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	02/11/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49154 Based on observation, interviews, and record reviews, the facility failed to ensure each resident was treated with respect, dignity, and care for each resident in a manner and in an environment that promotes the maintenance or enhancement of their quality of life, recognizing each resident's individuality for 1 (Resident #2) of 21 residents. The facility failed to ensure Resident #2 was treated with respect, dignity, and care when they failed to ensure Resident #2's room was cleaned daily, furnished with a covering on her bedroom window, and a furnished with a privacy curtain. This failure could place residents at risk for diminished quality of life, loss of dignity and self-worth, psychosocial harm and distrust with staff. Findings Included: Record review of Resident #2 's face sheet dated 02/20/2024 revealed she was [AGE] years old and was originally admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: Traumatic subarachnoid hemorrhage with loss of consciousness of 31 minutes to 59 minutes, subsequent encounter (bleeding in the space around the brain), unsteadiness on feet, unspecified lack of coordination, major depressive disorder, recurrent severe without psychotic features (mood disorder that caused a persistent feeling of sadness and loss of interest), osteoarthritis, unspecified site (degenerative joint disease), anxiety disorder, unspecified (excessive worry and fear), type 2 diabetes mellitus with other diabetic ophthalmic complication (eye condition that can cause vision loss and blindness in people who have diabetes), paranoid schizophrenia (experiencing strong, persistent paranoia or suspicion), cognitive communication deficit (difficulty paying attention, remembering, and responding accurately), need for assistance with personal care, difficulty in walking, schizoaffective disorder, bipolar type (mental health condition characterized by a mix of symptoms from schizophrenia and a mood disorder). The face sheet also revealed Resident #2 was in a room on Hall A. Record review of Resident #2 quarterly MDS dated [DATE] Section C - Cognitive Patterns revealed Resident #2 had a BIMS of 01 which indicated the resident's cognition was severely impaired. Additionally, Section GG - Functional Abilities revealed Resident #2 was independent and completed the following activities by herself with no assistance from a helper: eating, oral hygiene, toileting hygiene, upper and lower body dressing, putting on/taking off footwear, and personal hygiene. (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

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	02/11/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of Resident #2's Care Plan, dated 01/08/25, revealed Resident #2 had a focus area that Resident #2 had a behavior of destroying things in my room. Resident #2 sometimes tried to flush clothes etc. in the toilet to stop it up and tore down privacy curtains, blinds, etc. Resident #2 also sometimes refused allow staff to clean her room. The goal was the Resident #2 would allow staff to maintain her room as to provide a safe environment for her through the review date. Interventions were to encourage Resident #2 to not destroy property and to allow staff to clean her room, and to offer pleasant diversions such as snacks or listening to music with a therapist to allow staff to go in and clean when not present. Secondly, Resident #2 had a potential for an ADL self-care performance deficit related to schizoaffective disorder. Resident #2's activities of daily living self-performance fluctuated related to schizoaffective disorder but Resident #2 usually required assistance with activities of daily living as follows: Please adjust support. The goal was Resident #2 would maintain the current level of function in all activities of daily living through the review date. Interventions were that Resident #2 was independent with the following activities of daily living: chair/bed-to-chair transfer, eating, lower body dressing, lying to sitting on side of bed, oral hygiene, personal hygiene, putting on/taking off footwear, roll left and right, sit to lying, sit to stand, toilet hygiene, toilet transfer, tub/shower transfer, upper body dressing, and walk 150 feet. Third, Resident #2 was resistive to care (at times refused glucose checks (sugar), medication, baths being weighed) related to schizoaffective disorder. The goal was to give clear explanation of all care activities prior to and as they occur during each contact, if resident resists with activities of daily living, reassure resident, leave and return 5-10 minutes later and try again, praise the resident when behavior is appropriate. Fourth, Resident #2 had potential to be verbally aggressive related to schizoaffective disorder. The goal was the resident would verbalize understanding of need to control. Interventions were to monitor behavior each shift and document observed behavior and attempted intervention, and to provide frequent monitoring of Resident #2. Also, when the resident became agitated: Intervene before agitation escalated; Guide away from source of distress; Engage calmly in conversation; If response was aggressive, staff were to walk calmly away, and approach later. Fifth, Resident #2 had risk for falls related to psychoactive medication use. Goal was that resident would not sustain a serious injury related to falls through the review date. Goals were to be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Reinforce the of use of verbal cues for the resident. Ensure that the resident was wearing appropriate footwear, when ambulating transferring. The resident needs a safe environment floor free from spills and clutter; adequate, glare-free light; a working and reachable call light. Sixth, was that Resident #2 had a problem with vision related to history of cataracts. The goal was the resident would show no decline in visual function through the review date. Interventions were to Monitor/document/report as needed any signs or symptoms of acute eye problems: Change in ability to perform activities of daily living, decline in mobility, sudden visual loss, pupils dilated, gray or milky, complaints of halos around lights, double vision, tunnel vision, blurred or hazy vision. Finally, there was no documentation in the Care Plan for Resident #2 to not have a window covering, privacy curtain, call light due to pulling them down. Record Review of Resident #2's progress notes from 01/09/24 to 02/10/25 revealed there was no documentation of Resident #2 refusing to allow staff to clean her room or pulling the blinds off the window. (continued on next page)

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	02/11/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 2/9/25 at 12:05 PM Resident #2 sat on her bed. There was a strong smell of feces and urine throughout the room. The call light cord and button were observed to be wrapped and tied up hanging against the wall and out of Resident #2's reach. There was clothing, trash, and pullups scattered all over the floors through the room and restroom. The bedroom window did not have a covering and there was no privacy curtain in the room. A gate and house were visible through the window and the glass of the window was clear. The was no dresser in the room. The closet floor had a pile of clothes and briefs and there was no clothing hanging. There were no sheets on the mattress. There was dried and sticky red and brown stains on the floor. There was chicken strips and potatoes thrown on the floors and stains on the walls. There was a bedside table that had three wheels and was soiled with dried food and liquid. There was a food tray in the room with a tray ticket labeled as breakfast from 2/9/25. The was trash scattered on the floor and a meal ticket dated 1/31/25. In the restroom, there was square hole in the dry wall where the toilet paper dispenser previously was. The toilet tank did not have a lid which exposed the internal plumbing of the toilet. The toilet was filled with feces. The was no television or radio in the room and there were no decorations on the walls or in the room. During an interview on 2/9/25 at 12:15 PM, the ADM stated Resident #2 often did not allow staff to enter her room. He stated she had a history of destroying her room by throwing pullups, trash, clothes, and food throughout the room. He stated she had thrown food trays in the hallway. He stated she ripped blinds, curtains, and anything else she could off the walls. He stated she also put un-flushable objects in the toilet and clogged it. During an interview and observation on 2/9/25 at 12:25 PM, HK C was observed sweeping the floors of Resident #2's room. HK C stated Resident #2 often did not allow her to clean her room. She stated Resident #2 yelled at staff to get out of her room. She stated Resident #2 often tore things off the walls and threw things all over the room. During an interview on 2/10/25 at 11:32 AM, the Hospice RN stated she worked for a Hospice Provider and provided services to Resident #2. The Hospice RN stated Resident #2 received services from hospice CNA's on Monday, Wednesday and Friday. The Hospice RN stated Resident #2 was seen by one of their nurses weekly, and the chaplain and social worker every 4 weeks. The Hospice RN stated hospice CNA's showered, provided incontinent care, applied lotion, provided hair care, dressing, companion care, brushed her teeth, and filed her nails on hands and feet. The Hospice RN stated her staff gave report to the facility before they left to the charge nurse for each day they came. The Hospice RN stated Resident #2 was receptive to her most of the time, sometimes she becomes combative or agitated and would hit and swing her arms. The Hospice RN stated Resident #2 took medication to calm her. The Hospice RN stated her staff would try to go back before they leave the facility if she was calmed down and provide services she refused. The Hospice RN stated they notified the facility when Resident #2 refused baths. The Hospice RN stated their agency had an agreement with the facility that the facility would attempt to provide services that Resident #2 refused by hospice staff. The Hospice RN stated Resident #2 was legally blind. The Hospice RN stated she had not seen a privacy curtain in her room. The Hospice RN stated she had seen a curtain on Resident #2's window but could not remember when she last saw it. The Hospice RN stated she last saw Resident #2 January 29th. The Hospice RN stated she had not been able to contact the family. The Hospice RN stated she did not think she was able to dress herself. The Hospice RN stated she had seen pillows in Resident #2's room before. (continued on next page)

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	02/11/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/10/25 at 2:50 PM, CNA B stated she worked on Hall A. She stated Resident #2 preferred to be independent and did not allow staff to help her very much. She stated Resident #2 yelled at staff to get out of her room. CNA B stated Resident #2 used the toilet independently. She stated staff checked on Resident #2 every hour during rounds. She stated Resident #2 ate all meals and snacks in her bedroom. She stated Resident #2 had yanked the call light out of the wall previously. She stated she did not know why there were no blinds or privacy curtains in the room. She stated she did not know why there were no sheets or pillows on the bed and was supposed to have them. CNA B stated Hospice staff were supposed to come and shower Resident #2 and change her linens. She stated Hospice staff reported to the facility when Resident #2 refused care. She stated she would try to provide services Resident #2 refused by hospice staff later in the day. She stated she was trained to document every time Resident #2 refused care in her chart. She stated Resident #2 changed her own pullups. She stated Resident #2 ambulated in her room by feeling around the walls and furniture because she was blind. During an interview on 2/10/25 at 3:21 PM, CNA C stated Resident #2 was blind and she believed she could only see shadows. She stated Resident #2 preferred to do things herself independently such as dressing herself and toileting, and she was receiving hospice services. She stated Resident #2 screamed and yelled when given food trays. She stated Resident #2 had been refusing care and had mood swings and threw her food trays. She stated the dresser was removed from her room because she flipped it over several times. She stated she believed the privacy curtain was missing because it was in Resident #2's way and was hazardous. She stated Resident #2's door was always shut to keep residents that wander out of her room and Resident #2 from wandering out. CNA C stated she checked on Resident #2 every 1-2 hours. She stated the MT's also checked on her every twenty minutes. CNA C stated Resident #2 yanked on her call light cord off the wall before but Resident #2 knew how to use the call light. She stated she had helped Resident #2 change clothes in her room before. She stated CNA's and MT's passed out food trays on the halls. She stated Resident #2 always ate in her room. CNA C stated there not being a window covering or privacy curtain was a privacy concern as anyone passing by or looking in could see Resident #2 through the window or door while she was exposed. (continued on next page)

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	02/11/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/10/25 at 4:10 PM, RN A stated Resident #2 had told her to get out of her room before and refused to be examined, to have her blood sugar levels checked, showers, and refused medications. She stated Resident #2 was paranoid and had said she believed someone was trying to kill her. She stated Resident #2 regularly slept with the sheets and blankets over her head. She stated she checked on Resident #2 every 2 to 2.5 hours. She stated the CNA's also checked on Resident #2 when they heard her yelling and during their rounds. She stated Resident #2 tore down the privacy curtain and the soap and toilet paper dispensers in her restroom. She stated Resident #2 had ripped the call light cord out of the wall before. She stated she did not know why there were no blinds on the window in Resident #2's bedroom. She stated the MT's also checked on Resident #2 when they walked the floor. RN A stated staff were trained to document all refusals of care in Resident #2's chart. She stated hospice staff had told them when Resident #2 refused care from them before they leave and facility staff were supposed to document that information in the resident's chart. RN A stated facility staff could try to offer to provide Resident #2 the services she refused by hospice staff but she had never been told they were expected to offer to provide Resident #2 the services she refused by hospice staff. RN A stated Resident #2 was legally blind, therefore a potential negative outcome from not having a covering on the bedroom window could affect Resident #2's state of mind as she could think she saw something or someone outside her window. RN A stated Resident #2 dressed herself in her room and it did not allow her to have privacy. She stated the facility was gated however the bedroom windows were still visible through the bars of the gate and anyone that passed by could see though the window. She stated Resident #2 touched the furniture and walls when she walked. RN A stated they could not force Resident #2 to shower or be groomed. She stated the DON and hospice staff were aware that Resident #2 often refused care. During an interview on 2/10/25 at 4:35 PM, the Hospice CNA with stated she had worked with Resident #2 for four months. She stated Resident #2 had good and bad days. She stated initially Resident #2 loved to shower, talk, and read the bible however, about a month and a half ago, she began refusing showers and activities. She stated she saw Resident #2 three times a week. The Hospice CNA stated she would shower or give Resident #2 a bed bath, changed her linens, threw the trash, cleaned up if needed, and provided companion care. The Hospice CNA stated she also would cut Resident #2's fingernails and shave, if needed. She stated she notified the facility when Resident #2 refused care. She stated Resident #2 did not like to be touched. She stated Resident #2 often threw objects and food. She stated she had helped Resident #2 change clothes in her bedroom or in the shower room. She stated Resident #2 tore down or broke her blinds. She stated Resident #2 did not like it when people went in her room. She stated staff usually cleaned the room quietly. She stated she did not believe Resident #2 could see at all. The Hospice CNA stated Resident #2 toileted herself and flushed the toilet without being prompted. (continued on next page)

