

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 10/17/2025
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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure adequate supervision to prevent accidents for one of one (Resident #1) reviewed for accidents and supervision. The facility failed to prevent the elopement of Resident #1 on 10/5/2025. The noncompliance was identified as past noncompliance. The immediate jeopardy began on 10/16/2025 at 5:22 p.m. and ended on 10/17/2025 at 5:58 p.m. The facility had corrected noncompliance before the investigation began. This failure could place residents at risk for accidents and harm. Findings included:</p> <p>Record review of Resident #1's face sheet reflected, Resident #1 is a [AGE] year-old man admitted to the facility on [DATE]. The face sheet reflected Resident # 1 was admitted with a diagnosis of Chronic obstructive pulmonary disease, Anxiety disorder, Dementia severe with other behavior disturbances, Psychotic disorder with delusions due to known physiological condition, Major depressive disorder, Alzheimer's disease, Unsteadiness on feet, Need for assistance with personal care, and hypertension.</p> <p>Record review of Wander Risk assessment dated [DATE] revealed Resident #1 scored 28 which indicated that the resident was at high risk for elopement. The facility reported this was the assessment that they used to determine if a person was at risk for elopement.</p> <p>Record review of the Baseline Care Plan dated 07/17/2025 reflected that the Resident #1 was a wanderer with personalized interventions. The care plan reflected the following interventions: Assess for fall risk, Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation. Identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate. If the resident is exit seeking, stay with the resident and notify the charge nurse by calling out, sending another staff member, call system, etc.</p> <p>Record review of MDS initial assessment dated [DATE] for Resident #1 reflected a BIMS score of 5 which indicates severe impairment.</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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an observation on 10/15/2025 at 8:30 a.m. The facility was bordered along the south and west by uneven streets. The front door was located on the south side of the building with a church located across the street. There were two houses to the east side of the building. There was a fenced lot containing a water tower to the north side of the building. Observed keypad on the locked front door with a doorbell. The doorbell was rung by the surveyor. An incoming staff member input the code and verbally revealed the code to the surveyor while allowing entrance. The surveyor observed that there were no staff at the door to assist guests with entrance and exit. This surveyor noted red signs on the door on the inside and outside that read: Attention all visitors: do not let any residents outside. If you are taking a resident on pass, sign out at the nurses station. and Attention all visitors & staff make sure door closes when you enter/exit . The signs were located on the outside and inside of the entrance door and on the wall near the same door.</p> <p>Record review of hospital records, dated 10/5/2025, reflected Resident #1 was taken to the hospital for an assessment with the chief complaint of confusion related to dementia. The resident had a laceration to his left eyebrow prior to arrival that had Steris trips. Resident #1 was discharged from the hospital to a facility with a secured memory care unit.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/15/2025 at 9:15 a.m. the ADM stated on Sunday, October 5th she received a call at 2:14 p.m. from the MAD who asked her if she heard about the situation regarding Resident #1. She stated the MAD received a call from her Witness #3 who lived near the facility and asked if Resident #1 lived at the facility. The ADM stated the group of smokers had reportedly come in following their smoke break at 1:45PM and Resident #1 was seen sitting in the TV area on the couch at that time. The ADM stated Resident #1 was then reportedly seen by Witness #1 & Witness #2, who were driving in the neighborhood, and stopped as Resident #1 was sitting down. She stated Witness #1 & Witness #2 reported Resident #1 told them he was working out and was tired. She stated Witness #1 & Witness #2 caught the attention of a nearby homeowner, Witness #3 who then called the MAD to ask if the gentleman was a Resident. The ADM stated Witness #1 & Witness #2 reported stopping at 2:00 p.m. The ADM stated Witness #1 & Witness #2 called for an ambulance which arrived on location despite her understanding of no injuries. The ADM stated that after getting off the phone with the MAD she called the nurse at the facility to verify Resident #1's whereabouts. The ADM stated the nurse reported to her that she had just seen Resident #1 but he was no longer in the day area. The ADM explained that the resident had been located