STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675635	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ebony Lake Nursing and Rehabilitation Center	1001 Central Blvd Brownsville, TX 78520

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 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 and biologicals) to meet the needs of each resident for 1 of 4 residents (Residents #2), reviewed for pharmaceutical services, in that: The facility failed to ensure Resident #2's physician ordered Cozaar was held when her blood pressure was found to be out of parameters for administration. This failure could place residents at risk for not receiving medication as ordered. The findings included: 1. Record review of Resident #2's face sheet, dated 04/29/25, revealed the resident was an [AGE] year-old female who was initially admitted to the facility on [DATE] with diagnoses that included: other acute (sudden) kidney failure, secondary malignant neoplasm (cancerous tumor) of liver and intrahepatic bile duct, and secondary malignant neoplasm of retroperitoneum (is the space behind the peritoneum) and peritoneum (membrane that lines the abdominal cavity and covers the abdominal organs), essential (primary) hypertension (high blood pressure). Record review of Resident #2's MDS assessment, dated 04/22/25, revealed Resident #2 had a BIMS score of 10, indicating her cognition was moderately impaired. Record review of Resident #2's care plan with an initiation date of 04/21/25 reflected, [Resident #2] has altered cardiovascular status r/t (related to) CHF (congestive heart failure), hypertension with an initiation date of 05/02/25 with a goal of, The resident will be free from complications of cardiac problems through review date. with an initiation date of 05/02/25. Record review of Resident #2's physician's orders revealed orders for Cozaar Oral Tablet 50 MG, with additional directions of HOLD IF SBP (systolic blood pressure) <120 AND/OR DBP (diastolic blood pressure) <60 HOLD IF PULSE IS <60 with a start date of 04/18/25. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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	Record review of Resident #2's April 2025 MAR revealed, Resident #2's physician order for, Cozaar Oral Tablet 50MG (Losartan Potassium) Give 1 tablet by mouth one time a day for HTN (hypertension) HOLD IF SBP is <120 AND/OR DBP <60 HOLD IF PULSE IS <60 was administered on 04/19/25, 04/20/25 and 04/21/25 based on check offs and signatures completed by MA A, MA B and MA C while Resident #2's blood pressure was out of parameters for administration of medication. On 04/19/25 Resident #2 had a blood pressure of 106/60, on 04/20/25 Resident #2 had a blood pressure of 114/68 and on 04/21/25 Resident #2 had a blood pressure of 106/71. During an interview with MA C on 04/25/25 at 4:58pm she stated she worked with Resident #2 on 04/21/25 and was responsible for administering Resident #2's medication. MA C stated prior to administering Cozaar she needed to check both blood pressure and pulse in the order to see if they would receive the medication or not. MA C stated on 04/21/25 she checked Resident #2's blood pressure and stated it was out of parameters and was at 106/71 from what she could recall. MA C stated she did not know provide Resident #2 with Cozaar and held it and stated her blood pressure was not within parameters. MA C stated she signed the MAR as administered by mistake and stated she did not notify any nurse about Resident #2's blood pressure being out of parameters and medication being held and stated she should have notified the nurse. MA C did not recall who the overnight nurse was. MA C stated she had received in-services over signing the MAR. During a follow up interview with MA C on 05/13/25 at 2:55pm MA C stated she would have to go to her DON for what the facility policy stated over accurately documenting on the MAR. MA C stated incorrect documentation could negatively impact them really bad and stated she did not know what to answer. During an interview with MA B on 04/29/25 at 2:42pm she stated she worked with Resident #2 on 04/20/25 and was responsible for administering Resident #2's medication. MA B stated prior to administering Cozaar she needed to look at the parameters, MA B stated she checked Resident #2's blood pressure and it was 114/68 and stated based on that reading it should not have been administered. MA B stated she assumed the parameters for Resident #2 were the same as before because they never had parameters like Resident #2's at the facility before. MA B stated the blood pressure parameters at the facility were all almost the same and were usually 100/60 and stated this one kind of slipped on us and she stated after she took Resident #2's blood pressure she gave her the Cozaar medication and Resident #2 spit it out due to being nauseous. MA B stated that because she had placed the medication in Residents #2's mouth she documented it as administered. MA B stated she could have written a note about the administered and spit out medication but did not, MA B stated she probably just forgot to write a note because they were busy