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	04/15/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the resident environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistance devices to prevent accidents for of 3 residents 18 (Resident #13, Resident #1, and Resident #25) reviewed for accidents. 1. The facility failed to ensure Resident #13 wore a smoking apron when smoking as per her safe smoking assessment. 2. The facility failed to ensure Resident #1 had a safe smoking assessment completed prior to allowing him to smoke.3. The facility failed to ensure Resident#25 had a safe smoking assessment completed prior to allowing him to smoke. These failures could place residents at risk of injury and serious bodily harm.Findings include: 1.ˆ Record review of Resident #13's electronic face sheet, accessed on 04/15/2026, revealed a [AGE] year-old female who was admitted to the facility on [DATE], with diagnoses that included: Schizoaffective Disorder, Bipolar Disorder, and anxiety. Record review of Resident #13's Annual MDS assessment, dated 08/26/2025, revealed a BIMS of 15, which indicated no cognitive impairment. Further review revealed Resident #13 used tobacco.Record review of Resident #13's care plan, last reviewed on 01/21/2026, revealed: Focus: Resident smokes, resident lit a cigarette using a lit cigarette and knocked fire off which she burned clothes.Interventions. Resident to wear smoking apron . Record review of Resident #13's Safe Smoking Assessment, dated 04/06/2026, revealed: .This resident requires a fire-resistant smoking apron while smoking.During an observation on 04/13/2026 at 1:30 PM, Resident #13 was smoking with no apron on.During an interview on 04/15/2026 at 9:42 AM, Resident #13 stated that she never wore an apron and that she did not know she was supposed to wear an apron because she always followed the rules. During an observation on 04/14/2026 at 11:02 AM, Resident #13 was smoking with no apron on.During an observation on 04/14/2026 3:30 PM, Resident #13 was smoking with no apron on.2.ˆ Record review of Resident #1's electronic face sheet, accessed on 04/15/2026, revealed a [AGE] year-old male who was admitted to the facility on [DATE] and re-admitted on [DATE], with diagnoses that included: Chronic Obstructive Pulmonary Disease, Bipolar Disorder, and dementia. Record review of Resident #1's Annual MDS assessment, dated 03/27/2026, revealed a BIMS of 12, which indicated no cognitive impairment. Further review revealed Resident #1 used tobacco.Record review of Resident #1's care plan, initiated on 03/25/2026, revealed: Focus: Resident is a smoker. Resident noncompliant with smoking schedule and policy.Interventions: Perform smoking assessment according to facility policy.Record review of Resident #1's electronic medical record on 04/15/2026 revealed no evidence of a Safe Smoking Assessment.During an observation on 04/13/2026 at 1:30 PM, Resident #1 was smoking.During an observation on 04/14/2026 at 11:02 AM, Resident #1 was smoking.During an observation on 04/14/2026 3:30 PM, Resident #1 was smoking.3.ˆ Record review of Resident #25's electronic face sheet, accessed on 04/15/2026, revealed a [AGE] year-old male who was admitted to the facility on [DATE] and re-admitted on [DATE], with diagnoses that included: respiratory failure, tracheostomy, and dementia. Record review of Resident #25's Annual MDS assessment, dated 03/11/2026, revealed a BIMS of 09, which indicated moderate cognitive impairment. Further review revealed Resident #25 (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	used tobacco.Record review of Resident #25's care plan, initiated on 03/06/2026, revealed: Focus: Resident is a smoker.Interventions: Perform smoking assessment according to facility policy.Record review of Resident #25's electronic medical record on 04/15/2026 s revealed no evidence of a Safe Smoking Assessment. During an observation on 04/13/2026 at 1:30 PM, Resident #25 was smoking.During an observation on 04/14/2026 at 11:02 AM, Resident #25 was smoking.During an observation on 04/14/2026 3:30 PM, Resident #25 was smoking.During an observation and interview on 04/15/2026 11:00 AM, the DM was handing out cigarettes to residents. Smoking aprons were hanging on the hook outside, but no residents were offered a smoking apron. DM stated that she was not aware of any residents requiring an apron and that she has never seen any residents wearing aprons. She stated there was not a list of who required aprons, just a list of what cigarettes each resident smokes. No list observed in the cigarette box.During an interview on 04/15/2026 at 11:20 AM, the ADMN stated that all residents who smoked required a smoking assessment to determine if they were safe smokers and what precautions need to be taken. She stated that she was only aware of 3 residents who required aprons. She stated that some residents refuse to wear aprons. She stated that the apron should always be offered, and it should be in the care plan and documented if the resident refused the apron. She stated that there was no way to know if a resident was a safe smoker and what precautions needed to be taken if