STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676083	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brownsville Nursing and Rehabilitation Center	320 Lorenaly Dr 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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32107 Based on observation, interview, and record review the facility failed to ensure the assessment accurately reflected the resident's status for 2 (Resident #1 and #2) of 7 residents reviewed for accuracy of assessments. 1. The facility failed to ensure Resident #1 was coded in the MDS for a fall. 2. The facility failed to ensure Resident #2 was coded in the MDS for a fall. This failure could place residents at risk of improper or incorrect care and services necessary for their physical, mental, and psychosocial well-being. The findings included: 1. Record review of Resident #1's physician orders dated [DATE] revealed Resident #1 was admitted on [DATE] and was [AGE] years old. Resident #1 had diagnoses of Dementia, lack of coordination, Parkinson's(A chronic and progressive movement disorder that initially causes tremor in one hand, stiffness or slowing of movement) and unsteadiness on feet. Record review of Resident #1's comprehensive care plan reflected: The resident has had an actual fall r/t Poor Balance, Poor communication/comprehension Initiated: [DATE] Revision on: [DATE] due to Resident#1 fall on [DATE]. Record review of Resident #1's annual MDS dated [DATE] revealed: A score of 8 (moderately impaired) for Brief Interview of Mental status. required moderate assistance from seat to stand. No falls since previous quarterly MDS assessment. Record review of Resident#1's progress notes dated: (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] 05:50 NURSING - Nurse Note Note Text: [DATE] at 0500. Charge nurse noted a Resident in her bedroom in her right side of her body on the floor next to bed. Record review of facility's incident log not dated revealed that on [DATE] at 5 AM Resident #1 had an unwitnessed fall. An observation on [DATE] at 2:40 PM, revealed Resident #1 was in her bed laying down, well dressed and groomed. Resident #1 was holding her call light. Resident #1 said did not remember any recent falls. Interview on [DATE] at 2:50 PM , with MDS Nurse A said was in charge of coding long term care MDS and Resident #1 was a long term resident. She said Resident #1's fall should have been coded in the annual MDS dated [DATE]. She said not coding Resident#1's fall could reflect and Resident #1 not receiving the proper care and services. In an interview on [DATE] at 3:54 PM., DON said the fall for Resident #1 needed to be coded because the staff could missed the services and needs that a Resident #1's required. 2. Record review of Resident #2's physician orders dated [DATE] revealed resident was admitted to facility. Her primary diagnosis was Alzheimer's disease. Record review of Resident #2's comprehensive care plan reflected: Resident #2 had a witnessed fall with no injury Intervention: Activities Referral Initiated: [DATE]. Resident #2 fall [DATE] Intervention: Non-skid pad while in wheelchair Initiated: [DATE]. Record review of Resident #2's quarterly MDS dated [DATE] revealed: A score of 1 (severe impairment) for Brief Interview of Mental status. Resident required substantial/maximum assistance from seat to stand. No falls since prior quarterly MDS assessment. Record review of Resident #2's progress notes dated: [DATE] 6:18 PM NURSING - Nurse Note-GVN D Note Text: Alerted by CNA that patient was on the floor. Patient was found on the floor in her bedroom by the nurse manager, she was found lying down on the floor on her left side. She was picked up by staff and placed into her wheelchair. This nurse performed a head to toes assessment - 0.1cm x 0.3cm skin tear noted to the left elbow, no other skin impairments noted at this time. Patient remains within normal baseline, no change in mental status noted at this time. Np notified of change in condition, saw patient in person at 1800, no new orders given at this time . (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] 03:17 PM NURSING - Nurse Note-LVN B Note Text: Spoke to the resident's #2 son, in regards the fall. I explained to him how the incident happened. Resident was sitting in the dining room by second door of the dining room when she attempted to get up from wheelchair and fell on her left side. Her head did not hit the floor, there are no signs of redness or red/purple discoloration on the left side of the face or head. Staff members (were located by the main entrance of the dining room) tried breaking the fall but they were not able to reach to her on time. He verbalized understanding. Record review of facility's incident log revealed that on [DATE] at 4 PM, Resident #2 had an unwitnessed fall and [DATE] at 2:53 PM had a witnessed