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	04/23/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34957 Based on interview and record review the facility failed to ensure, based on the comprehensive assessment of a resident, that residents received treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the residents' choices for 1 of 4 residents (Resident #1) reviewed for quality of care/treatment. The facility failed to ensure Resident #1's admitting physician had the full hospital clinical discharge record which resulted in the physician holding a recommended medication (colchicine oral tablet 0.6 mg) for the resident. This failure could place residents at risk for improper care due to inaccurate records. Findings include: Record review of Resident #1's face sheet, dated 4/22/25, reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE] and discharged [DATE] (discharged to hospital for lung and abdominal pain). Resident #1 had diagnoses which included: epilepsy (seizures) (primary), pleural effusion (fluid in the lungs-admissions), other pericardial effusion (fluid around the heart), atrial fibrillation (irregular heart rhythm at admissions), and hypotension (low blood pressure at admissions). The RP was listed as: the resident. Record review of Resident #1's hospital transfer medication orders, dated 4/16/25, reflected: the medication. Colchicine Oral Tablet 0.6 mg (colchicine) twice per day given 0000 (midnight) and 0600 (6:00 AM) was put on hold. Record review of Resident #1's hospital discharge record reflected: the medication colchicine 0.6 mg tablet (1/2 X0.6mg) PO 0000 (midnight), 0600 (6:00 AM). Last taken: 04/16/25 06:25 0.3 mg. [medication was started on 4/16/25 at midnight] Record review of Resident#1's admissions MDS, dated [DATE], reflected: BIMS score was 15, which indicated cognitively intact. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident# 1's Baseline Care Plan, dated 4/17/25, reflected the goals and interventions included: oxygen therapy related to history of pleural effusion (fluid buildup in tissue around lung and chest); and anticoagulant (blood thinner) and pain medications. Record review of Resident #1's Nurse Note, dated 4/16/25 at 6:22 PM, authored by RN A, reflected: Resident #1's hospital transfer medication list was reviewed with the MD and the MD discontinued colicine [medication for inflammation around the lungs and heart] and Toradol. Record review of Resident #1's Nurse Note, dated 4/17/25 at 4:35 PM, authored by RN A read, Resident seen on rounds by [MD] and rec'd order to restart colicine 0.3 mg BID. Resident own RP. Record review of Resident #1's hospital discharge record reflected: the medication colchicine 0.6 mg tablet (1/2 X 0.6mg) PO 0000 (midnight), 0600 (6:00 AM). Last taken: 04/16/25 06:25 0.3 mg. Record review of Resident#1's Nurse Note, dated 4/16/25 at 6:22 PM, authored by RN A read, Reviewed order with [physician], discontinued colchicine and Toradol Record review of Resident #1's Nurse Note, dated 4/17/25 at 4:35 PM, authored by RN A reflected: physician saw the resident and re-ordered the medication colchicine at 0.3 mg BID. Record review of Resident #1 's Physician' Orders, dated April 2025, reflected: the medication colchicine oral tablet 0.6 mg, 2 tablets per day was documented as ordered on 4/19/25. Record review of Resident #1 's MAR, dated April 2025, reflected colchicine oral tablet 0.6 mg was given on 4/18/25 at 50 minutes past midnight and at 11:00 PM; and on 4/19/25 at 50 minutes past midnight; and second dose not given to resident because the resident was sent to the ER for a change of condition (abdomen and lung pain). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/22/25 at 12:30 PM, the physician stated: she permitted the admission of Resident #1 into the facility on [DATE]. The Physician stated she reviewed with the facility's admitting nurse (RN A) the hospital's discharged medication orders and held the medication colchicine oral tablet 0.6 mg twice per day. The Physician stated without the complete medical record she viewed, the medication as a treatment for goat and the resident had no signs or symptoms of goat. The Physician stated when she visited the resident on 4/17/25 in the facility and had access to the complete hospital record, she re-instated the medication colchicine. The Physician stated the resident missed two doses of the medication from the time of admission but had no adverse effects because the half-life of the medication was 27 hours. The MD stated the resident missed two does because she (MD) held the medication pending further review of the hospital record. The Physician stated the resident's hospitalization on [DATE] was not related to the missed two doses of the medication on 4/16/25. The Physician stated the resident received colchicine on 4/18/25 and 4/19/25. The Physician stated, if I had seen the [hospital] record when the patient had been admitted , I would have continued the medication (colchicine). The Physician stated the facility failing to have the complete hospital record at admissions for her review negatively affected continuity of care. The Physician stated food was not required before or after the resident was given the medication. The Physician stated with the existence of the full hospital record, she realized the IC Specialist recommended the medication to deal with fluid in the heart and lungs; and not prescribed to the resident for goat. The Physician stated she explained to Resident #1 the medication colchicine was held because she (the Physician) did not have access to the full hospital record on 4/16/25. The MD stated she admitted the resident to the facility and issued admissions orders based on the hospital medication discharge list. During an interview on 4/22/225 at 12:45 PM, the NP stated regarding hospital records at admissions: full records were required as part of continuity or care. The NP stated the facility's failure to have full records on 4/16/25 for Resident #1 resulted in the Physician holding the medication colchicine. The NP stated, once the records were received and reviewed by the Physician, the hold on the medication colchicine was removed and the resident received