Printed: 03/01/2025
Form Approved OMB
No. 0938-0391

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 12/04/2024
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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36954 Based on observations, interviews, and record review, the facility failed to ensure that each resident received adequate supervision and assistance devices to prevent accidents for 1 of 3 residents (Resident #1) reviewed for accidents and supervision. 1. The facility failed to ensure Resident #1 received direct supervision from staff on while smoking when Monitor Tech A was observed on a cell phone while assigned to monitor residents in the smoking area on 11/22/2024. 2. Monitor Tech A failed to follow protective measures put in place to use cigarette extenders and smoking aprons for residents' safety while residents were outside smoking, resulting in a burn to Resident #1 on 11/22/2024. 3. An Immediate Jeopardy situation was determined to have existed on 11/22/24. It was determined to be past non-compliance due to the facility having implemented actions that corrected the non-compliance on 11/27/24 before the beginning of the survey. This failure could place residents at risk for physical harm, pain, mental anguish, emotional distress, and serious injury. Findings included: (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record Review of Resident #1's face sheet dated 12/03/24 revealed a [AGE] year-old female admitted to the facility on [DATE]. Resident #1 had a medical history of unspecified dementia (loss of thinking, remembering, and reasoning interferes with daily life activities), anxiety (feeling of fear, dread, and uneasiness) restlessness and agitation (feeling uneasy, unable to relax, experiencing inner tension, often accompanied by physical movement), bipolar disorder (mental illness that causes unusual shifts in mood from extreme highs to lows), dystonia (involuntary muscle contractions that cause repetitive or twisting movement), seizures (abnormal burst of electrical activity in the brain that causes temporary changes in behavior, muscle control and awareness), tremor (a neurological condition that includes shaking or trembling movements in one or more parts of the body), altered mental status (a noticeable change in a person's mental function, often characterized by confusion, decreased alertness, unusual behavior), weakness (loss of strength), muscle weakness (loss of muscle strength or the inability to move a muscle normally), lack of coordination (disorder that cause clumsy, awkward movements), cognitive communication disorder (difficult to communicate), drug induced subacute dyskinesia (movement disorder as a result of taking certain drugs), and drug induced secondary parkinsonism (movement disorder). Record review of Resident #1's MDS dated [DATE] revealed, Section C - Cognitive patterns revealed a BIMS score of 1 which indicated Resident #1 had severe cognitive impairment. Record review of Resident #1's care plan dated 08/07/24 revealed focus: Resident #1 was at risk for injury while smoking and required supervised smoking, date initiated 08/07/24, Goals: Resident #1 will not smoke without supervision through the review date, date initialed 08/07/24, revision date 08/21/24, target date 11/15/24. Interventions: Resident #1 required supervision while smoking date initiated 08/07/24, observe clothing and skin for signs of cigarette burns date initiated 08/07/24, Resident #1 requires a smoking apron while smoking date initiated 09/22/24, use of cigarette extender when smoking date initiated 10/15/24. Record review of Resident #1's smoking assessments dated 10/11/2024 revealed under Section E Safety, 7a Smoking Apron, 7b Cigarette Holder, and 7c Supervision; and under Section F IDTC Decision 1. All residents are supervised smoking and resident uses a smoking extender and apron. Record review of progress notes for Resident # 1 dated 11/22/24 revealed Resident #1 noted to have a burn to left middle finger measuring 0.3 x 0.3 x 0. Contacted physician and order received to start Silvadene Cream (antibiotic used to treat and prevent wound infections in people with severe burns) BID x 7 days and monitor for infection. Notified Family Member. No issues or concerns at this time. Record review of Resident #1's physician orders dated 12/03/24 revealed an order for Silvadene external cream 1% (silver sulfadiazine) apply to left middle finger topically every shift to promote wound healing and prevent infection for 7 days, order date 11/22/24, start date 11/22/24, end date 11/29/22. Monitor left middle finger burn for signs and symptoms of infection every shift until healed every shift for infection prevention and wound healing, order date 11/22/24, start date 11/22/24. