STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676046	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care Nursing & Rehabilitation	200 County Rd 616 Brownwood, TX 76802

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the resident's right to reside and receive services in the facility with accommodation of residents' needs and preferences for 2 (Resident #10, Resident #26) of 24 residents reviewed for resident rights.The facility failed to ensure Resident #10's and Resident #26's call lights were within reach. This failure could place residents at risk of a diminished quality of life and lead to a loss of self-esteem and isolation.Findings included:Record review of Resident #10's electronic face sheet, dated 05/26/2026, reflected he was a [AGE] year-old male admitted on [DATE] with diagnoses including Alzheimer's disease (a progressive disease that slowly destroys memory and thinking skills, eventually impairing the ability to carry out the simplest tasks) and Glaucoma (slowly progressive eye disease that damages the optic nerve. If enough damage occurs, a person could lose their vision). Review of Resident #10's quarterly MDS assessment, dated 04/16/2026 reflected Resident #10 had a BIMS score of 00 indicating severe cognitive impairment. Further review indicated he had physical behavioral symptoms directed toward others one to three days a week and other behavioral symptoms not directed toward others one to three days a week. Resident #10 used a wheelchair for mobility, had impaired range of motion to both lower extremities, and was dependent on staff for bed mobility and transfers. Review of Resident #10's comprehensive care plan, dated 02/02/2026, reflected Resident #10 was a risk for falls related to fall history, confusion, medication side effects, and score on fall risk assessment with intervention of Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed.During an observation on 05/26/2026 at 3:28 p.m., Resident #10 was lying in bed with eyes closed. He was on an air mattress that had bolsters. His bed was against the wall and there was a fall mat to the right of the bed. His call light was wrapped around a square device on the wall out of the resident's reach.During an observation on 05/27/2026 at 1:47 p.m., Resident #10 was lying in bed with his eyes closed and the call light was wrapped around a square device on the wall out of the resident's reach. During an interview on 05/27/2026 at 1:47 p.m., CNA A stated she was familiar with Resident #10. She stated she kept the call light wrapped around the square box in his room because the night shift started doing it and she just continued. She stated Resident #10 would pull on the cord, would get tangled up in the cord and that was why it was stored the way it was. She stated he was not able to reach the cord when he was lying in the bed if it was wrapped around the square box.During an interview on 05/28/2026 at 1:40 p.m., Resident #10's representative stated she did not want his call light in his reach. She stated she did not understand why the facility would need to have it in Resident #10's reach and she would wind it around the square on the wall to keep it out of his reach when she was at the facility. She stated she did go to the care plan meetings, but no one had discussed his call light with her during those. She stated no one had ever told her his call light needed to be in his reach until now. Record review of Resident #26's electronic face sheet, dated 05/27/2026, reflected she was a [AGE] year-old female admitted on [DATE] and readmitted on [DATE] with diagnoses including dementia (a progressive disease that slowly destroys memory and thinking skills) and chronic pain (long history of pain).Record review of Resident #26's quarterly MDS assessment, dated 04/15/2026, reflected Resident #26 had a BIMS (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	score of 13 indicating intact cognition. Further review reflected Resident #26 used a wheelchair for mobility, needed moderate assistance from staff for bed mobility and transfers, and had no falls since readmission. Record review of Resident #26's comprehensive care plan, dated 12/14/2025, reflected Resident #26 had risk for falls related to history of falls, medication side effects, high fall risk assessment score, and decreased safety awareness with interventions that included Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed.During an interview on 05/27/2026 at 7:35 a.m., Resident #26 was sitting on the side of her bed eating breakfast. Her call light was in reach to the right side of her bed. She stated sometimes the call light was kept out of her reach but did not think the staff did that on purpose. She denied any accidents or other negative occurrences from the call light being out of reach.During an observation on 05/27/2026 at 1:26 p.m. Resident #26 was sitting in a recliner in her room with a bedside table in front of her eating lunch. Her call light was hanging on the middle of her bed out of reach. She stated she did not notice that the call light was on the bed and stated that she needed assistance to get up. She stated she thought it was due to there was not enough staff in the building. She stated she could get her back scratch bar to attempt to reach over and get the call light if she needed assistance. She stated she could not reach the call light without using something to reach it.During an observation and interview on 05/27/2026 at 1:47 p.m., CNA A was picking up trays on the hall where Resident #26 resided. She stated Resident #26 could not reach the call light on the side of the bed if she was sitting in her recliner. She stated Resident #26 did need stand by assistance to safely transfer. She stated maybe the hospice aide had sat her in the recliner and forgot to move