most of the time. MA B stated she thought she had told a nurse about Resident #2 being administered her Cozaar and then spitting it out but could not remember. MA B stated she had received in-services over signing the MAR and following the parameters after the incident had occurred. MA B stated the facility policy for medication parameters stated to always take the blood pressure before administering. MA B stated she had not followed the facility policy due to not reading the parameters. MA B stated it was important to review orders, parameters, and directions prior to administering medication because it was procedure and important for the resident safety. MA B stated providing blood pressure mediation to a resident who was not within parameters could be negatively impacted because their blood pressure could go down. (continued on next page)

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(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	During an interview with MA A on 05/13/25 at 8:57am she stated she worked with Resident #2 on 04/19/25 and was responsible for administering Resident #2's medication. MA A stated prior to administering Cozaar she needed to see how the patient was and check their blood pressure and compare it to the parameters listed on the order to see if they would receive the medication or not. MA A stated on 04/19/25 she checked Resident #2's blood pressure but did not recall the exact reading and stated she thought it was 100 or 114 over 70. MA A was shown Resident #2's April 2025 MAR that revealed a blood pressure of 106/62, MA A stated based on the blood pressure her Cozaar should not be administered. MA A stated she did not administer Cozaar to Resident #2 on 04/19/25 and stated she should have coded it as 4 which she stated indicated the resident was out of parameters and the medication could not be given. MA A stated she did not know why she signed it as administered and stated she was just in a rush. MA A stated she should have notified the nurse that the Resident #2's blood pressure was out of parameters and that the medication would be held, MA A did not remember if she notified the nurse. MA A stated she had received in-services over signing the MAR. MA A stated she did not recall seeing a facility policy over accurately documenting on the MAR. MA A stated incorrect documentation could negatively impact a resident's health. During an interview with the DON on 05/13/25 at 5:29pm she stated MA A was responsible for administration and documentation on the MAR for Resident #2's Cozaar on 04/19/25, MA B was responsible on 04/20/25 and MA A on 04/21/25. The DON stated the staff had to check the blood pressure and pulse prior to administering and stated a blood pressure under 120/60 or a pulse under 60 would require the medication to be held. The DON stated all 3 staff members checked Resident #2's blood pressure and stated her Cozaar should not have been administered on any of the 3 days based on her blood pressure of 106/62 on 04/19/25, 114/68 on 04/20/25 and 106/71 on 04/21/25. The DON reviewed Resident #2's April 2025 MAR and confirmed the blood pressure of 106/62 on 04/19/25, 114/68 on 04/20/25 and 106/71 on 04/21/25. The DON stated MA A and C did not administer the medication on 04/19/25 and 04/25. The DON stated MA A and MA C signed as administered in error and stated it should have been coded as out of parameters. The DON stated MA B gave the medication to Resident #2 but she spit it out. The DON stated she did not know why MA B administered Cozaar to Resident #2 when she had her blood pressure out of parameters and stated it was a mistake she overlooked. The DON stated staff had been trained to check the blood pressure, look at the parameters and to notify the nurse if out of parameters and to document if given or not. The DON stated MA B could have written a note and should have documented it as not administered and should have notified the nurse of the blood pressure being out of parameters and being held. The DON stated in all 3 situation the staff should have notified the nurses and stated they had not based on what she knew. The DON stated all 3 staff had been trained on signing the MAR and following medication parameters. The DON stated all 3 staff were trained immediately after and prior but could not recall when. The DON stated the facility policy for following parameters for medication stated they were responsible for following physician orders. The DON stated the 3 staff did not follow the facility policies. The DON stated incorrect documentation on the MAR could negatively impact the resident because it reflected something was provided when it was not. The DON stated providing blood pressure medication to a resident whose blood pressure was not in parameter could negatively impact them on a case by case basis and could lower the blood pressure. The DON stated she determined staff were competent to provide residents medication while following the order in place by doing medication pass audits, training, and competencies. The DON stated all 3 staff have completed competencies for order, parameters and documentation. (continued on next page)

