STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675537	A. Building B. Wing	03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brownwood Nursing and Rehabilitation	101 Miller Dr Brownwood, TX 76801

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 - Some	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** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 5 of 5 (Resident #1, Resident #2, Resident #3, Resident #4, and Resident #5) residents reviewed for comprehensive person-centered care plans.1. The facility failed to develop a care plan based on assessed needs with measurable objectives in the areas of Hypertension, adverse medication effects, altered cardiac problems, and Intravertebral disc disorder/Stenosis for Resident #1.2. The facility failed to develop a care plan based on assessed needs with measured objectives in the areas of Anticoagulant therapy, Seizure Disorder, hypertension, diuretic therapy, impaired visual function, hearing deficit, use of antidepressant medication, and use of anti-anxiety medication for Resident #2.3. The facility failed to develop a care plan based on assessed needs with measured objectives in the areas of Hypertension, Hypothyroidism, Cerebral Vascular Accident (stroke), antiplatelet medication, Advanced Stage Alzheimer's Dementia, and impaired visual function for Resident #3.4. The facility failed to develop a care plan based on assessed needs with measured objectives in the areas of Anticoagulant therapy, hypertension, diuretic therapy, impaired thought processes, impaired visual function, and use of antidepressant medication for Resident #4.5. The facility failed to develop a care plan based on assessed needs with measured objectives in the areas of Diabetes Mellitus Type 2, edema, adverse medication effect, Hypertension, impaired visual function, hearing deficit, urinary retention related to indwelling Foley Catheter, and use of antidepressant medication for Resident #5. These failures could place residents at risk for not receiving care and services to meet their needs and deficits.The findings include:1. Record review of Resident #1's Facesheet, dated 03/16/2026, revealed a [AGE] year-old male, with an admission date into the facility of 12/18/2025. Resident #1 had diagnoses which included Metabolic Encephalopathy (a syndrome of brain dysfunction caused by systemic illness, organ failure, or toxic substances, rather than direct structural brain injury), Essential (Primary) Hypertension (chronic high blood pressure without a known single organic cause) and Intervertebral disc stenosis of neurol canal of cervical region (the narrowing of the spinal canal caused by degeneration of the cushioning discs, bone spurs, or thickened ligaments, which compresses spinal nerves).Record review of Resident #1's admission MDS assessment, dated 12/22/2026, revealed Resident #1's BIMS score was 04, which indicated severe cognitive impact. Section I - Active Diagnoses revealed Resident #1 had Other Neurological Conditions as I0020 was coded 07, with diagnoses which of Hypertension and Coronary Artery Disease (a common heart condition caused by plaque buildup in the heart's arteries, restricting blood flow and oxygen, which can cause pain, shortness of breath, and heart attacks).Record review of Resident #1's Care Plan, with recent review date of 04/12/2025, revealed objectives that lacked the ability to be evaluated, quantified, and verified were: The Resident will remain free of (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 - Some	complications related to Hypertension through the review date (Hypertension); Resident will be free from adverse medication effects. (Adverse medication effects and behavior monitoring); Resident will remain free from s/sx of complications of cardiac problems thorough the review date (altered cardiovascular); Resident will remain free from pain or at level of discomfort acceptable to the resident through the next review date (Intervertebral Disc Disorder/Stenosis (abnormal narrowing of the spinal canal) 2. Record review of Resident #2's Facesheet, dated 03/16/2026, revealed a [AGE] year-old male, with an admission date into the facility of 01/17/2026. Resident #2 had diagnoses which included Unspecified Dementia (diagnosis used when symptoms of cognitive decline, such as memory loss, confusion, and impaired thinking, are present, but the underlying cause cannot be definitely determined or does not fit a specific pattern), unspecified severity, without behavioral disturbance, Unspecified atrial fibrillation (a common, often chronic, heart rhythm disorder where the upper chambers beat rapidly and irregularly), bradycardia (resting heart rate below 60 beats per minute), Anxiety Disorder, Other seizures, Essential (Primary) Hypertension and Chronic obstructive pulmonary disease (a progressive, incurable inflammatory lung disease causing obstructive airflow).Record review