

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675159	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/05/2024
NAME OF PROVIDER OR SUPPLIER Southbrooke Manor Nursing and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 W Main St Edna, TX 77957	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41651</p> <p>Based on interview and record review, the facility failed to ensure the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents for 1 (Resident #1) of 5 residents reviewed, in that:</p> <p>Resident #1 displayed aggressive behaviors, was transported without adequate supervision, and attacked the transport driver.</p> <p>This failure could lead to residents who display aggressive behaviors hurting themselves or others due to inadequate supervision.</p> <p>The findings were:</p> <p>Record review of Resident #1's facesheet, dated 05/05/2024, revealed the resident was admitted to the facility on [DATE] with diagnoses including: Unspecified Dementia, Generalized Anxiety Disorder, and Unsteadiness on Feet.</p> <p>Record review of Resident #1's Quarterly MDS, dated [DATE], revealed a BIMS score of 01 which indicted severe cognitive impairment.</p> <p>Record review of Resident #1's care plan, revised 05/01/2024, revealed [Resident #1] has potential to be physically aggressive to other residents and staff r/t Anger, Dementia, Poor impulse control.</p> <p>Record review of Resident #1's progress notes, dated 04/04/2024, revealed, CNA heard [Resident #1] talking loudly to another resident and looked up intime to see [Resident #1] strike another resident on the back of his head with a closed hand. The other in returned struck [Resident #1] with an open hand on his left side. CNA stated she could not get to them fast enough. Residents immediately separated and she went to get a charge nurse while having [Resident #1] with her, starting 1:1 monitoring. When asked what happened resident stated that he didn't know what this nurse was talking about. When asked if he struck his friend, he stated, No, he's my brother. I would not hit him Resident again became verbally abusive to other residents and aggressive to staff, he was kept one on one while awake. Took him outside for some fresh air which seemed to calm him down and he finally took his medication and went to sleep for most of the night. DON is aware of situation.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of progress notes dated 04/14/2024, revealed, [Resident #1] was sitting in chair in common area. He then stood up and went to double doors and knocked on them. [Resident #1] then walked up to another resident asking him to open the doors. The other resident asked [Resident #1] to leave him alone. This nurse was standing in between the 2 residents. This nurse could not get [Resident #1] to get away from the other resident so This nurse asked the other resident to stand up and go to his room for a few minutes. The other resident did get up and walk toward room. [Resident #1] then began to follow the other resident and was unable to redirect by this nurse. This nurse was in between the 2 residents and trying to redirect [Resident #1]. [Resident #1] kept saying that he just wanted to talk to the other resident because he needed the other resident to open the door. [Resident #1] was at the door of the other resident's room. The other resident wanted to get by and leave his room since [Resident #1] would not leave the doorway. [Resident #1] then slapped this nurse in the ear with his right closed hand. CNA came out of room and was able to get the other resident away and back into dining area. [Resident #1] kept following the other resident. The other resident went back into his room. [Resident #1] then went to a different resident asking if he could open the door. [Resident #1] did not listen to any redirection [Resident #1] remains on 1:1.</p> <p>Further review of progress notes dated 05/02/2024, revealed, Call to doorway of Hall 200 to assist nurse with [Resident #1] because he was trying to exit the hallway, [Resident #1] had nurse by wrist. While telling [Resident #1] to let go of nurse [Resident #1] began to hit this nurse. CNA was present who attempted to redirect resident so this nurse to exit hallway. [Resident #1] continued to try to corner the nurse and hit this nurse, alerted DON to assist with situation.</p> <p>Further review of progress notes dated 05/02/2024, revealed, [Resident #1's Responsible Party] notified of the situation and agreed to have [Resident #1] sent to [sic] psych hospital for evaluation. Explained we will notify her when a facility has been found, when he's accepted and when he will transfer .</p> <p>Further review of progress notes dated 05/03/2024, revealed, [Resident #1] transferred to [psychiatric hospital] via facility van accompanied by van driver .</p> <p>During an interview with the Facility Van Driver on 05/04/2024 at 2:02 p.m., the Van Driver stated that she was tasked with driving [Resident #1] to a psychiatric hospital for evaluation and treatment due to his recent display of aggressive behaviors toward peers and staff. The Van Driver stated she felt safe with the resident because they had a good relationship. The Van Driver stated she would personally calm him by playing dominoes and taking walks and was surprised by his behavior on the day of transport. The Van Driver confirmed that she was alone with Resident #1 during the transport and stated she would have asked for another staff member to accompany them if she had felt unsafe.</p> <p>During an interview with the DON on 05/05/2024 at 2:34 p.m., the DON stated that Resident #1 was being transported to a psychiatric hospital for evaluation and treatment due to recent displays of aggression toward peers and staff. The DON stated that the Van Driver had always calmed resident #1 in the past. The DON stated the Van Driver told her that Resident #1 approached the Van Driver while the vehicle was in motion, pulled the driver's hair, and choked her. The Van Driver told the DON that she parked in a convenience store parking lot and called the police. Police were able to calm Resident #1 who appeared to have no knowledge of the incident after a few minutes, and the Van Driver proceeded to transport Resident #1 to the psychiatric hospital without further incident. The DON confirmed that Resident #1 and the Van Driver were uninjured during the incident.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the Administrator on 05/05/2024 at 4:00 p.m., the Administrator stated the facility policy regarding sending staff to accompany residents during transport had been decided on a case-by-case basis depending on the circumstances in the past. The Administrator confirmed that due to the incident with Resident #1, the policy would change and that a staff member would accompany the Van Driver when transporting residents in the future. The Administrator confirmed that while Resident #1 and the Van Driver were uninjured during the incident, they could have had an accident that injured themselves and others on the highway.</p> <p>During an interview with the Administrator 05/05/2024 at 5:15 p.m., the Administrator confirmed the facility did not have a written policy regarding accompanying residents during transport.</p>		