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(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	Record review of Medication Pass Competency Assessment dated 07/03/24 for MA A, MA B and MA C reflected they were checked off as met for, MAR is read prior to preparing medications. And checked pulse and/or blood pressure and recorded prior to med administration when orders/indicated and Medication held if Vital signs were not within the parameters as ordered and Residents refusal of medication is recorded. Record review of Medication Pass Competency Assessment dated 04/28/25 for MA A, reflected she was checked off as met for, MAR is read prior to preparing medications. And checked pulse and/or blood pressure and recorded prior to med administration when orders/indicated and Medication held if Vital signs were not within the parameters as ordered and Residents refusal of medication is recorded. Record review of Medication Pass Competency Assessment dated 04/29/25 for MA B reflected she was checked off as met for, MAR is read prior to preparing medications. And checked pulse and/or blood pressure and recorded prior to med administration when orders/indicated and Medication held if Vital signs were not within the parameters as ordered and Residents refusal of medication is recorded. Record review of Medication Pass Competency Assessment dated 04/30/25 for MA C reflected she was checked off as met for, MAR is read prior to preparing medications. And checked pulse and/or blood pressure and recorded prior to med administration when orders/indicated and Medication held if Vital signs were not within the parameters as ordered and Residents refusal of medication is recorded. Record review on facility Inservice dated 04/21/25 that covered topic of FOLLOW MD ORDERS AND PARAMETER FOR MEDICATION ADMINISTRATION with a summary of, CMAS AND CHARGE NURSES SHOULD FOLOW THE MD ORDERS WHEN ADMINISTER [administering] MEDICATIONS AS WELL AS MEDICATION ADMINISTRATION PARAMETERS. CMAS SHOULD NOTIFY CHARGE NURSE WHEN HOLDING MEDCIATION AND WHEN RESIDENT REFUSE MEDICATION CHARGE NURSE TO NOTIFY MD OF MEDICAITON REFUSALS AND WHEN MEDICZTIONS ARE HELD. Revealed MA A, MA B and MA C had all received the education. Record review of employee counseling report dated 04/21/25 revealed MA C had documented the administration of medication however no medication was required or administered per the residents' parameters. Record review of facility policy titled Medication Administration with an implementation date of 10/24/22 stated, 8. Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside of the physician prescribed parameters. and 19. Report and document any adverse side effects or refusals. And 20. Correct any discrepancies and report to nurse manager.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 1 of 4 residents (Resident #2) reviewed for medical records accuracy, in that: Resident #2's April 2025 MAR documentation was inaccurate. Staff signed off on physician ordered medication as administered when it was not. This deficient practice could affect residents whose records are maintained by the facility and could place them at risk for errors in care, and treatment. The findings included: 1. Record review of Resident #2's face sheet, dated 04/29/25, revealed the resident was an [AGE] year-old female who was initially admitted to the facility on [DATE] with diagnoses that included: other acute (sudden) kidney failure, secondary malignant neoplasm (cancerous tumor) of liver and intrahepatic bile duct, and secondary malignant neoplasm of retroperitoneum (is the space behind the peritoneum) and peritoneum (membrane that lines the abdominal cavity and covers the abdominal organs), essential (primary) hypertension (high blood pressure). Record review of Resident #2's MDS assessment, dated 04/22/25, revealed Resident #2 had a BIMS score of 10, indicating her cognition was moderately impaired. Record review of Resident #2's care plan with an initiation date of 04/21/25 reflected, [Resident #2] has altered cardiovascular status r/t (related to) CHF (congestive heart failure), hypertension with an initiation date of 05/02/25 with a goal of, The resident will be free from complications of cardiac problems through review date. with an initiation date of 05/02/25. Record review of Resident #2's physician's orders revealed orders for Cozaar Oral Tablet 50 MG, with additional directions of HOLD IF SBP (systolic blood pressure) <120 AND/OR DBP (diastolic blood pressure) <60 HOLD IF PULSE IS <60 with a start date of 04/18/25. Record review of Resident #2's April 2025 MAR revealed, Resident #2's physician order for, Cozaar Oral Tablet 50MG (Losartan Potassium) Give 1 tablet by mouth one time a day for HTN (hypertension) HOLD IF SBP is <120 AND/OR DBP <60 HOLD IF PULSE IS <60 was administered on 04/19/25 by MA A, 04/20/25 by MA B and 04/21/25 by MA C based on check offs and signatures completed by MA A, MA B and MA C while Resident #2's blood pressure was out of parameters for administration of medication. On 04/19/25 Resident #2 had a blood pressure of 106/60, on 04/20/25 Resident #2 had a blood pressure of 114/68 and on 04/21/25 Resident #2 had a blood pressure of 106/71. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with MA C on 04/25/25 at 4:58pm she stated she worked with Resident #2 on 04/21/25 and was responsible for administering Resident #2's medication. MA C stated prior to administering Cozaar she needed to check both blood pressure and pulse in the order to see if they would receive the medication or not. MA C stated on 04/21/25 she checked Resident #2's blood pressure and stated it was out of parameters and was at 106/71 from what she could recall. MA C stated Resident #2's blood pressure was not within parameters and stated she did not provide Resident #2 with Cozaar and held it. MA C stated she signed the MAR as administered by mistake and stated she did not notify any nurse about Resident #2's blood pressure being out of parameters and medication being held and stated she should have notified the nurse. MA C did not recall who the overnight nurse was. MA C stated she had received in-services over signing the MAR. During an interview with MA B on 04/29/25 at 2:42pm she stated she worked with Resident #2 on 04/20/25 and was responsible for administering Resident #2's medication. MA B stated prior to administering Cozaar she needed to look at the parameters, MA B stated she checked Resident #2's blood pressure and it was 114/68 and stated based on that reading it should not have been administered. MA B stated she assumed the parameters for Resident #2 were the same as before because they never had parameters like Resident #2's at the facility before. MA B stated the blood pressure parameters at the facility were all almost the same and were usually 100/60 and stated this one kind of slipped on us and she stated after she took Resident #2's blood pressure she gave her the Cozaar medication and Resident #2 spit it out due to being nauseous. MA B stated that because she had placed the medication in Residents #2's mouth she documented it as administered. MA B stated she could have written a note about the administered and spit out medication but did not, MA B stated she probably just forgot to write a note because they were busy most of the time. MA B stated she thought she had told a nurse about Resident #2 being administered her Cozaar and then spitting it out but could not remember. MA B stated she had received in-services over signing the MAR and following the parameters after the incident had occurred. MA B stated the facility policy for medication parameters stated to always take the blood pressure before administering. MA B stated she had not followed the facility policy due to not reading the parameters. MA B stated it was important to review orders, parameters, and directions prior to administering medication because it was procedure and important for the resident safety. MA B stated providing blood pressure medication to a resident who was not within parameters could be negatively impacted because their blood pressure could go down. During an interview with MA A on 05/13/25 at 8:57am she stated she worked with Resident #2 on 04/19/25 and was responsible for administering Resident #2's medication. MA A stated prior to administering Cozaar she needed to see how the patient was and check their blood pressure and compare it to the parameters listed on the order to see if they would receive the medication or not. MA A stated on 04/19/25 she checked Resident #2's blood pressure but did not recall the exact reading and stated she thought it was 100 or 114 over 70. MA A was shown Resident #2's April 2025 MAR that revealed a blood pressure of 106/62, MA A stated based on the blood pressure her Cozaar should not be administered. MA A stated she did not administer Cozaar to Resident #2 on 04/19/25 and stated she should have coded it as 4 which she stated indicated the resident was out of parameters and the medication could not be given. MA A stated she did not know why she signed it as administered and stated she was just in a rush. MA A stated she should have notified the nurse that the Resident #2's blood pressure was out of parameters and that the medication would be held, MA A did not remember if she notified the nurse. MA A stated she had received in-services over signing the MAR. MA A stated she did not recall seeing a facility policy over accurately documenting on the MAR. MA A stated incorrect documentation could negatively impact a residents health. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow up interview with MA C on 05/13/25 at 2:55pm MA C stated she would have to go to her DON for what the facility policy stated over accurately documenting on the MAR. MA C stated incorrect documentation could negatively impact them really bad and stated she did not know what to answer. During an interview with the DON on 05/13/25 at 5:29pm she stated MA A was responsible for administration and documentation on the MAR for Resident #2's Cozaar on 04/19/25, MA B was responsible on 04/20/25 and MA A on 04/21/25. The DON stated the staff had to check the blood pressure and pulse prior to administering and stated a blood pressure under 120/60 or a pulse under 60 would require the medication to be held. The DON stated all 3 staff members checked Resident #2's blood pressure and stated her Cozaar should not have been administered on any of the 3 days based on her blood pressure of 106/62 on 04/19/25, 114/68 on 04/20/25 and 106/71 on 04/21/25. The DON reviewed Resident #2's April 2025 MAR and confirmed the blood pressure of 106/62 on 04/19/25, 114/68 on 04/20/25 and 106/71 on 04/21/25. The DON stated MA A and C did not administer the medication on 04/19/25 and 04/25. The DON stated MA A and MA C signed as administered in error and stated it should have been coded as out of parameters. The DON stated MA B gave the medication to Resident #2 but she spit it out. The DON stated she did not know why MA B administered Cozaar to Resident #2 when she had her blood pressure out of parameters and stated it was a mistake she overlooked. The DON stated staff had been trained to check the blood pressure, look at the parameters and to notify the nurse if out of parameters and to document if given or not. The DON stated MA B could have written a note and should have documented it as not administered and should have notified the nurse of the blood pressure being out of parameters and being held. The DON stated in all 3 situation the staff should have notified the nurses and stated they had not based on what she knew. The DON stated all 3 staff had been trained on signing the MAR and following medication parameters. The DON stated all 3 staff were trained immediately after and prior but could not recall when. The DON stated the facility policy for accurately documenting on the MAR and following parameters for medication stated they were responsible for accurately documenting on the medication MAR and following physician orders. The DON stated the 3 staff did not follow the facility policies. The DON stated incorrect documentation on the MAR could negatively impact the resident because it reflected something was provided when it was not. The DON stated providing blood pressure medication to a resident whose blood pressure was not in parameter could negatively impact them on a case by case basis and could lower the blood pressure. The DON stated she determined staff were competent to provide residents medication while following the order in place by doing medication pass audits, training, and competencies. The DON stated all 3 staff have completed competencies for order, parameters and documentation. Record review of Medication Pass Competency Assessment dated 07/03/24 for MA A, MA B and MA C reflected they were checked off as met for, MAR is read prior to preparing medications. And checked pulse and/or blood pressure and recorded prior to med administration when orders/indicated and Medication held if Vital signs were not within the parameters as ordered and Residents refusal of medication is recorded. Record review of Medication Pass Competency Assessment dated 04/28/25 for MA A, reflected she was checked off as met for, MAR is read prior to preparing medications. And checked pulse and/or blood pressure and recorded prior to med administration when orders/indicated and Medication held if Vital signs were not within the parameters as ordered and Residents refusal of medication is recorded. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Medication Pass Competency Assessment dated 04/29/25 for MA B reflected she was checked off as met for, MAR is read prior to preparing medications. And checked pulse and/or blood pressure and recorded prior to med administration when orders/indicated and Medication held if Vital signs were not within the parameters as ordered and Residents refusal of medication is recorded. Record review of Medication Pass Competency Assessment dated 04/30/25 for MA C reflected she was checked off as met for, MAR is read prior to preparing medications. And checked pulse and/or blood pressure and recorded prior to med administration when orders/indicated and Medication held if Vital signs were not within the parameters as ordered and Residents refusal of medication is recorded. Record review on facility Inservice dated 04/21/25 that covered topic of FOLLOW MD ORDERS AND PARAMETER FOR MEDICATION ADMINISTRATION with a summary of, CMAS AND CHARGE NURSES SHOULD FOLOW THE MD ORDERS WHEN ADMINISTER [administering] MEDICATIONS AS WELL AS MEDICATION ADMINISTRATION PARAMETERS. CMAS SHOULD NOTIFY CHARGE NURSE WHEN HOLDING MEDCIATION AND WHEN RESIDENT REFUSE MEDICATION CHARGE NURSE TO NOTIFY MD OF MEDICAITON REFUSALS AND WHEN MEDICZTIONS ARE HELD. Revealed MA A, MA B and MA C had all received the education. Record review of employee counseling report dated 04/21/25 revealed MA C had documented the administration of medication however no medication was required or administered per the residents' parameters. Record review of facility policy titled Medication Administration with an implementation date of 10/24/22 stated, 8. Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside of the physician prescribed parameters. and 19. Report and document any adverse side effects or refusals. And 20. Correct any discrepancies and report to nurse manager.