STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675159	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southbrooke Manor Nursing and Rehabilitation Cente	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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on observations, interviews and record reviews the facility failed to develop and implement a comprehensive person-centered care plan that included measurable objectives and time frames to meet a resident's medical and nursing needs to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 6 residents (Resident #1) reviewed for comprehensive care plans: The facility failed to ensure Resident #1's care plan reflected that he ate quickly and was known to put large amounts of food in his mouth. This deficient practice could place residents at risk of not being provided with the necessary care or services and having personalized plans developed to address their specific needs. The findings included: Record Review of Resident #1's Admission record, dated 10/17/24, revealed an [AGE] year-old male originally admitted on [DATE] and with diagnoses including dementia with mood disorder, weakness, dysphagia oropharyngeal phase (Patients with oropharyngeal dysphagia have difficulty transferring food from the mouth into the pharynx and esophagus to initiate the involuntary swallowing process), need for assistance with personal care, and muscle wasting and atrophy, not elsewhere classified. Record Review of Resident #1's quarterly MDS assessment, dated 10/06/24, reflected Resident #1 was severely impaired for daily decision making. The MDS showed the resident had a mechanically altered diet. (continued on next page)

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

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's care plan contained that Resident #1 had a swallowing problem related to swallowing difficulty and actual choking episode initiated on 4/7/24 with interventions to follow prescribed diet, monitor/document/report as needed any signs of symptoms of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appears concerned during meals, refer to speech therapist for swallowing evaluation, and resident to eat with supervision only. Also, Resident #1 was at risk for impaired nutritional problem due to diet restrictions and malnutrition, no salt added diet, pureed texture, honey thickened liquids consistency, large portions for all meals, initiated on 9/20/23 and revised on 8/28/24. Interventions included explain and reinforce to the resident the importance of maintaining the diet ordered encourage the resident to comply, explain consequences of refusal, obesity/malnutrition risk factors and provide, serve diet as ordered, monitor intake and record every meal. The care plan did not contain any information or interventions related to the resident's behavior of eating fast. Record review of Resident #1's physician orders, dated 10/17/24, showed an order for regular diet pureed texture, honey thickened liquids consistency, large portions all meals, with an order date of 6/13/24 and no end date. Record review of nursing notes, dated, 4/7/24, revealed a note that stated Resident was sitting at table eating dinner when I noticed he was backing away from the table and doing hand gestures for assistance. This nurse and CNA went over to resident, [Resident #1] was blue in color around the lips and unable to catch his breath. This nurse along with [RN D] & LVN and 2 CNAS attempted to stand him up to do Heimlich maneuver. Resident then was assisted to floor and abd thrusts were performed. Resident then coughed up a piece of chicken and returned to normal color. o2 sat @87% and placed on 02@2L and oxygen level increased to 94% on RA. Resident alert x1 which is his normal. 911 activated, resident transferred to [Hospital] ER accompanied by 3 EMTS. Report called in to RN .RP aware . FNP aware. DON aware. Written by LVN C on 4/7/24. During an interview on 10/17/24 at 1:33 p.m. RN D stated on 4/7/24 she was called to the locked unit to assist with a resident who was choking. RN D stated she knew the resident would eat quickly, like it was his last meal, but he had never choked before and staff would always tell him to slow down when eating. RN D stated she never initiated speech therapy to screen the resident because she was not the nurse who was responsible. RN D stated she did not recall if there was an intervention for staff to prompt the resident to slow down while eating. During an interview on 10/17/24 at 1:55 p.m. LVN C stated that Resident #1 was known to eat quickly. LVN C stated even when you would tell the resident to slow down, while eating, he would not listen. LVN C stated on 4/7/23 she observed the resident eating quickly and putting too much food in his mouth. LVN C stated he put too much chicken in his mouth and she could tell from his eyes that he was choking. LVN C stated they then did abdominal thrusts, and he was able to clear the food. LVN C stated she had talked to therapy about the resident eating quickly prior to the choking episode but she could not recall who she spoke to. LVN C stated he should have been care planned for eating quickly. During an interview on 10/17/24 at 2:39 p.m. the ST stated she did evaluate the resident after his choking episode but prior to the episode she had never evaluated him or been alerted by staff that he ate quickly. The ST stated while eating quickly was a red flag she may not have been alerted because he did not have any symptoms such as coughing or drooling while eating. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/17/24 at 3:18 p.m. the DON stated Resident #1 was known to be a messy eater, he would take big bites of his food, he would put more on his spoon than he should and would eat fast. The DON stated the resident behavior of eating quickly should have been in the care plan because it was out of the regular norm and put him at higher risk of choking. The DON stated they added the resident's behavior of eating quickly on 10/17/24 to the care plan. On 10/17/24 at 3:36 p.m. the DON stated they did not have a care plan policy.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 33866 Based on observations, interviews, and record review the facility failed to store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys, for 1 of 1 medication storage rooms. The facility failed to ensure the facility medication storage room was locked and secured while unattended. This failure could place residents at risk for harm by accidental ingestion of medications or drug diversion. The findings included: Observation on 10/15/2024 at 5:02 a.m., revealed the door to the facility's medication storage room was propped open with a metal box and was unattended. The medication storage room was located at the entrance to Hall 300, and there were no staff inside the room. LVN-A was observed standing in front of a medication cart parked on the opposite side of the circular nurse's station to the medication room. LVN-B was observed standing in front of another medication cart parked against the wall at the entrance to a hall on opposite side from medication room. There were 4 residents sitting in wheelchairs in the foyer next to the Nurse's station. Upon seeing the State Surveyor, LVN-A immediately gestured with her hand, using two fingers in a V-shape, pointing first to her eyes and then towards the medication room indicating she had visual access to the medication room. During an interview on 10/15/2024 at 05:04 a.m., LVN-A stated she had propped open the door to the medication room so that she could re-supply her medication cart without having to unlock/lock the door with her key each time she went into the medication room to get medications and supplies for her cart. LVN-A stated that propping the medication door was a routine practice for her, but she always stayed within eyesight of the medication room when she had it propped open. When asked what she would do if one of the residents sitting in the foyer next to the nurse's station started having a medical emergency such as a seizure, LVN-A stated she would go to the resident to render aide, and stated that in such a scenario, the medication room would be left open and unsupervised, allowing access to residents or unauthorized staff. LVN-A stated that leaving the medication room propped open and unsupervised could lead to residents wandering in and gaining access to medications. During an interview with LVN-B on 10/15/2024 at 5:08 a.m. LVN-B stated the door to the medication room had been propped open but stated it should not have been. LVN-B stated that if she was called away to attend to another resident, the medication room would have been left unsupervised allowing possible access to a confused resident. During an interview with the DON on 10/15/2024 at 8:11a.m., the DON stated the medication room door should always be kept closed and locked, and it was not acceptable to prop open the door to the medication room. The DON further stated that propping the door in open to the medication room could result in residents gaining unsupervised access to medications or theft of medications. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further interview with the DON on 10/17/2024 at 2:56 p.m. revealed that the facility did not have a specific policy regarding the medication storage room remaining locked but did confirm it was the facility expectation that the medication room should remain locked at all times unless being directly accessed by authorized staff.