resident #1 admitted to service from local nursing facility for altered mental status as well as shortness of breath was found to have aspiration pneumonia (a lung infection that occurred when something other than air, like food, liquid saliva, or stomach contents was inhaled into the lungs.) She also had significant /severe protein caloric malnutrition and failure to thrive. Patient was not responsive to therapy. Resident #1 was not doing very well at all. She was not able to eat or drink due to aspiration of everything she took in. After long discussion with responsible parties, it was decided to write a DNR and agreed hospice would be in line (appropriate). Resident #1 was placed on hospice care and would be transferred back to nursing facility later today, [DATE]. Interview on [DATE] at 1:40 PM with RP#2 revealed he had concerns about the nutritional assistance Resident #1 received while at the facility. He stated Resident #1 had food intolerance and did not get a sufficient diet. He claimed Resident #1 started to lose weight ,d+[DATE] months ago. He referenced Resident #1 having been diagnosed with malnutrition on the most recent hospital stay, [DATE] to [DATE]. He insinuated the facility neglected Resident #1's nutritional needs and her weight loss contributed to her death. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on [DATE] at 10:30 AM with the ADM revealed the facility had recent discrepancies with resident's weights. RR of an email, dated [DATE] from CRN reflected instructions to the facility for consistency in monitoring resident's weights. The email instructed the facility to ensure monthly weights were accurate upon admittance and readmittance; enter weights into the facility's computer program by the 10th day of each month; use the same scale, use the same staff, weigh each resident, and review the weights prior to entering them into the facilities computer program; the DON or the ADON should be entering the weights into the facility's computer program. Residents who had unstable weights, brought upon by new admission, readmission, significant weight loss, change the condition, or alternate feeding situations were weighed weekly until stable. The ADM stated a corporate compliance office presented to the facility in the month of [DATE], for an audit with resulted discrepancies with resident's weights. In turn, the facility initiated a PIP. RR of the PIP reflected [weights] were the area of concern; Improvement goal was to implement weight system for facility to ensure weights are monitored, obtained, correctly and interventions put into place. The internal CAP to fix discrepancies with residents' weights was assigned to the ADON. When asked, the ADM would not provide more specific information related to the PIP. She stated she was only allowed to provide the PIP and the CAP. She stated that every resident in the facility had been weighed and that all weight loss had been addressed. Resident # 1 was a resident identified to have had weight loss. She stated all other residents' weight were stable. The ADM produced a list of residents' names on reviewed for weight loss. Interview and observation on [DATE] at 10:47 AM with Resident #2 revealed he in her room sitting on her bed. She did not appear to be overly skinny or malnourished. She was not worried that she was losing weight. She stated, I have gained some weight since my arrival, on [DATE]. Interview and observation on [DATE] at 10:53 AM revealed a member of nursing staff taking Resident #3 from the common area to the dining room. He appeared in good spirits and ad an appropriate body shape and size. He did not appear to be malnourished. He voiced, and displayed in body language, that he got enough food to eat. Interview and observation on [DATE] at 1:35 PM with Resident #4 revealed her in a wheelchair at the nurse's station. She was smiling and engaging with staff. She did not appear to be underweight or malnourished. She voiced, and displayed in body language, that she got enough food to eat. Interview and observation on [DATE] at 1:50 PM with Resident #5 and RP #5 revealed the resident sleeping in bed, sitting up. She was of appropriate size and shape. She did not