

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675019	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/28/2024
NAME OF PROVIDER OR SUPPLIER Apex Secure Care Brownfield		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 E Lake St Brownfield, TX 79316	

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 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 04033</p> <p>Based on interviews, and record review, the facility failed to implement their written policies and procedures that prohibit and prevent the abuse of residents for one (Resident #1, 2, 3, 4, 5, and 6) of six residents reviewed for abuse.</p> <p>The facility failed to ensure the Abuse and Neglect Policy was implemented by the facility's staff member, when monitoring tech (MT A) abused Resident #1 and M T B, who witnessed this abuse failed to intervene and report it.</p> <p>This failure could place residents at risk of abuse, neglect, physical harm, pain, mental anguish, emotional distress, and serious harm.</p> <p>Findings included:</p> <p>Record review of Resident #1's (R#1) Admission Record dated 06/28/24, indicated R#1 was a [AGE] year-old male, who was admitted to the facility on [DATE] with diagnoses of pneumonia (infection that inflames air sacs in one or both lungs, which may fill with fluid), cognitive communication deficit (difficulty paying attention to a conversation, responding accurately), unspecified symbolic dysfunctions (language impairments that are caused by underlying medical conditions), mood disorder due to known physiological condition (a mental health condition that primarily affects your emotional status), bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), depression (a group of conditions associated with the elevation or lowering of a person's mood, such as depression or bipolar disorder), generalized anxiety disorder (Severe, ongoing anxiety that interferes with daily activities), Parkinsonism (a disorder of the central nervous system that affects movement, often including tremors), and mild cognitive impairment of uncertain or unknown etiology (the stage between the unexpected decline in memory and thinking that happens with age).</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 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of R#1's Quarterly Minimum Data Set (MDS) dated [DATE], indicated R#1 had a Brief Interview for Mental Status score of 6, which indicated he was severely impaired. This MDS's GG section for Self-Care indicated R#1 was dependent with toileting hygiene, required set-up or clean-up assistance with eating, substantial maximal assistance with oral hygiene, shower/bathe self, upper and lower body dressing, putting, or taking off footwear, and personal hygiene. This MDS's GG section for mobility indicated R#1 could independently roll left to right on his bed, sit to lying, lying to sitting, and sit to stand. This MDS indicated R#1 could independently walk 10 feet, once standing, in a room, corridor, or similar space, could walk 50 feet with two turns, once standing, and could walk 150 feet, once standing, in a corridor or similar space.</p> <p>Record review of R#1's current Care Plan (triggered items) indicated on 06/10/24 R#1 stated a staff member pushed him down; however, staff reported no falls were observed.</p> <p>Review of MT B's written statement indicated the incident dated 06/10/24 involved MT A being aggressive to R#1 by rush walking him and like adding force just to get him on the bed.</p> <p>Review of MT A's statement dated 06/10/24 indicated MT B redirected R#1 to his room, and they both called for assistance from the nursing staffs (LVN H, and CNA I). MT A said to his knowledge R#1 never fell .</p> <p>Record review of MT A's Employee Disciplinary Report Action dated 06/10/24 indicated he was suspended pending investigation.</p> <p>Record review of MT A's Employee Disciplinary Report Action dated 06/11/24 indicated he was discharged due to date of infraction on 06/09/24.</p> <p>Record review of MT B's Employee Disciplinary Report Action dated 06/10/24 indicated he was suspended due to date of infraction on 06/09/24.</p> <p>Record review of MT B's Employee Disciplinary Report Action dated 06/11/24 indicated he was discharged due to date of infraction on 06/09/24.