by members of the community and was being taken to the hospital. The ADM stated she went to the hospital and Resident #1 told her that he was just exercising, got tired, and sat down. She stated the Hospital#1 reported no injuries but noted that the resident's troponin level was elevated so they sent him to Hospital #2. The ADM said Hospital #2 stated Resident #1's Troponin levels were within range. The ADM stated she discussed the situation with Resident 1's POA and they decided it would be best to refer Resident #1 to a facility with a secure unit. The ADM stated that following the incident the MD made sure all doors worked to ensure there were no systems failures. She provided the MD report that all doors were locked, and all alarms were in working order. She stated they performed an elopement risk assessment on all residents. She stated there was one resident who was listed as a risk. She stated that Resident #2 was in a wheelchair, and it would take a long time for her to wheel herself from point A to point B. The ADM stated Resident #2 liked to go to the door, push on the handle to hear the noise, and then would stop. The ADM stated Resident #2 never attempted to leave the facility and would not be able to open the door fully on her own in order to exit. She stated that, for safety reasons, the door, when pushed on for 15 seconds would open and an alarm sounded. She stated two residents were removed from the elopement risk list following the assessments, but the interventions in their care plans remained in place as a precaution. She stated the two residents that were no longer considered an elopement risk never not attempted to leave. She stated that the door code was changed, and a message was sent to all residents' families with the new code and the request that they not let the residents out when exiting or entering unless they have been signed out. She stated then when guests would come and did not have the new code, she would let them in and discuss the matter with them for safety. She stated she updated the signage, and it was now larger and on red paper. The ADM stated another resident's family member reported to her he helped Resident #1 exit. She stated he informed her that he was not aware that he was a resident and apologized. She stated they send monthly reminders to family about the entrance and exit safety. She stated the code to the door was changed monthly. The ADM stated Resident #1 was considered an elopement risk but only because he had an incident during a time that his psych medications were being changed and titrated and he wanted to go out the door, but he was very redirectable. She stated they had not had any further issues once the medication reached therapeutic level. She stated the resident was very independent. She stated he wandered around the facility, but staff was not concerned that he would attempt to leave. She stated that following the incident on 10/5/2025 the resident apologized and stated, I messed it up, can I have another chance? She stated although they enjoyed having him but for his safety a secure unit was determined best for him. She stated that she wanted all the residents to have a good life and not live behind a locked door but understood when it was necessary.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/15/2025 12:47 p.m. CNA A stated she is inserviced abuse, neglect, and elopement. She stated an example of abuse or neglect is not checking on the residents or refusing to do anything for them. She stated she was here when Resident #1 eloped, and it was at the end of her shift. She stated he is not someone she would expect to leave but he did wander around, and he was very redirectable.</p> <p>During an interview on 10/15/2025 at 12:47 p.m. with CNA A stated she has worked in the facility for four years. She stated she is frequently in serviced on abuse, neglect, and elopement. She stated an example of abuse or neglect is not checking on the residents or refusing to do anything for them. She stated if she witnessed abuse or neglect, she would talk to the ADM who is the abuse coordinator. She stated elopement risks were noted in the chart and discussed in meetings. She stated that if a resident tried to go out the door an alarm will sound, and they will check the door to ensure the resident was safe to go outside. She stated she was at work when Resident #1 eloped, and it was at the end of her shift. She stated he is not someone she would expect to leave but he does wander around, and he was very redirectable. She stated the church had an event on 10/5/2025 and they were going in and out but stated she did not feel like there was anything the facility could do differently to prevent the situation.