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 12/03/24 at 2:51 PM the DON, stated she was notified on 11/22/24 of the injury to Resident #1's middle finger on her left hand. She stated the facility had a care plan meeting with Resident #1 and her family member the morning of the incident, but prior to the incident. She stated it was after the meeting that the resident reported the burn. She stated she assessed Resident #1's middle finger then called the doctor and received an order for treatment. She stated Resident #1 told her the burn happened when the Family Member helped her smoke. She stated Resident #1's Family Member denied the incident happened while he helped her smoke, but Resident #1 stated it happened when her Family Member helped her smoke. The DON stated that the next time her Family Member comes to visit she is going to talk with the Family Member about supervision when Resident #1 smokes. She stated that he needs to be made aware of the issues with her smoking and that she is too shaky, and he would need to hold the cigarette and use an extender. She stated the Family Member was adamant he held the cigarette the whole time, but Resident #1 stated she let it burn down too far when smoking with her Family Member. During a call on 12/03/24 at 12:18 PM, Family Member stated he did help Resident #1 smoke when he was at the facility. He stated the burns happened on a day he was not there. He stated when he helped her smoke at the facility, he would hold the cigarette for her the entire time because of her tremors. He stated the facility does have a cigarette extender, but he did not know if they used it or not. He stated the facility called and notified him of the burn, but he was not sure when that happened. During an interview on 12/03/24 at 12:51 PM, ADM stated, Resident #1 had always had cigarette extenders, and they have more on hand in case they are needed. He stated, Resident #1's Family Member denied being out there when she burned her hand, but Resident #1 said her Family Member was with her when it happened. He stated he was not sure when the incident happened. He stated the incident was not witnessed. He stated the facility staff reported the burn to the nurse and the physician was contacted for treatment. He stated, the facility initiated the use of the cigarette extender because of her tremors. During an interview on 12/03/24 at 2:00 PM, Resident #1 stated she burned her finger while smoking. She was able to lift her hand up and showed her middle finger on her left hand. The burn was visible and looked to have a scab over it. Resident stated she was in no pain at that time. During an interview on 12/04/24 at 2:54 PM the DON stated she assessed Resident #1 after the burn was reported. She stated, Resident #1 told her she let her cigarette burn down too far. During an interview on 12/03/24 at 3:55 PM, Monitor Tech B stated he worked when the burn incident occurred with Resident #1. He stated he was not the monitor tech outside monitoring the residents at that time. He stated he stayed inside the facility and monitored the live stream of the cameras in and around the facility. He stated Monitor Tech A was assigned to monitor residents when the burn happened, and that Monitor Tech A was fired over the burn. He stated that since the incident two staff members have to go outside and monitor residents when they smoke. He stated staff monitor residents while they smoke, and staff must make sure they do not burn themselves or their clothing. He stated that staff would place the residents' cigarette in the cigarette extender and monitor the residents with their cigarettes when they smoke. He stated that he recently started going out as a second staff to monitor residents during smoke breaks, and that before the burn happened, only one staff would go out to monitor residents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 12/3/24 at 4:05 PM, The ADM stated Monitor Tech A no longer works at the facility. The ADM stated he was terminated due to failure, failure to supervise. He stated on 11/22/2024 he saw him outside, in the smoking area, while taking residents out to smoke, and he saw him get on his phone. He stated he told the Maintenance Supervisor, he was not going to have that because they had an incident report where a resident had an injury from smoking, so he was not going have staff on their phones because they are hired to monitor residents. He stated, he was not sure if this was when burn occurred, but Monitor Tech A had too many write ups for being on his phone. During an interview on 12/03/24 at 4:33 PM, RN D stated the facility had 3 monitor techs during the day, but only one monitor tech would take the residents out to smoke. She stated with Monitor Tech A, they had to tell him to get off his phone when at work, and they had to report him to the supervisor for being on his phone often. She stated since the incident with Resident #1, staff were in-serviced over abuse, neglect, reporting, incident reports, residents smoking and monitoring residents. During an interview on 12/03/24 at 4:51 PM, Monitor Tech A stated he did work on the day of the incident with Resident #1. He stated he was outside monitoring residents and Resident #1 was smoking and there were around 20 something residents outside smoking. He stated, her cigarette burned her hand. He stated, the facility used to have bats (cigarette extenders) these things to put the cigarettes in so residents would not burn their fingers and for some reason they were thrown away by the Maintenance Supervisor. He stated he gave her the cigarette and lit it for her, but he did not see it get short or burn her finger. He stated, he did not place the cigarette in the cigarette extender because they did not have any. He stated he did not place the smoking apron on her that day either. He stated, he could not recall why he did not place the apron on her, he just did not. He stated, he knew her Family Member had been at the facility that day and outside for one of the smoke breaks, but he was not sure which one. He stated, about an hour later he was made aware of the burn to Resident #1's finger, he stated he was not sure when or how recent she had gotten the burn just that she had burned herself. He stated, he was told he was suspended and had too many write ups, so he assumed it was over this incident. He stated then a few days later he received a text message saying he was