there was no assessment. She stated that Resident #1 was not smoking when he got back from the hospital and just began again last week. She stated that if a resident was deemed to need an apron that not requiring an apron could result in burns or injuries. She stated that there is a list with cigarettes that stated what precautions were needed with each resident. Review of facility policy titled, Smoking Policy, revised 11/1/17, revealed in part: Smoking policies must be formulated and adopted by the facility.The facility is responsible for enforcement of smoking policies which must include at least the following provisions: .A safe smoking assessment will be done regularly for each resident who smokes.If the facility identifies that the resident needs assistance/supervision and/or protective devices for smoking, the facility includes this information in the residents care plan, and reviews and revises the plan periodically as needed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 5 (LVN D) staff and 2 of 18 (Resident #22 and Resident #64) reviewed for infection control procedures.The facility failed to ensure LVN D followed EBP while managing Resident #68's central line (a long, flexible catheter inserted into a large vein near the heart to deliver medications, fluids, or monitor blood flow over an extended period) on 4/13/26. The facility failed to ensure LVN D followed EBP while managing a Resident #58's G-tube (medical device inserted through the abdomen directly into the stomach) on 04/14/2026.The facility failed to ensure staff were notified of EBP for Resident #22 and Resident #64.The facility failed to have a PPE readily accessible to staff outside or inside of Resident #22's and Resident #68's room on 04/13/2026. These failures could place residents at risk for the transmission of communicable diseases.Findings included:Resident # 68Record review of Resident #68's electronic face sheet, dated 04/15/2026, reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnosis including osteomyelitis of the left ankle (infection of the bone). Record review of Resident #68's admission MDS assessment, dated 04/02/2026, reflected a BIMS score of 12 indicating moderate cognitive impairment. Further review reflected he was taking high-risk medication antibiotic, received IV medications and had an IV access site.Record review of Resident #68's electronic physician's order, dated 03/31/2026, reflected enhanced barrier precautions.Record review of Resident #68's comprehensive care plan, dated 03/31/2026, reflected Resident is on enhanced barrier precautions with interventions including Gloves and gown should be donned if any of the following activities are to occur: linen change, resident hygiene, transfer, dressing, toileting/incontinent care, bed mobility, wound care, enteral feeding care, catheter care, trach care, bathing, or other high-contact activity.During an observation on 4/13/2026 at 11:27 a.m., LVN D entered Resident #68's room to perform IV medication administration. There was an EBP sign to the left of Resident #68's door. There were no PPE on the door in inside of the room. LVN D performed hand hygiene by washing hands in sink with soap and water then drying them. She looked around room for gloves and stated she thought there were gloves in the room. LVN D left room and gathered supplies including alcohol wipes, saline flushes, and gloves from her medication cart. She then re-entered room and performed hand hygiene again. LVN D put on gloves and administered IV medication into central line (a long, flexible catheter inserted into a large vein near the heart to deliver medications, fluids, or monitor blood flow over an extended period) on Resident #68's right upper arm. No gown was worn by LVN D during IV medication administration including flushing the central line with normal saline, wiping down the IV port with alcohol wipes, or connecting and infusing IV medication into the central line.Resident #58Record review of Resident #58's electronic face sheet, dated 04/15/2026, reflected a [AGE] year-old male admitted on [DATE] and re-admitted on [DATE] with diagnosis including gastrostomy status (G-tube present).Record review of Resident #58's significant change MDS assessment, dated 01/28/2026, reflected Resident #58 was unable to complete the interview for BIMS score. Further review reflected Resident #58 used a feeding tube.Record review of Resident #58's electronic physician orders, dated 07/10/2025, reflected enhanced barrier precautions.Record review of Resident #58's comprehensive care plan, dated 07/09/2025, reflected Resident is on enhanced barrier precautions with interventions including Gloves and gown should be donned if any of the following activities are to occur: linen change, resident hygiene, transfer, dressing, toileting/incontinent care, bed mobility, wound care, enteral feeding care, catheter care, trach care, bathing, or other high-contact activity.During an observation and interview on 04/14/2026 at 1:13 p.m., LVN D performed medication pass to Resident #58 via G-tube. She performed hand hygiene when entering room prior to putting on gloves. She checked (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	placement of G-tube after getting supplies set up on bedside table. She administered liquid iron through the G-tube after flushing tube with 10ml water. She then administered nutritional supplement after flushing G-tube with 10ml water. She did not wear gown during medication or nutritional supplement administration. The resident was left in upright position after administration and LVN D removed her gloves and performed hand hygiene prior to leaving the room. She stated she should have worn the gown during medication and nutrition administration. She stated she was nervous about being watched and forgot to put on the gown. She stated there was an EBP sign outside of the room but forgot the gown because she was focused on giving the correct dose of medication. She stated the day prior, when she administered IV medication to Resident #68, she should have worn a gown. She stated not wearing a gown could cause infection spread from her to the resident or from the resident to her. She stated Resident #58 was on an oral antibiotic for skin infection around the G-tube. She was unsure if he had gotten the infection from the hospital due to his G-tube having recently been replaced by him pulling it out. She showed the stitches that were still present around the G-tube site. The skin was red, but no drainage and the dressing was clean and dry. She stated she had been trained on EBP including wearing a gown along with other PPE.Resident #22Record review of Resident #22's electronic face sheet, dated 04/15/2026, reflected a [AGE] year-old female admitted on [DATE] and re-admitted on [DATE] with diagnosis including sepsis (a life-threatening immune response to infection or injury).Record review of Resident #22's entry MDS assessment, dated 04/04/2026, reflected resident was re-admitted from acute care hospital on [DATE]. No further comprehensive assessment due at the time of review.Record review of Resident #22's electronic physician orders, dated 04/13/2026, reflected no order for enhanced barrier precautions.Record review of Resident #22's comprehensive care plan, dated 03/19/2026, reflected Resident is on enhanced barrier precautions with interventions including Gloves and gown should be donned if any of the following activities are to occur: linen change, resident hygiene, transfer, dressing, toileting/incontinent care, bed mobility, wound care, enteral feeding care, catheter care, trach care, bathing, or other high-contact activity.Posting at the residents room entrance indicating the resident is on enhanced barrier precautions.During an observation and interview on 04/13/2026 at 2:40 p.m., Resident #22's entrance to room had no EBP sign. There were no gowns present at the entrance or in the resident's room. Resident #22 stated the staff have never put on gowns up when connecting or disconnecting her IV medication.Resident #64Record review of Resident #64's electronic face sheet, dated 04/15/2026, reflected a [AGE] year-old male admitted on [DATE] with diagnosis including obstructive and reflux uropathy (condition where urine flow is blocked, potentially leading to kidney damage, while reflux uropathy involves the backward flow of urine into the kidneys).Record review of Resident #64's entry MDS assessment, dated 04/07/2026, reflected resident was admitted from acute care hospital on [DATE]. No further comprehensive assessment due at the time of review.Record review of Resident #64's electronic physician orders, dated 04/07/2026, reflected enhanced barrier precautions.Record review of Resident #64's comprehensive care plan, dated 04/07/2026, reflected Resident is on enhanced barrier precautions with interventions including Gloves and gown should be donned if any of the following activities are to occur: linen change, resident hygiene, transfer, dressing, toileting/incontinent care, bed mobility, wound care, enteral feeding care, catheter care, trach care, bathing, or other high-contact activity.Posting at the residents room entrance indicating the resident is on enhanced barrier precautions.During an observation and interview on 04/14/2026 at 11:09 a.m., Resident #64 was lying in the bed in his room. There was a foley catheter draining in a bag secured to his bedside. There was no EBP signage outside of the resident's door leading into his room. He had PPE in the room. During an interview on 04/14/2026 at 3:20 p.m., RN B stated he was the infection preventionist. He stated it was his responsibility to initially put up the EBP sign outside of resident's room when EBP was appropriate such as chronic wounds or indwelling device. He stated that foley catheter, IV access, and G-tube were all appropriate for EBP. He stated he felt the failure with Resident #64 not having an EBP sign outside of his room (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was because he changed rooms and the housekeeping staff did not move the sign with him. He stated he did not know why LVN D did not wear a gown when performing medication administration. He stated he monitored the staff and he did not have any concerns with LVN D not wearing gown during care