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	02/11/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/11/25 at 9:48 AM, the MS stated he supervised the MT's, maintenance staff, and housekeeping staff. The MS stated he expected housekeeping staff to clean the resident's rooms daily. The MS stated he expected for housekeeping staff to take advantage of times when residents were not in their rooms to clean them for those residents that would not allow housekeeping staff to clean their rooms. The MS stated they cannot ignore a residents room when it was dirty. They must figure out how to clean it. The MS stated Resident #2 was blind. The MS stated Resident #2 pulled the privacy curtain and blinds down in her room and she pulled the call light cords out of the wall every time he tried to re-install them so he stopped re-installing them. He stated he replaced the blinds on her window yesterday and she's already pulled them down. He stated he replaced the new call light cord yesterday. The MS stated that the potential negative outcome of not having privacy curtains and blinds on the window was that it did not allow Resident #2 to have privacy. The MS stated he would try to figure out another way to cover the window to ensure her privacy. During an interview on 2/11/25 at 10:48 AM, CMA A stated she attempted to pass medications to Resident #2 this morning twice, but she refused both times. She stated Resident #2 refused her medication yesterday as well. She stated sometimes she could get Resident #2 to take her medications by giving her a soda. She stated she must tell the nurse whenever Resident #2 refused her medications. She stated she believed the reason Resident #2 didn't have blinds on her windows and a privacy curtain in her room was because she tore them down. She stated she did not know how long ago that was. During an interview on 2/11/25 at 11:33 AM, CNA A stated she did rounds every two hours. She stated Resident #2 walked and sometimes used the wheelchair to ambulate and did not like to have help with anything. She stated Resident #2 touched the walls to get around when she walked and when in her wheelchair. CNA A stated Resident #2 dressed herself. CNA A stated hospice staff showered her and most of the time she refused. CNA A stated she did not follow up with Resident #2 to provide services she refused from hospice. CNA A stated she could ask Resident #2 if she wanted to provide the refused services but her answer was always no. She stated she was trained that they were required to follow up with Resident #2 if she refused hospice services. CNA A stated Resident #2 was supposed to wear socks but she did not keep them on. CNA A stated Resident #2 pulled the privacy curtains off the ceiling and blinds off the window. CNA A stated a potential negative outcome of not having a window covering was that Resident #2 would not have privacy. CNA A stated that CNA's were responsible for putting linens on the beds. CNA A stated she did not try to put sheets on Resident #2's bed on 2/9/25 because she yelled at her to get out of her room. CNA A stated Resident #2 used to have a pillow in her room but did not know where it was. During an interview on 2/11/25 at 3:15 PM, LVN B stated she was the charge nurse for Hall A on Sunday, 2/9/25. LVN B stated Sunday was the second time she had worked on that hall and was vaguely familiar with Resident #2. LVN B stated she went into Resident #2's room to check on her to verify she was breathing around approximately 10:00 AM. LVN B stated at that time, she did not speak to Resident #2 but she recalled Resident #2 grunted and had not spoken to her. LVN B stated she did not notice Resident #2's bedroom window did not have blinds. LVN B stated CNA's completed rounds every 2 hours. LVN B stated the window not having a covering caused Resident #2 to be exposed, not given privacy, and it also affected the temperature control in her bedroom. LVN B stated she would be concerned with Resident #2's safety with a privacy curtain in her room. LVN B stated she did not know if the facility provided an alternative to cover the window or provided a privacy screen for Resident #2 to ensure she had privacy and dignity in her room. LVN B stated hospice staff reported any concerns to the charge nurse before they left the facility. LVN B stated she expected staff to document refusals on the behavior monitoring logs and to notify family members of any concerns. (continued on next page)

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	02/11/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/11/25 at 4:20 PM the DON stated Resident #2 rejected care and would not allow anyone to go in her room. The DON stated Resident #2 tore up her room and tore things off the walls. The DON stated Resident #2 received hospice services. The DON stated she did not know how often nursing staff did rounds. The DON stated she was aware that Resident #2's window did not have blinds because Resident #2 ripped them off. She stated blinds were installed on the window yesterday and she had already ripped them down. She stated she could not recall seeing a window covering on her window prior to the one that was installed yesterday. The DON stated she did not know if there was a requirement for resident's room windows to have a covering. The DON stated a potential negative outcome to not having a window covering could be that Resident #2 did not have privacy which would cause her to be embarrassed if someone were to see her unclothed. The DON stated she expected staff to go back and try to provide care or get another staff to go back and try when Resident #2 refused care. The DON stated a potential negative outcome of there being a miscommunication between the facility and hospice could be that Resident #2's needs would not be met. The DON stated staff should be trained to follow up on refusals reported by hospice staff. The DON stated she was not aware staff were not aware they were required to follow up refusals reported by hospice. During an interview on 2/11/25 at 4:51 PM the ADM stated Resident #2 tore up and destroyed her room regularly. The ADM stated CNA's did rounds and checked on resident's every 2 hours. The ADM stated MT's were expected and trained to knock on the door and open to check on residents. The ADM stated the MS replaced the call light cord in Resident #2's room yesterday because she ripped them out of the wall the day before. The ADM stated Resident #2 had a habit of putting her sheets in the toilet and ripping them off her bed which could be why she did not have any sheets the past three days. The ADM stated a potential negative outcome of Resident #2 not having a window covering could put her at risk of exposure when she changed clothes. The ADM stated he was aware bedroom windows were supposed to be operable but he was not sure if there was a requirement for them to have a covering. The ADM stated the facility was responsible for ensuring privacy and dignity needs were being met. The ADM stated they had tried putting drapes, blinds, and tint on Resident #2's window to ensure her privacy and dignity but she kept ripping them down. The ADM stated there was no documentation in the Care Plan that Resident #2's room was approved to not have a privacy curtain or blinds on her window due to her behaviors. The ADM stated they would try to figure out how to cover the window and ensure Resident #2 had privacy. The ADM stated the staff that completed Care Plans was not available today. The ADM stated he expected staff to follow up and provide care to Resident #2 on care she refused from hospice staff. The ADM stated staff not following up could be a system failure as Resident #2 would not receive the care she needed. Record review of the facility policy titled Resident Rights, Revised December 2016, revealed in part the following documentation, Policy Statement. Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation. 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: 1. a dignified existence; 2. be treated with respect, kindness, and dignity; 3. be free from abuse, neglect, misappropriation of property, and exploitation; . (continued on next page)

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	02/11/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	20. privacy and confidentiality;

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	02/11/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41480 Based on observation, record reviews, and interviews, the facility failed to ensure each resident had a right to reside and recieve services in the facility with reasonable accomodation of the resident's needs and preferences for 1 (Resident #2) of 21 residents reviewed for accomodation of needs. The facility failed to provide a working communication system, that was easily at reach at the bedside, that would allow Resident #2 the ability to safely call for staff for assistance. This failure could place residents at risk of not having a means of directly contacting caregivers in an emergency or when they needed support for daily living. Findings included: Record review of Resident #2 's face sheet dated 02/20/2024 revealed she was [AGE] years old and was originally admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: Traumatic subarachnoid hemorrhage with loss of consciousness of 31 minutes to 59 minutes, subsequent encounter (bleeding in the space around the brain), unsteadiness on feet, unspecified lack of coordination, major depressive disorder, recurrent severe without psychotic features (mood disorder that caused a persistent feeling of sadness and loss of interest), osteoarthritis, unspecified site (degenerative joint disease), anxiety disorder, unspecified (excessive worry and fear), type 2 diabetes mellitus with other diabetic ophthalmic complication (eye condition that can cause vision loss and blindness in people who have diabetes), paranoid schizophrenia (experiencing strong, persistent paranoia or suspicion), cognitive communication deficit (difficulty paying attention, remembering, and responding accurately), need for assistance with personal care, difficulty in walking, schizoaffective disorder, bipolar type (mental health condition characterized by a mix of symptoms from schizophrenia and a mood disorder). Record review of Resident #2 quarterly MDS dated [DATE] Section C - Cognitive Patterns revealed Resident #2 had a BIMS of 01 which indicated the resident's cognition was severely impaired. Additionally, Section GG - Functional Abilities revealed Resident #2 was independent and completed the following activities by herself with no assistance from a helper: eating, oral hygiene, toileting hygiene, upper and lower body dressing, putting on/taking off footwear, and personal hygiene. Record Review of Resident #2's Care Plan, dated 01/08/25, included revealed Resident #2 had risk for falls related to psychoactive medication use. Goal was that resident would not sustain a serious injury related to falls through the review date. Interventions were to be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Reinforce the of use of verbal cues for the resident. Ensure that the resident was wearing appropriate footwear, when ambulating transferring. The resident needs a safe environment floor free from spills and clutter; adequate, glare-free light; a working and reachable call light. Record Review of Resident #2's Fall Risk assessment dated [DATE] revealed Resident #2 had not fallen in the past 3 months, was legally blind, and had a balance problem while standing/walking. (continued on next page)

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	02/11/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 2/9/25 at 12:05 PM Resident #2 sat on her bed. The call light cord and button were observed to be wrapped and tied up hanging against the wall and out of Resident #2's reach. During an interview on 2/9/25 at 12:15 PM, the ADM stated Resident #2 often did not allow staff to enter her room. He stated she had a history of destroying her room by throwing pullups, trash, clothes, and food throughout the room. He stated she had also thrown food trays in the hallway. He stated she also ripped blinds, curtains, and anything else she could off the walls. During an observation on 2/9/25 from 12:15 PM to 12:34 PM Resident #2 sat quietly on her bed and drank an orange soda while three housekeeping staff and maintenance staff were cleaning her room. The call light cord and button were observed to be wrapped and tied up hanging against the wall and out of Resident #2's reach. During an observation on 2/9/25 at approximately 1:31 PM Resident #2 was lying in bed. The room was clean. The call light cord and button were observed to be wrapped and tied up hanging against the wall and out of Resident #2's reach. During an observation on 2/10/25 at approximately 9:15 AM Resident #2 was lying in bed. The call light cord and button were observed to be wrapped and tied up hanging against the wall and out of Resident #2's reach. During observation on 2/10/25 at 10:30 AM Resident #2 sat quietly on her bed and drank an orange soda while two housekeeping staff were in the room sweeping and mopping the floors and emptying the trash. The call light cord and button were observed to be wrapped and tied up hanging against the wall and out of Resident #2's reach. During an interview on 2/10/25 at 2:50 PM, CNA B stated she worked on Hall A. She stated Resident #2 preferred to be independent and did not allow staff to help her very much. She stated Resident #2 yelled at staff to get out of her room. She stated staff checked on Resident #2 every hour during rounds. She stated Resident #2 had pulled the call light string in the bathroom in the past. She stated she was trained that the call light button in the bedroom was supposed to always be located at the bedside and within Resident #2's reach. She stated Resident #2 had yanked the call light out of the wall previously. She stated Resident #2 ambulated in her room by feeling around the walls and furniture because she was blind. During an observation on 2/10/25 at 3:20 PM Resident #2 was lying in bed with the blanket covering her face. HK B entered Resident #2's room. A tray of food and dishes were observed to be thrown on the floor. The call light cord and button were observed to be wrapped and tied up hanging against the wall and out of Resident #2's reach. (continued on next page)

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	02/11/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/10/25 at 3:21 PM, CNA C stated Resident #2 was blind and she believed she could only see shadows. She stated Resident #2's door was always shut to keep residents that wandered out of her room and Resident #2 from wandering out. CNA C stated she checked on Resident #2 every 1-2 hours. She stated the MT's also checked on her every twenty minutes. She stated she was trained that the call light button was supposed to always be placed by Resident #2's side within her reach. She stated Resident #2 had pressed the call button before for help. She stated the call light was not supposed to be rolled up against the wall. CNA C stated Resident #2 yanked on her call light cord before but Resident #2 knew how to use the call light. She stated a potential negative outcome of the call light button being out of Resident #2's reach prevented her the ability to call for help when needed. During an interview on 2/10/25 at 4:10 PM, RN A stated she checked on Resident #2 every 2-2.5 hours. She stated the CNA's also checked on Resident #2 when they heard her yelling and during their rounds. She stated Resident #2 had ripped the call light cord out of the wall before which could have been why the call light cord was wrapped up on the wall. She stated the MT's also checked on Resident #2 when they walked the floor. RN A stated Resident #2 pulled the call light string in the restroom when she needed assistance. She stated staff were able to determine which call light was activated because the noise it made for the bedrooms and restrooms were different. During an interview on 2/10/25 at 4:35 PM, the Hospice CNA with the Hospice Provider stated she had worked with Resident #2 for four months. The Hospice CNA stated the call light was normally placed in her bed and in her reach. She stated Resident #2 would not be able to call for help if there was an emergency while in her bed if the call light button was not placed within her reach. During an observation on 2/10/25 at approximately 5:15 PM Resident #2 was lying in bed with the blanket covering her face. The call light cord and button were observed to be wrapped and tied up hanging against the wall and out of Resident #2's reach. During an observation on 2/11/25 at approximately 9:08 AM Resident #2 was lying in bed with the blanket covering her face. The call light cord and button were observed to be wrapped and tied up hanging against the wall and out of Resident #2's reach. During an interview on 2/11/25 at 9:48 AM, the MS stated he supervised the MT's, maintenance staff, and housekeeping staff. The MS stated Resident #2 was blind. The MS stated Resident #2 pulled the privacy curtain and blinds down in her room and she pulled the call light cords out of the wall. He stated he replaced the new call light cord yesterday. He stated the MT's walking the floor were expected to walk the hall and observe and listen for the resident's to ensure they're safe. He stated MT's were not expected to open the doors to resident's room each time they passed by. The MS stated MT's would only open the bedroom doors if they heard something that caused them to have a concern. During an interview on 2/11/25 at 11:33 AM, CNA A stated she went into Resident #2's bedroom on 2/9/25 between 6:00 AM and 6:30 AM when doing rounds and did not recall where the call light button was located. CNA A stated she was trained that the call light button was supposed to be beside her bed in her reach. She stated Resident #2 touched the walls to get around when she walked and when in her wheelchair. She stated Resident #2 had used the call light in the past in the restroom. (continued on next page)