appear to be underweight. The RP stated he did not have any issues of concerns with the resident's weight loss. He thought the facility was taking good care of the resident. Interview and observation on [DATE] at 2:15 PM with the Resident #6 revealed him in bed watching television. He was a large man and appeared to be well nourished. It was true he lost some weight, but he liked the fact he was losing unwanted belly fat. He was in good spirits. He denied complaints with the facility. Interview and observation on [DATE] at 2:59 PM with Resident #7 revealed he in her room laying on her bed. She did not appear to be underweight. She stated the facility had been checking her weights and that she, her weight, was stable. She did not have any issues or concerns with her weight. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview and RR on [DATE] at 11:00 AM with the ADON revealed the facility implemented a weight watchers' program, the facility's PIP, on [DATE] for residents who reflected Sig. WL or Sev. WL. All residents were weighed, and the start date of the PIP was [DATE]. RR of the CAP reflected the ADON was responsible for: 1. Immediately begin to coordinate residents' weights, using the same staff to obtain weight every month; 2. Immediately begin reviewing weights before entering them into the facilities computer program and reweigh as identified; 3. Identify how each resident is supposed to be weighed and ensure the same method is used monthly; 4. Identify weight loss/weight gain under the weights and vital section in the facilities computer program. Create progress notes for weight loss; 5. Immediately begin to create a weekly red glass list (a list of residents flagged for weight loss; placed a red glass on their meal tray to alert staff to help provide nutrition) and provide copies to dietary, MDS, and DON no later than each Monday at 10:00 AM. The internal CAP started on [DATE]. It was signed by the ADM, DON, and the ADON. The ADON stated, every resident in the facility had been weighed. All residents who were outside of parameters were placed on a weight watchers plan. That meant they were weighed each week until stable. All resident identified have stabilized. Resident #1 was identified to have experienced Sev. WL on [DATE]. She received a CCP update, [DATE], and dietary consult, dated [DATE]. Resident #1 was supposed to maintain stable weight and nutritional parameters. Nursing staff was supposed to monitor resident weights and notify the physician of any negative findings. RR of the dietary consult reflected Resident #1 had lost 30 pounds in the last 3 months. Add supplements three times a day (360 calories.) RR reflected Resident #1 experienced Sev. WL prior to [DATE]. RR of Resident #1's weights indicated the resident was eligible for a nutritional intervention when she was weighed on [DATE]. She demonstrated Sev. WL at the 30, 90, and 180 day mark. On [DATE], she demonstrated Sev. WL at the 30, 90, and 180 day mark. On [DATE], she demonstrated Sev. WL at the 30, 90, and 180 day mark. On [DATE], she demonstrated Sev. WL at the 30, 90, and 180 day mark. Finally, on [DATE], she was found to have demonstrated Sev. WL at the 30, 90, and 180 day mark. On [DATE], Resident #1 was 115.3 pounds. On [DATE], Resident #1's weight was 135.4 pounds. Resident #1 continued to lose an additional 20.1 pounds (-14.84% loss in body weight) from [DATE] until [DATE]. RR of Resident #1's weights: Interval Significant Loss Severe Loss 1 month 5% Greater than 5% 3 months 7.5% Greater than 7.5% 6 months 10% Greater than 10% % Body Weight equation: 1st weight (higher) minus 2nd weight (lower) = difference. Example: ,d+[DATE].4=20.6 Difference / 1st weight (higher) = % of weight loss. Example: 20XXX,d+[DATE]= -13.20 % body weight loss. [DATE]-% of Gain/Loss percentages with weight taken of 135.4 pounds. On [DATE], the resident weighed 156 lbs. On [DATE], the resident weighed 135.4 which is a -13.20% Loss. Sev. WL (continued on next page)

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	676427	A. Building B. Wing	12/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skilled Care of Mexia	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.