of indwelling devices prior to 04/13/2026. He stated he felt she was nervous from being watched leading to the failure of the gown not being worn. He stated she was new to the back hallway. He stated he had seen her perform tasks before requiring EBP on the front hall and she used the gown then. He stated wearing the gown helped prevent the spread of infection from the nurses to the residents and from the residents to the nurses. He stated Resident #58 had a skin infection around the G-tube site, but he could not say it occurred from gown not being worn and he never saw the nurse not wear a gown during care for Resident #58. He stated the resident was in the hospital from pulling out his G-tube and the infection could have been from that experience. He stated staff were in-serviced on EBP in the past and if they had questions about using EBP they should come to him. He stated the training included visual watch one, then performance do one, and then instructing teach one when they were learning how to use EBP. He stated he was available to staff if they had questions. He stated he monitored that staff were performing infection control daily when he was in the building and worked full time as the treatment nurse. During an interview on 04/14/2026 at 3:25 p.m., the DON stated she expected staff to follow EBP policy. She stated she expected residents who had required EBP to have an EBP sign outside of their room to notify staff of the precautions with appropriate PPE available. She stated RN B was responsible for making sure the signs were outside of the residents' rooms. She stated she was not sure why some residents did not have an EBP sign. She stated she expected for nurses who administered medication through a G-tube or IV to wear a gown during administration. She stated she thought the nurse was nervous causing her to forget to wear the gown. She stated wearing the gown was to help prevent infection spread from the residents to the nurse and vice versa. She stated she did monitor that nurses were following EBP precautions by walking down the hallway and observing them. She stated she did not have any concerns with LVN D wearing EBP before 04/13/2026.During an interview on 04/14/2026 at 3:30 p.m., the RCN stated she expected staff to follow the EBP policy when performing care to indwelling devices. She stated she was in the building at least monthly and monitored that staff were following the EBP policy when in the building. She stated not following EBP could cause the spread of infections. She stated staff were to be notified of EBP by a sign being placed outside of the door to the resident's room requiring EBP. Review of facility policy titled Enhanced Barrier Precautions, dated 04/01/2024, reflected Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and glove use during high contact resident care activities. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. A single set of PPE cannot be used for more than 1 patient. EBP are indicated for residents with any of the following:. Wounds and/or, indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO.Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies.The facility will ensure PPE and alcohol-based hand rub are readily accessible to staff.Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator Alcohol Based Hand Rub Before and After [NAME] Gloves and Gown.Communication to Staff The facility will utilize postings outside the room and [electronic medical record] to communicate to staff if a resident requires EBP.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public on 1 of 64 resident rooms (room [ROOM NUMBER]) reviewed for environmental concerns.The facility failed to have hot water functioning in room [ROOM NUMBER]'s sink on 04/13/2026, 04/14/2026, and 04/15/2026.This failure could place residents and staff at risk of being uncomfortable and for infections from living in an environment that does not function.Findings included:Resident #9Record review of Resident #9's electronic face sheet, dated 04/15/2026, reflected an [AGE] year-old female admitted on [DATE] with diagnosis including Alzheimer's disease (a type of dementia with problems including memory, thinking, and reasoning that interfere with daily life) and dementia (loss of memory, thinking, and reasoning skills). Record review of Resident #9's quarterly MDS assessment, dated 02/11/2026, reflected that she had a BIMS score of 06 indicating severe cognitive impairment. Further review of the MDS reflected Resident #9 required partial assistance of staff for toileting hygiene and substantial assistance of staff for personal hygiene including washing hands. Resident #26Record review of Resident #26's electronic face sheet, dated 04/15/2026, reflected an [AGE] year-old female admitted on [DATE] and readmitted on [DATE] with diagnosis including dementia (loss of memory, thinking, and reasoning skills).Record review of Resident #26's quarterly MDS assessment, dated 03/02/2026, reflected that she was unable to complete interview for BIMS score. Further review reflected Resident #26 was dependent on staff for toileting hygiene and personal hygiene including washing