of Resident #2's admission MDS assessment, dated 12/17/2025, revealed Resident #2's BIMS score was 15, which indicated Intact Cognitive Response. Section I - Active Diagnoses revealed Resident #2 Non-traumatic Brain Dysfunction as I0020 was coded 02 with diagnoses of Hypertension, Non-Alzheimer's Dementia (neurodegenerative or vascular conditions causing cognitive decline), and Seizure Disorder (a neurological condition characterized by recurrent, unprovoked seizures caused by sudden, abnormal electrical activity in the brain).Record review of Resident #2's Care Plan, with recent review of date of 03/11/2026, revealed objectives that lacked the ability to be evaluated, quantified, and verified were: The resident will remain free from discomfort or adverse reactions related anticoagulant use through the review date. (Anticoagulant therapy); The resident will remain free from injury related to seizures activity related to seizures. (Seizure Disorder);The Resident will remain free of complication related to hypertension through review date. (hypertension); The Resident will be free of any discomfort or adverse side effects of diuretic therapy through the review date. (diuretic therapy); The Resident will maintain optimal quality of life within limitation imposed by visual function through the review date. (impaired visual function); Resident will maintain the highest level of communication for this resident through the next review date. (hearing deficit); The resident will be free from discomfort or adverse reactions related to antidepressant therapy through the review date. (use of antidepressant medication); The resident will be free from discomfort or adverse reactions related to anti-anxiety therapy. (use of anti-anxiety medication). 3. Record review of Resident #3's Facesheet, dated 03/16/2026, revealed an [AGE] year-old male, with an admission date into the facility of 02/11/2026. Resident #3 had diagnoses which included Other Acute Kidney Failure (a sudden, often reversible, drop in kidney function occurring within hours or days), Unspecified Dementia, Wedge compression fracture of first lumbar vertebra (occurs when the front part of the lumbar 1 vertebra collapse, often caused by osteoporosis), Essential (Primary) Hypertension, and unspecified glaucoma (a diagnosis of glaucoma where specific type, such as open-angle or angle-closure, has not been defined).Record review of Resident #3's admission MDS assessment, dated 02/13/2025, revealed Resident #3's BIMS score was 00, which indicates severe cognitive impact. Section I - Active Diagnoses revealed Resident #3 had Medically Complex Condition as I0020 was coded 13 with active of Hypertension, Renal insufficiencies (a condition where kidney underperform, failing to properly filter waste, balance electrolytes, or regulate blood pressure), and other fractures. Record review of Resident #3's Care Plan, with recent review of 03/01/2026, revealed objectives that lacked the ability to be evaluated, quantified, and verified were: The Resident will remain free of complications related to Hypertension/Hyperlipidemia through the review date.(Hypertension); The Resident will be free from s/sx of hypothyroidism through the review date. (hypothyroidism); The Resident will be free from s/sx of complications R/T Hx of CVA, needs will be met and dignity will be maintained through the next review date. (Cerebral Vascular (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Accident (stroke); The resident will be free from discomfort or adverse reactions related to antiplatelet use through the review date. (antiplatelet medication); The Resident will have needs anticipated and met by staff and dignity will be maintained daily through the next review date. (Advanced Stage Alzheimer's Dementia); The Resident will have no indications of acute eye problems through the review date. (impaired visual function). 4. Record review of Resident #4's Facesheet, dated 03/16/2026, revealed a [AGE] year-old female, with an admission date into the facility of 10/28/2025. Resident #4 had diagnoses which included Chronic obstructive pulmonary disease, Cognitive Communication Deficit (a communication impairment resulting from underlying cognitive issues, such as memory, attention, or executive function, rather than a primary language disorder), and Depression, unspecified (a common, serious mood disorder characterized by persistent sadness, loss of interest, and low energy, affecting daily functioning).Record review of Resident #4's Quarterly MDS assessment, dated 12/17/2025, revealed Resident #4's BIMS score was 13, which indicated intact cognition response. Section I - Active Diagnoses revealed Resident #4 had had Medically Complex Condition as I0020 was coded 13 with diagnoses of Hypertension, Depression, Mild cognitive impairment (a stage between normal aging and dementia, involving noticeable memory or thinking problems