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	09/18/2025

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review, the facility failed to ensure residents had a right to personal privacy and confidentiality of his or her personal and medical records for 12 residents' reviewed for residents' rights.The facility failed to ensure CMA A locked the medication cart computer screen and left an unidentified resident's picture exposed. This failure could place residents at risk of resident-identifiable information being accessed by unauthorized persons. The findings include:Observation and interview on 9/16/25 at 3:40 p.m. revealed CMA A walked out of a resident room from across the hall on the 400 hall and walked up to the unlocked computer screen on top of the medication cart counter which exposed a resident's picture. CMA A stated, she forgot to lock the computer screen and left the computer screen open which was a HIPAA violation and could result in an unauthorized person obtaining information from the resident and using their name fraudulently. During an interview on 9/16/25 at 5:40 p.m., the DON stated it was her expectation that staff locked the computer screens because exposed resident information was a HIPAA violation. The DON stated a resident's visible information could be used in the wrong way. Record review of the facility's document titled, Resident Rights, with revision date November 2021, revealed in part, .You have the right to: privacy, including during visits, phone calls and while attending to personal needs. Have facility information about you maintained as confidential

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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(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. (continued on next page)

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	675635	A. Building B. Wing	09/18/2025

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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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to maintain clinical records on each resident that were complete and accurately documented in accordance with accepted professional standards and practices for 1 (Resident #1) of 2 reviewed for accuracy and completeness of clinical records. The facility failed to accurately document in Resident #1's electronic medical record when she had her staples removed. This failure could place residents at risk for not receiving nursing services by adequately trained nurses and could result in a decline in health. Findings include: Record review of Resident #1's admission record dated 09/17/25 reflected an [AGE] year-old female with an admit date of 09/12/24 and a discharge date of 10/01/24. Her relevant diagnoses included left arm displaced comminuted (the pieces of the bone moved so much that a gap formed around the fracture) fracture of shaft of ulna(the long, tapering portion of the ulna bone), left arm displaced comminuted fracture of left humerus (long bone that runs from the shoulder and scapula), fracture of left pubis (one of the three bones that make up the hip bone), age-related physical debility (decline in strength and vitality associated with aging), and a commuted distal ulnar/radial fracture, left humeral shaft fracture, and left interior ramus fracture. Record review of Resident #1's Medicare 5-day MDS assessment dated [DATE] reflected a BIMS score of 9, which indicated her cognition was moderately impaired. Resident #1 had fractures and other multiple traumas as active diagnoses prior to being admitted . Record review of Resident #1's initial care plan dated 09/16/24 reflected: Problem: Resident #1 had an alteration in musculoskeletal status related to ulna/radius/humerus fracture, left pubis fracture. Interventions: in part included wearing a sling to the upper left extremity as per MD orders. Record review of Resident #1's progress note, dated 09/12/24 at 4:10 pm, authored by LVN B reflected in part [Resident #1] had been admitted from hospital . [Resident #1] was admitted to hospital related to a trip/fall at home in which she sustained a commuted distal ulnar/radial fracture, left humeral shaft fracture, left interior ramus fracture. [Resident #1] had left upper arm surgical wound with 30 staples, left wrist surgical wound with 12 staples. Record review of Resident #1's electronic medical record for the month of September 2024 reflected an entry on 09/23/24 which reflected: As per Dr., may remove staples from left surgical site. Start date 09/23/24. Order was signed off on 09/23/24 at 6:13 pm.Record review of Resident #1's progress note dated 09/30/24 at 4:49 pm, authored by LVN B reflected received orders from doctor, as per doctor may discontinue staples to left arm in facility. [Resident #1] and resident family made aware. In a telephone interview on 09/18/25 at 9:30 am, RN B said he remembered he entered an order to remove Resident #1's staples on 09/30/24 towards the end of his shift. RN B said he did not remember if he was the one who removed Resident #1's staples. In an interview on 09/18/25 at 10:00 am, LVN C said she received an order for Resident #1 on 09/23/24 to remove staples from the left surgical site. LVN C said she did not remember removing the staples herself and did not know who removed them. During a telephone interview on 09/18/25 at 10:37 am, Resident #1's RP said she had witnessed Resident #1's staples being removed on 09/23/24, by male nurse (did not get his name). Resident #1's RP said her mother had tolerated the removal and did not required medication. In an interview on 09/18/25 at 10:08 am, The DON said the facility's protocol for removing staples was to first obtain an order and then prepare the resident for the actual removal. The DON said after the removal, the nursing staff who removed the staples was required to enter a progress note that indicated whether the resident had tolerated the removal, if any significant findings were noted, the number of staples removed, and if any staples were left. The DON said the facility received two separate orders to remove Resident #1's staples, one on 09/23/24 and a second one on 09/30/24. She said she was not sure why they had received two. The DON said she was certain Resident #1's staples were removed on 09/23/24 as it was signed off on her electronic medical record. She said who signed off on the removal was the wound care nurse at that time and was no longer working at the facility. She said she could not explain why a second order was received on 09/30/24 and the documentation dated 09/30/24 was vague. The DON said the previous wound care nurse who removed Resident #1's staples had not documented the required information in Resident #1's electronic medical record. She said there were no negative outcomes to Resident #1 as her staples were removed on 09/23/24. This surveyor requested the facility's previous wound care nurse phone number but was not provided.Record review on 09/18/25 of Resident #1's electronic medical record reflected the previous wound care nurse had not documented she had removed Resident #1's staples. Record review of the facility's Documentation in the Medical Record policy dated 10/24/22