</p> <p>During an interview on 06/26/24 at 10:19 am with the MS C indicated on 06/10/24, he was reviewing the facility's videos when he discovered Hall B had a video with the date stamped 06/09/24 at 9:26 pm. This video revealed monitoring techs (MT A and MT B) were walking past Resident #1 (R#1), who was standing next to the handrail and holding on the hall's handrail with his right hand. MT A and MT B stopped next to R#, MT B grabbed R#1's left arm and MT A walked to R#1's right side and pulled and jerked his hand from the rail that he was holding. Afterwards, MT A and MT B walked R#1 to his room and closed the door. MS C said he was interviewing MT B because R#2 alleged he had called her a bitch. That was when MT B asked why he was being investigated, when they should be investigating MT A. MT B said on 06/09/24, he witnessed MT A push R#1 down in his room, after MT B and MT A escorted him to his room. MS C said this video revealed MT A was too aggressive with R#1, when he pulled on his arm and jerked his hand from the handrail. MT A said this video revealed MT A was walking too fast for R#1, because R#1, who walks very slowly, was being pulled by MT A towards his room.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/26/24 at 2:30 pm MT B said he saw R#1 walking around B Hall and he was not supposed to walk around because he was a fall risk. MT B said he was walking past R#1 with MT A, when they stopped and redirected R#1 to go to his room. That was when MT A directed MT B to grab his left arm and he complied, while MT A grabbed his right arm and hand, MT B stated MT A had to pull and jerk R#1's hand and arm, because R#1 was holding on to the handrail. Then MT A and MT B took R#1 by his arms to his room, but MT B had to direct MT A to slow down because R#1 could not keep up. Upon entering the room, MT B said MT A shoved R#1 from behind causing him to fall onto the floor, and they tried to pick him up but were unable to because of his size. MT B said he directed MT A to notify Licensed Vocational Nurse (LVN F) and he complied. MT B said once the nurses entered the room, they were informed R#1 had fallen and the nurses said they should not try to pick up the resident, instead they should notify the nurse first. MT B said he reported this incident to MS C the following day when questioned about another incident. MT B said he did not report this incident immediately after it happened because this was the first time, he has seen this happen, and it was his first time working in this type of facility.</p> <p>During an interview on 06/27/24 at 8:25 am R#1 indicated a man at the facility pushed him in his room and he did not want to return to the facility because he was afraid of this man.</p> <p>During an interview on 06/28/24 at 10:49 am with MS C indicated as soon as he observed the video involving MT A being too aggressive with R#1 as he and MT B took him to his room, he showed the video to the Administrator. Afterwards, MS C said he and the Administrator called MT A and suspended him over the phone pending an investigation.</p> <p>During an interview on 06/28/24 at 11:51 am with Nurse Practitioner (NP D) indicated staff should not have taken R#1 from the hallway and into his room, if he was not displaying a behavior or was unsteady on his feet. If R#1 was unsteady, staff should have provided him with a wheelchair, gently redirect him, and not make him leave the area, where he was standing and holding to the handrail.</p> <p>During an interview on 06/28/24 at 12:53 pm with LVN E indicated R#1's original Care Plan dated 03/13/24 included wandering and aggression that would be addressed by guiding away the source of distress, engaging him calmly in conversation, and if aggressive, staff were to walk away and respond later. LVN E said the plan did not include pulling R#1 away from the handrail and making him go to his room.</p> <p>During an interview on 06/28/24 at 1:28 pm with the Director of Nurses (DON) indicated R#1's Incident Report dated 06/07/24 at 5:12 pm R#1 revealed he had sustained a witnessed fall and had no new injuries, and this was the last noted fall.</p> <p>During an interview on 06/28/24 at 2:26 pm with LVN F indicated she was working on 06/09/24 and witnessed R#1 place himself on the floor and was not complying with redirection. During this shift, MT A asked her to go the R#1's room because R#1 was on the floor. LVN F said she entered R#1's room and saw him sitting on his bottom upright in front of his bed. LVN F said she it was never reported to her that R#1 had fallen or slipped off his bed. LVN F said she had asked the monitoring techs to redirect R#1 behaviors, turn him around, and guide him to his room, but never to force him away from the handrail or to his room. LVN F said if R#1 was noncompliant with redirection, the monitoring techs should report this to the nurse or leave him alone until he calms down or is easily redirected.</p> <p>(continued on next page)</p>		

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