that do not significantly interfere with daily independence), and Chronic Obstructive Pulmonary Disease.Record review of Resident #4's Care Plan, with recent review date of 04/16/2026, revealed objectives that lacked the ability to be evaluated, quantified, and verified were: The resident will be free from discomfort or adverse reactions related to anticoagulant use through the review date. (Anticoagulant therapy); The resident will remain free of complication related to hypertension through review date. (Hypertension); The resident will be free of any discomfort or adverse side effects of diuretic therapy through the review date. (diuretic therapy); The resident will maintain current level of cognitive function through the review date. (impaired thought processes); The Resident will maintain optimal quality of life within limitation imposed by visual function through the review date.(impaired vision). 5. Record review of Resident #5's Facesheet, dated 03/16/2026, revealed a [AGE] year-old female, with an admission date into the facility of 12/30/2025. Resident #3 had diagnoses which included Displaced fracture of glenoid cavity of scapula (a shallow, pear-shaped articular surface located on the lateral angle of the shoulder blade), left shoulder subsequent encounter for fracture with routine healing, Type 2 diabetes (a chronic condition where the body resists insulin or fails to produce enough, causing high blood sugar), Mild cognitive impairment (a stage between normal aging and dementia, involving noticeable memory or thinking problems that do not significantly interfere with daily independence), and unspecified atrial fibrillation.Record review of Resident #5's admission MDS assessment, dated 12/31/2025, revealed Resident #5's BIMS score was 07, which indicated moderate impairment. Section I - Active Diagnoses revealed Resident #5 had Fractures and Other Multiple Trauma as I0020 was coded 10 with Encounter Orthopedic aftercare, Hypertension, and Diabetes Mellitus (chronic metabolic disorder characterized by high blood sugar due to insufficient insulin production or ineffective insulin use).Record review of Resident #5's Care Plan, with recent review date of 01/29/2026, revealed objectives that lacked the ability to be evaluated, quantified, and verified were: The Resident will have no complications related to Diabetes through the review date. (Diabetes Mellitus Type 2); The resident's fluid balance will improve or not worsen through the next review date. (edema); The Resident will be free from adverse medication effects through next review date. (adverse medication effect); The resident will remain free of complication related to hypertension through review date. (hypertension); The Resident will have no indications of acute eye problems through the review date. (impaired visual function); Resident will maintain the highest level of communication for this resident through the next review date. (hearing deficit); The Resident will be/remain free from catheter-related trauma through review date. (urinary retention related to indwelling Foley Catheter); The Resident will be free from discomfort or adverse reactions related to antidepressant. (use of antidepressant medication). During an interview on 03/16/2026 at 12:20 p.m., MDS Coordinator A said she developed the goals for the care plan, and the (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	IDT reviewed and approved the goals. MDS Coordinator A said after the first quarter from the admission date, the IDT would review the goals and determine if the outcomes were measurable. MDS Coordinator A said she knew the goals in the care plans were not measurable, but she was doing her best to get the goals measurable. MDS Coordinator A said she and MDS Coordinator B were working together to develop goals that were measurable. During an interview on 03/16/2026 at 12:25 p.m., MDS Coordinator B said she agreed the goals in the care plans should be more measurable. MDS Coordinator B said the goals should be measurable to ensure the residents received the best services and care. During an interview on 03/16/2026 at 12:43 p.m., the DON said the IDT was responsible for creating the outcomes and to ensure the outcomes were measurable. The DON said she agreed the outcomes needed to be measurable so the facility can measure progress and decline. During an interview on 03/16/2026 at 1:37 p.m., the Administrator said she agreed the goals were not measurable and the issue was a pattern. The Administrator said goals should be written to be achievable so the resident could succeed the best and receive the correct services. Record review of the facility's policy, Comprehensive Care Planning, not dated, revealed the facility will develop and implement a comprehensive person- centered care plan for each resident, consistent with the resident rights that include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.