the call light after Resident #26's shower but was not sure why the call light was out of her reach.During an interview on 05/27/2026 at 1:55 p.m., LVN C stated she was the nurse for Resident #10 and Resident #26. She stated she was unsure why Resident #10's call light was not in reach but that Resident #10's representative would wrap it up sometimes because she was afraid he would hurt himself with the call light. She stated he was not able to reach the call light when it was wrapped up on the wall. She stated she had no documentation of the conversation between her and the representative in the past. She stated she did not know why Resident #26's call light was not in her reach. She stated she was responsible for making sure call lights were in reach of the residents. She stated she monitored the CNAs were keeping the call lights in reach. She stated not having call lights in reach could make the resident not be able to call for assistance.During an interview on 05/28/2026 at 9:06 a.m., the DON stated she expected residents to have access to their call lights. She stated everyone was responsible for making sure they put the call lights in residents' reach. She stated she monitored the direct care staff providing care and services based upon the care plans by actively rounding the hallways several times a day. She stated the facility had Champion rounds as well where an IDT member rounded their assigned rooms to check on the residents. She stated Resident #10's representative may have been storing the call light out of his reach because she had been told by the nursing staff the representative voiced that she did not want the call light in his reach because she was afraid of him hurting himself with it. She stated Resident #10 could not understand how to use the call light. She stated she had been in the care plan meetings with Resident #10's representative and the representative had made some comments but not on the call light. She stated she did not know why Resident #26's call light was stored out of her reach on 5/27/2026. She stated not having access to the call light could cause Resident #26 to possibly fall and she did not expect for her to use her back scratcher to reach the call light. During an interview on 05/28/2026 at 1:53 p.m., the ADMN stated his expectation would be for residents to have access to their call lights. He stated any direct care staff were responsible for making sure call lights were in reach of the residents. He stated the IDT were assigned rooms that were rounded on at least once a day in the morning and they monitored the call lights were in reach. He stated if the IDT member had a concern, they would round again before the stand down meeting in the afternoon. He stated he did not know off the top of his head who the IDT member would be for Resident #10 and Resident #26. He stated the call light could have been (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	moved after the IDT member had checked the rooms but was not sure. He stated he was not aware that Resident #10's call light was being kept out of his reach. He stated call lights not being in reach of residents could cause the resident to fall or not be able to call for assistance. He stated the facility did not have a policy on call lights, but he would provide the resident rights policy.Record review of the facility's policy titled Resident Rights, no date, reflected The resident has the right to be informed of, and participate in, his or her treatment, including:.2. The right to participate in the development and implementation of his or her person centered plan of care, including but not limited to:.d. The right to receive the services and/or items included in the plan of care.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident and an interdisciplinary team member collaborate with hospice representatives and coordinate the hospice care planning process for each resident receiving hospice services, to ensure quality of care for the resident, ensuring communication with the hospice medical director, the resident's attending physician and others participating in the provision of care for 2 (Resident #10, Resident #60) of 16 residents reviewed for hospice services.The facility failed to maintain a written hospice contract that was signed by the hospice authorized representative and the LTC facility representative before hospice care was furnished to Resident #60.The facility failed to communicate and document communication between the facility and the hospice provider, to ensure that the needs of the resident were addressed and met 24 hours per day for Resident #10.These failures could place the residents who receive hospice services at-risk of receiving inadequate end-of-life care due to a lack of documentation, coordination of care, and communication of resident needs. Findings included: Record review of Resident #10's electronic face sheet, dated 05/26/2026, reflected he was a [AGE] year-old male admitted on [DATE] with diagnoses including Alzheimer's disease (a progressive disease that slowly destroys memory and thinking skills, eventually impairing the ability to carry out the simplest tasks) and Glaucoma (slowly progressive eye disease that damages the optic nerve. If enough damage occurs, a person could lose their vision). Review of Resident #10's quarterly MDS assessment, dated 04/16/2026 reflected Resident #10 had a BIMS score of 00 indicating severe cognitive impairment. Further review indicated he had physical behavioral symptoms directed toward others one to three days a week and other behavioral symptoms not directed toward others one to three days a week. Resident #10 had a life expectancy of less than 6 months. Review of Resident #10's comprehensive care plan, dated 02/02/2026, reflected Resident #10 had a terminal