fall. Record review of a fall risk assessment for Resident #2 effective [DATE] at 4:13 PM had score of 7 with history of falls (last 3 months) with ,d+[DATE] falls. and [DATE] at 2:18 PM had score of 16, with history of falls (last 3 months) with ,d+[DATE] falls. Scoring, If the total score is 10 or greater, the resident should be considered at HIGH RISK for potential falls. A prevention protocol should be initiated immediately and documented on the care plan. Record review of Resident #2 Face Sheet, had discharge date of was discharged [DATE], patient was in hospice and expired [DATE] as per Nurse Progress note dated [DATE] by LVN C. [DATE] 5:51 PM NURSING - Nurse Note- LVN C Note Text: Approximately at 0530 was made aware by CNA that resident was not responding. Upon entering room resident in supine position on bed. No respiration n oted. No pulse noted. Unable to obtain vital signs. Called Hospice Nurse and made aware. As per Hospice Nurse, nurse will be here in facility shortly and will call RP. An interview conducted on [DATE] 10:44 AM, MDS Nurse A was asked regarding falls for Resident #2 in 2023. She looked up record and stated the resident had a laceration to left eyebrow. Fall for June was included in MDS dated [DATE]. MDS Nurse A stated that if any falls prior to MDS assessment, they are included. If fall before that MDS assessments, yes, falls are documented in that MDS, if falls after the current MDS then falls are logged on next MDS, whether there is an injury or not. MDS Nurse A responds after reviewing record that the resident had two falls in [DATE], one on [DATE], with intervention for an activity referral, and another fall [DATE], with intervention of a non-skid pad while in chair. She reviews MDS for October and stated no, they were not captured. She stated she is not sure why falls were not captured, that it was probably just an error in MDS. MDS Nurse A stated that falls are usually care planned and any incident, and that there was no negative outcome because it was in the care plan and it will have interventions that are put in place right away, which she stated interventions were implemented right away. She stated that the DON oversees MDS assessments. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on [DATE] at 11:03 AM, the DON looked up Resident #2 and stated Resident #2 had a fall on [DATE] and [DATE] in [DATE]. The DON stated they were care planned with the fall for [DATE] with intervention for an activity's referral, [DATE] fall with an intervention for non-skid pad. The DON stated the MDS nurse oversees MDS, then corporate nurse oversees once MDS is finished. The DON stated he does not know how often they go back on annual assessment, then he read instructions for J1900. The DON stated regarding negative outcomes for the resident, no, I don't think so, I don't know because incident is addressed immediately. The DON stated there are phone alerts that go to DON and administrator. Interventions are care planned specific to reason, such as if a fall, labs, UA whatever is going on is done. The DON stated that in my job MDS does not interfere in my job. The DON stated he had to cover an MDS nurse once, and was trained in MDS but does not understand, and again stated it does not affect his job because if there are incident interventions, they are put into place immediately. He stated he does not have to wait for supply for fall mats they go and get them if needed. The DON stated he performs ANE training every time there is an incident, the last one was about a week ago. He stated for night shift trainings he will stay late for night shift or come in during night shift or in the morning before shift is over and provide training and ensure training is completed and sign-in logs full. An interview on [DATE] at 11:32 AM., the Administrator stated that MDS assessments are completed by the 2 facility care managers. He stated that an Interdisciplinary Team oversees the accuracy and timeliness of the MDS assessments. He stated the interdisciplinary team is made up of the social services, care managers, nurse managers, activities director and dietary services. He stated the DON or other RNs can sign off on the accuracy of MDS assessment. If there are inaccuracies in MDS, an AD-HOC QAPI is held to review the issue, identify the system failure, and if there is a trend with a specific incident, such as like falls, then they would do a general audit of assessments with focus on that incident, for three months which he stated will be part of plan of correction which the facility has already begun by having LVN A auditing everything again. Record review of CMS's RAI Version 3.0 Manual Sections dated ,d+[DATE], that Administrator provided, reflected : J1800: Any falls since admission/entry or reentry or Prior to Assessment. Coding instructions: Code 1, yes if the resident has fallen since the last assessment. Continue to number of falls since admission/entry or reentry or prior to assessment. J1900: Any falls since admission/entry or reentry or Prior to Assessment. Coding instructions: Code 1, yes if the resident has fallen since the last assessment. Continue to number of falls since admission/entry or reentry or prior to assessment.