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	02/11/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/11/25 at 11:56 AM, RN B stated the call light button was supposed to be placed within Resident #2's reach and where she could find it. RN B stated CNA's were supposed to check on resident's every two hours. During observation on 2/11/25 at 2:20 PM Resident #2 was lying in bed with the blanket covering her face. Housekeeping staff were in the room sweeping and mopping the floors and emptying the trash. The call light cord and button were observed to be wrapped and tied up hanging against the wall and out of Resident #2's reach. During an interview on 2/11/25 at 3:15 PM, LVN B stated she was the charge nurse for Hall A on Sunday, 2/9/25. LVN B stated she went into Resident #2's room to check on her to verify she was breathing around approximately 10:00 AM. LVN B stated at that time, she did not speak to Resident #2 but she recalled Resident #2 grunted and had not spoken to her. LVN B stated the call light was supposed to be on the resident's bedside on their chair, it was not supposed to be rolled up on the wall. LVN B stated a potential negative outcome of the call light not being within the resident's reach was a safety issue because the resident could fall and could not use the call light to call for help. During an interview on 2/11/25 at 4:20 PM the DON stated she did not know how often nursing staff did rounds. The DON stated call lights were supposed to be within a resident's reach but from her understanding Resident #2 tried to wrap it around her neck before which could be why it was not placed within her reach. The DON stated she expected call light buttons to always be placed within residents reach while in their room or bed. The DON stated the resident would not be able to call for help if needed. The DON stated Resident #2 had not fallen in her room. During an interview on 2/11/25 at 4:51 PM the ADM stated CNA's did rounds and checked on resident's every 2 hours. The ADM stated MT's were expected and trained to knock and open doors to check on residents. The ADM stated the MS replaced the call light cord in Resident #2's room yesterday because she ripped them out of the wall the day before. The ADM stated he was not aware the call light was wrapped on the wall and not within Resident #2's reach for the past three days. The ADM stated staff were trained to ensure residents could reach the call button when in the room. Record review of the facility policy titled Call System, Resident, Revised September 2022, revealed in part the following documentation, Policy Heading. Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation. Policy Interpretation and Implementation. 1. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor. 49154

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	02/11/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49154 Based on observation, interviewn and record review, the facility, failed to ensure sure each resident had a right to a safe, clean, comfortable, and homelike environment in the facility and failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior in 1 (Resident #2) of 21 resident's rooms and restrooms reviewed for environment. The facility failed to ensure Resident #2's room was cleaned daily, homelike, clean, safe, and did not need repairs. These failures could place residents at risk for living in an unsafe, unclean, uncomfortable, and unhomelike environment which could cause a decline in resident psychosocial well-being. The findings included: Record review of Resident #2 's face sheet dated 02/20/2024 revealed she was [AGE] years old and was originally admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: Traumatic subarachnoid hemorrhage with loss of consciousness of 31 minutes to 59 minutes, subsequent encounter (bleeding in the space around the brain), unsteadiness on feet, unspecified lack of coordination, major depressive disorder, recurrent severe without psychotic features (mood disorder that caused a persistent feeling of sadness and loss of interest), osteoarthritis, unspecified site (degenerative joint disease), anxiety disorder, unspecified (excessive worry and fear), type 2 diabetes mellitus with other diabetic ophthalmic complication (eye condition that can cause vision loss and blindness in people who have diabetes), paranoid schizophrenia (experiencing strong, persistent paranoia or suspicion), cognitive communication deficit (difficulty paying attention, remembering, and responding accurately), need for assistance with personal care, difficulty in walking, schizoaffective disorder, bipolar type (mental health condition characterized by a mix of symptoms from schizophrenia and a mood disorder). The face sheet also revealed Resident #2 was in a room on Hall A. Record review of Resident #2 quarterly MDS dated [DATE] Section C - Cognitive Patterns revealed Resident #2 had a BIMS of 01 which indicated the resident's cognition was severely impaired. Additionally, Section GG - Functional Abilities revealed Resident #2 was independent and completed the following activities by herself with no assistance from a helper: eating, oral hygiene, toileting hygiene, upper and lower body dressing, putting on/taking off footwear, and personal hygiene. (continued on next page)

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	02/11/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of Resident #2's Care Plan, dated 01/08/25, revealed Resident #2 had a focus area that Resident #2 had a behavior destroying things in my room. Resident #2 sometimes tried to flush clothes etc. in the toilet to stop it up and tore down privacy curtains, blinds, etc. Resident #2 also sometimes refused staff to clean. The goal was the Resident #2 would allow staff to maintain her room as to provide a safe environment for her through the review date. Interventions were to encourage Resident #2 to not destroy property and to allow staff to clean her room, and to offer pleasant diversions such as snacks or listening to music with a therapist to allow staff to go in and clean when not present. Second, resident #2 was resistive to care (at times refused glucose checks (sugar), medication, baths being weighed) related to schizoaffective disorder. The goal was to give clear explanation of all care activities prior to and as they occur during each contact, if resident resists with activities of daily living, reassure resident, leave and return 5-10 minutes later and try again, praise the resident when behavior is appropriate. Third, Resident #2 had potential to be verbally aggressive related to schizoaffective disorder. The goal was the resident would verbalize understanding of need to control. Interventions were to monitor behavior each shift and document observed behavior and attempted intervention, and to provide frequent monitoring of Resident #2. Also, when the resident became agitated: Intervene before agitation escalated; Guide away from source of distress; Engage calmly in conversation; If response was aggressive, staff were to walk calmly away, and approach later. Fourth, Resident #2 had risk for falls related to psychoactive medication use. Goal was that resident would not sustain a serious injury related to falls through the review date. Goals were to be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Reinforce the of use of verbal cues for the resident. The resident needs a safe environment floor free from spills and clutter; adequate, glare-free light; a working and reachable call light. Fifth, was that Resident #2 had a problem with vision related to history of cataracts. The goal was the resident would show no decline in visual function through the review date. Interventions were to Monitor/document/report as needed any signs or symptoms of acute eye problems: Change in ability to perform activities of daily living, decline in mobility, sudden visual loss, pupils dilated, gray or milky, complaints of halos around lights, double vision, tunnel vision, blurred or hazy vision. Finally, there was no documentation in the Care Plan for Resident #2 to not have a window covering, privacy curtain, call light due to pulling them down. Record Review of Resident #2's Fall Risk assessment dated [DATE] revealed Resident #2 had not fallen in the past 3 months, was legally blind, and had a balance problem while standing/walking. Record Review of Resident #2's progress notes from 01/09/24 to 02/10/25 revealed there was no documentation of Resident #2 refusing to allow staff to clean her room or pulling the blinds off the window. During an observation on 2/9/25 at approximately 9:45 AM HK C went into the room that the state surveyors were working in a room on Hall A and asked if she could collect the trash in the room. (continued on next page)

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	02/11/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 2/9/25 at 12:05 PM, Resident #2 sat on her bed. There was a strong smell of feces and urine throughout the room. There was clothing, trash, and pullups scattered all over the floors through the room and restroom. The bedroom window did not have a covering and there was no privacy curtain in the room. A gate and house were visible through the window as the glass of the window was clear. The was no dresser in the room. The closet floor had a pile of clothes and pullups and there was no clothing hanging. There were no sheets on the mattress. There was dried and sticky red and brown stains on the floor. There was chicken strips and potatoes thrown on the floors and stains on the walls. There was a bedside table that had three wheels and was soiled with dried food and liquid. There was a food tray in the room with a tray ticket labeled as breakfast from 2/9/25. The was trash scattered on the floor throughout the room and restroom. There was a meal ticket dated 1/31/25 found on the bedroom floor. In the restroom, there was square hole in the drywall where the toilet paper dispenser previously was. The toilet tank did not have a lid which exposed the plumbing. The toilet was filled with feces. The was no television or radio in the room and there were no decorations on the walls or in the room. During an interview on 2/9/25 at 12:15 PM, the ADM stated Resident #2 often did not allow staff to enter her room. He stated she had a history of destroying her room by throwing pullups, trash, clothes, and food throughout the room. He stated she had thrown food trays in the hallway. He stated she ripped blinds, curtains, and anything else she could off the walls. He stated she also put un-flushable objects in the toilet which clogged it. During an interview and observation on 2/9/25 at 12:25 PM, HK C was observed sweeping the floors of Resident #2's room. HK C stated Resident #2 often did not allow her to clean her room. She stated Resident #2 yelled at staff to get out of her room. She stated Resident #2 often tore things off the walls and threw things all over the room. During an observation on 2/9/25 from 12:15 PM to 12:34 PM, Resident #2 sat quietly on her bed and drank an orange soda while three housekeeping staff and the MS were in her room. Housekeeping staff picked up trash, clothing, pullups, and old food scattered on the floors throughout the bedroom and restroom areas. Housekeeping staff cleaned the walls and swept, scraped, and mopped the floors. Housekeeping staff rolled Resident #2's bed to the middle of the room while she sat quietly on it. Housekeeping staff swept and mopped the area where the bed was located and then rolled the bed back to its original location. The MS unclogged the toilet filled with feces in the restroom that was inside the bedroom. Resident #2 said, thank you have a nice day, as the staff left her room. The call light cord and button were observed to be wrapped and tied up hanging against the wall and out of Resident #2's reach. During an interview on 2/10/25 at 10:07 AM, the DM stated the kitchen served chicken strips and potatoes on Friday (2/7/25) for dinner as a substitute for the residents that did not want the steak fingers. During observation on 2/10/25 at 10:30 AM Resident #2 sat quietly on her bed and drank an orange soda while two housekeeping staff were in the room sweeping and mopping the floors and emptying the trash. The call light cord and button were observed to be wrapped and tied up hanging against the wall and out of Resident #2's reach. (continued on next page)

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	02/11/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/10/25 at 11:32 AM, the Hospice RN stated she worked at a Hospice Provider and provided services to Resident #2. The Hospice RN stated Resident #2 received services from hospice CNA's on Monday, Wednesday and Friday. The Hospice RN stated she had not seen a privacy curtain in her room. The Hospice RN stated she had seen a curtain on Resident #2's window but could not remember when she last saw it. The Hospice RN stated she had concerns about the cleanliness of the room during time she came to see Resident #2. She stated almost every time she had come there had been food and drinks thrown on the floor. During an interview on 2/10/25 at 2:50 PM, CNA B stated she worked on Hall A. She stated Resident #2 preferred to be independent and did not allow staff to help her very much. She stated Resident #2 yelled at staff to get out of her room. She stated Resident #2 destroyed her room and had thrown pullups, clothes, toilet paper, trash, and food all round her room. CNA B stated Resident #2 used the toilet independently. She stated staff checked on Resident #2 every hour during rounds. She stated Resident #2 ate all meals and snacks in her bedroom. CNA B stated Resident #2 had flushed the toilet without being prompted. She stated Resident #2 had yanked the call light out of the wall previously. She stated she did not know why there were no blinds or privacy curtains in the room. She stated she did not know why there were no sheets or pillows on the bed and was supposed to have them. CNA B stated Hospice staff were supposed to come and shower Resident #2 and change her linens. She stated Hospice staff reported to the facility when Resident #2 refused care. She stated she would try to provide services Resident #2 refused by hospice staff later in the day. She stated Resident #2 changed her own pullups. She stated Resident #2 ambulated in her room by feeling around the walls and furniture because she was blind. She stated housekeeping staff were supposed to clean resident's rooms daily and more if requested. CNA B stated CNA's passed out food trays to residents that ate in their rooms and were supposed to notify housekeeping of rooms that needed to be cleaned. CNA B stated she was trained that CNA's were also responsible to clean rooms when needed. During an interview on 2/10/25 at 3:18 PM, HK B stated she was responsible for cleaning rooms on Hall A. She stated she had not worked on 2/2/25. She stated she swept and mopped the floors and threw out trash in resident's rooms. She stated she checked Resident #2's room three times (after each meal) during her shifts because Resident #2 threw her food trays on the floor. She stated Resident #2 ate all her meals in her bedroom. She stated she was not trained to clean the room three times a day but this was her preference due to Resident #2 having behaviors of throwing food trays, trash, and clothes. She stated there were times that Resident #2 would not let her in to clean the room but she was trained to leave and go back later if that happened. (continued on next page)