fired. He stated the text message was from the Maintenance Supervisor. He stated, the Maintenance Supervisor and the ADM knew the extenders were thrown away, and the facility was out of them, but after the burn happened he guessed someone had to take the fall for it, so they fired him. During an interview on 12/03/24 at 5:05 PM the ADM stated he was not aware that staff had taken residents to smoke the week or possibly two weeks before 11/22/24 and allowed the residents to smoke without the use of cigarette extenders. He stated he was not aware the staff allowed Resident #1 to smoke the week before Thanksgiving without the smoking apron placed over her. He stated he did order more extenders after the incident with Resident #1 when her finger was burned. He stated he purchased 36 cigarette extenders on 11/22/224 after the incident with Resident #1 and additional smoking aprons. The cigarette extenders were received on 11/25/24. He stated that after the incident with Resident #1 he in-serviced staff over abuse and neglect, resident rights, monitoring residents while they smoke, reporting incidents with staff, and the Maintenance Supervisor in-serviced the monitor techs after the incident with Resident #1. During an observation on 12/03/24 at 5:05 PM, two boxes of cigarette extenders were observed in the ADM's office, in his desk drawer. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 12/03/24 at 5:10 PM, the Maintenance Supervisor stated, the ADM asked him to look at the cameras the day after the incident to see who the monitor tech was and if the monitor tech had done their job, and to make sure they had monitored the residents. He stated all the ADM wanted him to look for was, which monitor techs had worked and if the monitor techs were doing their jobs. Stated he looked at the camera footage and saw Monitor Tech A was on his phone while outside monitoring residents during the smoke break. He stated Monitor Tech A was standing near the coke machine and he saw him pull out his phone then hung it up, then he got on his phone again. He stated Monitor Tech A was then on his phone while the residents smoked. He stated he had spoken with Monitor Tech A, prior, about him being on his phone and warned him to not be on his phone when he monitored residents. He stated he let Monitor Tech A know he was suspended. He stated he was not told about the burn for incident with Resident #1, and he was only told to look to see what the monitor techs were doing in the video. He stated he did not look to see if Resident #1 did or did not have the apron on or if she was using the extender because he was only told to look to monitor the monitor techs. He stated he had Monitor Tech A throw away 1 cigarette extender around 2-3 weeks ago because it had some paint on it, so he told Monitor Tech A to throw that extender away. He stated the ADM had cigarette extenders in the office, and he gave them to the monitor techs. He stated he told the monitor techs if residents refuse the apron or extender to make sure and report it to the nurses and the administrators. He stated he did a training on Monday or Tuesday of last week with the monitor techs and he gave the ADM the in-service where everyone (staff) signed. He stated Monitor Tech A was suspended because he saw him on his cell phone while outside monitoring residents during smoke breaks. He stated he did not know if Resident #1 smoked without the apron on or if she smoked without using the extender, but she was supposed to have the apron on. He stated they administrative staff would do daily compliance checks of the smoking box. During an interview on 12/03/24 at 5:40 PM Monitor Tech C stated after the incident with Monitor Tech A the facility ordered the cigarette extenders. He stated he was told Monitor Tech A took the residents out to smoke and was on his cell phone. That Monitor Tech A wasn't paying attention to the residents, and the facility let him (monitor Tech A) go. He stated, staff are not to be on their phones when taking residents out to smoke because burns could happen and if you don't pay attention residents could get burned. He stated the facility did have cigarette extenders before the incident but ran out of them, and after the incident with Monitor Tech A, the facility ordered more. He stated he was unsure how long the facility was out of the cigarette extenders, be he thought it was maybe a week or two before the incident happened. Monitor Tech C was unsure of the date and he was asked to check dates he worked and he stated it was before the incident on 11/22/24 possibly they ran out the week of 11/17/24 - 11/23/24. He stated he thought it was reported to the Maintenance Supervisor. He stated he was told that staff had to keep a closer eye on the residents when they were smoking while the facility was out of extenders. He stated, during the time the facility did not have the cigarette extenders, Resident #1 did smoke without the cigarette extender while he was the monitor tech that monitored them. He stated the new extenders had the resident's names on them, so they knew who used them. He stated the Maintenance Supervisor had provided him with training on how to monitor smoke breaks and to use the smoking aprons and cigarette extenders. He stated since the incident, he was in-serviced over abuse, neglect, monitoring residents when out smoking and they cannot be on their cell phones. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 12/04/24 at 1:20 PM LVN E stated, he was told in report that Resident #1 had burned herself with a cigarette and there were orders for burn care. He stated that within the last month she had gone out to smoke regularly since she had gotten cigarettes regularly. He stated smoking assessments are done for all residents if they smoke or not and the assessment will document if they require supervision when they smoke. He stated all of the residents that smoke required supervision. He stated Resident #1 required supervision, the use of a smoking apron, and cigarette extender. He stated Resident #1 should have worn a smoking apron at all times when outside to smoke, He stated he had not observed her smoke without one. He stated he believed the cigarette extender was incorporated as another intervention and was in place at the time she received the burn. He stated since the time of the burn incident, the facility added an additional monitor tech to monitor during smoke breaks, a log to write down and check off indicating staff have placed the apron on the resident and extender on the cigarette, and to notify the nurse if the items are not available and that the nurse needs to be nodified if the resident is not complying with the interventions. He stated Resident #1 used the extender for the cigarette and smoking apron when she smoked. He stated, on 11/25/24, when he returned to work a few days after the incident happened, he provided wound care for Resident #1, and she did not indicate pain, but the area was still fluid filled. He stated he provided wound care to Resident #1 on 11/26/24, and the wound no longer had fluid in it, and the resident denied any pain. He stated he was told that Monitor Tech A was on his phone while he monitored residents for a smoke break. He stated he was told that there was an incident where Resident #1 had burned herself, and the camera footage showed Monitor Tech A was on his phone during that time. He stated it was told to him by the Maintenance Supervisor. During an interview on 12/04/24 at 1:50 PM, CNA F stated, she was told about the incident with Resident #1, and her finger was burned when she was outside to smoke. She stated the facility needed more monitor techs outside when resident's smoke. She stated the facility has changed it now, and they will have two staff going out to monitor residents when they smoke. She stated the facility had cigarette extenders for the residents to use. She stated she didn't know if the facility had always had them but knew they have them now. She stated they should store them in the toolbox with the cigarettes. She stated since the incident they have placed more staff outside to watch during the smoke breaks. She stated if a resident did refuse an apron or extender, a supervisor would need to be told and staff should not let the resident smoke until the supervisor went out there. She stated the facility in-serviced staff over abuse, neglect, reporting abuse or neglect, incidents and accidents, and residents that smoke, and to monitor residents when they smoke. During an interview on 12/04/24 at 2:00 PM CNA G stated she worked on 11/22/24, and she walked into the dining room while Resident #1 was talking with another resident. She stated the other resident asked if they could get ice for Resident #1's finger because she burned her finger. She stated she looked at Resident #1's finger, and it was red. She stated she knew Monitor Tech A was the monitor tech that supervised the smoke break the day of the incident. She stated she observed Monitor Tech A on his phone when he was outside assigned to monitor residents during smoke breaks. She stated every now and then she would see residents wear an apron when they were outside for a smoke break. She stated she never saw Resident #1 wear a smoking apron when she would go outside to smoke. She stated she was not sure how long the facility had cigarette extenders, but she had seen them. She stated since the incident, as far as she knew, the facility will have more staff outside during the smoke breaks, and the facility in-serviced staff over abuse and neglect, reporting, incident, monitoring residents, and reporting to the nurse or administrator. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 12/04/24 at 2:25 PM CNA I stated she had worked with Resident #1 over the past weekend. She was told about the burn on her finger, and Resident #1 had burn marks on her wheelchair cushion over the past weekend. She stated she was told they (facility staff) Resident #1 was smoking and maybe something happened, that a monitor tech wasn't paying attention and Resident #1 burned herself. She stated she wasn't out there when Resident #1 was smoking and never saw her smoke. She stated she doesn't know if Resident #1 wore an apron while smoking and was told she refused the apron. She stated the facility had smoking extenders and aprons for residents to use while they smoked. She stated, when she first started ,she was a monitor tech, and the residents had extenders then. She stated she received new training after Resident #1 burned her finger. She stated the training was regarding monitor techs supervising and checking for aprons and extenders, abuse and neglect, and reporting. During an interview on 12/04/24 at 2:36 PM Monitor Tech J stated he was not working the day of the incident with Resident #1 but was told they didn't have an extender the day she burned herself. He stated he heard she dropped the cigarette and burned herself. He stated as a monitor tech, when they go outside to monitor the residents on a smoke break, staff are to put smoking aprons on residents, give cigarettes to residents, and monitor the residents. He stated they were to watch for cigarette falls, burns, fires, and