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32107 Based on observation, interview, and record review, the facility failed to enact a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption, for 1 (Resident #1) of 3 residents reviewed, in that: A plastic bag with food inside that contained tamales was found in Resident #1's night stand. The food was unlabeled, undated and not refrigerated. This deficient practice could lead to illness due to foodborne pathogens. The findings were: Record review of Resident #1's physician orders dated 05/29/24 revealed Resident #1 was admitted on [DATE] and was [AGE] years old. Resident #1 had diagnoses of Dementia, lack of coordination, Parkinson's (A chronic and progressive movement disorder that initially causes tremor in one hand, stiffness or slowing of movement) and unsteadiness on feet. Record review of Resident #1's annual MDS dated [DATE] revealed: A score of 8 (moderately impaired) for Brief Interview of Mental status. required moderate assistance from seat to stand. Observation on 05/30/24 at 8:41 AM., it was observed that Resident #1's nightstand had a plastic bag with aluminum foil inside. Resident #1 said she did not know what was inside the bag or who had brought the bag for her. In an interview on 05/30/24 at 8:42 AM., CNA B said she had the morning shift; however, she had gone inside Resident #1's room because when she came in to start her shift Resident #1 was in the dining area. She said she had not noticed the bag on top of the nightstand before. CNA B said Resident #'1's family brought food to her from the outside. In an interview on 05/30/24 at 8:44 AM, CNA C said he had not entered Resident #1's room since he started his morning shift. He said the plastic bag contained tamales, however he was not sure how long the bag of tamales had been in Resident #1's nightstand. He said he had worked the previous day from 6 am to 6 PM and did not remember seeing the bag of tamales. He said the bag with tamales was not label, dated, or refrigerated. He said food brought from the outside had to be labeled, dated and if needed refrigerated. In an interview on 05/30/24 at 8:50 AM, LVN D said she had worked the previous day from 6 am to 6 pm and had not seen the bag of food. She said the bag with tamales most probably was brought in by a family member for Resident #1 during the night shift. She said she did her rounds early in the morning of 05/30/24 and did not see the bag of food. She said Resident #1 could have hidden the tamales inside her nightstand. She said the bag of tamales was not labeled or dated as the facility's policy indicated. She said any resident could get sick if the food was not properly stored. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/30/24 at 9:01 AM., the DON said family members that brought in food from the outside should know that they need to tell the nurse about the food so the food can be properly stored and labeled. He said he was not sure what had happened with Resident #1's food. He said he would in-service staff on it. In an interview on 05/30/24 at 9:03 AM., the Dietary Manager said better to have tamales refrigerated. She said food can stand two hours outside the refrigerator then there is a possibility that the food can go bad. In an interview on 05/30/24 at 10:30 AM., the Administrator said there was a potential for a negative outcome if the food was not properly stored. In an interview on 05/30/24 at 12:33 PM., CNA E said he worked the previous night shift and one of Resident #1's family members brought tamales for her around 7 PM or 8 PM. He said the family member gave Resident #1 one tamale. He said later on Resident #1 said she was hungry, and he gave her two more tamales. He said he was aware that the tamales needed to be refrigerated however he did not want to get Resident #1 upset so he left the bag of tamales on the nightstand. He said he did not go back at the end of his shift to pick up the bag of tamales and put it in the refrigerator. Record review of the facility policy Use and storage of food brought in by family or visitors dated 01/27/23 revealed:' Is the right of the residents of this facility to have food brought in by family or other visitors, however the food must be handled in a way to ensure the safety of the residents. 2. All food items that are already prepared by the family, or visitor brought in must be labeled with content and dated. a. the facility may refrigerate labeled and dated prepared items in the nourishment refrigerator.