hands.During an observation and interview on 04/13/2026 at 2:36 p.m., Resident #9 was sitting on the side of her bed in room [ROOM NUMBER]. She stated as far as she knew, the hot water had never worked. She stated I guess they just don't want me to wash my hands with hot water. She stated she would like hot water to work in the sink. During an observation on 04/13/2026 at 2:46 p.m., Resident #26 was lying in the bed next to the window in room [ROOM NUMBER]. She would not answer questions. She did not appear to be in any distress.During observations on 04/13/2026 from 2:36 p.m. until 04/15/2026 at 9:37 a.m. reflected room [ROOM NUMBER]'s sink had no working hot water.During an interview on 04/15/2026 at 9:23 a.m., RN A stated she was aware room [ROOM NUMBER]'s hot water did not work. She stated she expected hot water to be functioning in resident rooms. She stated Resident #26 was a full assist with all ADLs and Resident #9 needed standby assist to get up first thing but then could move around in the room unassisted. She stated the nursing staff was told not to use the sink due to there had been many reports to the maintenance department. She stated she had been told the problem was in the wall in the past. She stated the facility had attempted to fix the problem in the past and the water would work for a little while but then would stop working again. She stated she had personally made several maintenance care requests to have the sink fixed and it continued to stop working after a little while. She stated she thought the hot water worked a week ago but was unsure about the time. She stated the staff used a QR (square-shaped, black-and-white codes scanned using a smartphone or tablet camera, providing instant access) scan code that was on the wall to let maintenance know when there was a repair that needed attention. She stated hot water was needed to wash hands and help prevent infection spread. She stated she had not made a request to maintenance department today.During an interview on 04/15/2026 at 9:26 a.m., RN B stated he was the infection preventionist in the facility. He stated resident rooms should have hot water for the residents and the staff to use. He stated the reality was that plumbing pipes burst and other issues arise. He stated he was not aware that the hot water in room [ROOM NUMBER] was not working. He stated that the best practice was for hands to be washed with water and soap using vigorous hand washing to kill bacteria. He stated it would be better to have hot water but if staff and residents were performing mechanical scrubbing, the (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	infection spread would not occur. He stated that nurses have access to a sink in the restroom behind the nurses' station to wash their hands with hot water when needed. He stated hand sanitizer could also been used by staff to prevent infection spread. He stated there were purple wipes for staff to wipe down items in the room and the housekeepers sanitize rooms and hall as well. He stated he did not know how long the hot water had not worked. He stated staff told maintenance about issues through maintenance care and voiced that he would ask the maintenance director if he was aware of the issue.During an interview on 04/15/2026 at 9:37 a.m., the Maint D stated he was unaware of any room not having hot water. He stated all resident rooms should have hot water. He went into room [ROOM NUMBER] and verified the hot water did not work. He pulled up the protective covering on the pipes under the sink and turned a knob. The hot water worked after he turned the knob. He stated he had no idea why the hot water knob was not on. He stated it could not have been over a week or two that way. He stated all the maintenance requests go to him through maintenance care and he does spot checks at times in the residents' rooms. He stated he does hot water checks at the end of the hall. He stated his checks would not include room [ROOM NUMBER] due to it was in the middle of the hallway and did random checks on those rooms. He stated there were no open requests in the computer program for room [ROOM NUMBER]. He stated staff could call him on the phone or use the QR scan code to have the issue come up in the computer program to notify him of repair needed. During an interview on 04/15/2026 at 10:01 a.m., the ADMN stated she had no knowledge of hot water not working in room [ROOM NUMBER]. She stated she expected resident rooms to have hot water in the room and stated a reasonable person would want hot water to wash their hands with. She stated she did not know why the hot water was not working in room [ROOM NUMBER]. She stated she would look for a policy on hot water working in resident rooms.During an interview on 04/15/2026 at 10:14 a.m., the Corporate Liaison stated she was responsible for turning off the water in room [ROOM NUMBER]. She stated on Sunday 3/12/2027, she had noticed the sink was leaking in room [ROOM NUMBER] when she was visiting with Resident #26. She stated she had turned off the hot water valve when she fixed the leak with plumbers' tape. She stated she had just forgotten to turn the