possible altercations between residents. He stated, since the incident, he was in-serviced on cigarette count, extenders, aprons, to pay attention to residents, and to not have phones. He stated all monitor techs were present for the in-service training. He stated they were told they needed to be better at watching residents and to not horse around. He stated they discussed using aprons and extenders for residents. He stated the training was held because of burns residents received and cigarettes falling while residents were smoking. During an interview on 12/04/24 at 2:50 PM Monitor Tech H stated he was told about the incident with Resident #1. He stated he was told that she was outside on the back patio area smoking, and staff (Monitor Tech A) was supposed to monitor her, but he was not because he was on his cell phone. He stated he knew Resident #1 tended to hold her cigarette in a downward position, in her hand, and cigarette ash would fall on her fingers. He stated he told the other monitor techs, in the past, to keep an eye on her. He stated , since the incident, he was in-serviced over abuse and neglect, monitoring residents when they smoke, that two staff have to be outside during smoke breaks, that staff have to place the aprons on the residents and use the extenders, and if a resident refuses to use them they have to have the nurse come outside and the nurse will handle how the resident will smoke. Observation on 12/03/24 at 1:10 PM, two staff members were observed with residents outside in the smoking area. Observed Monitor Tech C, place the smoking apron on Resident #1. Monitor Tech C, assisted Resident #1 with making sure the apron covered her left lap/leg area before he handed her the cigarette in the extender. Monitor Tech C lit the cigarette for her, and she used her left hand to hold the cigarette in the extender. Resident #1 continued to have tremors while she smoked the cigarette, and she was observed moving her left hand up and down and touched the cigarette to the apron on her left side. Monitor Tech C was observed assisting her hold her hand up and he made sure the apron continued to cover her. Two staff were observed outside assisting and monitoring residents during the smoke break. Resident #1 continued to smoke the cigarette and held it with her left hand and the cigarette was in the extender. Resident #1 observed with several black marks on the left side of the smoking apron from where her hand moved the cigarette up and down against the apron. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. Implementing interventions to reduce accident risk and hazards shall include the following: b. Assigning responsibility for carrying out interventions. c. Ensuring-that interventions are implemented. 5. Monitoring the effectiveness of interventions shall include the following: a. Ensuring that interventions are implemented correctly and consistently. System approach to Safety 2. Resident supervision Is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment. Resident Risk and Environmental Hazards I. Due to their complexity and scope, certain resident risk factors and environmental hazards are addressed In dedicated policies and procedures. These risk factors and environmental hazards include: d. Smoking The following policy reviewed: Smoking Policy - Residents dated 2001 revised date July 2017 Policy Statement: The facility shall establish and maintain safe resident smoking practices. Policy Interpretation and Implementation: 6. The resident will be evaluated on admission to determine if he or she is a smoker or non-smoker. If a smoker the evaluation will include: d. Ability to smoke safely with or without supervision, (per a completed Safe Smoking Evaluation). 9. Any smoking related privileges, restrictions, and concerns (for example, need for close monitoring) shall be noted on the care plan, and all personnel caring for the resident shall be alerted to these issues. 11. Ant resident with restricted smoking privileges requiring monitoring shall have the direct supervision of a staff member, a family member visitor or volunteer worker at all times during smoking. The ADM was notified on 12/04/24 at 12:25 PM, that a past non-compliance IJ situation had been identified due to the above failures. It was determined these failures placed Resident #1, in an IJ situation on 11/22/24. (continued on next page)

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 12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apex Secure Care Brownfield	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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility implemented the following interventions: in-serviced staff over: Verbal, Physical, Sexual, Neglect, Abuse Policy & Protocol, Resident Rights, Injuries of Unknown Source AND Incidents of Theft and / or Misappropriation of Resident Property all on 11/26/24. In-serviced staff over: Safety and Supervision of Residents on 11/22/24, Accident and Incident Investigating and Reporting on 11/26/24. The facility implemented with a start date 11/26/24 that two staff members to be present during resident smoke breaks to monitor residents. Maintenance Supervisor in-serviced the monitor techs with additional in-service for cigarette count daily, smoking aprons being worn, use of smoke (cigarette) extenders, pay attention to residents no phones during smoke breaks on 11/27/24. The facility purchased 36 cigarette extenders on 11/22/24 and received them on 11/25/24, and additional smoking aprons for resident use. Monitor Tech A was suspended on 11/22/24 and terminated on 11/25/24.