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	07/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brownsville Nursing and Rehabilitation Center	320 Lorenaly Dr 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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record reviews the facility failed to ensure the residents right to be informed of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers, for 1 of 5 residents (Resident #3, Resident #6) reviewed for consent for antipsychotic medications in that: 1. Resident #3 was prescribed and administered Haldol (an antipsychotic) without prior consent based on information of the benefits, risks, and options available. 2. The facility failed to ensure psychoactive medication consents for Resident #6's were signed and dated by his guardian for the use of Zyprexa (antipsychotic medication), Buspirone (anxiolytic medication), lorazepam (benzodiazepine medication), and Risperidone (antipsychotic medication). These failures could affect the right to self-determination of all facility residents who receive medication by allowing them to receive medication without their prior knowledge or consent, or that of their responsible party or emergency contacts. The findings included: 1. Record review of Resident #3's admission record dated 06/17/2025, revealed an admission date of 08/15/2024, and a re-admission date on 11/25/2024, with a diagnoses which included dementia (a group of thinking and social symptoms that interferes with daily functioning) without behavioral disturbance, psychotic disturbance (delusions and hallucinations), mood disturbance, and anxiety, and traumatic subdural hemorrhage (a type of bleeding near the brain that can happen after a head injury) with loss of consciousness of 30 minutes or less. Record review of Resident #3's admission MDS, dated [DATE], revealed a BIMS of 01, indicating severe cognitive impairment. There were no potential indicators of psychosis, and no behavioral symptoms were indicated. Active diagnoses included: traumatic brain dysfunction (an impairment in the normal functioning of the brain caused by an outside force, usually a violent blow to the head), and dementia. Resident #3 was not receiving an antipsychotic.Record review of Resident #3's Progress Note written by LVN J, dated 10/28/2024 at 11:18 AM revealed, As per NP (S), new order for Haldol Deconate 50mg IM Q month for aggression behavior. (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #3's Progress Note Orders - Administration Note on 10/28/2024 written by LVN J revealed This order is outside of the recommended dose or frequency. Haldol Decanoate Intramuscular Solution 50 MG/ML (Haloperidol Decanoate) Inject 50 mg intramuscularly one time a day every 1 month(s) starting on the 28th for 1 day(s) for 50mg IM Q month - The frequency of monthly is below the usual frequency of every 28 days.Record review of Resident #3's Progress Note dated 10/29/2024 at 08:18 PM written by LVN K, revealed Administered monthly haloperidol.Record review of resident #3's care plan, dated 11/19/2024, revealed:FOCUS: The resident uses antipsychotic medications (HALDOL) r/t AGITATION Date Initiated: 11/19/2024 Revision on: 11/19/2024.GOALS: Resident will have no injuries related to medication usage Date Initiated: 11/19/2024 Target Date: 12/31/2024.INTERVENTIONS/TASKS: o psych consult Date Initiated: 11/19/2024 Revision on: 11/19/2024 LN o Discuss side effects of medications with resident/RP Date Initiated: 11/19/2024 LN o Keep environment free of clutter and safety hazards Date Initiated: 11/19/2024 LN o Monitor behaviors. Notify MD of new or worsening behaviors Date Initiated: 11/19/2024 LN SS o Monitor vital signs as ordered by MD and PRN Date Initiated: 11/19/2024 LN o Monitor/document/report PRN any adverse reactions of antipsychotic medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person. Date Initiated: 11/19/2024 LN. Record review of Resident #3's medical record did not reveal consent for the antipsychotic Haldol until 02/22/2025.During an interview on 06/25/2025 at 03:38 PM Resident #3's RP stated she had gone to the facility sometime around February to sign a consent for a medication they wanted to give Resident #3. The RP stated she could not remember the name of the medication. She said they told her it was for sleep because he woke up in the night and because he walked around. During an interview on 06/26/2025 at 01:14 PM LVN P stated for an antipsychotic to be given to a resident, the LVN needed to make sure she had a consent form, the correct diagnosis, the right reason, the right time, the right route, the right patient, and the right documentation. During an interview on 06/26/2025 at 01:48 PM LVN K stated he could not recall if he had administered the Haldol injection to Resident #3 on 10/29/2024 or not. He stated he had just started working as a nurse at the facility (October 2024). LVN K stated Resident #3 did not have behavior. In an interview on 06/26/25 at 05:33 PM the DON stated to administer an antipsychotic; consent must be signed prior to giving an antipsychotic. The DON stated he had seen the consent for the Haldol for Resident #3 had been signed in February 2025. The DON stated the consent should have been signed by the RP and checked by the nurse before the Haldol was administered. 2. Record review of Resident #6’s admission record dated 09/06/24, revealed a [AGE] year-old male with diagnoses which included: Alzheimer’s disease, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety and cognitive communication deficit. Record review of Resident #6’s quarterly MDS assessment dated [DATE] revealed resident had a BIMS score of 6 indicating moderately impaired cognition and that Resident #6 was taking antipsychotic and antianxiety medications. Record review of Resident #6’s physician orders revealed orders which included the following: (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Zyprexa 2.5MG tablet Give 1 tablet by mouth two times a day for mood disorder effective 09/14/24; Zyprexa 5MG tablet Give 1 tablet by mouth three times a day for agitation effective 12/17/24; Buspirone 5MG tablet Give 1 tablet by mouth two times a day for mood disorder effective 03/19/25; Lorazepam 0.5MG tablet Give 1 tablet by mouth every 12 hours as needed for mood disorder effective 01/08/25; Risperidone 0.25MG tablet Give 1 tablet by mouth one time a day for mood disorder effective 04/04/25. Record review of Resident #6’s MAR revealed Zyprexa, Buspirone, and Lorazepam had been administered on dates prior to have received the signed consents. Record review of Resident #6’s “Informed Consent for Psychoactive Medications” for Zyprexa 2.5MG and Zyprexa 5MG revealed both forms were signed and dated by the doctor and resident’s RP on 05/22/25. Record review of Resident #6’s “Informed Consent for Psychoactive Medications” for Buspirone revealed the form was signed by the doctor but was not dated. The same form revealed resident’s RP signed and dated on 05/21/25. Record review of Resident #6’s “Informed Consent for Psychoactive Medications” for Buspirone revealed a second consent form was signed and dated by the doctor and resident’s RP on 06/25/25. Record review of Resident #6’s “Informed Consent for Psychoactive Medications” for lorazepam revealed the form was signed and dated by the doctor and resident’s RP on 06/27/25. Record review of informed consents revealed there was no actual consent form for Risperidone. Interview was attempted with Resident #6 on 07/14/25 at 9:35 am but resident was unable to answer any medication questions. During an interview on 07/14/25 at 10:28 am, LVN F stated that when a doctor gave an order for an antipsychotic medication, the nurse was to verify the order and make sure it was correct. Once the order was verified that it was correct, then the consent is needed from the family, either verbally or signed on paper. LVN F stated that verbal orders that were obtained by the phone, were to be verified with another nurse present during the phone call. Once the family gave consent, LVN F stated both nurses were to sign the form and then hand the form off to the medical records office. LVN F stated that the ADON H, ADON I, or the DON were responsible for reviewing the consents that were submitted for the new orders that were received. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/14/25 at 3:37 pm, MDS D stated that when a psychotropic medication was ordered by a doctor, the nurse that received the order had to obtain the family’s consent before the medication was given. MDS D stated that consents, either verbal or in person, are signed off on a paper form. MDS D verified which one of Resident #6’s medications needed a consent. MDS D stated that Zyprexa 2. 5MG and Zyprexa 5MG, Buspirone, Lorazepam, and Risperidone all needed consents. The consents for Zyprexa, Buspirone and lorazepam had been uploaded to their computer system however the consent form for Risperidone was not found. MDS D stated those were the only consents she was able to find in the system for Resident #6. During an interview on 07/15/25 at 10:39 am, the DON stated that when a doctor gave an order for an antipsychotic, consent from the family was required. The DON stated that the family was informed of the new order and the family was allowed to give consent or refuse. If the family gave consent over the phone, then two nurses received the verbal consent and both nurses signed the actual consent form. The DON stated that consents were monitored every morning during the reports from the morning meeting. The DON stated that new medications or new orders were discussed in every morning meeting. The DON stated that ADON H, ADON I, or he himself would review that the forms have been signed correctly. If the consent had not been done, there would be a hold on medication administration and notify the doctor that the medication was not administered. The DON reviewed Resident #6’s medication administration record and stated the medications had been administered on dates prior to have received the written consent forms. The DON states he was unaware the consent forms had not been signed by RP nor by the doctor. A record review of the facility's policy Nursing Facility Residents' Rights, dated November 2021, revealed, Participation in Your Care You have the right to: -Have any psychoactive medications prescribed and administered in a responsible manner as mandated by the Texas Health and Safety Code, 242.505, and refuse to consent to the prescription of psychoactive medications. A record review of the facility's policy Use of Psychotropic Medication(s), dated 03/05/25, revealed, Policy Explanation and Compliance Guidelines: 9. Prior to initiating or increasing a psychotropic medication, the resident, family, and/or resident representative must be informed of the benefits, risks, and alternatives for the medication, including any black box warnings for antipsychotic medications, in advance of such initiation or increase. 10. The resident has the right to accept or decline the initiation or increase of psychotropic medication. 11. The facility will document that the resident or resident representative was informed in advance of the risks and benefits of the proposed care, the treatment alternatives or other options and the preferred option to accept or decline in a format the facility deems to use (e.g., written consent form, narrative note, etc.).

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure the residents had the right to be free from abuse, neglect, and misappropriation of property for 6 of 8 residents (Residents #6, #9, #7, and R#10) reviewed for abuse. 1.The facility failed to ensure Resident #6 was free from abuse when Resident #7 dug her nails on Resident #6's left forearm that resulted with multiple skin tears with serosanguineous drainage on 01/02/2025. 2.The facility failed to ensure Resident #9 was free from abuse when Resident #6 hit Resident 9 on her upper left arm with a closed hand on 03/25/2025.3.The facility failed to ensure Resident #7 was free from abuse when Resident #2 slapped Resident #7 on the left side of the face with a closed hand on 03/25/2025. 4.The facility failed to ensure Resident #7 was free from abuse when Resident #6 grabbed Resident #7 by the hair and arm on 04/11/2025. 5.The facility failed to ensure Resident #10 was free from abuse when Resident #6 rolled his wheelchair towards her and hit her left knee and caused a skin tear on 03/28/2025. The findings included: Resident #6Record review of Resident #6's admission record dated 07/15/2025 reflected a [AGE] year-old-male with an admission date of 09/06/2024. His relevant diagnoses included Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), dementia (a group of thinking and social symptoms that interferes with daily functioning), unspecified mood (affective) disorder (a serious mental illness that causes persistent and intense changes in a person's mood, energy, and behavior) , and cognitive communication deficit (difficulties in communication that arise from impairments in cognitive processes like attention, memory, problem-solving, and executive functions). Record review of Resident #6's quarterly assessment dated [DATE] reflected a BIMS score of 06, which indicated his cognition was severely impaired. Further review reflected Resident #6 had behavioral problems with physical behavioral symptoms directed towards others (e.g., hitting kicking, pushing, scratching, grabbing, abusing others sexually) that occurred 1 to 3 days. Verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) that occurred 4 to 6 days, but less than daily. Record review of Resident #6's quarterly care plan dated 05/12/2025 reflected the following: Problem: [Resident #6] is/has potential to be physically aggressive r/t dementia (date initiated 04/21/2025 and revised on 07/11/2025). Goal: [Resident #6] will not harm self or others through the review date (date initiated 04/21/2025). Interventions: Administer medications as ordered, monitor/document for side effects and effectiveness (date initiated: 04/21/2025), communication, provide physical and verbal cues to alleviate anxiety; give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, encourage seeking out of staff member when agitated (date Initiated 04/21/2025), give the resident as many choices as possible about care and activities (date initiated 04/21/2025), monitor/document/report PRN any s/sx (signs and symptoms) of resident posing danger to self and others (date initiated 04/21/2025) Resident #9Record review on 07/12/2025 of Resident #9's admission sheet dated 07/14/2025 reflected an [AGE] year-old female with an admission date of 08/14/2023 and an original admit date of 02/06/2023. Her relevant diagnoses included Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), dementia (a group of thinking and social symptoms that interferes with daily functioning), mood disorder, and obsessive-compulsive personality disorder (a personality disorder characterized by an intense focus on order, perfectionism, and control).Record review on 07/12/2025 of Resident #9's change of condition MDS assessment dated [DATE] reflected a BIMS score of 06, which reflected her cognition was severely impaired. Record review on 07/12/2025 of Resident 9's quarterly care plan dated 05/22/2025 reflected no behavioral problems and the resident to resident on 03/25/2025 had not been care planned. Resident #7Record review of Resident #7's face sheet dated 07/14/2025 reflected a [AGE] year-old-female with an admission date of 09/16/2019. Her relevant diagnoses included Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), emotional lability (a sign or symptom exaggerated changes in mood or affect in quick secession), mood disorder, and dementia(a group of thinking and social symptoms that interferes with daily functioning) . Record review of Resident #7's annual MDS assessment dated [DATE] reflected a BIMS score of 03, which reflected her cognition was severely impaired. Record review of Resident #7's comprehensive care plan dated 06/19/2025 reflected:Problem: [Resident #7] does tend to get verbally/physically abusive with staff and residents. She isn't easily redirected at time. Resident #10Record review of Resident #10's admission sheet dated 07/14/2025 reflected a [AGE] year-old-female with an admission date of 03/25/2025 and a discharge

