

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675700	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/30/2024
NAME OF PROVIDER OR SUPPLIER  Brookshire Residence and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  710 Hwy 359 S Brookshire, TX 77423	

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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46561</p> <p>Based on interview and record review, the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for one (Resident #3) of four residents reviewed for accommodation of needs.</p> <ol style="list-style-type: none"> <li>1. Resident #3 was taken in the personal vehicle of Driver A to a dialysis appointment. Her wheelchair could not be accommodated, and she was asked to use her walker for mobility.</li> <li>2. Resident #3 expressed being tired after dialysis and was left to wheel herself without assistance back to her room.</li> </ol> <p>This failure could decrease the resident's quality of life, increase anxiety, and put other residents at risk for not having their needs and preferences met.</p> <p>Findings included:</p> <p>Record review of Resident #3's face sheet revealed a seventy-year-old woman who was admitted to the facility on [DATE]. Her admitting diagnoses were end stage renal disease, anxiety disorder, dependence on renal dialysis (the process of removing excess water, solutes, and toxins from the blood in people whose kidneys can no longer perform these functions naturally), osteoarthritis (degenerative arthritis) of right hip, unsteadiness on feet, and abnormalities of gait and mobility.</p> <p>Record review of Resident #3's care plan revealed that she had limited physical mobility related to weakness and pain the right leg (revised 05/09/22). Interventions stated that to walk 10 feet, she required supervision or touching assistance by staff to walk as necessary. To wheel 50 feet, she required supervision or touching assistance by staff for locomotion using a wheelchair, and tasks were to provide supportive care and assistance with mobility as needed (revised 02/08/24).</p> <p>Record review of Resident #4's MDS assessment (clinical assessment to determine resident's strength and needs) set of Section C - Cognitive Patterns dated 03/07/24 revealed a score of 09/15, moderately impaired.</p> <p>Record review of Resident #3's progress notes documented on 05/27/24 at 9:30 am by LVN B stated that Resident went out to dialysis via facility van. Alert. Denied pain at this time. Respiration even and unlabored. No sign of distress of discomfort noted .</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 05/29/24 at 2:55 pm during Resident Council, Residents were asked if they had ever missed an appointment due to the facility transportation van being out of service. Resident #3 explained that when the facility van was broken, the facility would usually coordinate with a different transportation company to fill in. She explained that the last time she went to dialysis on 05/27/24, she went in Driver A's personal car because they could not get another transportation company to come out. Resident #3 also voiced the concern that after she had returned from dialysis, she was often drained and she would have to wheel herself back to her room, which was quite some distance from the drop off destination.</p> <p>In an interview on 05/30/24 at 8:35 am with Resident #3, she stated that when she went to dialysis on 05/27/24 in Driver A's personal car, she had to leave her wheelchair behind because it would not fit in the car and they had to take her walker instead. She expressed that she had problems balancing herself so she had to take her time walking because she felt like she would fall and it made her very nervous. She explained that Driver A took her to her appointment in her personal car because on her way to dialysis the week prior, Driver A and herself witnessed a tire blowout from an 18-[NAME] truck. She felt like this prompted Driver A to check the van the next scheduled appointment day, but she felt like as the driver, she should have been checking the van at the end of each day to ensure that it was in good condition for its next trip. She explained that when she usually came back from her four-hour dialysis appointment, Driver A would punch in the code for the facility door in the front of the building and that would be it. She explained that she would never assist her back to her room by pushing her wheelchair and if done, she would have to ask first. Resident #3 also stated that at the Dialysis Center, the protocol is for all visitors to press a button and wait for a staff member to come to the door and escort them inside. She said that Driver A would walk alongside her as she rolled herself to the door, punch the button, and drive off. Driver A never waited until Resident #3 was met with the Dialysis center staff or was safely inside of the building.</p> <p>In an interview on 05/30/24 at 10:24 am, Driver A stated that she took Resident #3 in her personal car on 05/27/24 after she noticed that the facility van's tire was unraveled. She stated that she was not going to take a chance and she let LVN B know. She explained that she had no other way to get Resident #3 to her appointment and if she called the alternate transportation company, it would take too long and Resident #3 would be late. She stated that the Dialysis center was 12 minutes away and she used quick judgement because she was not going to drive the van. She explained that Resident #3's wheelchair did not fit, and they took her walker instead because she could walk. The interview was cut short so that Driver A could transport a resident to their upcoming appointment.