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE], the resident weighed 159 lbs. On [DATE], the resident weighed 135.4 which is a -14.84% Loss. Sev. WL On [DATE], the resident weighed 164 lbs. On [DATE], the resident weighed 135.4 which is a -17.44% Loss. Sev. WL On [DATE], the resident weighed 160 lbs. On [DATE], the resident weighed 135.4 which is a -15.38% Loss. Sev. WL [DATE]-% Gain/Loss percentages with weight taken of 135.00 pounds. On [DATE], the resident weighed 160 lbs. On [DATE], the resident weighed 135 pounds which is a -15.63 % Loss. Sev. WL On [DATE], the resident weighed 160 lbs. On [DATE], the resident weighed 135 pounds which is a -15.63 % Loss. Sev. WL On [DATE], the resident weighed 158 lbs. On [DATE], the resident weighed 135 pounds which is a -14.56 % Loss. Sev. WL. [DATE]-% Gain/Loss percentages with weight taken of 132.00 pounds. On [DATE], the resident weighed 135 lbs. On [DATE], the resident weighed 132 pounds which is a -2.22 % Loss. WNL On [DATE], the resident weighed 159 lbs. On [DATE], the resident weighed 132 pounds which is a -16.98 % Loss. Sev. WL On [DATE], the resident weighed 157 lbs. On [DATE], the resident weighed 132 pounds which is a -15.92 % Loss. Sev. WL [DATE]- % Gain/Loss percentages with weight taken of 130 pounds. On [DATE], the resident weighed 132 lbs. On [DATE], the resident weighed 130 pounds which is a -1.52 % Loss. WNL On [DATE], the resident weighed 160 lbs. On [DATE], the resident weighed 130 pounds which is a -18.75 % Loss. Sev. WL On [DATE], the resident weighed 164 lbs. On [DATE], the resident weighed 130 pounds which is a -20.73 % Loss. Sev. WL [DATE]- % Gain/Loss percentages with weight taken of 115.3 pounds. On [DATE], the resident weighed 130 lbs. On [DATE], the resident weighed 115.3 pounds which is a -11.31 % Loss. Sev. WL (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE], the resident weighed 132 lbs. On [DATE], the resident weighed 115.3 pounds which is a -12.65 % Loss. Sev. WL On [DATE], the resident weighed 164 lbs. On [DATE], the resident weighed 115.3 pounds which is a -29.70 % Loss. Sev. WL Interview on [DATE] at 9:20 AM with the NP revealed Resident #1's weights were supposed to be monitored by the facility. There were missed opportunities for weight loss intervention, but the NP was not able to determine if keeping her weight up would have made much of a difference in her health. Resident #1 had often refused medications, refused treatments, and refused to eat; therefore, the resident's non-compliance was a large factor. Weight loss would have been hard to combat. The NP stated, Resident #1 was very ill. She thought the facility took good care of her. Interview on [DATE] at 10:30 AM with the DTCN revealed she reviewed the residents' weights every month. She did not recall Resident #1's weight loss in August, September, or October. She reviewed monthly weight reviews and utilized a formula to determine weight loss/weight gain; however, she did not notice any weight loss for Resident #1 until [DATE]. The dietician stated, it was hard to keep her weight up because she did not feel like eating. Had Resident #1's Sev. WL been discovered prior to [DATE], she would have started the intervention on that date. The negative potential outcome for failing to intervene on [DATE] was hard to determine. A dietary intervention on [DATE] may not have slowed her health decline. Since the intervention never happened, we would not know. Resident #1's Sev. WL put her at risk for general weakness, dehydration, confusion, bed sores, muscle wasting, dry mouth, and stress on the immune system. Safeguards in place to discover residents' weight loss were the monthly weights in PCC, staff observations, and resident record reviews. The failure to address the Sev. WL for Resident #1 fell upon missing the weights in review of the documentation. Interview and RR on [DATE] at 11:30 AM with the SW revealed Resident #1 started to decline over the past few months. She lost a lot of weight. The facility tried to accommodate her, but she often just did not have an appetite. RR of dental notes reflected the dentist on [DATE] and [DATE]. RR of Resident #1's OSR report indicated an order for a mechanical soft diet having begun on [DATE]. Interview, observation, and RR on [DATE] at 12:25 PM with MDSC revealed she oversaw entering resident information in the MDS System. Resident #1's weight, entered on her Quarterly review date of [DATE], was 132 pounds (from [DATE]). K0300, Weight Loss: Asks if the Resident had loss of 5% or more in the last month or loss of 10% or more in last 6 months. MDSC entered a 0 for K0300, meaning No she had not. To