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, or mistreatment, were reported immediately to the State Survey Agency, within two hours if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, for 3 (Resident #5, Resident #3, and Resident #2) of 4 residents reviewed for neglect. The facility failed to report allegations of resident neglect for Resident #5 to the State Survey Agency within the allotted time frame of 2 hours on 05/24/25 when Resident #5 had a fall at around 7:30 AM and sustained a serious bodily injury (distal fibular diametaphyseal fracture). The facility failed to report two Resident – to – Resident altercations. One on 11/15/24 between Resident #3 and Resident #2. The other occurred on 03/25/25 with Resident #2 and an unknown resident. The facility failed to report unwitnessed injury for Resident #2 on 11/11/24, 11/13/24, 12/17/24, 01/07/25, 02/04/2025, and 03/19/25. The facility failed to report an unwitnessed fall with skin tear to Resident #2 ' s nose. These failures could place all residents at increased risk for potential abuse/neglect due to unreported allegations of abuse and neglect. The findings included: 1.Record review of Resident #5 ' s admission sheet reflected a [AGE] year-old female with an admission date of 03/18/25 and an original admission date of 03/02/24 and a discharge date of 03/22/25). Her relevant diagnoses included dementia (a group of symptoms affecting memory, thinking, and social abilities, which interfere with daily life), abnormalities of gait and mobility (any deviations from typing walking pattern, often indicating underlying neurological, musculoskeletal, or other medical conditions), unsteadiness on feet. Record review of Resident #5 ' s quarterly MDS assessment dated [DATE] reflected she had a BIMS score of 12, which indicated her cognition was moderately intact. Record review of Resident #5 ' s quarterly care plan dated 03/04/24 reflected Resident #5 was at risk for falls related to impaired mobility and history of falls. Her interventions in part included to anticipate and meet her needs, call light within reach, and to ensure [Resident #5] wore appropriate footwear (when ambulating or mobilizing in wheelchair. Record review on 06/17/25 of Resident #5 ' s progress note dated 01/18/25 at 11:09 a.m., authored by LVN T reflected reported to NP purple skin discoloration to right dorsal foot and right inner extremity .Order x-ray, arterial scan to extremity and consult with Dr. Orders in place. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review on 06/17/25 of Resident #5 ' s radiology result report dated 01/18/25 signed at 6:52 p.m., reflected Resident #5 had an acute distal fibular diametaphyseal fracture with soft tissue swelling. Record review on 06/17/25 of Resident #5 ' s progress note dated 01/18/25 at 10:50 p.m., authored by LVN C reflected charge nurse reported .foot right 2 views results serviced 01/18/25 to NP T. As per NP T repeat foot 2 views x-ray, tibia-fibula right 2 views x-ray . Record review on 06/17/25 of Resident #5 ' s intake reflected the facility reported her injury on 01/19/25 at 3:57 p.m. In a telephone interview on 06/17/25 at 02:45 p.m., LVN C said he did not remember much of Resident #5 ' s 01/18/25 incident. He said the only thing he remembered was that he had been given report by the outgoing nurse that Resident #5 had complained her ankle being discolored. An interview on 06/19/25 at 10:30 a.m., LVN U said on 01/18/25 (did not remember the time), Resident #5 had complained to her of having purple skin discoloration to her lower right inner extremity. She said while she assessed her, Resident #5 had voiced that she had not fallen or injured her right leg in any way. LVN U said she immediately notified Resident 4 ' s NP and received order for a scan and x-ray. In an interview on 06/19/25 at 10:55 p.m., the DON said Resident #5 had complained her lower right leg was discolored, purple in color on 01/18/25 around 11:00 a.m. He said the charge nurse had conducted a head-to-toe assessment and notified Resident #5 ' s NP. He said NP ordered a duplex and an x-ray to right tibia-fibula and to right foot. The DON said the facility had received confirmation from the mobile X-ray company on 01/18/25 at 6:52 p.m. that Resident #5 had a fracture. He said staff must have not read the report until 10:48 p.m. He said Resident #5 ' s NP was notified, and he had ordered a repeat x-ray to confirm fracture. The DON said the reason the NP had ordered a repeat x-ray was because Resident #5 had not complained of pain or reported any injury. The DON said Resident #5 had a repeated x-ray on 01/19/25 and the findings confirmed Resident #5 had an acute distal fibular diametaphyseal fracture. The DON said since Resident#4 ' s NP had requested a repeated x-ray; they did not considered Resident #5 having a fracture until the results from the second x-ray came in. He said Resident #5 ' s NP had not deemed it a fracture yet because he had ordered a second x-ray that was the reason the facility had reported the incident to state on 01/19/25 after the results from the second x-ray confirmed the findings from the first x-ray taken on 01/18/25. The DON said the facility would not call a fracture, until the NP/Dr. called it a fracture. An interview on 06/19/25 at 11:00 a.m., the Administrator the facility had received Resident #4 ' s x-ray results of a fracture on 01/18/25 at 7:00 p.m., but her NP had ordered a repeat to confirm the finding. The Administrator said the repeated x-ray was done and confirmed on 01/19/25 that Resident #4 had sustained an acute right distal fibular diametaphyseal fracture. He said he reported the fracture within 2 hours of confirming fracture. The Administrator said he did not report the fracture to state on 01/18/25 because Resident #4 ' s NP had not confirmed the fracture. A telephone interview on 06/19/25 at 12:48 p.m., NP T said he had ordered a repeated x-ray for Resident #4 to confirm the findings of the first x-ray which indicated she had a distal fibular diametaphyseal fracture. He said the second x-ray would serve as a confirmation only and he would go with the first x-ray findings to diagnose her as having a fracture. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #3's admission record dated 06/17/2025, revealed an [AGE] year old male with an admission date of 08/15/2024, and a re-admission date on 11/25/2024, with a diagnoses which included dementia (a group of thinking and social symptoms that interferes with daily functioning) without behavioral disturbance, psychotic disturbance (delusions and hallucinations), mood disturbance, and anxiety, and traumatic subdural hemorrhage (a type of bleeding near the brain that can happen after a head injury) with loss of consciousness of 30 minutes or less. Record review of Resident #3's admission MDS, dated [DATE], revealed a BIMS of 01, indicating severe cognitive impairment. There were no potential indicators of psychosis, and no behavioral symptoms were indicated. Active diagnoses included: traumatic brain dysfunction (an impairment in the normal functioning of the brain caused by an outside force, usually a violent blow to the head), and dementia. 3. Record review of Resident #2's admission record dated 06/17/2025, revealed a [AGE] year old male with an admission date of 07/06/2021,with a diagnoses which included Alzheimer ' s Disease (a progressive disease that destroys memory and other important mental functions), dementia (a group of thinking and social symptoms that interferes with daily functioning) without behavioral disturbance, psychotic disturbance (delusions and hallucinations), mood disturbance, and anxiety. Record review of Resident #2's Change in Condition MDS, dated [DATE], revealed a blank BIMS, indicating severe cognitive impairment. There were no potential indicators of psychosis, verbal behavioral symptoms occurred 1 – 3 days, and other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily waste, or verbal/vocal symptoms like screaming, disruptive sounds) occurred 1 – 3 days. Active diagnoses included: Alzheimer ' s Disease and dementia. Record review of Resident #2 ' s Care Plan dated 04/02/2025 revealed: FOCUS: · The resident is potential to be physically aggressive with staff when redirected. Physically aggresive with staff during showers, dressing, adl care UPSET WHEN REDIRECTED FROM OTHER PATIENTS BED. APT TO SLEEP IN OTHER'S ROOMS. AND ON SOFA. Date Initiated: 09/09/2021 Revision on: 11/11/2024 GOALS: · The resident will not harm self or others through the review date. Date Initiated: 09/09/2021 Revision on: 12/26/2024 Target Date: 07/01/2025 INTERVENTIONS/TASKS: · (continued on next page)