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	02/11/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/10/25 at 3:21 PM, CNA C stated Resident #2 was blind and she believed she could only see shadows. She stated Resident #2 preferred to do things herself independently such as dressing herself and toileting, and she was receiving hospice services. She stated Resident #2 screamed and yelled when given food trays. She stated Resident #2 had been refusing care and had mood swings and threw her food trays. She stated the dresser was removed from her room because she flipped it over several times. She stated she believed the privacy curtain was missing because it was in Resident #2's way and was hazardous but did not specifically know why. She stated Resident #2's door was always shut to keep residents that wander out of her room and Resident #2 from wandering out. CNA C stated she checked on Resident #2 every 1 to 2 hours. She stated the MT's also checked on her every twenty minutes. CNA C stated Resident #2 yanked on her call light cord before but Resident #2 knew how to use the call light. She stated Resident #2 threw water at her the other day. She stated she had helped Resident #2 change clothes in her room before. CNA C stated Resident #2 was supposed to have sheets and a pillow on her bed. She stated there was no clean linen when she arrived at work this morning. CNA C stated she was trained to clean up resident's room if she saw a mess and she was also supposed to locate the cause of any odors she smelled in resident's rooms. She stated she was trained to tell maintenance staff when toilets were clogged. She stated CNA's and MT's passed out food trays on the halls. She stated Resident #2 always ate in her room. CNA C stated Resident #2 could slip and fall on any trash, clothes, food, pullups, and liquids scattered on the floor. CNA C stated old food and liquids, and feces could attract bugs and rodents. She stated feces was also a hazard to Resident #2's health. She stated a potential negative outcome of not having sheets and pillows could cause Resident #2 to have skin irritation from the plastic mattress. During an interview on 2/10/25 at 4:10 PM, RN A stated Resident #2 threw trays of food and water on the floors. She stated housekeeping staff must clean the room daily and must try again if the resident refused. She stated Resident #2 had clogged up the bathroom and flooded her sink in her bedroom before. She stated Resident #2 tore down the privacy curtain and the soap and toilet paper dispensers in her restroom. She stated Resident #2 had ripped the call light cord out of the wall before. She stated she did not know why there were no blinds on the window in Resident #2's bedroom. RN A stated staff were trained to document all refusals of care in Resident #2's chart. RN A stated Resident #2 was legally blind, therefore a potential negative outcome from not having a covering on the bedroom window could affect Resident #2's state of mind as she could think she saw something or someone outside her window. RN A stated Resident #2 dressed herself in her room and it did not allow her to have privacy. She stated the facility was gated however the bedroom windows were still visible through the bars of the gate and anyone that passed by could see though the window. She stated the CNA's could clean up food on the bedroom floors and then call housekeeping to prevent attracting roaches and other bugs. She stated housekeeping was supposed to clean bedrooms every day. She stated a potential negative outcome of feces left in the toilet could cause infection or get all over the floor which was a sanitary issue. RN A stated staff were trained to identify odors smelled in resident's room and clean it up. RN A stated a potential negative outcome of having clothing, trash, food, liquid, and pullups scattered all over the floor could cause Resident #2 to trip and fall because she could not see and a fall would be bad for her. She stated Resident #2 could hit her head or break a leg. She stated Resident #2 had not fallen that she was aware of. She stated Resident #2 touched the furniture and walls when she walked . (continued on next page)

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	02/11/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/10/25 at 4:35 PM, the Hospice CNA with the Hospice Provider stated she had worked with Resident #2 for four months. She stated Resident #2 had good and bad days. She stated initially Resident #2 loved to shower, talk, and read the bible however, about a month and a half ago, she began refusing showers and activities. She stated she saw Resident #2 three times a week. The Hospice CNA stated she would shower or give Resident #2 a bed bath, changed her linens, threw the trash, cleaned up if needed, and provided companion care. The Hospice CNA stated about a week and a half ago, Resident #2 was agitated and she shattered the lid of the toilet tank. She stated she told RN A and the Hospice RN about it. She stated facility staff cleaned up the mess. She stated Resident #2 often threw objects and food. The Hospice CNA stated there was almost always food on the bedroom floor when she came. She stated she had never seen feces in her toilet. She stated she had helped Resident #2 change clothes in her bedroom or in the shower room. She stated Resident #2 tore down or broke her blinds. The Hospice CNA stated Resident #2 could be at risk of falling if trash, blankets, clothes, pullups, liquids, and food were on the floors. She stated Resident #2 did not like when people went in her room. She stated staff usually cleaned the room quietly. She stated she did not believe Resident #2 could see at all. The Hospice CNA stated Resident #2 toileted herself and flushed the toilet without being prompted. She stated Resident #2 left pullups all over her room. During an interview on 2/11/25 at 9:48 AM, the MS stated he supervised the MT's, maintenance staff, and housekeeping staff. The MS stated he expected housekeeping staff to clean the resident's rooms daily. The MS stated he expected for housekeeping staff to take advantage of times when residents were not in their rooms to clean them for those residents that would not allow housekeeping staff to clean their rooms. The MS stated they cannot ignore a residents room when it was dirty. They must figure out how to clean it. The MS stated leaving old food and liquids on the floor and feces in the toilet was an infection and safety issue. The MS stated Resident #2 was blind. The MS stated rooms must be cleaned every day even if the resident throws them out and he expected them to try to go in again later and clean the room quietly. The MS stated trash and clothing on the floor was a trip hazard to Resident #2. The MS stated and he pulled out shirts from the pipes yesterday and that's why the plumbing and toilets were clogged up. The MS stated he had unclogged the pipes for Resident #2's room through the ceiling as well as plunged her toilet on Sunday (2/9/25) to unclog it. The MS stated Resident #2 threw the lid to the toilet tank and it broke all over the floor in her room sometime in December so he was afraid to put another lid on the toilet tank because he felt she could hurt herself. The MS stated he had spoken to the ADM about it and wasn't instructed to replace the lid of the toilet tank. The MS stated Resident #2 pulled the privacy curtain and blinds down in her room and she pulled the call light cords out of the wall. He stated he replaced the blinds on her window yesterday and she already pulled them down. He stated he replaced the new call light cord yesterday. The MS stated he expected housekeeping staff to attempt to clean Resident 2's room multiple times a day due to her behaviors of throwing things. The MS stated HK B and HK C were the staff that worked on Sunday and were responsible to clean resident's rooms. He stated the MT's walking the floor were expected to walk the hall and observe and listen for the resident's to ensure they're safe. He stated MT's were not expected to open the doors to resident's rooms each time they passed by. The MS stated MT's would only open the bedroom doors if they heard something that caused them to have a concern. The MS stated he was not aware the chicken strips and the potatoes that were found on the floor in Resident #2's room on Sunday were served on Friday. He stated that was a health and safety hazard. The MS stated a potential negative outcome of the issues in the room was that it would be unsanitary, it could cause odors, and it could attract insects and other pests. The MS stated that the potential negative outcome of not having privacy curtains and blinds on the window was that it did not allow Resident #2 to have privacy. The MS stated he would try to figure out another way to cover the window to ensure her privacy. (continued on next page)

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	02/11/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/11/25 at 10:30 AM, HK A stated housekeeping staff were supposed to get carts ready with chemicals and supplies when they first arrived for their shift in the mornings and then to the dining room to clean after breakfast every morning. She stated they usually start cleaning the dining room around 8:30 AM. HK A stated afterwards they cleaned resident's rooms. HK A stated all housekeeping staff should've cleaned in every room before 12:00 PM. HK A stated she was not aware Resident #2's room had not been cleaned prior to 12:00 PM on 2/9/25. HK A stated she was not aware of the extent of the mess in Resident #2's room. HK A stated HK C was responsible to clean all the rooms on Hall A that morning. HK A stated she would tell the nurse if a resident did not allow her to clean their room. HK A stated she could also continue to try to go back later to clean the room or try to go in when she was asleep. HK A stated she was trained to clean restrooms, look under beds for trash, sweep and mop the floors, and clean food or spills in the rooms. HK A stated Resident #2 could slip and fall because she could not see. HK A stated Resident #2's toilet and sink were stopped up sometimes because she stuffed paper towels in them. HK A stated there had been issues with pipes being stopped up. HK A stated housekeeping was supposed to check the restrooms and toilets and log repairs needed in the maintenance logbook. During an interview on 2/11/25 at 11:33 AM, CNA A stated she went into Resident #2's bedroom on 2/9/25 between 6:00 AM and 6:30 AM when doing rounds and saw the mess in her room. CNA A stated she opened the door to check if Resident #2 was breathing, but she did not go all the way into the room. CNA A stated Resident #2 was asleep in the bed. CNA A stated Resident #2 did not say anything to her when she went into the room. CNA A stated she recalled she smelled the odor of feces in Resident #2's bedroom when she opened the door but she did not go into Resident #2's restroom or check to identify what caused the odor. She stated she did not recall where the call light button was located. CNA A stated Resident #2 drank soft drinks, tea, and some water. She stated she reported the mess in Resident #2's room to RN B afterwards. CNA A stated she was expected to pick up the trays and clean food she observed on the floors. She stated she did rounds every two hours. She stated Resident #2 walked and sometimes used the wheelchair to ambulate and did not like to have help with anything. She stated Resident #2 touched the walls to get around when she walked and when in her wheelchair. CNA A stated she did not notify anyone from housekeeping about the condition of Resident #2's room that morning. CNA A stated all CNAs could clean food on the floor. CNA A stated she went back into Resident #2's room that morning before 12:00PM to check on Resident #2 but could not recall the time. CNA A stated Resident #2 dressed herself. CNA A stated hospice staff showered her and most of the time she refused. CNA A stated she did not follow up with Resident #2 to provide services she refused from hospice. CNA A stated she could ask Resident #2 if she wanted to provide the refused services but her answer was always no. She stated she was trained that they were required to follow up with Resident #2 if she refused hospice services. She stated Resident #2 clogged up her toilet with objects before. CNA A stated a potential negative outcome of food and debris being scattered all over the floor was that Resident #2 could trip and fall and hurt herself. CNA A stated Resident #2 pulled the privacy curtains off the ceiling. CNA A stated a potential negative outcome of not having a window covering was that Resident #2 would not have privacy. She stated a potential negative outcome of the toilet being clogged with feces in it was that Resident #2 could get sick. CNA A stated that CNA's were responsible for putting linens on the beds. CNA A stated she did not try to put sheets on Resident #2's bed on 2/9/25 because she yelled at her to get out of her room. CNA A stated Resident #2 used to have a pillow in her room but did not know where it was. (continued on next page)

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	02/11/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/11/25 at 11:56 AM, RN B stated she was not aware of the mess in Resident #2's room the morning of 2/9/25. She stated the CNA's would let them and housekeeping know if residents refused to let them clean their rooms. She stated CNA's and housekeeping staff cleaned resident's rooms. She stated all staff were expected to identify any odors coming from a resident's room and to let the charge nurse know if they could not find it. RN B stated the CNA's could write maintenance related issues they identified in the maintenance logbook . She stated CNA's and housekeeping staff could use a plunger to unclog a toilet. RN B stated clogged toilets could overflow, which put the resident's at risk of falling and infection. RN B stated trash left on Resident #2's bedroom floor put her at risk of falling because she was blind. RN B stated CNA's were supposed to check on resident's every two hours. During observation on 2/11/25 at 2:20 PM Resident #2 was lying in bed with the blanket covering her face. Housekeeping staffing was in the room sweeping and mopping the floors and emptying the trash . (continued on next page)

