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 04/29/2026
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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to immediately inform the resident, consult with the resident's physician, and notify, consistent with his or her authority, the resident's representative when there was a significant change in the resident's physical, mental, or psychosocial status for 1 of 3 residents (Resident #1) reviewed for change in condition. LVN D failed to identify a significant change in condition experienced by Resident #1 on 4/10/26. This failure could place residents at risk for not receiving the appropriate care and services to maintain their health and safety.Finding included: Record review Resident #1's face sheet dated 04/28/26 revealed a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus (a chronic condition where the body either doesn't produce enough insulin or doesn't use insulin effectively, leading to high blood sugar levels), hemiplegia and hemiparesis following cerebral infraction affecting right dominant side (complete paralysis and weakness on one side of the body are common, often debilitating, effects of a stroke). Record review of Resident #1's quarterly MDS assessment, dated 3/25/26 reflected BIMS(Brief Interview for Mental Status) score of 12, indicated cognition was moderate impaired. Section GG revealed Resident #1 was dependent for toileting hygiene (Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.) Record review of Resident #1's care plan dated 12/24/24 reflected a focus area that Resident #1 had an ADL self-care performance deficit related to limited mobility, hemiplegia, hemiparesis. Bed mobility: the resident is dependent by times 2 staff to turn and reposition in bed. Record review of electronic progress notes dated 4/10/2026 07:50 p.m., revealed authored by LVN D REPORTED PER CNAS THAT WHILE CHANGING HIM THEY NOTICED DISCOLORATION TO LT LOWER BACK CLOSE TO ARM PIT, THIS NURSE CHECKED RESIDENT AND OBSERVED THAT HE HAD DRY SCRATCH LIKE AREAS TO LOWER BACK CLOSE TO ARM PIT WITH PURPLE DISCOLORATION AND RESIDENT STATED IT THIS HAPPENED BECAUSE I FELL YESTERDAY During an interview on 4/28/26 at 1:55 p.m., LVN D stated that Resident #1 complained of pain to his right side of trunk/back area on 4/10/26 and LVN D stated that she assessed Resident #1 and saw a discoloration on his left side of the trunk/back area about 5 inches long. LVN D stated that she asked resident how it happened and he told her that he fell the day before. LVN D stated that she did not called the doctor because it was part of the fall incident from 4/9/26. LVN D stated that she did not do a change in condition because she thought was a discoloration after the fall but the discoloration came out until the next day. During interview on 4/29/26 at 5:53 p.m., the DON stated that LVN D did not follow up with the doctor regarding the discoloration because it was part of the fall incident on 4/9/26. The DON stated LVN D did not have to follow up with the physician and that there was not a negative outcome. The DON stated that the change of condition or skin assessment was not done because it was part of the fall from 4/9/26. Record review of the facility policy titled, Notification of Changes implemented date 10/24/22, revealed the following: It is the purpose of this policy is to ensure that the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification.

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

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 04/29/2026
NAME OF PROVIDER OR SUPPLIER Ebony Lake Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 Central Blvd Brownsville, TX 78520	

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and interview the facility failed to develop and implement a comprehensive care plan for each resident that included measurable objectives and time frames to meet resident's mental and psychosocial needs for 1 (Resident #1) of 3 residents. The facility failed to develop a care plan to address Resident #1's the use of a mechanical lift during transfer. This failure places the resident at risk of inappropriate transfers with resulting injury. The findings included: Record review Resident #1's face sheet dated 04/28/26 revealed a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus (a chronic condition where the body either doesn't produce enough insulin or doesn't use insulin effectively, leading to high blood sugar levels), hemiplegia and hemiparesis following cerebral infraction affecting right dominant side (complete paralysis and weakness on one side of the body are common, often debilitating, effects of a stroke). Record review of Resident #1's quarterly MDS assessment, dated 3/25/26 reflected BIMS score of 12, indicated cognition was moderate impaired. Section GG revealed Resident #1 was dependent for toileting hygiene (Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.) Record review of Resident #1's care plan dated 12/24/24 reflected a focus area that Resident #1 had an ADL self-care performance deficit related to limited mobility, hemiplegia, hemiparesis. Transfer: the resident is dependent by times 2 staff to transfer Resident #1. This care plan did not specify the use of a mechanical lift. Record review of electronic progress notes dated 4/9/2026 06:15 a.m., revealed authored by LVN C CALLED BY CNAS UPON ENTERING RESIDENT ROOM, RESIDENT ON THE FLOOR ON HIS LEFT SIDE. CNAS WERE PROVIDING PATIENT CARE, WHEN RESIDENT GRABBED HIMSELF