hot water valve back on. She stated she was the responsible party for Resident #26 and was just attempting to fix the leak to help prevent an accident. She stated she had no intention of leaving the hot water valve off in the room. She stated the Maintenance Director was available to fix items in the building including the plumbing, but she knew how to fix it. She stated she did not want to bother the Maintenance Director on a Sunday since she could fix the issue. She stated she should have notified the Maintenance Director about the issue when it occurred but stated she was comfortable making plumbing repairs in the building because her husband was a contractor. During an interview on 04/15/2026 at 10:16 a.m., the ADMN stated she did not find any policy on hot water in resident rooms. During an interview on 04/15/2026 at 11:41 a.m., the ADMN stated she expected the Corporate Liaison to notify her of any maintenance issues in the building. She stated the Corporate Liaison could perform minor repairs in the building because she wears many hats. The ADMN stated she should have been notified by the Corporate Liaison of a repair that had been made to the sink in room [ROOM NUMBER] and only found out about it after she had started asking questions on why the water was not working.Record review of the facility's maintenance care log reflected on 04/15/2026 at 9:31 a.m., RN B had documented the hot water in room [ROOM NUMBER]'s sink was not working. No other hot water issues observed in the log.Record review of facility's admission agreement reflected You have the right to: Live in safe, decent and clean conditions

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	675537	A. Building B. Wing	04/15/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs) to meet the needs for 1 of 5 residents (Resident #29) reviewed for pharmaceutical services, in that: LVN D failed to reorder Latanoprost Ophthalmic Emulsion (0.005 % (Latanoprost) Resident #29 before his supply was depleted. This failure could place residents at risk for a decline in health and of not receiving the intended therapeutic benefit of the medications. The findings included:Record review of Resident #29's face sheet not dated, revealed a [AGE] year-old male initially admitted on [DATE] with the diagnosis of Glaucoma (a condition in which the optic nerve becomes damaged by high fluid pressure in the eye leading to irreversible vision loss or blindness if untreated). Record review of Resident #29's admission MDS dated [DATE] revealed Section-C Cognitive Patterns Resident #29 had a BIMS score of , 00 meaning severe cognitive impairment. Section -B Hearing, Speech and Vision - documented Resident 29's was: Adequate-sees fine detail, such as regular print in newspapers/booksRecord review of Resident #29's Care Plan last revised on 03/01/2026 indicated the resident had impaired visual function related to his diagnosis of glaucoma. Interventions included: Arrange for eye consultation with eye care practitioner as required. Monitor/document/report to MD (physician) the following signs and symptoms of acute eye problems: Change inability to perform Activities of Daily Living, Decline in mobility, Sudden visual loss, Pupils dilated, gray or milky, complaints of Halos around lights, double vision, tunnel vision, blurred or hazy vision. The resident utilizes glasses, encourage their use. Record review of Resident #29's physician orders revealed Latanoprost Ophthalmic Emulsion (0.005 % (Latanoprost) Instill 1 drop in both eyes 1 time a day related to Glaucoma. Administer 30 minutes after Dorzolamide eye drops.Record review of Resident #29's medication administration record on 04/14/2026 at 4:45 p.m. for March and April 2026 revealed Resident #29's Lantanoprost eye drops had not been administered on 04/13/2026 or 04/14/2026 and was scheduled to be administered at 5 p.m. Record review of Resident #29's nursing progress note by LVN D dated 04/14/2026 at 7:26 p.m. This nurse had ordered Latanoprost Ophthalmic Emulsion 0.005 percent eye drops on 04/13/26. Pharmacy did not deliver eye drops last night; this nurse called the pharmacy will be delivered on 04/14/26 during the night. made aware that this nurse is ordering eye drops. Resident went to [physician] optometrist today. No new orders received. Physician was made aware that this resident did not receive Latanoprost eye drops on 04/13/26 or 04/14/26During an Interview on 04/14/2026 at 1:00 PM Resident #29's POA stated that Resident #29 was not receiving his eye drops for his glaucoma like they were ordered. He stated he had seen the staff administer the residents medication and he was very concerned because they were for his glaucoma. He stated he demonstrated to the nurse LVN D how to encourage the resident to take his eye drops as ordered so that Resident # 29 would cooperate and not refuse the eye drops. During an observation and an interview at during scheduled medication administration for Resident #29, on 04/14/26 at 5:00 p.m. LVN D stated that Resident # 29 was out of his Latanoprost, but that he would get them later tonight. She stated he was out of the medication yesterday at 5:00 