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	02/11/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/11/25 at 3:15 PM, LVN B stated she was the charge nurse for Hall A on Sunday, 2/9/25. LVN B stated Sunday was the second time she had worked on that hall and was vaguely familiar with Resident #2. LVN B stated she was not aware Resident #2's room had not been cleaned until it was brought to her attention by a CNA when the State surveyors arrived that morning around 9:00 AM. LVN B stated she responded that housecleaning was cleaning down that hall (Hall A). LVN B stated she saw that HK C was cleaning the rooms on Hall A that morning when the State surveyors first arrived. LVN B stated she went into Resident #2's room to check on her to verify she was breathing around approximately 10:00 AM. LVN B stated at that time, she did not speak to Resident #2 but she recalled Resident #2 grunted but had not spoken to her. LVN B stated she could not smell currently and did not smell the odor in Resident #2's bedroom. She stated she saw clothes on the floor. LVN B stated she assumed HK C had cleaned every room on that hall so she went to check the rooms on Hall's B and C. She stated she did not follow up with housekeeping to verify Resident #2's room was cleaned because HK C was still working on Hall A the last time, she saw her. LVN B stated she did not notice Resident #2's bedroom window did not have blinds. She stated she expected CNA's to pick up items on the floor such as trash, water, clothes, anything that could be a safety concern and cause a resident to trip and fall. LVN B stated CNA's completed rounds every 2 hours. LVN B stated she was trained to pick up mess and food from the floors. LVN B stated she was trained to clean up safety hazards and housekeeping sanitized it. LVN B stated she was responsible to ensure residents were provided with a sanitary and safe living environment as the charge nurse assigned to that hall that morning. LVN B stated she should have redirected housekeeping staff or been more diligent and observed the full extent of the mess in Resident #2's room during her rounds. LVN B stated food on the floors could place Resident #2 at risk of infection control, safety risk, and it was also and integrity issue for Resident #2 in her home as her space should have been clean. LVN B stated trash and clothes on the floor could cause a fall. LVN B stated feces left in the toilet was an infection control and integrity issue and could cause a resident to contract clostridium difficile (bacterium in the colon that caused diarrhea and inflammation). LVN B stated the window not having a covering caused Resident #2 to be exposed, not given privacy, and it also affected the temperature control in her bedroom. LVN B stated she would be concerned with Resident #2's safety with a privacy curtain in her room. LVN B stated she did not know if the facility provided an alternative to cover the window or provided a privacy screen for Resident #2 to ensure she had privacy and dignity in her room. LVN B stated a potential negative outcome of a clogged toilet was that it could overflow and cause feces to get on the floor, which could cause resident's to slip and fall, and it was also unsanitary. LVN B stated hospice staff reported any concerns to the charge nurse before they left the facility. LVN B stated she expected staff to document refusals on the behavior monitoring logs and to notify family members of any concerns. During an interview on 2/11/2025 at 3:55 PM the ADM stated the housekeeping staff were responsible for cleaning all bathrooms in the facility, daily. The ADM stated the MS supervised the housekeeping staff. (continued on next page)

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	02/11/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/11/25 at 4:20 PM the DON stated she came to the facility on Sunday (2/9/25) after she was notified that state surveyors were at the facility. She stated she was not aware of the condition of Resident #2's bedroom until she was told about it sometime in the afternoon. She stated she last worked on 2/7/25. The DON stated Resident #2 rejected care and would not allow anyone to go in her room. The DON stated Resident #2 tore up her room and tore things off the walls. The DON stated Resident #2 received hospice services through Interim. The DON stated Resident #2 could slip and fall from liquids and food on the floor. She could trip on clothes and trash on the floor. The DON stated Resident #2 had not fallen in her room. The DON stated she was not aware of nursing staff being aware of the condition of that room and being aware it had not been cleaned. The DON stated she expected nursing staff to attempt to clean the rooms. The DON stated she expected nursing staff to follow up and ensure Resident #2's room was cleaned after they saw housekeeping were done cleaning rooms on the hall. The DON stated she had worked that this facility since mid-November and had not trained staff on that yet. The DON stated staff were responsible for the hallways they were assigned to during their shift. The DON stated she did not know how often nursing staff did rounds. The DON stated she was aware that Resident #2's window did not have blinds because Resident #2 ripped them off. She stated blinds were installed on the window yesterday and she had already ripped them down. She stated she could not recall seeing a window covering on her window prior to yesterday. The DON stated she did not know if there was a requirement for resident's room windows to have a covering. The DON stated a potential negative outcome to not having a window covering could be that Resident #2 did not have privacy which would cause her to be embarrassed if someone were to see her unclothed. The DON stated she expected staff to go back and try to provide care or get another staff to go back and try when Resident #2 refused care. The DON stated a potential negative outcome of there being a miscommunication between the facility and hospice could be that Resident #2's needs would not be met. The DON

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	02/11/2025

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 46425 Based on observation, interview, and record review, the facility failed to provide information to resident's and their representatives on their rights related to filing grievances or concerns for 12 of 21 confidential residents. The facility failed to ensure 12 of 21 confidential residents were provided, through postings in prominent locations; the Grievance Procedure, were provided access to the Grievance form, were provided information in regards to who the facility grievance officer was, their contact information, how to file an anonymous grievance, and their right to obtain a written decision related to their grievance. This failure could place the residents at risk of unresolved grievances and decreased quality of life. Findings include: Interviews and Record Review during Resident Council on, 02/10/2025 at 2:00pm, 12 of 21 confidential residents, stated they did not have access to the Grievance form, they did not know they could file a Grievance anonymously, the Grievance procedure had never been discussed in Resident Council, and they had not observed a posting of the Grievance procedure in prominent locations. Residents attending Resident Council did not know where to acquire a grievance form, who to turn the form into, and what happens once a grievance was filed. The Residents did not know they had the right to receive a written decision once their grievance was resolved. Twelve Residents attended the meeting, the 12 Residents in attendance had all been Residents of the facility for 6 plus months. Record Review of the facility Grievance policy on 2/11/2025 at 1:07pm; according to the facilities' Grievance policy a copy of the Grievance/complaint procedure should be posted on the resident bulletin board. Observed prominent postings on 2/10/2025 at 1:30pm; the facility did not include instructions regarding the Grievance procedure with any of the prominent postings. Grievance forms were not available and there was no access to submit a Grievance anonymously. (continued on next page)

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	02/11/2025

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the ADM on 2/11/2024 at 2:35pm; the ADM stated he was the Grievance Officer for the facility. The ADM stated he was responsible for the review of Grievances and assign them to department heads. The ADM stated the Grievance form was kept at the Nurses' Station and in the ADM's office. The ADM stated the Residents can access the Grievance form at the Nurses' station, they would have to ask for the notebook and the Residents would have to know the Grievance form was available at the Nurses' station. The ADM stated staff completed Grievance forms for Residents, Residents do not ask for forms and complete them on their own. The ADM stated there was no procedure for Residents to submit Grievances anonymously. The ADM stated the facility has 72 hours to resolve Grievances once they were submitted. The ADM stated he assigned the Grievance to the appropriate department, that department addresses the grievance with the complainant, resolved the grievance, and explained the resolution to the complainant. The resolution was documented on the Grievance form and the completed form was submitted to the ADM for review. The ADM stated completed Grievance forms were kept in a notebook. The ADM stated he monitored the Grievance process for success by following up with the staff member assigned to resolve the Grievance, the ADM stated he will also meet with the complainant to ensure they were satisfied with the resolution. The ADM stated he was responsible for ensuring staff were trained on the Grievance process. The ADM stated he was not aware the Grievance procedure was not being discussed in Resident Council. Grievance Policy Record Review of the Grievance Policy last updated in 2009. Policy Statement: Residents and their representatives have the right to file grievances, either orally or in writing, to the facility staff or to the agency designated to hear grievances. The Administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident and/or their representative. The Resident and/or the representative has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents; and other concerns regarding their LTC facility stay. The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have. Policy Interpretation and Implementation: 1. Any resident, family member, or representative may file a grievance or complaint. 2. Residents, family, and representatives have the right to voice or file grievances without discrimination or reprisal in any form, and without fear of discrimination or reprisal. 3. All grievances from resident or family concerning issues of residents' care in the facility will be considered. Actions will be responded to in writing. 4. Upon admission residents are provided with written information on how to file a grievance. 5. Grievances may be submitted orally or in writing and may be filed anonymously. (continued on next page)

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	02/11/2025

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. The contact information for the individual with whom a grievance may be filed is provided to the resident or representative upon admission. 7. The ADM has delegated the responsibility of grievance investigation to the ADM. 8. The grievance officer will review and investigate the allegations and submit the written report of such findings to the ADM with five working days of receiving the grievance. 9. The grievance officer will coordinate actions with the appropriate state and federal agencies depending on the nature of the allegations. 10. The ADM and staff will take immediate action to prevent further potential violations of resident rights while the alleged violation is being investigated. 11. The ADM will review the findings with grievance officer to determine what corrective actions need to be taken. 12. The resident or person filing the grievance on behalf of the resident, will be informed (verbally or in writing) of the findings of the investigation and actions will be taken to correct any identified problems. A written summary of the investigation will be provided to the resident and a copy will be filed in the business office. 13. If the grievance is filed anonymously the grievance officer will inform the resident that a grievance has been anonymously filed on his or her behalf and the steps that will be taken to investigate the grievance and report the findings. 14. The results of all grievances files investigated and reported will be maintained on file for a minimum of three years from the issuance of the grievance decision. 15. This policy will be provided to the resident or the resident's representative upon request.

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	02/11/2025

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49927 Based on interviews and record reviews, the facility failed to ensure all Pre-Admission Screening and Resident Review (PASRR) Level I residents with mental illness were provided with an accurate PASRR Level I for 1 of 6 residents (Resident #16) reviewed for PASRR screening, in that: Resident #16 did not have an accurate and updated PASRR Level 1 assessment reflecting a diagnosis of mental illness. These failures could place residents, with an inaccurate PASRR Level 1 and no PASRR Level 2 Evaluation, at risk for not receiving care and services to meet their needs. The findings included: Resident #16: Record review of Resident #16's electronic face sheet dated revealed a [AGE] year-old male admitted to the facility on [DATE]. The face sheet included the following diagnoses: Type 2 Diabetes (problem in the body where blood sugar levels are not regulated, leading to high blood sugar levels) with Diabetic Neuropathic Arthropathy (nerve damage caused by high blood sugar levels), Unspecified Head Injury, Generalized Anxiety Disorder(excessive, ongoing worry that is hard to control), Major Depressive Disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and Intermittent Explosive Disorder (a mental disorder that causes people to have periods of intense anger and sudden outbursts without any reason). Record review of Resident #16's Quarterly MDS dated [DATE], revealed under section I, indicated Resident #16 had a Psychotic Disorder, as well as an active diagnoses of Intermittent Explosive Disorder. Additionally, under Section C Cognitive Patterns, Resident #16's MDS revealed a BIMS of 10, indicating the resident was moderately, cognitively impaired. (continued on next page)

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	02/11/2025

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #16's care plan dated 11/23/2024, under Diagnoses, indicated Resident #16 had a diagnosis of Major Depressive Disorder and Intermittent Explosive Disorder. Additionally, the care plan included a focus area that began on 09/08/2020 which stated, The resident has episodes of verbal and physical aggression r/t intermittent explosive disorder., with a goal that began on 09/08/2020 which stated, The resident will verbalize understanding of need to control physical and verbal aggressive behavior through the review date., with the Interventions/Tasks that included the following: Administer medications as ordered. Monitor/document for side effects and effectiveness.; Monitor/document/report PRN any s/sx of resident posing danger to self and others. When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. The care plan also included a focus area that began on 09/08/2020 which stated The resident has potential for psychosocial well-being problem r/t little or no interest in doing activities. , with a goal that began on 05/24/2023 which stated, I will express satisfaction with type of activities and level of activity involvement when asked through the review date., with the Interventions/Tasks that included the following: Explain to the resident the importance of social interaction, leisure activity time and encourage participation in group activities. Remind him when food socials, bingo and movie/popcorn activities are scheduled as he enjoys these.; Provide resident with activity calendar monthly.; Remind resident when and where activities are scheduled. The care plan also included a focus area that began on 09/08/2020 which stated, The resident has an ADL self-care performance deficit r/t psychosis., with a goal that began on 09/08/2020 that stated, The resident will improve current level of function AEB independence in all ADLs through the review date. The care plan also included a focus area that began on 07/09/2018 which stated, I use antidepressant medications(Zoloft) r/t depression., with a goal that began on 08/02/2021 which stated, I will be free from discomfort or adverse reactions related to antidepressant therapy through the review date., with the Interventions/Tasks that included the following: Administer ANTIDEPRESSANT medications as ordered by physician. Monitor/document side effects and effectiveness Q-SHIFT.; Monitor/document/report PRN adverse reactions to ANTIDEPRESSANT therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in ADL ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance probs, movement problems, tremors, muscle cramps, falls; dizziness/vertigo; fatigue, insomnia; appetite loss, wt loss, n/v, dry mouth, dry eyes. The care plan also included a focus area that began on 09/08/2020 which stated, I have depression and anxiety. I take meds to help me feel less anxious and to stabilize my mood. Current med-Zoloft, Depakote., with a goal that began on 09/08/2020 that stated. The resident will remain free of s/sx of distress, symptoms of depression, anxiety or sad mood by/through review date., with the Interventions/Taks that included the following: Administer medications as ordered. Monitor/document for side effects and effectiveness.; Monitor/document/report PRN any risk for harm to self: suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possessions or writing a note), intentionally harmed or tried to harm self, refusing to CNA LPN. Record review of Resident #16's physician's Order Summary as of 02/11/2025 revealed under Diagnoses Major Depressive Disorder Recurrent, Severe Without Psychotic Features, Intermittent Explosive Disorder, and unspecified Psychosis Not Due To A Substance Or Known Psychological Condition. Resident #16 was prescribed Sertraline HCl Oral Capsule 150 MG once a day r/t Major Depressive Disorder Recurrent, Severe Without Psychotic Features, and Depakote Oral Tablet Delayed Release 125 MG r/t Intermittent Explosive Disorder. (continued on next page)