prognosis and received hospice services with intervention If receiving hospice services, work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met. Further review reflected Resident #10 had potential for impaired visual function related to Glaucoma with intervention Administer medications as ordered. Review of Resident #10's electronic Physicians Orders reflected: Admit to [nursing facility] with [hospice company] on 1/31/26 terminal dx: Alzheimer's disease. Call [hospice phone number] for any COC. Further review reflected an order dated 02/02/2026 for dorzolamide hcl-timolol mal ophthalmic solution 2-0.5 % instill 1 drop in both eyes two times a day for Glaucoma. An order dated 01/31/2026 for latanoprost ophthalmic solution 0.005 % instill 1 drop in both eyes one time a day for Glaucoma.Review of Resident #10's MAR, dated February 2026, reflected no documentation that hospice provider was notified of medication refusals: Resident #10 did not receive latanoprost eye drops scheduled for PM one time on:o2/5 with progress note resident hit at staff. Resident #10 did not receive dorzolamide eye drops scheduled for AM seven times on:o2/7 coded resident refused by RN B;o2/11 coded resident refused by RN B;o2/20 coded resident refused by RN B;o2/21 coded resident refused by RN B;o2/22 coded resident refused by RN B;o2/25 coded resident refused by RN B;o2/26 coded resident refused by RN B. Resident #10 did not receive dorzolamide eye drops scheduled for PM one time on:o2/5 coded resident refused.Review of Resident #10's MAR, dated March 2026, reflected no documentation that hospice provider was notified of medication refusals: Resident #10 did not receive latanoprost eye drops scheduled for PM one time on:o3/8 with progress note resident grabbing nurse's arms not allowing eye drops to be administered. Resident #10 did not receive dorzolamide eye drops scheduled for AM sixteen times on:o3/2 coded resident refused by RN B;o3/3 coded resident refused by RN B;o3/6 coded resident refused by RN (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B;o3/7 coded resident refused by RN B;o3/8 coded resident refused by RN B;o3/11 coded resident refused by RN B;o3/12 coded resident refused by RN B;o3/16 coded resident refused by RN B;o3/17 coded resident refused by RN B;o3/20 coded resident refused by RN B;o3/21 coded resident refused by RN B;o3/22 coded resident refused by RN B;o3/25 coded resident refused by RN B;o3/26 coded resident refused by RN B;o3/30 coded resident refused by RN B;o3/31 coded resident refused by RN B. Resident #10 did not receive dorzolamide eye drops scheduled for PM one time on:o3/8 coded resident refused.Review of Resident #10's MAR, dated April 2026, reflected no documentation that hospice provider was notified of medication refusals: Resident #10 did not receive latanoprost eye drops scheduled for PM one time on: o4/6 coded resident refused. Resident #10 did not receive dorzolamide eye drops scheduled for AM fifteen times on:o4/3 coded resident refused by RN B;o4/4 coded resident refused by RN B;o4/5 coded resident refused by RN B;o4/6 coded resident refused by RN B;o4/8 coded resident refused by RN B;o4/9 coded resident refused by RN B;o4/13 coded resident refused by RN B;o4/14 coded resident refused by RN B;o4/17 coded resident refused by RN B;o4/18 coded resident refused by RN B;o4/19 coded resident refused by RN B;o4/22 coded resident refused by RN B;o4/23 coded resident refused by RN B;o4/27 coded resident refused by RN B;o4/28 coded resident refused by RN B. Resident #10 did not receive dorzolamide eye drops scheduled for PM one time on:o4/6 coded resident refused.Review of Resident #10's MAR, dated May 2026, reflected no documentation that hospice provider was notified of medication refusals: Resident #10 did not receive latanoprost eye drops scheduled for PM two times on: o5/6 coded resident refused;o5/7 coded resident refused. Resident #10 did not receive dorzolamide eye drops scheduled for AM twelve times on:o5/1 coded resident refused by RN B;o5/2 coded resident refused by RN B;o5/3 coded resident refused by RN B;o5/6 coded resident refused by RN B;o5/7 coded resident refused by RN B;o5/11 coded resident refused by RN B;o5/12 coded resident refused by RN B;o5/15 coded resident refused by RN B;o5/16 coded resident refused by RN B;o5/17 coded resident refused by RN B;o5/25 coded resident refused by RN B;o5/26 coded resident refused by RN B;Review of Resident #10's progress notes, accessed on 05/27/2026, reflected no evidence of communication between the facility and the hospice provider for Resident #10's eye drop refusals.During an observation on 05/27/2026 at 10:03 a.m., LVN C attempted to administer eye drops to Resident #10. LVN C entered the room and donned clean gloves after performing hand hygiene. LVN C explained to Resident #10 that she needed to give him his eye drops. Resident #10 was lying in bed with eyes closed. Resident #10 refused to open his left eye. LVN C attempted to assist Resident #10 in opening his eye and Resident #10 began shaking his head back and forth and pushing on LVN C's arms. LVN C stepped back and attempted to explain the importance of the eye drops to Resident #10. Resident #10 opened his eyes and smiled. LVN C attempted to instill the eye drops and Resident #10 shut his eyes and pushed her away from him again.During an interview on 05/27/2026 at 1:55 p.m., LVN C stated she was the nurse for Resident #10 and had attempted to give him his eye drops that morning. She stated he would not let her give him the medication. She stated she documented on the MAR that he refused the eye drops. She stated she did not call the hospice provider about him refusing the eye drops. She stated the hospice provider was aware that he would refuse the eye drops and if she was present when the hospice