STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675635	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/25/2026
NAME OF PROVIDER OR SUPPLIER: Ebony Lake Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents had the right to formulate an advance directive for 1 (Resident #2) of 7 residents reviewed for Advance Directives. The facility failed to ensure Resident #2's OOH-DNR was completed. The OOH-DNR form did not have the physician's signature for Resident #2. This failure could affect all residents who have implemented advance directives and established their choice not to be resuscitated at risk of receiving CPR against their wishes. The findings were: Record review of Resident #2's electronic face sheet dated 03/24/2026 reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included: nontraumatic intracerebral hemorrhage in the cortical hemisphere (a spontaneous bleeding event not caused by injury within the brain's superficial gray matter), other toxic encephalopathy (a brain dysfunction resulting from exposure to hazardous substances like industrial chemicals, heavy metals, solvents or medication), pneumonia due to inhalation of food and vomit, and Wernicke's encephalopathy (a life-threatening, acute neurological emergency caused by severe deficiency of vitamin B1. Record review of Resident #2's Quarterly MDS assessment dated [DATE] reflected a BIMS score of 09 which reflected moderate cognitive impairment. Resident #2 had unclear speech, was sometimes understood by others and sometimes understood others. Record review of Resident #2's comprehensive care plan dated 03/19/2026 reflected, Resident #2's FOCUS: Resident #2 [sic] is a DNR. Date Initiated: 02/05/2026 Revision on: 02/05/2026. Record review of Resident #2's Progress Note dated 02/04/2026 at 11:29 am reflected, a SS note concerning the quarterly care plan meeting RP wants to switch from Full code status to DNR. Record review of Resident #2's order summary dated 03/25/2026 reflected a DNR order dated 02/04/2026. Record review of Resident #2's OOH-DNR dated 02/04/2026 reflected the RP and two witness's signatures. The OOH-DNR did not have a physician's signature. During an interview on 03/24/2026 at 03:41 pm, SS A stated the DNR for Resident #2 had not been signed by the physician. She said she considered it valid due to the RP requesting the resident's code status be changed from full code to DNR. She said she did not know why the physician had not signed the DNR form yet, but the RP and witnesses had signed it on 02/04/2026. She said if anything happened in the facility, the DNR would be honored even though the physician had not signed it. During an interview on 03/24/2026 at 03:50 pm, the DON stated there was not a physician's signature on Resident #2's OOH-DNR that was signed by the RP and two witnesses on 02/04/2026, but it would be honored if anything would happen to Resident #2 while at the facility. She said they had sent Resident #2's OOH-DNR to the doctor, but he had not signed it. She said there was an order for the OOH-DNR. During an interview on 03/24/2026 at 04:30 pm, the Administrator stated they had already contacted the doctor about signing Resident #2's OOH-DNR. She said he had already signed it and sent it back. She said they had already uploaded it into PCC. She said if the RP requested and signed a OOH-DNR and there were two witnesses, but the physician had not signed, the OOH-DNR would be honored in-house if something would occur. Record review of the facility's Residents' Rights Regarding Treatment and Advanced Directives policy dated 10/24/2022, revealed: Policy:It is the policy of this facility to support and facilitate a resident's right (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

Printed: 06/05/2026
Form Approved OMB
No. 0938-0391

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	03/25/2026

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to request, refuse and/or discontinue medical and surgical treatment and to formulate an advance directive.Policy Explanation and Compliance Guidelines:1.On admission, the facility will determine if the resident has executed an advanced directive, and if not, determine whether the resident would like to formulate an advance directive. 3.Upon admission, should the resident have an advance directive, copies will be made and placed in the chart as well as communicated to the staff. Record review of the 02/04/2026 OOH DNR Order instructions for issuing and OOH-DNR Order revealed the Purpose: The Out-of-Hospital Do-Not-Resuscitate (OOH-DNR) Order on reverse side complies with Health and Safety Code (HSC), Chapter 166 for use by qualified persons or their authorized representatives to direct health care professionals to forgo resuscitation attempts and to permit the person to have a natural death with peace and dignity.Applicability: This OOH-DNR Order applies to health care professions in out-of-hospital settings, including physicians' offices, hospital clinics and emergency departments. Implementation: A competent adult person at least [AGE] years of age, or the person's authorized representative or qualified relative may execute or issue an OOH-DNR Order. The person's attending physician will document the existence of the Order in the person's permanent medical record. The OOH-DNR Order may be executed as follows: .In addition: the OOH-DNR Order must be signed and dated by two competent adult witnesses, who have witnessed either the competent adult person making his/her signature in section A, or authorized declarant making his/her signature in either sections B, C, or E, and if applicable, have witnessed a competent adult person making and OOH-DNR Order by nonwritten communication to the attending physician, who must sign in Section D and also the physician's statement section.