</p> <p>In an interview on 05/30/24 at 10:55 am with the DON, she stated that she did not know that Driver A had transported Resident #3 to Dialysis on 05/27/24 in her personal vehicle until earlier that day. She explained that this action could be a liability and the chain of command would consist of herself, the DON, followed by the Admin. The DON said she questioned whether LVN B knew Resident #3 was not transported by the facility van because she would not have documented that if it was not factual.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 05/30/24 at 11:32 am, Admin stated that he did not know if there was any harm in having a resident in a personal vehicle because it was the same driver driving the car, who drove the van. The Admin said he did not see the potential for harm in this situation because it was the same driver and Resident #3 had to go to dialysis. He stated that he would have liked to be included in the decision, but he was glad that she made it to her appointment. When he was informed about Resident #3 not being pushed back to her room after dialysis appointment, he stated that he had asked Driver A and she said that she had started pushing her back to her room.</p> <p>In a follow up interview with Resident #3 on 05/30/24 at 12:04 pm, she stated that she could not recall the last time that Driver A pushed her to her room. She stated that perhaps it was around the time that she first was admitted to the facility.</p> <p>In an interview on 05/30/24 at 12:59 am, DN F stated that Resident #3 was always on time for her appointments, but her problem with transportation was that Driver A never pushed Resident #3 inside the Dialysis Center. She stated that Driver A would walk with Resident #3 as she wheeled herself to the door, push the call button and leave. She stated that the driver would never wait for staff from the center to open the door. She explained that after dialysis, Resident #3 is usually very tired, and she would often have to wait for Driver A because she was not outside once dialysis was over. She also noted that after dialysis, Resident #3 would have to wheel herself from inside the center back outside to the van. DN F expressed that it was bad that she had to wait.</p> <p>An interview was attempted on 05/30/24 at 1:03 pm with LVN B by telephone. LVN B did not answer the call and a voicemail was left. No call back was received.</p> <p>In a follow up interview on 05/31/24 at 1:47pm, Driver A stated that the protocol for residents when they attend their dialysis appointments was that she would push those who were not able to push themselves inside the building. She stated that Resident #3 could push herself and she did ask her on 05/29/24 to be pushed inside because her arms were hurting. She explained that she pushed her inside and that was it. Driver A stated that when it came to Resident #3, she never got pushed, Never. She said that when it came to her residents, she would see what they needed. If she felt like they needed to be pushed, then that was what she would do and explained that if residents are able to push themselves, I let them. Why take that away from them?. Driver A said she could not say how Resident #3 moved when using her walker on 5/27/24 because she was always in a wheelchair.</p> <p>Record review of the facility's transportation policy (not dated) stated that the facility shall help arrange transportation for residents as needed.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46561</p> <p>Based on observation, interview, and record review the facility failed to provide the necessary services to maintain grooming and personal care for two (Resident #1 and Resident #2) of ten residents reviewed for ADL care.</p> <ol style="list-style-type: none"> <li>1. Resident #1 had not had a shower since 05/11/24.</li> <li>2. Resident #2 did not receive his scheduled shower on 05/28/24.</li> </ol> <p>These failures could place residents at risk for skin break downs, odor, and diminished quality of life.</p> <p>Findings included:</p> <p>Resident #1</p> <p>Record review of Resident #1's face sheet revealed a sixty-eight-year-old woman who was readmitted to the facility on [DATE]. Her admitting diagnoses were Parkinson's disease (progressive disorder that affects the nervous system), cerebral infarction (stroke), hypertensive heart failure, and chronic obstructive pulmonary disease (COPD- lung disease). Her face sheet also indicated that she had a C bed with an even room number.</p> <p>Record review of Resident #1's care plan revealed that she had the potential for impairment to skin integrity, fragile skin, and limited mobility. Interventions initiated on 04/19/21 stated to keep skin clean and dry and perform weekly skin assessments (dated 4/13/21). Resident #1 also had an ADL self-care performance deficit related to confusion, dementia, impaired balance/mobility, and Parkinson's. Interventions included that the resident required substantial/maximal assistance by staff with bathing/showering 3x per week and as necessary, revised 02/08/24.</p> <p>Record review of Resident #1's MDS (clinical assessment to determine resident's strength and needs) Section C - Cognitive Patterns revealed a score of 10/15, moderately impaired.</p> <p>Record review of the facility Shower schedule stated that on Monday, Wednesday, and Friday, A beds with even room numbers showers should be completed on the 6am-2pm shift and A beds with odd room numbers showers should be completed on the 2pm-10pm shift. On Tuesday, Thursday, and Saturday, all B and C beds with even room numbers should complete showers on the 6am-2pm shift and odd room numbers should be completed on the 2pm-10pm. This indicated that Resident #1 was scheduled to receive showers on Tuesday, Thursday, and Saturday on the 6am-2pm shift.</p> <p>Record review of the shower sheets on 05/30/24 for Halls C and D for the month of May 2024 revealed that Resident #1 had received a shower on 5/11/24. No other shower sheets could be located for this resident.