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	07/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brownsville Nursing and Rehabilitation Center	320 Lorenaly Dr Brownsville, TX 78520

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer medications as ordered. Monitor/document for side effects and effectiveness. Date Initiated: 11/11/2024 LN RN · COMMUNICATION: provide physical and verbal cues to alleviate anxiety; give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, encourage seeking out of staff member when agitated. Date Initiated: 09/09/2021 CNA LN RN SS · Monitor/document/report PRN any s/sx of resident posing danger to self and others. Date Initiated: 09/09/2021 CNA LN RN SS · When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. Date Initiated: 11/11/2024 CNA LN RN FOCUS: · The resident has a behavior problem r/t Vascular Dementia, Mood disorder, Delusional disorder: RP REFUSES PSCHIATRIC SERVICES. ONLY WANTS PRIMARY MD TO FOLLOW UP WITH BEHAVIORS. Bangs on exit doors Wanders into other residents rooms Rummages through other residents personal belongings Takes other residents seeing eye glasses and puts them on Removes nurses items behind nurses station Urinates in trash cans, hallway, other residents rooms Defecates in trash cans urinates in closets at times likes to eat meals on sofa with bedside table 4/9/24 combative during adl care causing skin tear. RESIDENT NOTED EATING CRAYONS DURING ACTIITY TIME. APT TO PUT ACTIVITY OBJECTS IN MOUTH 9/3/24 ALTERCATION WITH ANOTHER RESDIENT punches, scratches, kicks staff during care Date Initiated: 07/09/2021 Revision on: 11/11/2024 GOALS: · The resident will have fewer episodes by review date. Date Initiated: 07/09/2021 Revision on: 12/26/2024 Target Date: 07/01/2025 INTERVENTIONS/TASKS: · 4/9/24 Administer wound care to skin tear as ordered-patient removes dressing Date Initiated: 04/11/2024 Revision on: 04/11/2024 LN RN (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	· 9/3/24 MEDICATON REVIEW Date Initiated: 09/04/2024 Revision on: 09/04/2024 LN RN SS · Anticipate and meet The resident's needs. Psychiatric consult 12/15/21 with medication recommendations-RP refused. Date Initiated: 07/09/2021 Revision on: 12/30/2021 CNA LN RN · Caregivers to provided opportunity for positive interaction, attention. Stop and talk with him/her as passing by. Date Initiated: 07/09/2021 CNA LN RN SS · Explain all procedures to the resident before starting and allow the resident to adjust to changes. Date Initiated: 03/17/2022 Revision on: 03/17/2022 CNA LN RN · If reasonable, discuss The resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident. Date Initiated: 07/09/2021 CNA LN RN SS · Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Date Initiated: 07/09/2021 CNA LN RN SS · Praise any indication of The resident's progress/improvement in behavior. Date Initiated: 03/17/2022 CNA LN RN SS · Reward the resident for appropriate behavior by (OFFERINC SNACKS, ICE ACTACREAM-PER FAMILY REQUEST)- ATTEMPTED FOOD, SNACKS AND ICE CREAM. Date Initiated: 04/11/2024 Revision on: 04/11/2024 CNA LN RN SS. Record review of Resident #2 ' s CPS Report dated 11/11/2024 revealed Today is 11/11/24. 77 yo has significant injuries to his face that may have been caused by another resident. There are concerns about the level of care that 77yo is receiving if another resident has assaulted him and caused these injuries. 77 yo has an injury to his mouth and was described as having a swollen lip. 77 yo has a bruise near his eye. Staff are unable to explain how this occurred. Staff did not seem to be aware of the injuries until concerns were voiced to them. There was not believed to be physical abuse by staff personnel at the facility. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2 ' s Progress Notes dated 11/11/2024 at 11:25 AM written by LVN W revealed, head to toe assessment performed. residents affected areas measured. purplish discoloration to left forearm measured at 2cm (0.787 inches) in length and 2cm (0.787 inches) in in height. purplish discoloration to left side of 52w9chin measured at 1/2 cm in height. resident denies any pain when affected areas are assessed. no skin tears or abnormal skin breakage noted. Record review of Resident #2 ' s Progress Notes dated 11/13/2024 at 09:06 AM written by LVN P revealed LVN P assessed Resident #3 with reddened discoloration to bilateral (left and right) forearms. Record review of Resident #3 ' s Progress Notes on 11/15/24 at 12:06 PM written by LVN W revealed Resident #3 displayed physical behaviors toward Resident #2. Verbal comments were made by Resident #3 to Resident #2. Resident #3 pushed Resident #2 away from him. Record review of Resident #3 ' s Progress Notes on 11/15/24 at 12:07 PM written by LVN W revealed the interaction between both residents was stopped by staff. Residents were separated from each other. Residents PCP made aware of the incident. Order received to increase clonazepam 1mg BID scheduled (Resident #3), and psych consult. orders carried out. The residents ' behavior was to be monitored continuously. Record review of Resident #2 ' s Progress Notes on 11/15/2024 at 12:26 PM written by LVN W revealed Resident #2 was seen interacting with Resident #3. Resident #2 approached Resident #3 in their face. Resident #3 struck Resident #2 which caused Resident #2 to stumble back. Resident #2 proceeded to push Resident #3. Record review of Resident #2 ' s Progress Notes on 11/15/2024 at 12:26 PM written by LVN W revealed Resident #2 and Resident #3 were separated immediately by nursing staff. Resident #2 continued walking down the hallway. Resident #2 ' s behavior was to be monitored continuously. Record review of Resident #2 ' s Progress Notes dated 12/17/2024 at 09:06 AM written by LVN X revealed Monitor discoloration to the left arm and to the left side of the chin. every shift. Record review of Resident #2 ' s Progress Notes dated 01/07/2025 at 12:00 PM written by LVN J revealed CNA alerted this SN of resident having discoloration to bilateral upper extremities (left arm and right arm) and discoloration to right side of scalp. Upon assessment, red discoloration to bilateral arms noted, no skin tears to bilateral arms noted, and no swelling to bilateral arms noted. Purplish discoloration to scalp noted, approximately 2x2cm. Record review of Resident #2 ' s Change in Condition Note dated 02/04/2025 at 04:28 PM written by LVN J revealed Resident observed with a bump to forehead and was reported to physician. A new order was given to monitor Resident #2 for 24 hours for any changes. Record review of Resident #2 ' s Progress Note dated 03/10/2025 at 09:30 PM written by LVN B revealed LVN B was made aware by CNA that Resident #2 was found in supine position next to the bed. Resident #2 was assessed, and a skin tear was noted to bridge of his nose. Record review of Resident #2 ' s Change in Condition Note dated 03/10/2025 at 09:33 PM written by LVN B revealed Type: Change of Condition Signs/Symptoms Details: unwitnessed fall, started 03/10/2025. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2 ' s Orders - Administration Note dated 03/19/2025 at 10:01 AM written by RN V revealed Monitor discoloration to the left arm and to the left side of the chin. every shift. Record review of Resident #2 ' s Progress Note dated 03/25/2025 at 08:48 PM written by LVN C revealed S/P 1/3 Resident to Resident, Vital signs BP 124/68, pulse 67, Respiration 18, oxygen saturation 97 Room air and temperature 97.8F. Record review of Resident #2 ' s Progress Note dated 03/25/2025 at 11:52 AM written by LVN J revealed Resident (#2) is S/P Day 2/3 of Resident to Resident. Interview on 06/16/2025 at 02:30 PM Resident #2 ' s FM stated Resident #2 always had bruises, but it was nothing like what it was that time with a swollen lip and bruised eye in November 2024. He said the facility told him it was unwitnessed, and they did not know what happened. He said he had not heard anything back from the facility. Interview on 06/18/2025 at 02:10 PM CNA Z stated she had been a CNA since August 2024 and had worked at the facility the entire time. She said if she would see a resident fall or found a resident on the floor, she would tell the nurse right away. CNA Z stated she would not move or leave the resident until the nurse said they could get them up. CNA Z stated she would stay with the resident until the nurse said it was ok to leave. CNA Z stated they try to keep the residents busy. They offer snacks, puzzles, and some watch television. CNA Z stated if there was a resident-to-resident altercation, they try to separate residents, and they call for the nurse. She said there was a nurse in the unit at all times. CNA Z stated CNAs reported any changes to a resident immediately to the nurse. CNA Z stated she would abuse/neglect the administrator because he is the Abuse Coordinator. Interview on 06/25/2025 at 04:00 PM LVN X stated he had not worked at the facility for over two months. LVN X stated he could not remember the progress note he wrote on 12/17/2024 which said, Monitor discoloration to left arm and left side of chin. He said he thought it was already reported by the prior shift. Interview on 06/26/2025 at 01:14 PM LVN P stated she could not remember why she completed a Skin and Wound Assessment on Resident #2 on 03/25/2025. LVN P stated Resident #2 was not a faller. She said he paced the hall and has Alzheimer/Dementia. LVN P stated Resident #2 self-ambulated and was an assisted feeding. LVN P stated Resident #2 had unexplained bruising and they did not know why. LVN P stated for discoloration out of nowhere, it should be reported to the doctor, RP, and DON. LVN P stated for changes of a resident either a CNA reported or assessed by the nurse, the doctor would be notified, she would follow through with orders, notify family, complete a Change in Condition form, and let all the team members know what was going on including the DON. LVN P stated if a CNA told her a resident had fallen or was on the floor or if she saw a resident on the floor or a resident fell she would assess the resident, make sure they were safe, contact doctor, follow through with orders, contact family, notify DON, and put in Incident Report. LVN P stated if there was a Resident – to – Resident altercation (verbally or physically) she would immediately separate residents, assess the residents, contact doctor, make sure residents were safe, contact family, complete an Incident /accident report, monitor for 72 hours, and notify DON. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/26/2025 at 05:33 PM the DON stated he would have to look at Resident #2 ' s chart to know if he fell a lot because he had not been at the facility long and did not know all the residents yet. The DON stated he was not sure if Resident #2 had a history of a lot of unexplained bruising. He said all incidents are reported to the doctor (bruising, skin tears, change in condition, etc.). The DON stated all changes a CNA would report or if he would see to a resident are reported. He said if a CNA would tell him a resident had fallen or was on the floor or if he saw a resident on the floor or he had seen the resident fall, he would assess, notify doctor and RP, and follow all orders given. He said if it was safe to put the resident in bed, he would help put them in bed. He said if the fall were unwitnessed, he would get an x-ray, and report to State if needed. The DON stated if there were a Resident – to – Resident altercation (verbally or physically), first thing would be to separate them, safety first, assess, notify doctor and RP. He said if orders were given, he would follow through with the orders. Interview on 06/26/2025 at 06:42 PM the Administrator stated Resident #2 had a few falls since he had been at the facility. He said he had been at the facility since 02/03/2025. He said he was not aware of any unexplained bruising on Resident #2. He stated that no one had reported any unexplained bruising on Resident #2 to him. The Administrator stated abuse/neglect, injuries of unknown origin, and falls with major injuries were to be reported to State. Record review of the facility ' s Abuse, Neglect and Exploitation policy dated 08/15/22 reflected: Policy: It is a policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing policies and procedures that prohibit and prevent, neglect, exploitation, and misappropriation of property. IV. Identification of Abuse, Neglect and Exploitation A. The facility will have written procedures to assist staff in identifying the different types of abuse – mental/verbal abuse, sexual abuse, physical abuse, and the deprivation by an individual of goods and services. This includes staff to resident abuse and certain resident to resident altercations. B. Possible indicators of abuse include, but are not limited to: 2. Physical marks such as bruises or patterned appearances such as a handprint, belt or ring mark on a resident ' s body. 3. Physical injury of a resident, of unknown source. VII. Reporting/Response: The facility will have written procedures that include: Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.

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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** Based on interviews, and record review, the facility failed to ensure the assessment accurately reflected the resident's status for 1 (Resident #3) of 5 residents reviewed for accuracy of assessments. The facility failed to ensure Resident #3 was evaluated before administering an antipsychotic (Haldol). This failure could place residents at risk of receiving care and services to meet their needs. The findings included: Record review of Resident #3's admission record dated 06/17/2025, revealed an admission date of 08/15/2024, and a re-admission date on 11/25/2024, with a diagnoses which included dementia (a group of thinking and social symptoms that interferes with daily functioning) without behavioral disturbance, psychotic disturbance (delusions and hallucinations), mood disturbance, and anxiety, and traumatic subdural hemorrhage (a type of bleeding near the brain that can happen after a head injury) with loss of consciousness of 30 minutes or less. Record review of Resident #3's admission MDS, dated [DATE], revealed a BIMS of 01, indicating severe cognitive impairment. There were no potential indicators of psychosis, and no behavioral symptoms were indicated. Active diagnoses included: traumatic brain dysfunction (an impairment in the normal functioning of the brain caused by an outside force, usually a violent blow to the head), and dementia. Resident #3 was not receiving an antipsychotic. Record review of Resident #3's chart 10/25/2024 through 06/26/2025, revealed no evaluations were completed prior to Haldol being administered. Record review of Resident #3's Progress Note written by LVN J, dated 10/28/2024 at 11:18 AM revealed, As per NP (NP S), new order for Haldol Decanoate 50mg IM Q month for aggression behavior. Record review of Resident #3's Progress Note on 10/28/2024 at 11:19 AM written by LVN J revealed, Orders - Administration Note: This order is outside of the recommended dose or frequency. Haldol Decanoate Intramuscular Solution 50 MG/ML (Haloperidol Decanoate) Inject 50 mg intramuscularly one time a day every 1 month(s) starting on the 28th for 1 day(s) for 50mg IM Q month - The frequency of monthly is below the usual frequency of every 28 days. Record review of Resident #3's Progress Note dated 10/29/2024 at 08:18 PM written by LVN K, revealed Administered monthly haloperidol. Record review of resident #3's care plan, dated 11/19/2024, revealed: FOCUS: o The resident uses antipsychotic medications (HALDOL) r/t AGITATION Date Initiated: 11/19/2024 Revision on: 11/19/2024. GOALS: o Resident will have no injuries related to medication usage Date Initiated: 11/19/2024 Target Date: 12/31/2024. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	INTERVENTIONS/TASKS: o psych consult Date Initiated: 11/19/2024 Revision on: 11/19/2024 LN o Discuss side effects of medications with resident/RP Date Initiated: 11/19/2024 LN o Keep environment free of clutter and safety hazards Date Initiated: 11/19/2024 LN o Monitor behaviors. Notify MD of new or worsening behaviors Date Initiated: 11/19/2024 LN SS o Monitor vital signs as ordered by MD and PRN Date Initiated: 11/19/2024 LN o Monitor/document/report PRN any adverse reactions of antipsychotic medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person. Date Initiated: 11/19/2024 LN. In an interview on 06/26/25 at 10:25 AM PA N stated she was the one who discontinued Resident #3's Haldol order on 06/19/2025. She said she spoke to MD O about the Haldol order for Resident #3, and they decided they wanted Resident #3 to evaluated by psychiatric services. PA N stated she did not see on the notes where Resident #3 had been evaluated. PA N stated before giving Haldol a resident would have to be evaluated by psych first. In an interview on 06/26/25 at 02:16 AM LVN Q stated she called PA N to have Resident #3's Haldol discontinued on 06/19/2025 due to checking the chart with resident had no behaviors and no evaluation. LVN Q stated she received an order for psychiatric services to come evaluate Resident #3. In an interview on 06/26/2025 at 05:33 PM, the DON stated to administer an antipsychotic, an evaluation needed to be done prior to giving the antipsychotic. A record review of the facility's policy Use of Psychotropic Medication(s), dated 03/05/25, revealed, Policy Explanation and Compliance Guidelines: 5.The indications for initiating, maintaining, or discontinuing medication(s), as well as the use of nonpharmacological approaches, will be determined by evaluating the resident's physical, behavioral, mental, and psychosocial signs and symptoms in order to identify and rule out any underlying medical conditions, including the assessment of relative benefits and risks, and the preferences and goals for treatment. 7. The resident's medical record shall include documentation of this evaluation and the rationale for chosen treatment options. 13.Residents who receive an antipsychotic medication will have an Abnormal Involuntary Movement Scale (AIMS) test performed on admission, every six months, with a significant change in condition, change in antipsychotic medication, PRN or as per facility policy.

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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. (continued on next page)

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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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial need that were identified in the comprehensive assessment for 1 of 5 residents (Resident #2) reviewed for comprehensive person-centered care plans.The facility failed to develop interventions in a comprehensive person-centered care plan for Resident #2 to address his behavior of putting small items in his mouth such as crayons.This deficient practice could place residents at risk of not being provided with the necessary care or services and not having personalized plans developed to address their specific needs.The Findings include: Record review of Resident #2's admission record dated , revealed a [AGE] year-old male with an admission date of 07/06/2021,with a diagnoses which included Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), dementia (a group of thinking and social symptoms that interferes with daily functioning) without behavioral disturbance, psychotic disturbance (delusions and hallucinations), mood disturbance, and anxiety. Record review of Resident #3's quarterly MDS assessment dated [DATE] reflected a blank BIMS score, which indicated a severe cognitive impairment. There were no potential indicators of psychosis, verbal behavioral symptoms occurred 1 - 3 days, and other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing, or smearing food or bodily waste, or verbal/vocal symptoms like screaming, disruptive sounds) occurred 1 - 3 days. Record review of Resident #2's quarterly care plan dated 06/13/2025 reflected the following: Problem: Resident #2 has a behavior problem r/t vascular dementia, mood disorder, delusional disorder:RP refuses psychiatric services. Only wants primary MD (Medical Doctor) to follow up with behaviors (no date); Resident #2 noted eating crayons during activity time. Apt to put activity objects in mouth (no date),Goal: Resident #8 will have fewer episodes by review date (date initiated 07/09/2021, revision on 12/26/2024, target date 09/16/2025).Interventions: no interventions noted for Resident #2's behavior of eating crayons. During an observation on 07/11/2025 at 10:07 p.m., Resident #2 was observed pacing back and forth down the memory unit's hall. His steps were balanced and steady. He was not interviewable. In an interview on 07/11/2025 at 10:15 p.m., CNA KK said she had worked with Resident #2 for over 2 years. She said Resident #2 kept to himself and walked repeatedly down the memory unit hall. She said at times he had been physically combative with staff and other residents. She said there had been times in which he had refused care but was easily redirected. She said Resident #2 liked to put small objects in his mouth and/or lick them. CNA KK said staff in the memory unit know Resident #2's behavior of trying to take small objects from them so as soon as they see Resident #2 approach them, they will hide those small objects and redirect him. In an interview on 07/11/2025 at 1:45 p.m., the MDS D said it was her responsibility to ensure a resident's MDS, and care plan were accurate and updated. She said if a resident had a problem related to behaviors and continued with the same behavior(s) at the next assessment, she would not update it. She said if the resident displayed a new behavior problem(s), she would simply add to the existing problem (behavior) listed on their previous care plan assessment. MDS D said her office was housed in the memory unit and for the most part would spend her time out in the memory unit's hall while she worked. She said this allowed her to become familiar with the residents. MDS D said Resident #2's behavior problems included, banging on doors, wandered into other residents' rooms and went through their closet/drawers, took small objects they had, and being aggressive with staff and other residents. She said Resident #2's behavior problems were a weekly occurrence and needed constant redirection. She said she remembered a time when the Activity Aide mentioned to her look [Resident #2] tried to eat crayons while he participated in an activity. She said she immediately cared for his behavior but forgot to include an initiation date for that behavior. She said she had also failed to include intervention(s) for that behavior. MDS D said in hindsight, she should have not been so specific but rather entered a general statement that read, Resident #2 likes to put small objects in his mouth and/or lick them. She said an interventionshe could have entered was to keep small objects away from his reach and to redirect him. The MDS D said there were no negative outcomes to Resident #2 for not having any interventions in place for his behavior of eating crayons. She said the staff that worked in the memory unit were aware of his behavior and would keep a close eye on him and knew not to give him any small objects

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	676083	A. Building B. Wing	07/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brownsville Nursing and Rehabilitation Center	320 Lorenaly Dr 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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (continued on next page)