pm also and she had ordered the medication at that time, but it still had not come in. She went to Look in the emergency med kit and stated they did not have the eye drops in house. She stated she had notified the residents family member that the resident was out of his eye drops but had not documented that yet. She stated the resident's family member who was his POA had explained to her the medication latanoprost was to decrease the pressure in Resident #29's eye because he had glaucoma. She stated that not getting the medication as it was ordered could increase the pressure in his eye and possibly affect his vision. During an interview with the DON on 4/15/26 11:00 a.m. stated her expectation was that Nurses should have documented medication immediately when it was given and order medication from the (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pharmacy before it ran out. She stated a negative outcome for the resident could have been not receiving the care and medication needed and could possibly harm his eyesight. She stated the resident should not run out of medication and she expected her nursing staff to make her, the family and the physician aware immediately if they are unable to obtain a resident's ordered medication. She stated the medication nurses were responsible for ordering medication and ensuring it was obtained from the pharmacy before any resident ran out. The DON was asked for a policy on The ordering of Medication, but she stated her Corporate Nurse told her there was no policy that specifically addressed the topic or procedure for medication reordering. Record review of the admission Agreement for the facility , stated the following in part: In the absence of a designated pharmacy, or the failure of a designated pharmacy to supplyrequired medications, the Health Care Center is authorized to use the pharmacy of its choice tomeet the residents immediate needs.The Health Care Center has contracted with an Institutional Pharmacy that meets all state andfederal Nursing Home regulations as well as Texas State Board of Pharmacy Nursing Homeregulations.The contracted pharmacy provides:.Access to a local 24-hour pharmacy for emergency needs in most markets

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure drugs and biologicals used in the facility were stored in locked compartments and permitted only authorized personnel to have access to the keys for 1 of 18 (Resident # 68) residents reviewed for storage of drugs and biologicals. The facility failed to ensure Resident #68's medication was locked when unattended by authorized personnel. This failure could place residents at risk of having access to unauthorized medications, leading to possible harm or drug diversions. Findings included: Resident #68Record review of Resident #68's electronic face sheet, dated 04/15/2026, reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnosis including osteomyelitis of the left ankle (infection of the bone). Record review of Resident #68's admission MDS assessment, dated 04/02/2026, reflected a BIMS score of 12 indicating moderate cognitive impairment. Further review reflected he was taking high-risk medication antibiotic, received IV medications and had an IV access site. Record review of Resident #68's electronic physician orders, reviewed on 04/13/2026, reflected an order for ampicillin sodium injection solution reconstituted 2gm to be infused intravenously six times daily until 4/30/2026.During an observation and interview on 04/13/2026 at 11:27 a.m., Resident #68 was sitting in a wheelchair in his room. LVN D entered room to administer IV ampicillin (an antibiotic medication) into Resident #68's IV access. She hung the reconstituted medication in the IV bag on IV pole in the room and primed the IV tubing. She began administering IV ampicillin. There was another ampicillin bag that was not reconstituted sitting on Resident #68's bedside table. LVN D stated she was unsure why the medication was in the room. She stated maybe another nurse had left the medication in Resident #68's room. LVN D left Resident #68's room and the medication was left sitting on Resident #68's bedside table. During an observation of Resident #68's room on 04/13/2026 at 12:31 p.m., revealed the unused ampicillin bag that was not reconstituted continued to sit on Resident #68's bedside table.During an interview on 04/14/2026 at 1:21 p.m., LVN D stated medication should not be left in residents' rooms. She stated leaving medication in a residents' rooms could cause that resident to use the medication appropriately or another resident to have access to that medication resulting in medication error or misappropriation. She stated it would also make the medication count off in the medication room. She stated the night shift nurse must have left the medication in the room because the resident used that medication so often, but she was not sure if that was the reason why the ampicillin was in the room. She stated she did not remove the medication when she saw it because she was nervous from being watched. She stated the medication should never be left in the room unattended by a nurse. During an