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's ADL Updates for showers in PCC (resident information database) for a 28-day focus from May of 2024 revealed that there were no ADL updates and no notification for showers.</p> <p>In an interview on 05/29/24 at 2:40 pm during the Resident Council, attendees were asked if anyone had not received a shower that week. Resident #1 stated that the last time she received a shower was 3 weeks ago.</p> <p>A follow up interview was attempted on 05/30/24 at 9:50 am, however Resident #1 was in therapy.</p> <p>In an interview on 05/30/24 at 9:52 am, CNA B stated she is the head CNA and she does not normally work on the floor, unless someone had called out like they did today. She explained the main way of documenting showers were first done through the shower sheet and followed by a PCC (online resident portal) entry. She stated that some staff would give showers, but they refused to do shower sheets. When she was on the floor, she explained that she would do showers, even if they were short. Regarding Resident #1, she stated that she gave her a bed bath during the morning of 05/29/24 after therapy and she documented it under bed bath in PCC. She explained that she gave her bed bath on a day that she was not assigned be showered because she tried to do that when she worked the floor and felt a resident needed to be cleaned up. The surveyor let her know that after review of the shower sheets, only one sheet documented a shower on 5/11/24 and she confirmed that she had given that shower. CNA B was informed about residents not consistently getting showers per the shower sheets. She was surprised and said she did not know that was happening. She explained the harm in residents not getting showers were that they could get skin breakdowns, odors, and flaky skin.</p> <p>Resident #2</p> <p>Record review of Resident #2's face sheet revealed a sixty-four-year-old man who was admitted to the facility on [DATE]. His admitting diagnoses were a displaced fracture of the right femur, hypertensive heart failure, muscle wasting and atrophy (tissue or organ wasting), and major depressive disorder. His face sheet also indicated that he had a B bed with an odd room number.</p> <p>Record review of Resident #2's care plan revealed that he had the potential for impairment to skin integrity, fragile skin, and incontinence revised 10/18/22. Interventions stated to keep skin clean and dry and perform weekly skin assessments (dated 12/16/22). Resident #2 also had an ADL self-care performance deficit related to dementia, impaired balance, and CVA (stroke). Interventions included that the resident required partial/moderate assistance by staff with bathing/showering 3x per week and as necessary, revised 02/08/24.</p> <p>Record review of Resident #2's MDS (clinical assessment to determine resident's strength and needs) Section C - Cognitive Patterns revealed a score of 3/15, severe cognitive impairment.</p> <p>Record review of the facility Shower schedule stated that on Monday, Wednesday, and Friday, A beds with even room numbers showers should be completed on the 6am-2pm shift and A beds with odd room numbers showers should be completed on the 2pm-10pm shift. On Tuesday, Thursday, and Saturday, all B and C beds with even room numbers should complete showers on the 6am-2pm shift and odd room numbers should be completed on the 2pm-10pm. This indicated that Resident #2 was scheduled to receive showers on Tuesday, Thursday, and Saturday on the 2pm-10pm shift.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the shower sheets on 05/29/24 for Halls C and D dated 05/29/24- 05/14/24 revealed that Resident #2 had one shower sheet dated 5/14/24.</p> <p>In an interview on 05/29/24 at 1:42 pm, Resident #2 stated that his shower was due on Tuesday, but he did not get one yesterday and no one ever showed up. He could not remember when the last shower was he received.</p> <p>In an observation and interview on 05/29/24 at 2:00 pm, the surveyor looked through the shower sheets at the nurse's station for Hall C and D. It was observed that no shower sheet could be located for Resident #2. Resident #2 wheeled himself from his room on Hall C and sat at the nurse's station. The surveyor asked the group of 4 staff members if those papers consisted of all the shower sheets and a nurse responded yes. The surveyor asked aloud Did Resident #2 receive a shower on Tuesday 05/28/24?. In a rude and elevated tone, CNA T responded NO, he did not get a shower yesterday. CNA T stated Resident #2 did not get a shower yesterday because there were only 2 aides on Hall C and D and she couldn't give him a shower. CNA T stated that if she could not give a resident a shower on their designated shower days, they would have to miss a day, but stated she would personally give Resident #2 one today because she was backed up yesterday and didn't have the support.</p> <p>In an interview on 05/30/24 at 6:29 am, LVN A stated that some residents would tell her if they did not receive their shower. She stated that during the morning of 05/29/24, Resident #2 told her that he did not receive his shower. She explained that there are no shower techs and aides are responsible for doing their own showers. She said that aides would often state that if they did not give a shower, it would be because they did not have enough people on the floor, and it would be too much to do that day.</p> <p>In an interview on 05/30/24 at 9:41 am, CNA A stated that showers are to be documented through the shower sheets. Some residents were hospice, some were self-showers, and some would refuse, all of which should be documented. She stated that she was at the nurse's station when CNA T spoke like that in front of the resident and it made her mad because even if they were short, stuff still needed to get done. She explained candidly that if a shower sheet was not done, then a resident did not receive a shower.