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	02/11/2025

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #16's Preadmission Screening and Resident Review Level One (PL1) form dated 04/23/2015 revealed under section C0100 Mental Illness an answer of NO, indicating the resident does not have a mental illness. There were no additional PL1 screenings provided by the facility for Resident #16. There were no additional documents provided to suggest Resident #16 had a completed PASRR Evaluation. Record review of Resident #16's Diagnostic Report, undated, revealed the following under Diagnosis: Major Depressive Disorder Single Episode, Severe Without Psychotic Features with an onset date of 02/15/2018 and a received date of 06/7/2024; Intermittent Explosive Disorder with an onset date of 11/16/2016 with no received date; unspecified Psychosis Not Due To A Substance Or Known Psychological Condition with an onset date of 12/17/2014 with no received date; Major Depressive Disorder Recurrent, Severe Without Psychotic Features with an onset date of 3/1/2024 with no received date. During an interview conducted on 02/11/2025 at 3:30 PM the VPO stated the staff that was assigned to PASRR tasks was unavailable for interview. The VPO verified Resident #16 did not show to have a mental illness identified on his PL1 screening. The VPO verified Resident #16's active diagnoses included Major Depressive Disorder and Intermittent Explosive Disorder. The VPO stated, to her knowledge, Resident #16's PL1 should have been updated to reflect his mental illness once a mental illness diagnosis was received. The VPO stated PL1 screenings should have been reviewed during a residents' quarterly care planning meetings and as updates were received. The VPO stated Resident #16 was receiving psychiatric services. The VPO stated it was important for a residents PL1 screening to be accurate in case the resident wanted additional services. The VPO stated she could not speculate what a negative outcome could have been for a resident if their PL1 was not accurate. During an interview conducted on 02/11/2025 at 3:55 PM the ADM stated he was not aware what Resident #16's PL1 screening indicated. The ADM stated Resident #16 was receiving psychiatric services. The ADM stated he believed Resident #16 did have a diagnosis of Major Depressive Disorder and Intermittent Explosive Disorder. The ADM stated he believed Resident #16's PL1 should have indicated yes to a mental illness for the resident since he had a mental illness diagnosis. The ADM stated it was important for residents to have an accurate PL1 so the residents would have access to services. The ADM stated he could not say what a negative outcome could be for a resident that did not have an accurate PL1 as PASRR was not his area of expertise. Record review of the facility's policy titled, Admission Criteria, revised March 2019 revealed the following: 9. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process. a. The facility conducts a Level I PASARR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for a MD, ID or RD. b. If the level I screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process. (continued on next page)

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	02/11/2025

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(1) The admitting nurse notifies the social services department when a resident is identified as having a possible (or evident) MD, ID or RD. (2) The social worker is responsible for making referrals to the appropriate state-designated authority. c. Upon completion of the Level II evaluation, the state PASARR representative determines if the individual has a physical or mental condition, what specialized or rehabilitative services he or she needs, and whether placement in the facility is appropriate. d. The state PASARR representative provides a copy of the report to the facility. e. The interdisciplinary team determines whether the facility is capable of meeting the needs and services of the potential resident that are outlined in the evaluation. f. Once a decision is made, the state PASARR representative, the potential resident and his or her representative are notified. Record review of the document titled, Preadmission Screening and Resident Review (PASRR) Process for Individuals with Mental Illness located at https://www.hhs.texas.gov/sites/default/files/documents/pasrr-process-for-people-with-mental-illness.pdf, revealed the following: Examples of MI Examples of MI diagnoses are: o Schizophrenia o Mood Disorder (Bipolar Disorder, Major Depressive Disorder or other mood disorder) o Paranoid Disorder o Severe Anxiety Disorder o Schizoaffective Disorder o Post Traumatic Stress Syndrome What is a PASRR Evaluation? o Completed by the local intellectual and developmental disability authority (LIDDA), local mental health authority (LMHA) or local behavioral health authority (LBHA) to confirm or deny the suspicion of MI, ID or DD/RC. o Face to face evaluation of the person with a positive PASRR Level 1 (PL1) screening form who is suspected of having a MI, I, or DD/RC.

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	02/11/2025

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46425 Based on observation, interview and record review, the facility failed to provide an ongoing program to support residents in their choice of activities, facility-sponsored group, designed to meet the interest of and support the physical, mental, and psychosocial well-being of 3 of 21 residents reviewed for activities. The facility: 1. Failed to engage in activities at scheduled times. 2. Failed to offer engaging activity replacement for scheduled activities that were cancelled or not completed. This failure could affect Residents of the facility by not addressing their physical, mental, and psychosocial needs for each to attain or maintain their highest practicable physical, mental, and psychosocial outcome. The findings include: Resident #20 Record review of Resident #20's electronic face sheet revealed a [AGE] year-old male most recently admitted to the facility on [DATE]. The face sheet listed under Diagnoses Information, Diabetes (blood sugar issues), heart failure (heart does not pump blood as well as it should), and anemia (low iron levels). Record review of Resident #20's Quarterly MDS dated [DATE], revealed under Section C Cognitive Patterns, the MDS revealed a BIMS of 15 indicating the resident was cognitively intact. Record review of Resident #20's most recent care plan, undated, revealed a focus area including activities; the care plan stated Resident #20 enjoys participating certain activities, at times Resident may enjoy observing activities, the AD will encourage and remind Resident to attend scheduled activities, and the AD will praise the Resident for attending activities of his choice. Interview with Resident #20 on 2/10/2025 at 9:52am revealed activities often did not occur as scheduled; there are no alternative activities offered, there was often no activity offered at the scheduled time, and the AD was not present in the dining room or the commons area during the scheduled activity time. Resident #20 stated he had been told the AD was pulled away from activities to perform other duties. Resident #20 stated the AD cannot perform the scheduled activities because she was asked to perform many other duties. Resident #20 stated he felt let down and bored when activities do not occur as schedule. Resident #20 stated he was trying to leave his room and interact with others to help with his depression. Resident #24: (continued on next page)

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	02/11/2025

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #24's electronic face sheet revealed an [AGE] year-old female most recently admitted to the facility on [DATE]. The face sheet listed under Diagnosis Information a diagnosis of Heart Failure (heart does not pump blood as well as it should), muscle weakness (decline of muscle strength), and Hypertension (high blood pressure). Record review of Resident #24's Quarterly MDS dated [DATE], revealed under Section C Cognitive Patterns, the MDS revealed a BIMS of 15 indicating the resident was cognitively intact. Record review of Resident #24's most recent care plan, undated, revealed a focus area concerning activities which stated involve me in activities: provide me with activities calendar and encourage participation in group activities, and staff in encouraging me to participate in meaningful activities, remind me when activities are scheduled and assist to attend. Surveyor interviewed Resident #24 on 2/11/2025 at 10:33am, Resident #24 stated she had noticed more often activities did not occur as scheduled on the activities calendar and the AD was not present during the scheduled activities. Resident #24 stated she feels the AD wants to please all of Residents; therefore, she was busy shopping for Residents all the time, completing individual activities in rooms with Residents, and trying her best to fundraise for a trip to a Bingo Hall. Resident #24 stated the AD was so very kind, she stated the AD was asked to hel other staff with their duties which keeps her from hosting activities. Resident #24 stated she felt disappointed when the activities did not occur as scheduled. Resident #24 stated she looked forward to the scheduled activities, especially any art activity, Resident #24 felt down when the Bowling in the front yard activity did not occur today as she had been looking forward to it. Resident #24 stated all the Residents enjoy Bingo when they have it, she stated overall she felt the activities help her to be motivated to get out of her room. Resident #59: Record review of Resident #59's electronic face sheet dated 2/11/25 revealed a [AGE] year-old male most recently admitted to the facility on [DATE]. The face sheet listed under diagnosis indicated diagnoses of Muscle Weakness (decline of muscle strength), Anemia (low iron), and Anxiety Disorder (feelings of worry or fear). Record review of Resident #59's Quarterly MDS dated [DATE], revealed under section C Cognitive Patterns, the MDS revealed a BIMS of 6 indicating the resident was severely cognitively impaired. Record review of Resident #59's most recent care plan, undated, revealed a focus area involving activities; Resident #59 will be invited and encouraged to attend activities, especially activities involving fluid and food intake, interacting with other Residents, Bingo, and Dominoes. Resident #59 will be provided with an activities calendar, and he will be informed of any changes to the activities. Surveyor interviewed Resident #59 on 2/10/25 at 3:45am, Resident #59 stated he would attend activities if they occurred as scheduled. Resident #59 stated he feels disappointed when he continuously showed up for a scheduled activity and the activity does not occur as scheduled. Resident #59 stated he had noticed several activities had not been held as scheduled over the past two weeks. Resident #59 stated there were no alternative activities offered when the scheduled activity did not occur. (continued on next page)

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	02/11/2025

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of the dining room on 2/10/25 beginning at 8:30am, review of the activities calendar revealed the scheduled activity at 8:30am was Meditation, there were 3 residents sitting in the dining area; the residents in the dining room stated they were waiting for the activity to start; all 3 residents informed surveyor they had not seen the AD. Continued observation of the dining room and commons area at 8:53am revealed the residents in the dining room remained waiting for the activity, they had not seen the AD. Observation of the dining room on 2/10/25 at 10:10am, review of the activities calendar revealed the scheduled activity was a Poker Tournament, there were four male residents in the dining room who informed this surveyor they were waiting for the activity. The residents informed the surveyor they had not seen the AD. Continued observation of the dining room at 10:25pm revealed the same three male residents waiting for the activity; the residents informed this surveyor they had not seen the AD and nothing was set up for the activity. Observation of the dining room and the front yard on 2/11/25 at 10:15am, review of the activities calendar revealed the scheduled activity was Bowling in the front yard, there was nothing set up for the activity and no residents were in the dining room or the front yard. Continued observation of the dining room at 10:25am revealed Residents #20, #24, and #59 were in the dining room, Residents in the dining room stated they were looking for the Bowling Activity scheduled for 10:00am. Residents stated they guessed the activity was not going to happen. Observation of the dining room and the therapy hallway on 2/11/25 at 2:10pm revealed there were 3 residents in the dining room; the AD was not in the area. Surveyor asked Resident #20, #24, and #59 if the 2:00pm scheduled activity of Resident Council was going to happened as scheduled; all the present residents informed Surveyor they were waiting for the activity; however, they had not seen the AD. Continued observations of the dining room and therapy hall at 2:25pm revealed the same 3 residents in the dining room; Residents informed Surveyor the activity did not occur as scheduled and they had not seen the AD. Interview on 2/11/2025 at 2:55pm, the ADM stated his expectation was for the AD to follow the scheduled activities calendar. The ADM stated he was not aware that the AD was assisting with other duties that take away from her hosting of her scheduled activities. The ADM stated he has encouraged to ask for help if needed, there has been no request for help. The ADM said no other staff have been assigned to hold the activity when the AD was unable to host an activity. The ADM stated he expected her AD to go to the rooms to personally invite Residents to the scheduled activity if no residents showed up to the activity. The ADM stated he expected the AD to change the activity if there was no interested in the scheduled activity. The ADM stated the potential negative outcome to the residents if the scheduled activity was cancelled was boredom, increased behaviors, and depression. (continued on next page)

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	02/11/2025

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 2/11/2025 at 1:15PM, the AD stated she had been pulled by Residents pulling her in different directions to meet their needs, she stated she never tells a Resident no if they ask her for anything. The AD stated she was busy with fundraising, decorating, and shopping for Residents individual needs. The AD stated the ADM has encouraged her to ask for help, however, she has a hard time asking for help. The AD stated she wanted to make everyone happy. The AD stated she did not announce or leave announcements for the Residents when an activity was cancelled. The AD stated she did not ask other staff to cover the activity for her when she could not attend the activity. The AD stated she walked around and invited residents to activities when there was no resident in attendance for an activity. The AD stated she changed a scheduled activity if there was no interest in the scheduled activity. The AD stated he added activities to the calendar that were requested by Residents. The AD stated she thinks Residents feel disappointed when activities did not happen as scheduled. The AD stated the potential negative outcome for residents when activities did not occur as planned was a loss in quality of like and the Residents will be bored which can potentially increase behaviors. Record Review indicated the AD completed an online training and was a licensed AD. Record Review of facility activity calendar policy dated 2020 reflected the following: Both large and small group activities are part of the activity program. The calendar will state all activities available for the entire month, which may also include scheduled in-room activities. The activity calendar will be displayed in high-visibility high traffic areas. Activities will be scheduled 7 days a week including holidays. The AD will be properly trained and be licensed to perform activity duties. Individual activities and room visit policy program will be provided for those residents whose situation or condition prevents participation in other types of activities, and for those residents who did not wish to attend group activities.