the medications prior to the hospitalization on [DATE]. Attempted phone interview on 4/22/25 at 2:30 PM, with the Admission Coordinator. A message was left to return call to the state surveyor. During an interview on 4/22/25 at 2:31 PM, the Business Office Manager stated the process of admissions started with reviewing the clinical record from the hospital and determining whether the resident's needs could be met by the facility. The BOM stated the facility should have the clinical record to include the medication profile to discuss with the admitting physician. The BOM stated, the facility's procedure for all admissions was for the hospital record to be sent to the physician by email prior to any resident admitting to the facility. The BOM stated upon any admission the nurse either with verbal orders or the actual hospital record reconciled orders with the physician. The BOM stated she was not involved in the transfer of Resident #1 on 4/16/25. The BOM stated she was only a backup to the Admission Director when the latter was not available. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During telephone interview on 4/22/25 at 2:45 PM, Resident #1 stated she was not feeling well. Resident #1 stated she was pissed when not given her [colchicine oral tablet 0.6 mg twice per day] when admitted to the facility on [DATE]. Resident #1 stated the Physician explained to her at admissions the full hospital records were not available and she (the Physician) held back the colchicine medication. Resident #1 stated, once the full hospital records became available to the Physician, the Physician re-instated the colchicine medication; and she received the medication on the day of her ER transfer (4/19/25). Resident #1 stated she was sent to the ER because she had abdominal and chest pains not because of not receiving the medication colchicine at admissions. During telephone interview on 4/22/25 at 3:05 PM, Medication Aide B stated Resident #1 received her medications on time and never complained about the medications. Medication Aide B stated, Resident #1 did not require food with her medications. Medication Aide B stated she followed physician orders and documented in the April 2025 MAR all medications ordered by the physician to include colchicine. During an interview on 4/22/25 at 3:50 PM, RN A stated she was the admitting nurse on 4/16/25 at 5:06 PM for Resident #1. RN A stated at admissions she had the hospital medication list only and not the total hospital record; no labs, no H&P, and no other documentation. RN A stated she could not give an explanation why the facility did not have the total hospital record at the time of Resident #1's admission. RN A reviewed the hospital medication list at 6:22 PM with the admitting physician by telephone and the Physician held colchicine oral tablet 0.6 mg twice per day and Toradol because both medications affected the kidney and were not intended for long term use. RN A stated the Physician needed to review the entire hospital record before resuming the held medications. RN A stated the Physician received the records the next day (4/17/25) and re-ordered the held medication; the resident missed two doses of the colchicine. RN A stated, Resident #1 told her she (Resident #1) could not understand the reasoning for the colchicine not ordered at admissions; the resident was not concerned about the Toradol (anti-inflammatory medication) because it was a PRN medication. RN A stated complete admission records were required at time of admissions because you needed a complete history on the resident. During an interview on 4/22/25 at 4:10 PM, the DON stated Resident #1 was admitted without the medication colchicine because the physician was uncertain why the resident was on a goat medication and held the medication; the resident had no pain related to goat. The DON stated the physician saw the resident within 24 hours, reviewed the full hospital record and re-ordered the medication. The DON stated the facility should have had all the hospital records for the physician rather than just a medication list on admission for continuity of care. The DON stated there was no adverse effect to the resident by missing two doses of the medication. The DON stated he had no explanation why the total hospital record was not available to the physician at the time of the resident's admission. During an interview on 4/22/25 at 4:30 PM, the Administrator stated at admissions the facility should attempt to get the full hospital record because it tells us a story of the patient. The Administrator stated the full resident record allowed the admitting physician to provide continuity of care. The administrator stated she had no explanation for the admission manager not having readily available the full hospital record for the physician. During an interview on 4/23/25 at 8:45 AM, the Administrator stated the physician was sent by email on 4/16/25 the hospital Clinical Update pdf which included the hospital H&P. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Resident Admission Agreement, dated revised 10/14/2021, read, .The Resident or his or her Legal Representative, acknowledges that the Facility shall render medical services to the Resident under the general and specific instructions of the Resident's Attending Physician Record review of the facility's Admission policy, dated 10/24/22, read: .The facility will maintain an admission policy governing admission to the facility to ensure fair and impartial admission practices The policy did not address any admission checklist when the resident was transferred from the hospital to include reconciliation of hospital medications and availability of the hospital clinical record. Record review of the facility's Medication Reconciliation policy, dated 4/10/23, read, .Pre-Admission Processes: a. Obtain current medication list from referral sources (i.e., hospital .). The policy did not address to obtain the hospital clinical record for clinical notes in reference to the hospital medications. Record review of the facility's policies did not reflect a policy on the items to check when the facility accepted new admissions from a hospital for review by the admitting physician.