</p> <p>In an interview on 05/30/24 at 10:06 am, ADON stated that Resident #1 had a bed bath on 05/29/24 and a shower on 05/30/24. She stated there was no documentation in PCC for her showers because all of her information had not been uploaded yet and they could only update from the shower sheet to PCC. She was informed that only 1 shower sheet was located for Resident #1 on 05/11/24 and PCC should only reflect one shower sheet per her explanation. ADON stated that the only staff to come to her about not being able to give showers due to shortages was CNA T, and that shower would have to be given to the next shift. ADON did not have a response as to why CNA T, who worked the 2pm-10pm shift and told her about being short staffed on 05/28/24, did not inform the 10pm-6am or 6am-2pm shift that Resident #2 needed a shower. She stated that an in-service had been started and ongoing in regard to this matter. No copy of the in-service was attained. She explained that the responsibility to make sure residents received their showers fell on the nurses.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 05/30/24 at 10:55 am with the DON, she stated that the shower sheets are the main source of documenting showers and that they had not fully transitioned to PCC. When told about the conversation had with CNA T at the nurse's station, she expressed that CNA T was lazy and her response was just an excuse to not do any work. She said the upper management was working on letting her go from the facility but still did not want to be short staffed. She agreed that it was all in how staff communicated with the residents. She explained the harm in residents not getting scheduled showers were that there could be a risk in skin problems going undocumented, unnoticed, and skin breakdowns.</p> <p>Record review of the facility's Activities of Daily Living (ADLs), Supporting policy (not dated) listed: Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.</p> <p>1. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with:</p> <ol style="list-style-type: none"> <li>1. Hygiene (bathing, dressing, grooming, and oral care);</li> <li>2. Mobility (transfer and ambulation, including walking);</li> <li>3. Elimination (toileting);</li> <li>4. Dining (meals and snacks); and</li> <li>5. Communication (speech, language, and any functional communication systems).</li> </ol> <p>2. Interventions to improve or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, preferences, stated goals and recognized standards of practice.</p> <p>3. The resident's response to interventions will be monitored, evaluated and revised as appropriate.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46561</p> <p>Based on interview and record review, the facility failed to ensure each resident received food that accommodates resident preferences for one (Resident #4) of 3 residents reviewed for food preferences.</p> <p>1. Resident #4 required total assistance during feedings and was served cold food during mealtimes.</p> <p>This failure could place resident who require assistance from staff during mealtimes at risk of not enjoying meals that meet their preferences.</p> <p>Findings Included:</p> <p>Record review of Resident #4's face sheet revealed an eighty-one-year-old woman who was admitted to the facility on [DATE]. Her admitting diagnoses were hemiplegia (total paralysis) and hemiparesis (partial paralysis) following cerebral infarction affecting left non dominant side, dysphagia (difficulty swallowing), encounter for attention to gastronomy (attention to how food is prepared), and cerebral infarction (stroke).</p> <p>Record review of Resident #4's care plan revealed that she had an ADL self-care performance deficit related to dementia, hemiplegia/paresis, impaired balance, and limited mobility. Intervention revised 01/16/23 stated that Resident #4 required substantial/maximal assistance by staff to eat and required g-tube feeding.</p> <p>Record review of Resident #4's MDS (clinical assessment to determine resident's strength and needs) Section C - Cognitive Patterns dated 05/01/24 revealed a score of 3/15, severely impaired.</p> <p>In an interview on 05/29/24 at 3:15 pm during Resident Council, Resident #3 stated that there were people who needed to be fed, but there would only be one aide to feed them. She explained that by the time the staff would come back around to feed them, the food would be cold. Another resident (name undisclosed) in the council agreed and stated that they should not have to ask for their food to be warmed up because it was a common consideration and you should treat people the way you wanted to be treated.</p> <p>In an interview on 05/30/24 at 8:29 am with Resident #4, she stated that she can eat breakfast, lunch, and dinner by mouth. She described her food as warm today but said it was usually cold. Resident #4 said that it would be delivered to her hot, but by the time the aide would come back to feed her, the food would be cold. When asked, staff would warm her food up in the microwave, but it was only on request, and she shrugged her shoulders and said most of time she would let it be.</p> <p>In a follow up interview on 05/30/24 at 8:35 am with Resident #3, she expressed that she knew they never warmed up Resident #4's food and can recall that it had sat there for 30 minutes before in the past. She stated that bothered her.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 05/30/24 at 10:06 am, the ADON was informed that residents that required feeding assistance were receiving food that was cold. She agreed that staff should be warming up food if the food was cold. Residents have the right to have hot meals.</p> <p>Record review of the facility's policy titled Resident Rights (not dated) listed: Employees shall treat all residents with kindness, respect, and dignity.</p> <p>No dietary policy was requested.</p>		