STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675019	A. Building B. Wing	11/25/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interviews, and record review, the facility failed to ensure in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls, and permitted only authorized personnel to have access to the keys for 1 of 2 treatment carts (treatment cart for Hall A, B and C) reviewed for proper medication storage.LVN C failed to ensure the treatment cart, which contained medications, was not left unlocked and unsupervised in the hallway near the nurse's station.This failure could place residents at risk of having access to unauthorized medications and/or lead to possible harm, drug overdose, or drug diversions.During an observation on 10/02/25 at 1:59 PM, the treatment cart for Hall A, B and C was observed sitting outside the nurse's station and was unlocked and unsupervised. The cart was located in close proximity to residents and no staff were present to supervise the cart. Upon inspection of the drawers in the cart with LVN C, prescription medications, creams, and supplies were observed. During an interview on 10/02/25 at 2:02 PM with LVN C, she stated she was the charge nurse on duty and was responsible for the unlocked treatment cart. She stated she was unsure why the cart was unlocked and she was not supervising the cart at the time it was observed to be unlocked. LVN C stated she had been trained on properly securing treatment carts through periodic in-services conducted at the facility. She stated carts should be locked at all times when unsupervised. LVN C stated a potential negative outcome for failure to lock the treatment cart would be a resident could open the cart and get ahold of a medication or something that could cause them harm in some way. During an interview on 10/02/25 at 2:29 PM, the ADON stated the treatment carts should be locked at all times when unattended or unsupervised. He stated the treatment carts contained insulin and diabetic supplies, over the counter medications, tube feeding supplies and wound care supplies. He stated the charge nurse was responsible to assure unsupervised carts were locked at all times. He stated staff were trained on properly securing carts through facility in-services, but he did not recall the date of the last training. He stated carts were kept in designated areas and he conducted rounds and random cart checks to monitor cart security. The ADON stated a potential negative outcome for failure to lock the treatment cart was a resident could access the cart and obtain a medication or object that could cause them harm. During an interview on 10/02/25 at 3:10 PM, the ADM stated the policy for treatment carts was that they were locked at all times when unsupervised. He stated the charge nurse was responsible to assure carts were locked when unattended. The ADM stated carts were monitored for security by random rounds conducted by himself and the ADON. He stated his expectation of staff was to follow the facility's policy at all times by assuring unsupervised carts were locked. The ADM stated a potential negative outcome for failure to secure unsupervised carts would be a resident could get into the cart and take something that could result in harm to the resident. Record review of the facility's policy titled, Storage of Medications, revised April 2019, revealed the following: Policy StatementThe facility stores all drugs and biologicals in a safe, secure, and orderly manner.Policy Interpretations and Implementation1. Drugs and biologicals used in the facility are stored in locked compartments.8. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals are locked when not in use.9. Unlocked medication carts are not left unattended.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure, in accordance with accepted professional standards and practices, medical records were maintained on each resident that were complete and accurately documented for 8 of 16 residents (Residents #1, #2, #3, #4, #5, #6, #7, #8) reviewed for clinical records. The facility failed to ensure evening medications refused by Residents #1, #2, #3, #4, #5, #6, #7 and #8 were accurately documented in the Medication Administration Record by CMA A, on 09/21/25. This failure could place residents at risk of not receiving the intended therapeutic effects of their medications and could contribute to possible adverse reactions.Findings include: 1. Record review of Resident #1's, undated, face sheet revealed in part, an [AGE] year-old female with an original admission date of 08/27/24. Resident #1 had diagnoses which included: unspecified dementia (loss of cognitive functioning), unspecified severity with other behavioral disturbance and Intermittent Explosive Disorder (mental health condition characterized by sudden, intense episodes of anger or aggression). Record review of Resident #1's quarterly MDS, dated [DATE], revealed a BIMS score of 99, which indicated the resident's cognitive status could not be determined using the BIMS assessment as the assessment may have been completed properly or the resident required a different evaluation method to assess cognitive function. Record review of Resident #1's active physician orders, as of 10/01/2025, revealed in part: Mirtazapine Oral Tablet 7.5mg, give one at bedtime for appetite stimulation, start date 10/07/24. Olanzapine Oral Tablet, give 2.5mg one by mouth at bedtime related to Intermittent Explosive Disorder, start date 03/22/25. Divalproex Sodium Oral Capsule Delayed Release Sprinkle 125mg, Give 4 capsules two times daily related to Intermittent Explosive Disorder, start date 03/22/25. Record review of Resident #1's Medication Administration Record, dated 09/01/25-09/30/25, revealed in part CMA A documented the following medications as taken by the resident on 09/21/25: Mirtazapine 7.5mg Give one at bedtime for appetite stimulation, start date 10/07/24 at 1900 (7:00PM). Olanzapine 2.5mg Give one at bedtime related to Intermittent Explosive Disorder, start date 03/22/25 at 1900 (7:00PM). Divalproex 125mg Give 4 capsules twice daily related to Intermittent Explosive Disorder, start date 03/22/25 at 1900 (7:00PM). 2. Record review of Resident #2's, undated, face sheet revealed in part, a [AGE] year-old male with an original admission date of 07/31/25. Resident #2 had the following diagnoses which included: anoxic brain damage, not elsewhere classified (brain injury), cognitive communicate deficit (inability to communicate), and tremor unspecified (involuntary shaking). Record review of Resident #2's annual MDS, dated [DATE], revealed a BIMS score of 05, which indicated the resident's cognitive ability was severely impaired. Record review of Resident #2's active physician orders, as of 09/30/2025, revealed in part: Sinemet Oral Tablet 25/100mg (Carbidopa/Levodopa), Give one two times daily related to tremor, unspecified, start date 07/31/25. Record review of Resident #2's Medication Administration Record, dated 09/01/25-09/30/25, revealed in part CMA A documented the following medications as taken by the resident on 09/21/25: Sinemet Oral Tablet 25/100mg (Carbidopa/Levodopa), Give one two times daily related to tremor, unspecified, start date 07/31/25 at 1900 (7:00PM). 3. Record review of Resident #3's, undated, face sheet revealed in part, a [AGE] year-old male with an original admission date of 09/02/22. Resident #3 had the following diagnoses: Bipolar disorder, current episode manic without psychotic features, severe (mental health disorder), intermittent explosive disorder (mental health condition characterized by sudden, intense episodes of anger or aggression), and hyperlipidemia, unspecified (plaque in the blood vessels). Record review of Resident #3's annual MDS, dated [DATE] revealed a BIMS score of 02, which indicated the resident's cognitive ability was severely impaired. Record review of Resident #3's active physician orders, as of 10/01/2025, revealed in part: Carbamazepine ER Oral Tablet Extended Release 12-hour 400mg. Give one tablet by mouth every 12 hours related to bipolar disorder, current episode manic without psychotic features, severe, do not crush or chew, start date 01/05/24. Depakote Oral Tablet Delayed Release 125mg (Divalproex Sodium). Give one tablet two times a day related to intermittent explosive disorder, start date 08/27/25. Gemfibrozil Oral Tablet 600mg. Give one two times a day related to hyperlipidemia unspecified, start date 04/02/24. Record review of Resident #3's Medication Administration Record, dated 09/01/25-09/30/25, revealed in part CMA A documented the following medications as taken by the resident on 09/21/25: Carbamazepine ER Oral Tablet Extended Release 12-hour 400mg. Give one tablet by mouth every 12 hours related to bipolar disorder, current episode manic without psychotic features, severe, do not crush or chew, start date 01/05/24 at 2000