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F 0657 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 observation, interviews and record reviews, the facility failed to review and revise comprehensive care plans for 4 residents (Residents, #1, #2, #7, and #6) of 10 residents reviewed comprehensive care plan revisions. 1.The facility failed to review and revise Resident #1's comprehensive person-centered care plan from Full Code Status to DNR Status when ordered DNR was dated [DATE]. 2.The facility failed to review and revise Resident #7's comprehensive person-centered care plan when he had a resident-to-resident altercation with Resident #6 when she grabbed his left forearm and pierced skin with her fingernails which caused multiple skin tears on [DATE] at 5:30 p.m., 3. The facility failed to review and revise Resident #2's comprehensive person-centered care plan when he had a resident-to-resident altercation with Resident #7 when he striked her on the face with a closed hand on [DATE] at 3:00 p.m. 4.The facility failed to review and revise Resident #6's comprehensive person-centered care plan when he had a resident-to-resident altercation with: Resident #9 when he striked her left upper arm with a closed hand on [DATE] at 2:30 p.m. Resident #10 when he pushed his wheelchair toward her left knee which caused a skin tear on [DATE] at 3:15 p.m. Resident #7 when he grabbed her by the hair and her arm on [DATE] at 12:25 p.m. These failures could affect residents and place them at risk of not receiving appropriate interventions to meet their current needs. The findings included:: 1.Record review of Resident #1's admission record dated [DATE] revealed he was a [AGE] year-old male with an admission date of [DATE]. Diagnoses included dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities), and osteoarthritis (a degenerative joint disease, in which the tissues in the joint break down over time). Record review of Resident #1's Care Plan dated [DATE] revealed the following:FOCUS: RESOLVED: Resident #1 is a full code Date Initiated: [DATE] Revision on: [DATE] Resolved Date: [DATE]GOALS: RESOLVED: Facility will comply with resident/family wishes Date Initiated: [DATE] Revision on: [DATE] Target Date: [DATE] Resolved Date: [DATE] INTERVENTIONS/TASKS: RESOLVED: If a resident has a cardiac arrest, initiate CPR and call 911. Notify MD/RP and follow MD orders after notification. Date Initiated: [DATE] Revision on: [DATE] Resolved Date: [DATE] LN [DATE] o RESOLVED: Keep emergency cart well supplied and ready for use at all times Date Initiated: [DATE] Revision on: [DATE] Resolved Date: [DATE] LN [DATE] o RESOLVED: [NAME] chart and all pertinent documents with FULL CODE Date Initiated: [DATE] Revision on: [DATE] Resolved Date: [DATE] LN SS [DATE]. FOCUS: CANCELLED: Resident #1 is a DNR Date Initiated: [DATE] Revision on: [DATE] Cancelled Date: [DATE]GOALS: CANCELLED: Facility will comply with resident/family wishes Date Initiated: [DATE] Revision on: [DATE] Target Date: [DATE] Cancelled Date: [DATE]INTERVENTIONS/TASKS: CANCELLED: Ensure signed DNR is in medical record Date Initiated: [DATE] Revision on: [DATE] Cancelled Date: [DATE] LN SS [DATE] CANCELLED: If resident has a cardiac arrest, do not call 911 or initiate CPR. Notify MD/RP and follow instructions after notification Date Initiated: [DATE] Revision on: [DATE] Cancelled Date: [DATE] LN [DATE] CANCELLED: Keep resident as comfortable as possible at all times Date Initiated: [DATE] Revision on: [DATE] Cancelled Date: [DATE] LN [DATE] o CANCELLED: [NAME] chart and all pertinent documents with DNR status Date Initiated: [DATE] Revision on: [DATE] Cancelled Date: [DATE] LN [DATE] CANCELLED: Send copy of DNR paperwork upon transfer from facility Date Initiated: [DATE] Revision on: [DATE] Cancelled Date: [DATE] LN [DATE] CANCELLED: Social services consult if resident/family want to change code status Date Initiated: [DATE] Revision on: [DATE] Cancelled Date: [DATE] SS [DATE].Record review of Resident #1's Facility Internal Patient Self-Determination Checklist Texas dated [DATE] revealed the Full Code status box checked. Record review of Resident #1's OOH-DNR signed by RP and witnesses on [DATE] and the physician signed on [DATE]. Record review of Resident #1's Physician's Order for DNR dated [DATE]. In an interview on [DATE] at 06:42 PM, the Administrator stated Resident #1 was a full code when he first came in, but the RP signed the DNR after he had been admitted . The nurses can see the code status on their computers on the first page. It would have been updated when his code status changed. 2. Record review of Resident #2's admission record dated , revealed a [AGE] year-old male with an admission date of [DATE],with a diagnoses which included Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), dementia (a group of thinking and social symptoms that interferes with daily functioning) without behavioral disturbance, psychotic disturbance (delusions and hallucinations), mood disturbance, and anxiety. Record review of Resident #2's quarterly MDS assessment

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure residents remained free from accidents, hazards and each resident received adequate supervision and assistance while providing care for 1 of 5 residents (Resident #1) reviewed for accidents and supervision. The facility failed to ensure Resident #1 received supervision when outside in his wheelchair. Resident #1 wheeled his way down the parking lot to the road, flipping his wheelchair where the parking lot met the roadway pinning Resident #1 on the roadway where he was unable to get up. The non-compliance was identified as past non-compliance. The Immediate jeopardy began on 12/31/2024 and ended on 01/02/2025. The facility had corrected the noncompliance before the survey began. This deficient practice has the potential to affect all residents in the building by causing resident injuries, such as falls, fractures, and even death due to improper supervision. The findings included: Record review of Resident #1's admission record dated 06/17/2025 revealed he was a [AGE] year-old male with an admission date of 12/27/2024. Diagnoses included dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities), and osteoarthritis (a degenerative joint disease, in which the tissues in the joint break down over time). Record review of Resident #1's Care Plan dated 12/31/2024 revealed: FOCUS: o CANCELLED: Resident #1 is an elopement risk/wanderer r/t Dementia Date Initiated: 01/02/2025 Revision on: 01/31/2025 Cancelled Date: 01/31/2025 GOALS: o CANCELLED: The resident's safety will be maintained through the review date. Date Initiated: 12/31/2024 Revision on: 01/31/2025 Target Date: 01/15/2025 Cancelled Date: 01/31/2025 INTERVENTIONS/TASKS: o CANCELLED: Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Resident prefers: Date Initiated: 12/31/2024 Revision on: 01/31/2025 Cancelled Date: 01/31/2025 ACTA CNA LN RN SS 01/31/2025 o CANCELLED: Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes. Date Initiated: 12/31/2024 Revision on: 01/31/2025 Cancelled Date: 01/31/2025 ACTA CNA 01/31/2025 o CANCELLED: Pt Wandering seeking to exit. Wander guard placed for safety and monitoring. Date Initiated: 12/31/2024 Revision on: 01/31/2025 Cancelled Date: 01/31/2025 LN RN SS 01/31/2025. Record review of Resident #1's admission MDS dated [DATE] revealed Resident #1 had severe cognitive impairment with a BIMS of 03. Wandering impact was blank. Resident #1 was substantial/maximal assistance (Helper does more than half the effort) for ADLs. Record review of Resident #1's Wandering Evaluation dated 12/27/2024 revealed Resident #1 was not a wandering risk. Record review of Resident #1's Progress Notes revealed on 12/31/24 at 01:15 PM, Resident #1 had an unwitnessed fall from his wheelchair outside the facility. Record review of 12/31/24 at 03:45 PM Progress Notes for Resident #1 revealed on assessment, Resident #1 sustained a 1-inch abrasion to his right elbow when he fell. Observation on 06/19/25 at 08:15 AM revealed from the front door of the facility to the road in front of the facility where Resident #1 fell out of his wheelchair, while unsupervised on 12/31/24 at 01:15 PM, is approximately 150 feet. The road outside the facility is a busy road with a hospital across the street with cars parked on both sides of the roadway making visibility difficult for oncoming cars. Review of the weather on 12/31/24 at 01:15 PM revealed it was 72 degrees and clear. Record review of Resident #1's Progress Notes dated 12/31/24 at 03:45 PM written by LVN F revealed Resident #1 had an unwitnessed fall outside. Resident #1 was assessed. The Doctor and RP were notified. The Doctor ordered STAT