FROM MATTRESS AND ROLLED OVER TO THE RIGHT SIDE LANDING ON HIS RIGHT SIDE. ASSESSED RESIDENT HEAD TO TOE ASSESSMENT, LEFT LOWER SHOULDER BLADE SCRATCH, NO PAIN OR DISCOMFORT NOTED. NO BRUISING OR SKIN TEAR NOTED. During an interview on 4/28/26 at 1:55 p.m., LVN D stated Resident #1 required a 2 person mechanical lift transfer and for bed mobility. LVN D stated CNAs could find the type of transfers each resident required under their care plan. LVN D referred to Resident #1's care plan and stated the 2 person mechanical lift transfer was not indicated on Resident #1's care plan. LVN D stated CNAs could ask nurses about transfers if unsure and nurses would advise/educate CNAs on special transfers. LVN D stated MDS nurses were the people in charge of updating care pans. LVN D stated that by using one person assistance for bed mobility Resident #1 could have injured himself. During interview on 4/29/26 at 3:56 p.m., the MDS Nurse stated the MDS nurses were in charge of creating individualized care plans for residents. The MDS Nurse stated that care plans were created within 48 hours of admission, re- assessed after 14 days of admission, quarterly and as needed when change of condition has occurred. The MDS Nurse stated that Resident #1 needed a 2 person mechanical lift transfer. The MDS Nurse said that a mechanical lift transfer was something that would be included in a resident's care plan to provide appropriate and safe transfer that a resident may require. The MDS Nurse referenced Resident #1's care plan and stated there was no indication of a 2 person mechanical lift transfer. The MDS Nurse stated that by not being included, CNAs may not know the proper transfer needed and if not verified with a nurse a wrong transfer may be completed and result in some type of injury. The MDS Nurse did not know why type of transfer was not included in Resident #1's care plan. During an interview on 4/29/26 at 5:53 p.m., the DON stated the MDS nurse was in charge of creating individualized care plans. The DON stated care plans were created upon admission within 48 hours, updated 14 days after admission, quarterly, and upon change of condition. The DON stated failure to update proper information for example transfer type could result in a wrong transfer and potentially result in a potential accident. The DON did not know why Resident #1's care plan did not (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	include the transfer type. The DON stated mechanical lift transfers were included in care plans for CNAs to reference and carry out proper care residents required. Record review of the facility's policy titled Comprehensive Care Plans with implemented date 10/24/22 revealed It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident's rights, that incudes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 interviews and record review, the facility failed to ensure residents remained free from accidents, hazards and each resident received adequate supervision and assistance when being repositioned in bed for 1 (Resident #1) of 3 residents reviewed for accidents and hazards, CNA E failed to use two staff assist as required by Resident #1's care plan for bed mobility Resident #1 sustained a fall, on 4/9/26. This deficient practice has the potential to affect all residents in the building who require assistance with bed mobility by 2 staff members by causing falls and injuries. Findings included: Record review Resident #1's face sheet dated 04/28/26 revealed a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus (a chronic condition where the body either doesn't produce enough insulin or doesn't use insulin effectively, leading to high blood sugar levels), hemiplegia and hemiparesis following cerebral infraction affecting right dominant side (complete paralysis and weakness on one side of the body are common, often debilitating, effects of a stroke). Record review of Resident #1's quarterly MDS assessment, dated 3/25/26 reflected BIMS(Brief Interview for Mental Status) score of 12, indicated cognition was moderate impaired. Section GG revealed Resident #1 was dependent for toileting hygiene (Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.) Record review of Resident #1's care plan dated 12/24/24 reflected a focus area that Resident #1 had an ADL self-care performance deficit related to limited mobility, hemiplegia, hemiparesis. Bed mobility: the resident is dependent by times 2 staff to turn and reposition in bed. Record review of electronic progress notes dated 4/9/2026 06:15 a.m., revealed authored by LVN C CALLED BY CNAS UPON ENTERING RESIDENT ROOM, RESIDENT ON THE FLOOR ON HIS LEFT SIDE. CNAS WERE PROVIDING PATIENT CARE, WHEN RESIDENT GRABBED HIMSELF FROM MATTRESS AND ROLLED OVER TO THE RIGHT SIDE LANDING ON HIS RIGHT SIDE. ASSESSED RESIDENT HEAD TO TOE ASSESSMENT, LEFT LOWER SHOULDER BLADE SCRATCH, NO PAIN OR DISCOMFORT NOTED. NO BRUISING OR SKIN TEAR NOTED. Record review of Resident #1 x rays taken on 4/12/26 reflected: No evidence of a pneumothorax. No acute left rib fracture. During an interview on 4/28/26 ay 11:00 a.m., Resident #1 stated that one night he fell because there was supposed to be 2 CNAs and only one changed him. Resident #1 stated that he tried to grab from the mattress and when CNA E pulled the sheet he fell to the floor. Resident #1 stated that after 2 days the doctor ordered x rays. Resident #1 stated that the CNA E did not wait for the other CNA. LVN C was attempted to be contacted via telephone on 4/28/26 at 1:35 p.m., and 