</p> <p>During an interview on 10/15/2025 1:35 p.m. Resident #1's POA stated that she believed the facility did everything in their power to provide care and ensure the safety of Resident #1. Resident #1's POA stated she felt like Resident #1 was going to figure out how to get out if that was what he wanted. She stated he can't live alone even though he thinks he is fine and there is nothing wrong with him, but he does not realize he has dementia since he is still so independent. She stated the staff do a really good job at redirecting her father. She stated it was hard for her to have him move to another facility with a secure unit as he was so happy at the facility and the staff were so amazing to him. She stated her father is really upset with himself over the situation and wishes he could return to the facility. She stated she never had any concerns about any of the care her father received at the facility. She stated she does not feel the facility had done anything wrong and hopes they are not in trouble. She stated the staff were very quick in assessing the situation and she went to the facility to get his belongings and stated she knows they have checked all their system policies for errors but doesn't believe there was any neglect on the facilities part. She stated she believed if Resident #1 wanted to leave he was going to figure out a way. She stated she does sometimes find him sitting near the door.</p> <p>During an interview on 10/15/2025 at 1:50 p.m. CMA A stated on 10/5/2025 she had gone out with the group that was smoking and as they all came in Resident #1 wanted to stay outside but she encouraged him to come in because it was hot. She stated that he agreed to come in and sat in the day area to watch tv. She stated she left to give medications. She stated that he does wander but they keep up with him and redirect him. She stated he has not harmed anyone with his wandering. She stated his confusion just made it hard.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/15/2025 at 2:18 p.m. Nurse A stated she had worked at the facility for six years. She stated she was the RN on shift on 10/5/2025. She stated Resident #1 went out with the smokers around 1:00 p.m., following lunch. She stated CMA A went outside with the group and when they were all coming in Resident #1 needed encouragement to come in. She stated the smoke area was not near the front door, it is in another area, so the residents were not roaming by either door. She stated the resident came in and sat in the TV area. She stated she went down the hall to perform a task for another resident and she stated she last saw the resident at 1:45pm and then she got a call from the ADM just after 2:00PM. She stated she knew the door was locked as she had recently come in and needed the code. She stated they did not hear the alarm go off. She stated while the door required a code if the door is pushed open for a period of time it will open for fire safety, but an alarm will sound. She stated the alarm would be heard and they would assess the situation. She stated there was a big church group having an event across the street and some people were coming and going into the facility. She stated she believed the resident walked out with a visitor. She stated that signs were on the door prior to the incident to use code and not to let out the residents. She stated she is frequently in serviced on abuse, neglect, and elopement risks. She stated an example of abuse or neglect would be yelling at the residents or keeping things away from them and not answering the call light. She denied witnessing abuse and neglect within the facility. She stated if she did witness abuse or neglect, she would call the hotline, notify the DON, ADM and manager on duty. She stated there was not anything that they could have done differently to prevent the incident with Resident #1. She stated they were aware of his wandering, but he was typically redirectable.</p> <p>During an interview on 10/15/2025 at 4:13 p.m. The DON stated she was not working the day Resident 1 eloped. She stated she came to the facility afterwards and the nurses reported to her that the door was locked and had not been alarmed. She stated that on the weekends a lot of people come in and out. She stated that Charge nurse B reported to her that after smoking she had seen the resident on the couch watching the tv. She stated Resident #1 got around well and did not use a walker but denied Resident #1 was at risk for eloping.</p> <p>During an interview on 10/15/2025 at 4:20 p.m. The ADM stated she frequently in-services staff on abuse, neglect, and elopement. She stated they review those policies along with others upon hire and throughout the year and any update or incident. She stated an example of abuse or neglect was not providing care. She stated she expected if staff witnessed abuse or neglect that they reported to the abuse coordinator who the DON but also to their supervisor. She stated that if a resident was missing, she expected her staff to start the elopement procedure and go to every room looking for the resident. She stated staff were assigned areas to look at and if the resident was not in the building, staff moved outside the building to search. She stated Maintenance checked doors daily and noted the findings on their log, as it is a part of their scheduled inspections. She stated they reviewed the policies with staff following the incident. She stated she did an elopement risk assessment on each resident following the incident on 10/5/2025.