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	02/11/2025

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 41480 Based on observations, interviews, and record reviews, the facility failed to ensure menus were followed for all residents for 2 of 3 (02/10/25 noon meal and 02/11/25 noon meal) meals observed. The facility failed to follow the week 4 menu for two lunch services served at the facility on Monday 02/10/25 and Tuesday 02/11/25. These failures could place residents that eat food from the kitchen at risk of poor intake, and/or weight loss. The findings included: Observation on 02/10/25 at 12:00 PM of dining room lunch meal trays being served consisting of cilantro lime chicken, mashed potatoes, beans, fruit cocktail and beverage. Observation on 02/10/25 at 01:15 PM of test meal tray served consisting of cilantro lime chicken, mashed potatoes, beans, fruit cocktail and beverage. Observation on 02/11/25 at 12:15 PM of dining room lunch meal trays being served consisting of beef goulash, squash medley, mixed green salad, baked cookie, and beverage. Record review Monday Week 4 menu dated 09/27/24 revealed noon menu cilantro lime chicken, rice pilaf, charro beans, tortilla chips, salsa, dessert empanada and beverage. Record review Tuesday Week 4 menu dated 09/27/24 revealed noon menu beef goulash, squash medley, mixed green salad, biscuit, margarine, dressing of choice, fresh baked cookie, and beverage. In an interview on 02/11/25 at 02:15 PM the DM stated the dietitian approved for him to substitute a starch for a starch. He stated he did not have enough rice pilaf to serve so he substituted it with mashed potatoes. He stated the residents do not like tortilla chips, so they did not serve or make any substitutions for the tortilla chips. He stated hot sauce was substituted for salsa because the residents like it better. He stated he did not serve biscuits with the noon meal on 02/11/25 because he did not have enough room on the steam table to put them. He stated he offered sliced bread to residents who wanted bread. He stated all staff had been trained to follow the menus . He stated all staff have safe serve certificates. He stated he had his safe serve and DM certificate. He stated the potential negative outcome was residents not receiving the proper nutrition and calories which could lead to weight loss. In an interview with the ADM on 02/11/25 at 02:35 pm he stated his expectation is for staff to follow the menu. He stated the DM is responsible for training all staff. He stated all staff have been trained and have safe serve certificates. Record review of Menus policy revised 10/2017 revealed the following: (continued on next page)

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	02/11/2025

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy statement - menus are developed and prepared to meet resident choices including religious, cultural, and ethnic needs while following established national guidelines for nutritional adequacy. Policy interpretation and implementation: . 6. Deviations from posted menus are recorded (including the reason for the substitution and/or deviation) and archived .

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	02/11/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41480 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for dietary services, in that: 1. The facility failed to store and date foods stored in the refrigerator. 2. The facility failed to ensure foods were served at temperature above 135 degrees Fahrenheit. These failures could place residents at risk for food contamination and foodborne illness. The findings included: The following observations were made on 02/09/25 beginning at 09:45 AM during initial observation of the kitchen: Observed the following in the walk-in refrigerator: Styrofoam cup covered with tin foil on top shelf no label and no date. Bag of white shredded cheese opened with no label and no date. Pie uncovered and no date. Styrofoam cup with lid on top shelf with no label and no date. Observed the following in the panty: Personal jacket on top of open backet with individual syrup condiments. Home cookies in open container in paper sack no date. Personal drink on shelf with spices. During an observation and interview on 02/09/25 beginning at 12:15 PM with [NAME] A she took temperature of puree chicken on steam table. Temperature was 103.4 degrees Fahrenheit. [NAME] A stated she needed to reheat the puree chicken. Observed [NAME] A prepare puree meal tray and send to the window to serve. Did not observe [NAME] A or any other staff reheat puree chicken. During an interview on 02/09/25 at 01:35 PM with [NAME] A she stated she did not temp or reheat the puree chicken. She stated she was nervous and forgot. She stated the puree should have been served at 160 degrees Fahrenheit. She stated she had been trained on how to reheat food to proper temperature. She stated serving food below 160 degrees Fahrenheit could cause harm to residents. (continued on next page)

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	02/11/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/11/25 at 02:15 PM with the DM, he stated all items in the refrigerator should be dated. He stated all staff have been trained to date items in the refrigerator. He stated the potential negative outcome could be serving spoiled food to residents. He stated no personal items should be placed in the panty. He stated all staff have been trained on proper storage of food in the panty. He stated the potential negative outcome could be cross contamination of food causing residents to get sick. He stated [NAME] A should have reheated the food in the microwave before serving. He stated the puree process using the blender causes the food to lose heat. He stated staff have been trained on how to reheat food. He stated the potential negative outcome could be food poisoning. During an interview on 02/11/25 at 02:30 PM with the ADM, he stated all food should be dated in the refrigerator. He stated all food should temp at 165 degrees Fahrenheit or higher. He stated the DM is responsible for training all kitchen staff. He stated all staff were trained and had safe serve certificates. He stated the potential negative outcome of serving food below 165 degrees Fahrenheit could be illness in residents. He stated the potential negative outcome of storing personal items and undated food could be cross contamination and food spoilage. Record review of the facility policy, titled Food Receiving and Food Storage, revised November 2022 reflected the following: Policy: Foods shall be received and stored in a manner that complies with safe food handling practices . Refrigerated/frozen Storage: 1. All foods stored in the refrigerator or freezer are covered, labeled, and dated (use by date) . 7. Refrigerator foods are labeled, dated, and monitored so they are used by their use by date, frozen or discarded . Record review of the facility policy, titled Food Preparation and Service, revised November 2022 reflected the following: Policy: Food and nutrition services employees prepare, distribute and serve food in a manner that complies with safe food handling practices . General Guidelines . Food Preparation, Cooking and Holding Time/Temperatures 1. The danger zone for food temperatures is above 41 degrees Fahrenheit and below 135 degrees Fahrenheit. This temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illness. 2. Potentially hazardous foods include meats, poultry, seafood, cut melon, eggs, milk, yogurt and cottage cheese. (continued on next page)

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	02/11/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. The longer foods remain in the danger zone the greater the risk for growth of harmful pathogens. Therefore, PHF (Potential Hazardous Food) must be maintained at or below 41 degrees Fahrenheit or at or above 135 degrees Fahrenheit. 11. Mechanically altered hot foods prepared for a modified consistency diet remain above 135 degrees Fahrenheit during preparation or they are reheated to 165 degrees Fahrenheit for at least 15 seconds if holding for hot service .

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	02/11/2025

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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49927 Based on observations, interviews, and record reviews, the facility failed to maintain and ensure safe and sanitary storage of residents' food items for 3 of 3 refrigerators reviewed for food safety (Room D6, D8, and E9) in that: The refrigerator located in Room D6 did not have a temperature log present for the refrigerator. The refrigerator located in Room D8 did not have a temperature log present for the refrigerator. The refrigerator located in Room E9 did not have a temperature log present for the refrigerator. These failures could place residents at risk for food borne illnesses. Findings include: During an observation on [DATE] at 10:37 AM, Resident Room E9 contained a personal refrigerator. There was not a log present indicating the refrigerator's daily temperatures. The refrigerator contained perishable food items such as mayonnaise and cheese. During an observation on [DATE] at 10:45 AM, Resident Room D6 contained a personal refrigerator. There was not a log present indicating the refrigerator's daily temperatures. The refrigerator contained perishable food items such as Crunch N [NAME]. It was unable to be determined what the Best Used By date was on the food box. During an observation on [DATE] at 11:23 AM, Resident Room D8 contained a personal refrigerator. There was not a log present indicating the refrigerator's daily temperatures. The refrigerator contained perishable food items such as ketchup, milk, and cereal. The individual carton of milk contained a sell by date of [DATE]. The expiration date on the ketchup was not legible as part of the date was missing. The expiration date on the individual cereal was not legible, as the ink was smeared. During an interview on [DATE] at 02:00 PM, the MS stated the housekeeping staff were responsible for checking the temperatures of the residents' personal refrigerators and cleaning them daily. The MS stated any staff member was responsible for ensuring spoiled food was discarded from residents' refrigerators, when they saw it, but the housekeeping staff were responsible for checking the refrigerators and cleaning them daily. The MS stated the facility did not maintain a log for each resident's refrigerator to ensure they were checked daily for adequate temperatures and to ensure the refrigerator did not contain perished food items. The MS stated the logs were a good idea, and he planned to speak to the ADM about implementing them. The MS stated it was important to check the residents' personal refrigerators to ensure they are at an adequate temperature because food could spoil if it is not. The MS stated it was also important for staff to throw away any expired food. The MS stated residents were at risk of consuming spoiled food and getting sick if staff were not checking their refrigerators properly. (continued on next page)

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	02/11/2025

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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 02:15 PM, the HKA said housekeeping was responsible for cleaning the residents' refrigerators daily and ensuring they were at an adequate temperature. HKA was unable to state what temperature the residents' refrigerators were supposed to maintain. HKA stated housekeeping staff were responsible for throwing away any expired food from the residents' personal refrigerator. HKA stated there was not a log for each residents' refrigerator for the housekeeping staff to track when refrigerators were checked or cleaned. The HKA stated residents were at risk of eating expired or spoiled food if their refrigerators were not checked by staff to ensure they were working properly or if staff did not throw away expired food. During an interview on [DATE] at 03:55 PM, the ADM stated the housekeeping staff were responsible for cleaning and checking the residents' personal refrigerators to ensure they were clean and working properly. The ADM stated he was not aware of a log that staff used to track their daily checks of residents' refrigerators. The ADM stated any spoiled or expired food should have been thrown away by the housekeeping staff. The ADM stated a milk carton dated [DATE] should not have been in a resident's refrigerator, as it should have been discarded by housekeeping staff. The ADM stated the residents were at risk of consuming spoiled food and/or drinks if the refrigerators were not cleaned and checked adequately. The ADM stated this could result in residents becoming sick. Record review of the facility's policy titled Refrigerators and Freezers, revised [DATE], revealed: Policy Statement This facility will ensure safe refrigerator and freezer maintenance, temperatures, and sanitation, and will observe food expiration guidelines. Policy Interpretation and Implementation 2. Monthly tracking sheets for all refrigerators and freezers will be posted to record temperatures. 3. Monthly tracking sheets will include time, temperature, initials, and action taken. The last column will be completed only if temperatures are not acceptable. 4. Food Service Supervisors or designated employees will check and record refrigerator and freezer temperatures daily with first opening and at closing in the evening. 7. All food shall be appropriately dated to ensure proper rotation by expiration dates. Received dates (dates of delivery) will be marked on cases and on individual items removed from cases for storage. Use by dates will be completed with expiration dates on all prepared food in refrigerators. Expiration dates on unopened food will be observed and use by dates indicated once food is opened. 8. Supervisors will be responsible for ensuring food items in pantry, refrigerators, and freezers are not expired or past perish dates. Supervisors should contact vendors or manufacturers when expiration dates are in question or to decipher codes. (continued on next page)

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	02/11/2025

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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's undated policy titled APEX NURSING HOME FOR FOODS BROUGHT BY FAMILY MEMBERS did not include information pertaining to a resident's personal refrigerator. The policy revealed the following: FOOD PREPARED AT A FAMILY MEMBERS HOME MUST BE SERVED TO THAT FAMILY MEMBER'S RESIDENT ONLY. IT IS NOT TO BE SHARED WITH OTHER RESIDENTS. FOOD MUST BE PREPARED SAFELY AND COOKED TO PROPER TEMPERATURE. COLD FOOD MUST BE STORED AT PROPER TEMP 41 DEGREES OR BELOW. RESIDENT FOOD FOUND NOT BEING STORED IN SAFE CONDITIONS SHOULD BE DISPOSED OF UPON DISCOVEREY.