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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 2 (Resident #1 and Resident #3) of 7 residents reviewed for medical records accuracy, in that: 1.The facility failed to provide physician or NP documentation in the electronic medical record for Resident #1 from 01/01/2026 through 03/24/2026. 1.The facility failed to provide physician or NP documentation in the electronic medical record for Resident #3 from 02/21/2026 through 03/24/2026. 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 #1's electronic face sheet dated 03/23/2026 reflected the resident was a [AGE] year-old male who had an initial admission on [DATE] and was readmitted to the facility on [DATE]. His diagnoses included: Cerebral infarction (stroke) affecting right dominant side, Parkinson's disease (a neurodegenerative disorder where brain cells that produce dopamine die, causing motor issues like tremors, stiffness, and slowness, alongside non-motor symptoms like smell loss, constipation, and depression), Alzheimer's disease (a progressive, irreversible brain disorder that slowly destroys memory, thinking skills, and eventually the ability to perform daily tasks), end stage renal disease (the kidneys can no longer filter waste and fluids effectively), dependence on kidney dialysis, and Type 2 Diabetes Mellitus (a chronic condition where the body becomes resistant to insulin and/or fails to produce enough of it, causing sugar to build up in the blood instead of entering cells for energy Record review of Resident #1's Medicare 5-Day MDS assessment dated [DATE] reflected a blank BIMS score which reflected Resident #1's interview was not completed or attempted. Resident #1 had no speech, was rarely/never understood by others and rarely/never understood others. Resident #1 was dependent (helper did all of the effort. The resident did none of the effort to complete the activity or, the assistance of 2 or more helpers was required for the resident to complete the activity) for toileting, showering, and personal hygiene. The resident was always incontinent of bladder and bowels. Record review of Resident #1's Progress Note dated 01/30/2026 at 11:13 am by LVN C revealed FNP D was in the facility to assess Resident #1 and medication changes were ordered. Record review of Resident #1's Progress Note dated 02/03/2026 at 11:15 am written by LVN C revealed FNP C was in the facility assessing Resident #1. FNP D ordered a new medication. LVN C documented that FNP D would follow-up with Resident #1 when she rounded on 02/06/2026. Record review of Resident #1's Progress Note dated 02/20/2026 at 11:23 am written by LVN C revealed FNP C was in the facility to assess Resident #1 and medication changes were made. Record review of Resident #1's Progress Note dated 03/17/2026 at 02:03 pm written by LVN E revealed Resident #1 was seen by FNP F and to notify her if lab values were critical in the morning. Record review of Resident #1's Progress Notes and Miscellaneous section revealed there was no documentation written by the physician or NP from 01/21/2026 through 03/24/2026. 2. Record review of Resident #3's electronic face sheet dated 03/23/26 reflected the resident was a [AGE] year-old female who had an initial admission on [DATE] and was readmitted to the facility on [DATE]. Her diagnoses included: Hypertension (high blood pressure), Type 2 Diabetes Mellitus (a chronic condition where the body becomes resistant to insulin and/or fails to produce enough of it, causing sugar to build up in the blood instead of entering cells for energy), heart disease, and other toxic encephalopathy (a brain dysfunction resulting from exposure to hazardous substances like industrial chemicals, heavy metals, solvents or medication) Record review of Resident #3's Medicare 5-Day MDS assessment dated [DATE] reflected a BIMS score of 09 which reflected moderate cognitive impairment. Resident #3 had clear speech, was usually understood by others and usually understood others. Resident #3 required substantial/maximal assistance (Helper did MORE THAN HALF the effort. The helper lifted or held (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's trunk or limbs and provided more than half the effort dependent) for toileting and showering. The resident was frequently incontinent of her bladder and occasionally incontinent of her bowels. Record review of Resident #3's Progress Note dated 02/23/2026 at 08:13 pm written by LVN G revealed NP H was in the facility and was notified of Resident #3's high blood sugar (number not documented in note). NP H was also notified of the family's request to review Resident #3's medications and to discontinue some of the medications. LVN G wrote, and he did. Record review of Resident #3's Progress Notes and Miscellaneous revealed there was no documentation written by the physician or NP from 02/21/2026 through 03/24/2026. During an interview on 03/24/2026 at 03:50 pm, the DON stated the doctors and NPs should have notes in the Progress Notes or Miscellaneous on PCC. She said they wrote their notes on paper and then the notes were uploaded into the Miscellaneous tab on PCC. The DON stated she did not know why Resident #1's and Resident #3's charts had no doctor or NP notes in PCC. She said she would talk to the doctor. She said if the doctors or NPs' notes were not in the computer, it would not show a resident's progress or status. During an interview on 03/24/2026 at 04:30 pm, the Administrator stated there should be notes from the doctors and NPs in PCC. She said they were always on their computers when they were at the facility. She said she would talk to the NP's doctor to ensure notes were being put in PCC for every visit they made. She said there were some NPs who came three days a week. She said she did not know how or why there were no doctor or NP notes in PCC for Resident #1 or Resident #3. Record review of the facility's Documentation in Medical Record policy dated 10/24/2022, revealed: Policy:Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. Policy Explanation and Compliance Guidelines:1.Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. 2.Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred. 3. Principles of documentation include, but are not limited to: b. Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care.