</p> <p>Record review 10/15/2025 at 11:00 a.m. of each resident's chart revealed that all had a reassessment for elopement risk performed on 10/5/2025 following the incident. There was one resident assessment, Resident #2 , that flagged as at risk. Resident#2's care plan addressed the risk with interventions.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an observation on 10/15/2025 this surveyor and ADM walked Resident # 1's elopement route, a total of five minutes to the corner where Resident #1 was located, according to Google maps. The ADM stated Resident #1 was located on the opposite corner of the block less than 0.2 miles away from the facility.</p> <p>10/16/2025 9:30 a.m. Reviewed Visitation Policy. Policy states, The resident has the right to receive the visitors of his or her choosing at the time of his or her choosing. The facility will provide immediate access to a resident by immediate family and other relatives of the resident, subject to residents right to deny or withdraw consent at any time.</p> <p>During an interview on 10/16/2025 at 10:34 a.m. ED stated the situation was call: 2025-1683. He stated that they were contacted at 2:00 PM, arrived on the scene at 2:10 PM, cleared the scene at 2:21 p.m. and arrived at the hospital at 2:27 PM. He stated the reported reason Resident #1 was taken to the hospital was altered mental status. The ED provided the information to request the full report, and an email request was sent.</p> <p>During an interview on 10/16/2025 at 11:00 a.m. Witness #3 stated on 10/5/2025 around 2:00 p.m. Witness #1 & Witness #2 called him to his neighbor's yard and asked if he knew the gentleman, later identified as Resident #1, sitting in the yard. He stated he did not. He stated Witness #1 was on the phone with EMS at the time. He stated he offered Resident #1 water. He stated he was sitting on the ground near a ditch propping himself up with his hand. He stated he did not appear to be injured though he did have a bandage on his eyebrow. He stated Resident #1 thought he was in a different town. He stated he called a nearby facility to ask if Resident #1 was a resident and staff confirmed he was.</p> <p>10/16/2025 10:567 a.m. Made attempt to reach Witness #1 & Witness #2 left voicemail. No call back.</p> <p>During an interview on 10/16/2025 at 1:15 p.m. Witness #4 stated he was at the facility visiting his aunt on 10/5/2025 and that a gentleman in the sitting area walked with him to the door. He stated that he put the code in and the gentleman told him he was going to go exercise. He stated he had assumed he was another visitor and not a resident. He stated he left the building sometime between 1:30 p.m. and 2:00 p.m. He stated he later came to the facility to identify the man from a picture. He stated Resident #1 was in fact the gentleman who walked out the door with him.</p> <p>During an interview on 10/16/2025 at 3:27 p.m. Resident #1's Provider A stated that it's always a possibility with any resident that they could decide to leave the facility. He stated that Resident #1 had dementia and although he had not ever seen behavior indicating he would attempt to elope it was difficult to predict due to his diagnosis. He stated that he does not recall Resident #1 being a fall concern for him but considering his age and the fact that he had an incident earlier in the day he would then be at risk for another fall. He stated due to Resident #1 being in a nursing facility there is concern about his safety outside alone.</p> <p>10/16/2025 5:22 p.m. Informed ADM of active IJ and provided IJ template.</p> <p>10/17/2025 10:00 a.m. Observation Facility called a Code Orange over the intercom system. All staff went to their assigned search areas, including outside the building, to look for the missing resident. A resident was located, and the code ended at 10:03 AM. This was a mock drill in which a resident volunteered to wait in a room other than his own until he was located.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on 10/17/2025 at 1:52 p.m. Nurse D stated she has worked at the facility for 6 years. She stated she works weekdays 8:00 a.m. to 5:00 p.m. She stated that she was inserviced on abuse, neglect, elopement risk and prevention following the elopement of Resident #1. Nurse D stated an example of abuse and neglect is making someone sit still if they do not want to, or refusing to give a resident water or medication, yelling at the resident. She denied witnessing abuse or neglect in the facility. Nurse D stated if she witnessed abuse or neglect, she would tell the ADM immediately as she is the abuse coordinator. She stated that the CNAs and Nurses should do their rounds and if they notice someone is not in their usual place talk with other staff and call a code orange and everyone separates and checks all rooms, closets, and walk around the building. She stated they would let the charge nurse, the DON, and the ADM know if a resident was missing.