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	02/11/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49279 Based on observations, interviews, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infection for 4 of 20 residents (Resident #27, #51, #328, and Resident #16) reviewed for infection control. 1. CNA A failed to utilize hand hygiene when assisting Residents #27, #51, and #328 with their meals on 2/09/2025. 2. LVN B failed to utilize hand hygiene between glove changes when providing wound care to Resident #16 on 2/10/2025. These failures could place residents at risk for infection, and cross-contamination. Findings include: Resident #27 Record review of Resident #27 undated face sheet revealed a [AGE] year-old male originally admitted to the facility on [DATE]. Resident #27 had a medical history of muscle wasting and atrophy (a condition where muscles shrink and lose mass, resulting in weakness and decreased functionality), hemiplegia (a condition that causes paralysis or weakness on one side of the body), and muscle weakness. Record review of Resident #27 quarterly MDS dated [DATE] revealed Section C- Cognitive Patterns a BIMS score of 04 which indicated Resident #27 was not cognitively intact. Record review of Resident #27 care plan dated 11/23/2024 revealed resident required eating set up and clean up assistance. Resident #51 Record review of Resident #51 undated face sheet revealed a [AGE] year-old female originally admitted to the facility on [DATE]. Resident #51 had a medical history of muscle wasting and atrophy (a condition where muscles shrink and lose mass, resulting in weakness and decreased Functionality), dysphagia (difficulty swallowing), and atresia of foramina of Magendie and Luschka (malformation of the brain). Record review of Resident #51 quarterly MDS dated [DATE] Section C- Cognitive patterns revealed a BIMs score of 06 which indicates resident was not cognitively intact. Record review of Resident #51 care plan dated 12/01/2024 revealed Resident #51 required eating assistance with support provided one-person physical assist. Resident #328 (continued on next page)

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	02/11/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #328 undated face sheet revealed [AGE] year-old female originally admitted to the facility on [DATE]. Resident #328 had a medical history of muscle weakness, lack of coordination, and profound intellectual disabilities. Record review of Resident #328 Admission MDS dated [DATE] revealed Section C- Cognitive patterns revealed a BIMs score of 00 which indicates resident was not cognitively intact. Record review of Resident #328 care plan dated _revealed Resident #328 required eating assistance with support provided one-person physical assist. Resident #16 Record review of Resident #16 undated face sheet revealed a [AGE] year-old male originally admitted to the facility on [DATE]. Resident #16 had a medical history of muscle weakness, unspecified head injury, and Charcot's joint (nerve damage to the foot). Record review of Resident #16 MDS dated [DATE] revealed Section C- Cognitive patterns revealed a BIMs score of 10 which indicated resident had moderate cognitive impairment. Record Review of Resident #16's Physician orders revealed the following wound care order dated 1/02/2025: TX to Right medial plantar wound- (wound on the inner part of the foot) Cleanse wound and peri wound skin with wound cleanser, pat dry with gauze, apply Calcium Alginate Silver to wound, cover with super absorbent dressing and secure every other day. During a dinning observation on 2/09/2025 between 12:38pm and 1:02pm, CNA A was observed feeding Resident #27, #52, and #328. CNA A was observed setting up each of the residents' trays with utensils, condiments, and drinks. CNA A provided a spoonful of food to a resident, and proceeded to move to another resident and provided a spoonful for that resident. CNA A used the resident's napkin and cleaned the resident's mouth. CNA A proceeded to assist the residents with their meals, going between each resident and assisting as needed with their meals. During this time CNA A did not utilize hand hygiene with ABHS or soap and water, prior to assisting the residents with their meal and when moving from one resident to another to assist with feeding. During an interview with CNA A on 2/10/2025 at 3:21pm, she stated she was assisting three residents with feeding on 2/9/2024. She stated the infection preventionist was the DON. She stated she had been trained on infection control and utilizing ABHS when moving from one resident to another during feedings. She stated she did use ABHS a few times but not all the time. She stated the potential negative outcome could be spreading germs between the residents. During a wound care observation on 2/10/2025 at 4:41pm for Resident #16, LVN B did not utilize hand hygiene prior to donning (putting on) clean gloves. LVN B removed soiled dressing from Resident #16's right foot and discarded the soiled dressing in the trash. LVN B grabbed a disinfecting wipe and cleaned the bedside table. LVN B allowed table to air dry for approximately 4 minutes and doffed (took off) dirty gloves. LVN B did not utilize hand hygiene prior to donning clean gloves. (continued on next page)

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	02/11/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with LVN B on 2/10/2025 at 5:00pm, she stated she had been trained on infection prevention and handwashing. She stated she believed her infection preventionist was the DON, but she was not sure. She stated she was PRN at the facility. She stated she had been trained on handwashing between glove changes but did not remember the last in-service. She stated she realized she had not been washing her hands between glove changes and caught herself towards the end of the wound care. She stated the potential negative outcome of not utilizing hand hygiene between glove changes could be spreading infection towards the residents and staff. During an interview with the DON on 2/11/2025 at 2:45pm, she stated she was the infection preventionist. She stated she was unsure when the facility nursing staff had their last training on hand washing as she had just been hired in November of 2024, but it should be done quarterly. She stated they would be having training prior to the end of this month. She stated she expects staff to sanitize their hands between feeding residents, each time. She stated she expects staff to sanitize their hands between glove changes. She stated compliance was monitored through observation and when she was on the floor, she monitors the staff for hand hygiene. She stated the potential negative outcome of staff not utilizing hand hygiene can be the spread of germs and spread of infection. During an interview with the ADM on 2/11/2025 at 3:00pm, he stated the DON was the infection preventionist. He stated staff are trained periodically and once a month on infection control and handwashing. He stated staff are trained to wash their hands between glove changes. He stated during feeding if they staff are assisting residents, and they don't touch the residents, they can continue assisting others. He stated if they stop to feed, or utilize utensils for the residents, they are supposed to use ABHS between each resident. He stated compliance was monitored by observation and throughout the day. He stated his expectation of staff was for them to utilize the infection control practices they have been trained on. He stated a potential negative outcome of not following those infection control practices could be sickness and spreading germs or infection. Record review of facility undated polity titled Infection Control During Feeding revealed: The purpose of this policy is to provide guidelines for infection control practices during resident feeding, focusing on hand hygiene, equipment sanitation, and overall food safety to minimize the risk of infections and foodborne illness in the nursing home setting . 1. Hand Hygiene Importance of Handwashing Handwashing is the most effective method of preventing the spread of infections. Proper hand hygiene should always be performed before and after assisting a resident with feeding. Additionally, it is crucial after various activities to prevent contamination. When to Wash Hands Hand hygiene is required at the following times: o Before assisting residents with eating or drinking. (continued on next page)

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	02/11/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	o After touching any part of the body (e.g., hair, face, nose). o After touching utensils, food containers, dishes, or drinking cups. o After clearing away used dishes or utensils . Record review of facility policy titled Policy Statement revised October 2023 revealed: .1. Hand hygiene is indicated: a. immediately before touching a resident; b. before performing an aseptic task (for example, placing an indwelling device or handling an invasive medical device); c. after contact with blood, body fluids, or contaminated surfaces; d. after touching a resident; e. after touching the resident's environment; f. before moving from work on a soiled body site to a clean body site on the same resident; and g. immediately after glove removal. Record review of facility policy titled Procedure last revised October 2023 revealed: .Applying and Removing Gloves l. Perform hand hygiene before applying non-sterile gloves. 2. When applying, remove one glove from the dispensing box at a time, touching only the top of the cuff. 3. When removing gloves, pinch the glove at the wrist and peel away from the hand, turning the glove inside out. 4. Hold the removed glove in the gloved hand and remove the other glove by rolling it down the hand and folding it into the first glove. 5. Perform hand hygiene.

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	02/11/2025

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 49927 Based on observations, interviews, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public for 1 of 1 facility reviewed for environmental concerns. 1. The residents' hand sink in room D5 was not operational for 2 of 3 days. 2. The hand sink in the women's restroom was not operational for 2 of 3 days. 3. The hand sink and toilet in room A8 was not operational for 1 of 3 days. 4. The hand sink and toilet in room A6 was not operational for 1 of 3 days. These failures could place residents and the public at risk of a diminished quality of life due to exposure to an environment that is nonfunctional, uncomfortable, unsanitary, and unsafe. The findings included: During an observation on 2/9/2025 at 10:32 AM the hand sink in residents' room D5 was observed with standing water in the basin of the sink. The water continued to rise in the basin of the sink as the water ran, after being turned on. During an observation on 2/9/2025 at 12:05 PM the toilet in resident's room A6 was observed to be full of feces. The toilet was not able to be flushed. The toilet had no cover on the tank of the toilet. The plumbing of the inside of the toilet tank was visible and accessible. During an observation on 2/9/2025 at 1:17 PM the hand sink in the public women's restroom, located near the nurse's station, was observed with standing water in the basin of the sink. The water continued to rise in the basin of the sink as the water ran, after being turned on. During an observation on 2/9/2025 at 1:20 PM the hand sink in resident's room A8, occupied by state surveyors during the survey, was observed to have standing water in the basin of the sink. The water continued to rise in the basin of the sink as the water ran, after being turned on. During an observation on 2/10/2025 at 10:06 AM the hand sink in resident room D5 had standing water in the basin of the sink. The water continued to rise in the basin of the sink as the water ran, after being turned on. During an interview on 02/10/2025 at 10:15 AM the MS was informed of the standing water in resident's room A5 and the women's restroom,. The MS stated he would check on the concerns immediately. During an interview and observation on 02/10/2025 at 10:25 AM the MS was observed in resident's room A5 with a plunger,. The MS stated he used the plunger on the sink and was able to drain the water. (continued on next page)

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	02/11/2025

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 2/10/2025 at 1:00 PM standing water was observed on the floor in the bathroom of resident room A8, occupied by state surveyors during the survey. It was observed that the toilet would not drain when flushed. Standing water was observed in the basin of the hand sink. During an interview and observation on 02/10/2025 at 4:00 PM the MS stated he was working on the plumbing in the facility and stated the plumbing lines were clogged on 3 of 6 hallways. The MS stated they were able to get the plumbing lines cleared and stated the toilet in resident room A8 (occupied by state surveyors) should be working. It was observed the toilet in resident room A8 was able to flush. The MS stated clothing items were pulled from the plumbing lines while they were working on them. The MS stated he believed that was what caused the plumbing lines to be clogged. During an interview on 2/11/2025 at 9:48 AM the MS stated the toilet in resident's room A6 was full of feces and would not flush because the toilet was stopped up. The MS stated he was aware of the missing toilet tank top. The MS stated he was concerned the resident would break the toilet tank top again, so he did not replace it. The MS stated this was reported to the ADM. During an interview on 2/11/2025 at 2:00 PM the MS stated he was responsible for maintenance of the building as well as supervising the housekeeping staff. The MS stated the housekeeping staff was responsible for cleaning bathrooms daily, so they were responsible for reporting any concerns they saw regarding maintenance, to the MS. The MS stated sometimes housekeeping staff plunged a toilet themselves, but he still required this to be reported to him, so he could ensure it was done properly. The MS stated there was a maintenance log, kept in the monitor room, that all staff used to report maintenance concerns. The MS stated there was nothing reported prior to 2/10/2025 regarding the plumbing in resident rooms A6, A8, or D5 or the women's restroom not functioning properly. The MS stated the plumbing was stopped up off and on lately, and they were working on it. The MS stated it was his expectation for staff to report any plumbing concerns immediately and to record it in the maintenance log. The MS stated it was important for staff to report any plumbing concerns as it could pose as a safety concern if toilets overflow, resulting in falls, and a sanitation concern for residents. During an interview on 2/11/2025 at 2:20 PM HKA stated housekeeping staff cleaned toilets and hand sinks in all rooms daily. The HKA stated all housekeeping staff should have reported any concerns of stopped up sinks or toilets to the MS. The HKA stated there was a maintenance log in the monitor room for housekeeping staff to report any maintenance needs. The HKA stated she was not aware of any sinks or toilets that were stopped up recently. The HKA stated if she observed a clogged sink or toilet she tried to unclog it herself, and she reported it to the MS. The HKA stated it was common for the toilet in resident room A6 to become stopped up, as the resident was known to place non-flushable items in the toilet. The HKA stated if this occurred, she reported it to the MS. The HKA stated if the hand sinks and toilets in the facility were not functioning, the residents would not be able to use them and could get sick. The HKA stated if water overflows from toilets onto the floor, this could have caused an accident and a resident could have fell . (continued on next page)

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	02/11/2025

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/11/2025 at 3:55 PM the ADM stated the housekeeping staff were responsible for cleaning all bathrooms in the facility, daily. The ADM stated the MS supervised the housekeeping staff. The ADM stated any staff could have reported a clogged toilet or a clogged sink, but the housekeeping staff should have seen it, as they clean bathrooms daily. The ADM stated any maintenance request should have been recorded in the maintenance log in the monitor room. The ADM stated the MS was responsible for ensuring maintenance requests were completed. The ADM stated he expected any maintenance request to be reported as soon as it was seen by any staff. The ADM stated he was unaware of the clogged sinks and toilets throughout the facility. The ADM stated the MS completed plumbing maintenance on 2/10/2025, and to his knowledge everything was now functioning properly. The ADM stated he believed the plumbing issues began from residents placing non-flushable items in their toilets. The ADM stated if toilets overflow, this would have been a safety concern as it could have led to falls. The ADM stated if sinks were not functioning properly, this would have been a sanitation concern and could result in germs being spread. During an interview on 2/11/2025 at 4:51 PM the ADM stated he was unaware of the missing toilet tank cover in resident's room A6. The ADM stated the housekeeping staff were expected to handle maintenance requests such as plunging toilets when maintenance staff was unavailable, such as on weekends. The ADM stated if a resident's toilet was left unmaintained, containing feces, the resident could be at risk of infections. Record review of the facility policy titled, Maintenance Service revised December 2009 revealed the following: Policy Statement Maintenance service shall be provided to all areas of the building, grounds, and equipment. 1. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. 2. Functions of maintenance personnel include, but are not limited to: a. maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines. b. maintaining the building in good repair and free from hazards.