interview on 04/14/2026 at 3:25 p.m., the DON stated her expectation would be for medication to be stored in the medication room or on the medication cart. She stated the medication should not be stored in a resident's room. She stated she did not know why medication would be left in a resident's room. She stated leaving medication in a resident's could cause medication misappropriation or medication error if the medication was lost or taken wrong by the resident or another resident. She stated she monitored that medication was stored appropriately when she walked down the halls and is in the building during the week. She stated the nurses had been trained on medication storage.During an interview on 04/14/2026 at 3:30 p.m., the RCN stated she expected medications, including IV antibiotic medication, to be stored in the medication room or on the medication carts. She stated she was in the building at least monthly and monitored medication storage while in the building. She stated not storing the medication in the medication room or in the nurses' cart could lead to medication misappropriation and medication error. She stated she did not know why an IV antibiotic medication had been left in a room without the nurse present. Record review of the facility's policy titled Medication Storage in the Facility, dated 2025, reflected (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to license nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Procedure . 2. Only licensed nurses, the Consultant Pharmacist, and those lawfully authorized to administer medications (e.g. medication aides) are allowed unsupervised access to medications. Medication rooms, carts, and medication supplies are locked or attended to by persons with authorized access.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observations, and interviews, the facility failed to post nurse staffing information that included the resident census for 3 days (04/13/2026, 04/14/2026, and 04/15/2026) of 3 days reviewed for required postings.The facility failed to include the daily resident census 04/13/2026, 04/14/2026 and 04/15/2026 on the daily nurse staffing required posting.This failure could place all residents, their families, and facility visitors at risk of not having access to information regarding staffing data and the facility census.Findings included:During an observation on 04/13/2026 at 9:10 a.m., the daily nurse staffing was posted on the front hallway across from the ADON's and DON's office. There was a zero for the resident census. During an observation on 04/14/2026 at 9:10 a.m., the daily nurse staffing was posted on the front hallway across from the ADON's and DON's office. There was a zero for the resident census. During an observation on 04/15/2026 at 9:10 a.m., the daily nurse staffing was posted on the front hallway across from the ADON's and DON's office. There was a zero for the resident census. During an interview on 04/15/2026 at 10:47 a.m., the ADMN stated the ADON hung up the daily nurse staffing. She stated she was unaware if there needed to be a census posted on the daily nurse staffing. She stated she would look for a policy for daily nurse staffing. During an interview on 04/15/2026 at 10:48 a.m., the ADON stated she posted the daily nurse staffing. She stated the facility had a new program that tracked the staffing hours and she had been instructed to print the daily staffing report from it and hang it. She stated before the new system, she had a paper that was physically filled out by her. She stated she was unaware the updated system did not pull over the census. She stated she did not know the census was a requirement on the posting. She stated the DON monitored that she put out the daily nurse staffing. She stated she did not feel any families or visitors would want to know the daily census for the resident population. During an interview on 04/15/2026 at 10:50 a.m., the DON stated the ADON was responsible for posting the daily nurse staffing. She stated she did not know the census should be included on that posting. She stated the computer system the facility had been using populated the posting and she was told the information was all on that form. She stated she had never been asked by any family or visitor what the census was in the facility and felt no negative outcome had occurred from the posting not having the census. During an interview on 04/15/2026 at 11:41 a.m., ADMN stated she did not have a policy for nurse staff posting and she expected the regulations to be followed. She stated the facility had been using a new system for about a year and they did not realize it was not pulling over the census on the paper that was posted. She stated she was working with the program and believed they had found the reason why the census did not populate but was continuing to work on it. She stated if a family member or visitor had asked her, she would have informed them of the resident census. She stated she was aware of the daily census by the daily meetings she attended. She stated that she did not believe any family or visitors were negatively impacted by the daily census not being posted.