</p> <p>Record Review on 10/17/2025at 2:00 PM of Maintenance records over the last month revealed the door locks and door alarms were tested daily to ensure they were locked, code was working, and alarms were working. Observed that all entrance/exit doors were locked and alarms were functioning.</p> <p>In an interview on 10/17/2025at 2:20 p.m. CNA C stated that he works the night shift. He stated he has worked at the facility for a few months but has been a CNA for 14 years. He stated he was inserviced on abuse, neglect, elopement response and prevention following the elopement of Resident #1. He stated an example of abuse or neglect would be failing to check on a resident throughout the night. He denied witnessing abuse or neglect while working at the facility. He stated if he did witness abuse or neglect, he would make sure the resident was safe and inform the charge nurse as well as the abuse coordinator, who was the ADM. He stated for elopement prevention he understands they are to make sure they were monitoring the residents who wander and redirect if necessary. He stated that guests who take a resident from the facility for any reason need to sign them out. He stated that if a resident is missing staff are to look in areas they frequent and then inform charge nurse to call a code orange. He stated everyone would then fan out and look in each room and outside for the residents. He stated the ADM, and the DON would be informed if a resident was missing.</p> <p>In an interview on 10/17/2025 at 2:32 p.m. CMA C stated she works night shift. She stated she has worked here for four years. She stated she was inserviced on abuse, neglect, elopement prevention and response on following the elopement of Resident #1. She stated an example is a CNA leaves a resident unattended and does not change them during the night or put multiple briefs or pads under the resident. She stated she previously reported witnessed neglect, and the situation was resolved appropriately. She stated she would call and inform the charge nurse and explain in detail what she witnessed. She stated for prevention if they saw a resident wandering, they would intervene and redirect and if they noticed a resident has exited the building or is missing they would call a code orange and everyone would search every room and the outside area until the resident is found and they would notify the ADM</p> <p>During observation on 10/17/2025 at 3:00 p.m. surveyor noted additional sign and signs in red on entrance and exit and near keypads reminding visitors do not allow any suspected residents outside. If family members are taking a resident out on pass, sign out at the nurse's station.</p> <p>(continued on next page)</p>		

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 10/17/2025
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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In interview on 10/17/2025 at 3:34 p.m. ADON stated she was inserviced on abuse, neglect, elopement prevention and response following the elopement of Resident #1. She stated that in meetings and in report they discuss who is an elopement risk. She stated she has worked at the facility for three years and was a CMA prior. She stated that she expects staff who witness abuse or neglect to intervene and report immediately to the abuse coordinator who is the ADM. She stated that elopement prevention the facility uses is to lock the door, see patients every two hours, if they are seen near doors they will be redirected. She stated if a resident is missing staff should look for a resident and call a code orange let the charge nurse know and the ADM. Staff are to search every room and outside until the resident is located.</p> <p>Based on observations, interview and record review the following post event actions were taken by the facility prior to surveyor entrance:</p> <p>Resident #1 was discharged to a facility with a secure unit.</p> <p>All door locks and alarms were inspected by maintenance personnel to ensure they were functioning properly.</p> <p>ADM, who is an RN, performed a wander risk assessment for all current residents.</p> <p>Residents who were considered at risk care plans were updated with elopement preventative interventions.</p> <p>All staff were inserviced on abuse and neglect, elopement prevention, and elopement response.</p> <p>The facility conducted code orange drills to ensure staff were able to follow the elopement response policy.</p> <p>The facility added additional large print signage in red to the entrance / exit requesting that visitors ensure the door closes and not to let residents out of the facility when they enter and exit the building.</p> <p>The facility sent a message to all responsible parties and or families encouraging visitors to ensure the door closes and not to let residents out of the facility when they enter and exit the building.</p>		