4/29/26 at 11:00 a.m., all attempts unsuccessful. CNA E was attempted to be contacted via telephone on 4/28/26 at 1:40 p.m., and 4/29/26 at 11:05 a.m., all attempts unsuccessful. During a phone interview on 4/28/26 at 1:42 p.m., CNA F said that she did know Resident #1 was a two person assist. CNA F said that she told CNA E to wait for her as she was giving assistance to another resident and CNA E decided to do the bed mobility by herself. CNA F said that if not following the plan of care, the resident pr herself could be harmed. During an interview on 4/28/26 at 1:55 p.m., LVN D stated Resident #1 required 2 person assist for bed mobility. LVN D stated that Resident #1 did not fall during her shift. LVN D stated that Resident #1 complained of pain to his right side of his trunk/back area on 4/10/26 and LVN D stated that she assessed Resident #1 and saw a discoloration on his left side of his trunk/back area about 5 inches long. LVN D stated that she asked the resident how it happened and he told her that he fell the day before. LVN D stated that she did not call the doctor because it was part of the fall incident from 4/9/26. During an interview on 4/29/26 at 5:53 p.m., the DON stated said staff should follow the plan of care of each resident to do the proper transfer. The DON said that both the resident and the staff could get injured if the failed to follow the plan of care. Record review of the facility policy titled, Incidents and Accidents, (continued on next page)

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	675635	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	implemented date 8/15/22, revealed the following: It is the policy of this facility for staff to report, investigate, and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain an infection control program designed to provide a safe, comfortable, and sanitary environment to help prevent the development and transmission of diseases for 1 of 1 (Resident's #1) CNA A failed to wash her hands or use hand sanitizer between change of gloves change while providing perineal care for Resident #1. The failure could place residents at risk for spread of infection and cross contamination.Findings include: Record review Resident #1's face sheet dated 04/28/26 revealed a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus (a chronic condition where the body either doesn't produce enough insulin or doesn't use insulin effectively, leading to high blood sugar levels), hemiplegia and hemiparesis following cerebral infraction affecting right dominant side (complete paralysis and weakness on one side of the body are common, often debilitating, effects of a stroke). Record review of Resident #1's quarterly MDS assessment, dated 3/25/26 reflected BIMS(Brief Interview for Mental Status) score of 12, indicated cognition was moderate impaired. Section GG revealed Resident #1 was dependent for toileting hygiene (Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.) Record review of Resident #1's care plan dated 12/24/24 reflected a focus area that Resident #1 had an ADL self-care performance deficit related to limited mobility, hemiplegia, hemiparesis. Bed mobility: the resident is dependent by times 2 staff to turn and reposition in bed. During an observation on 4/28/26 at 2:15 p.m., revealed CNA A and CNA B entered Resident #1's room and placed supplies on the bedside table. CNA A washed her hands, donned a gown and gloves. CNA A removed Resident #1's soiled brief and placed it in the trash can. CNA A removed her gloves and donned gloves without washing or sanitizing her hands. CNA A then cleaned Resident #1's peri-area, removed her gloves, but did not wash or sanitize her hands before donning new gloves. CNA A and CNA B washed their hands before and after the procedure only. During an interview on 4/28/26 at 2:25 p.m., with CNA A, she stated I should have sanitized or washed my hands before donning new gloves. She stated she should have washed her hands or used hand sanitizer between glove changes. CNA A stated, I forgot about it because I was nervous. She stated the potential negative outcome could be a spread of infection. She stated she had training on infection control, and handwashing. During an interview on 4/29/26 at 5:53 p.m., with the DON, she stated hands should be washed if gloves were visibly soiled or staff could use hand sanitizer between glove changes. She stated the ADON and DON were responsible for monitoring the staff for compliance with infection control. She stated the potential negative outcome could be cross contamination or infection even though the staff had the gloves as a barrier, they still could contaminate or give the resident an infection. Review of facility's policy on Infection Prevention Control Program with a date implemented 5/13/23 revealed This facility has established and maintains 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 disease and infections as per accepted national standards and guidelines. Review of the Center for Disease Control and Prevention website, on 5/6/26 (https://www.cdc.gov/handhygiene/providers/index.html), Know when to clean your hands:Immediately before touching a patient.Before performing an aseptic task such as placing an indwelling device or handling invasive medical devices.Before moving from work on a soiled body site to a clean body site on the same patient.After touching a patient or patient's surroundings.After contact with blood, body fluids, or contaminated surfaces.Immediately after glove removal.