determine the response for K0300, she only looked at the last months weight, not the 180 day mark. Observation of the MDSC utilizing a calculator, she calculated Resident #1's weights. Although the previous weight of [DATE] was WNL, 180 days out, [DATE], had the difference of -15.92 % Body Weight Loss. Sev. WL. She stated, I should have marked yes. She did not recall the previous list for residents' weights, until she received it in [DATE]. Prior, she asked for more information. The facility was supposed to follow the RAI manual for date entry into the MDS. She did not recall having received specific instruction to calculate the weight differences with a calculator, or mathematical formula. Safeguards in place to combat data discrepancies were the RAI and corporate checks each quarter. The failure for the correct entry fell upon the MDSC and human error. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on [DATE] at 1:18 PM with the Med. Dir. revealed it would have been difficult to keep Resident #1's weight up at the end of life. There was no way to determine if earlier weight loss interventions would have helped with the resident's existing medical condition. It may have extended her life, but not necessarily increased quality. The Med. Dir. did not think Resident #1 was neglected in any way. Interview and record review with the DOR, and the OT revealed, revealed Resident #1 had occupational therapy for independent eating from [DATE] to [DATE], which she was successful. The OT stated, I observed her in the dining room eating with RP #2, and she did not demonstrate the need for further intervention, she could eat on her own. Interview and RR on [DATE] at 2:44 PM with the DON revealed Resident #1 received a dietary intervention on [DATE] for weight loss. RR of Resident #1's weight indicated the facility missed opportunities to address Resident #1's weight loss on [DATE], [DATE], [DATE], and [DATE]. An earlier nutritional intervention could have helped Resident #1 with muscle mass, cognition, and more energy. Some negative results of her weight loss could have been skin breakdown, falls, and depressed mood. Given Resident #1's medical conditions, it would have been hard for her to maintain weight. However, the facility would not know because we did not put any dietary interventions in place. The resident went without diagnosis of weight loss due to a failure. The failure fell upon the facility. The facility should have been monitoring the weights per policy and per Resident #1's CCP. All other residents at the facility were weighed. Any residents that were found out of ranges were under dietary supervision. Interview on [DATE] at 4:06 PM with the ADM revealed the facility staff was trained to monitor residents' weights through the facility policy. The ADON oversaw entering the weights, gauging the difference of loss/gain, and the ADON, or the DON, would tell the dietician about any changes. The DTCN had access to PCC, could remote access, address concerns, and implement intervention from other locations. The facility did miss opportunities for intervention on ,d+[DATE], ,d+[DATE], ,d+[DATE], and ,d+[DATE]. The MDSC missed an opportunity on [DATE]. Based on resident's medical conditions, increasing Resident #1's weight would have been difficult, but we would not know, because there was no intervention put in place. The failure resulted from how the facility was monitoring weights. The facility should have been monitoring the weights per policy and per Resident #1's CCP. The current PIP and the CAP have addressed all weight loss at the facility. All other residents at the facility were weighed. No resident was at risk for harm due to weight loss. RR of the facility Resident Weight Policy, dated [DATE], reflected the facility reviewed residents' monthly weights to determine residents with significant weight change. Significant weight change will be defined as 5% or greater in one month (30 days,) 7.5% or greater in three months (90 days,) 10% or greater in 6 months (180 days.) Weights will be recorded, along with interventions. Follow up will be recorded in the designated location. The physician, and the family will be notified. In addition, in acute care plan for weight loss will be initiated and the clinical record would have been reviewed for significant change of condition. All significant weight changes would have been referred to the DTCN on the next visit. The DTCN could generate a copy of the report and can review the weight record on PCC. The DTCN will complete assessment also significant weight losses. DTCN will review all facility interventions, formulate appropriate recommendations.