nurse was in the building, she would tell her about him refusing. She stated she had not documented the conversations with the hospice nurse but she was in the building every week. She stated she would be who reached out to the hospice company if there was any change in condition. She stated she did not know if she had to reach out to the ordering physician every time a medication was refused. During a telephone interview on 05/28/2026 at 10:37 a.m., RN B stated she did document code refused on the MAR when Resident #10 refused his eye drops. She stated she would let hospice know if the hospice nurse was in the building on the day of his refusal but did not call them every time Resident #10 refused his eye drops. She stated she would make several attempts to administer the eye drops but Resident #10 would shut his eyes and push her away. She stated she felt the hospice was aware of his refusals without being called every day. She stated she never documented her (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	conversations with the hospice nurse and did not know she should do that. She stated the hospice physician would be the physician that was ordering the eye drops and the hospice nurse would be the one to tell him about the refusals. During an interview on 05/28/2026 at 1:40 p.m., Resident #10's representative stated she was aware that Resident #10 not getting his eye drops for Glaucoma. She stated she had asked RN B how the eye drops were going and she was told they are not going. Resident #10's representative stated she was concerned he would go blind and that his behaviors would be worse if he could not see. She stated she had voiced her concerns with the facility and the hospice provider. She stated she was unsure if the facility was notifying the hospice provider after his refusals. She stated the hospice physician was ordering the eye drops. She stated she felt that it was in the approach to him stating that if he was sleeping then she thought the nurses could gently open his eyes and give the drops. She stated that if they woke him up and were talking to him explaining what was happening he would get agitated and grab at the nurse because he could not understand what they were doing. Review of Resident #60's electronic face sheet, dated 05/27/2026, reflected a [AGE] year-old male who was admitted on [DATE] and readmitted on [DATE] with diagnosis including heart disease. Review of Resident #60's comprehensive care plan, dated 05/05/2026, reflected Resident #60 had a terminal prognosis and was receiving hospice services with intervention work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met.Review of Resident #60's electronic physician orders, dated 05/22/2026, reflected Admit with [hospice company] 5/22/26. Dx: Heart Disease.Review of facility's contract binder reflected no evidence that the facility had a hospice contract with Resident #60's hospice provider.During an interview on 05/28/2026 at 1:08 p.m., the ADMN stated he was not able to locate a contract between the facility and Resident #60's hospice provider. He stated he had contacted the hospice company's Administrator to see if they had a copy of the contract to provide him and was waiting for them to send over the contract. He stated he had been hired two weeks ago. He stated he was told by the interim ADMN before him all of the contracts needed were in the contract binder. He stated he had not noticed the hospice contract was not in that binder until now. During a telephone interview on 05/28/2026 at 2:23 p.m., hospice staff stated that the medical director for the hospice company was the ordering physician for Resident #10's eye drops. The hospice staff stated they were aware of Resident #10 not taking the eye drops because Resident #10's representative would notify them. The hospice staff stated the facility would notify them when they came into the building but that was at the most once a week.During a follow-up interview on 05/28/2026 at 1:53 p.m., the ADMN stated his expectation would be for hospice contracts to be obtained prior to a resident being admitted on hospice services. He stated the ADMN was responsible for making sure the hospice contract was signed and stored in the facility. He stated he continued to wait for Resident #60's hospice company's Administrator to fax over the contract. He stated that the DON would be the hospice contact when she was in the facility per policy. He stated the DON would need to designate that task to another person if she was not in the facility. He stated he was told when he started on 5/11/2026 that all the contracts were in a binder by the interim ADMN and had not noticed the hospice contracts were not there. He stated the facility should have had a contract from the hospice in the facility before a resident on that hospice was admitted . During an interview on 05/28/2026 at 2:33 p.m., the DON stated she did not know she was the hospice contact per the facility policy. She stated she expected the nurses who could not administer medications to contact the ordering physician or the hospice provider via the hospice nurse. She stated typically after a resident refused medication three times, the facility would facilitate getting the physician to discontinue the medication. She stated she felt Resident #10's being adamant that he received the eye drops was why the physician had not been contacted to get the drops discontinued. She stated the staff were afraid of Resident #10's retaliating against them and she had been known to slam doors and raise her voice. She stated the eye drops were for glaucoma and if he did not receive them, he could lose his vision. She stated the nurses were making the attempts to administer, but they (continued on next page)

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