x-ray of skull, shoulders bilaterally, femur bilateral, hip bilaterally, humerus bilaterally, ankles bilaterally, elbows bilaterally, and wrist bilaterally. Results negative for fracture or injury. Resident #1 had no complaints of pain and verbalized refusal to take pain medication. Record review of Resident #1's Progress Notes dated 01/01/2025 at 05:55 AM written by LVN C revealed LVN C reported x-ray results to doctor. LVN C notes there were no new orders given. Record review of Resident #1's Progress Notes dated 12/31/2024 at 08:29 PM written by LVN C revealed S/P Fall 24 hours: Resident in his bedroom without complain of pain or discomfort. Resident continues with wander guard placed on the right ankle. No seeking behaviors noted at this time. Record review revealed between 12/31/2024 - 01/02/2025, staff and residents were interviewed, in-services on Abuse/Neglect, Elopement, Notifying Nurses of Residents Going Outside re-education for all staff was initiated and ongoing. Record review of Resident #1's Care Plan was updated on 01//02/2024 to include elopement risk/wanderer/ related to dementia with intervention of a wander guard. Record review of Resident #1's Progress Notes dated 01/06/2025 at 02/27 PM written by LVN W revealed Resident #1's

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (continued on next page)

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F 0692 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 observation, interview, and record review, the facility failed to ensure residents received therapeutic diets that were prescribed by the attending physician for 1 of 4 residents (Resident #8) reviewed for therapeutic diets.The facility failed to ensure Resident #8 received a house shake on 07/14/2025 with his breakfast tray as ordered by his physician with orders dated 07/11/2025 for a house shake with meals for malnutrition and a revised order effective 07/14/2025 for a house shake with meals for supplement.This failure could place residents at risk for poor intake, weight loss, unmet nutritional needs, and a loss of dignity.Findings Included:Record review of Resident #8's admission sheet dated 07/14/2025, reflected a [AGE] year-old male with an admission date of 01/14/2020, with a diagnoses which included vascular dementia (brain damage caused by multiple strokes), cognitive communication deficit (deficits in communication skills resulting from cognitive impairments like attention, memory, problem-solving, and sequencing), need for assistance with personal care, and age-related physical debility (decline in physical function and strength that commonly occurs with aging).Record review of Resident #8's quarterly MDS assessment dated [DATE] reflected a BIMS score of 04, which indicated his cognition was severely impaired.Record review of Resident #8's quarterly care plan dated 06/12/2025 reflected a nutritional problem related to current diet: regular diet, mechanical soft texture, regular liquids consistency, add fortified foods with all meals (date initiated 01/28/2020 and revised on 02/26/2024). His goal was to maintain adequate nutritional status as evidenced by maintaining weight through review date (date initiated 01/28/2020 and revised on 01/20/2025). Resident #8's interventions in part included, provide, and serve supplements as ordered: Med Plus 2.0 (date initiated/revised 07/10/2025).Record review on 07/15/2025 of Resident #8's weight history reflected07/04/2025 146.6 lbs.07/05/2025 136.0 lbs.06/05/2025 136.0 lbs.05/03/2025 144.2 lbs.Record review of Resident #8's order summary dated 07/15/2025 reflected an active order effective 07/11/2025 for a house shake with meals for malnutrition and a revised order effective 07/15/2025 for a house shake with meals for supplement.During an observation on 07/15/2025 at 10:25 a.m., this Surveyor, while observing residents in the memory unit, noticed a meal tray on the dining room counter. As per the meal ticket on the meal tray, it belonged to resident #8. The food and drinks on the tray seemed untouched. His meal ticket dated 07/15/2025, breakfast reflected the following:Texture: mech softSpecial diets: regular diet, fluids-thinNotes: milk of choice- 8 oz, juice of choice- 4 oz, water-8 oz. (ounces)Standing orders: fortified foodIn an interview on 07/15/20/2025 at 10:30 a.m., CNA KK said Resident #8 had refused his breakfast and she had placed it on the dining room counter in case he requests it later.In an interview on 07/15/2025 at 10:35 a.m., the DM said she was responsible for ensuring all residents' meals were served according to their physician's orders. She said each resident had a meal ticket which indicated their diet, texture, allergies, dislikes, and any standing order(s). She said she would print the meal tickets on a daily basis, and that was how the dietary aides would know what to serve each resident. The DM said there were several ways in which she would know if a resident received a new dietary order for a house shake. She said one way would be for the nursing staff that received the order to complete a dietary slip which indicated the new order and given to her. Another way would be if the nursing staff noticed the house shake was not included in the resident's meal tray, they would let her know, and the last way was when she did her weekly thorough checks on any new orders for that week. The DM said if the resident's meal ticket did not indicate a house shake, the dietary aides would not place one on their tray. The DM said the facility had been out of house shakes for about a month. She said they were substituting the house shakes with fortified milk. The DM said the way the dietary aides would identify a fortified milk glass from a regular milk glass was they would write an F on the fortified milk covers. The DM was observed as she inspected Resident #8's breakfast tray. She said, unfortunately the milk does not have an F therefore he was served regular milk and Resident #8's milk ticket did not indicate house shake. She said she was not given a dietary slip from the nurse that reflected Resident #8's order for a house shake.In an interview on 07/15/2025 at 11:00 a.m., LVN F said he had notified Resident #8's NP that on 07/11/2025, he had refused his breakfast and only eaten 30 % of his lunch. He said the NP gave an order for a house shake with each meal. LVN F said he did not remember if he had completed a dietary slip for Resident #8's house shake order nor did her remember if he had notified the DM. LVN F said he had corrected Resident #8's order on 07/15/2025 to reflect house shake for supplement. He said on 07/11/2025, he had indicated the house shake for malnutrition, and Resident #8 was not

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for 1 (Resident #3) of 5 residents reviewed for pharmacy services. The facility failed to verify there was a physician's order for Haldol (an antipsychotic) and to ensure the order had an indication of its use. This failure could place residents at risk for receiving an antipsychotic medication without a physician's order or an indication for use resulting in a resident receiving a medication which could cause a decline in health status. The findings included: Record review of Resident #3's admission record dated 06/17/2025, revealed an admission date of 08/15/2024, and a re-admission date on 11/25/2024, with a diagnoses which included dementia (a group of thinking and social symptoms that interferes with daily functioning) without behavioral disturbance, psychotic disturbance (delusions and hallucinations), mood disturbance, and anxiety, and traumatic subdural hemorrhage (a type of bleeding near the brain that can happen after a head injury) with loss of consciousness of 30 minutes or less. Record review of Resident #3's admission MDS, dated [DATE], revealed a BIMS of 01, indicating severe cognitive impairment. There were no potential indicators of psychosis, and no behavioral symptoms were indicated. Active diagnoses included: traumatic brain dysfunction (an impairment in the normal functioning of the brain caused by an outside force, usually a violent blow to the head), and dementia. Resident #3 was not receiving an antipsychotic. Record review of Resident #3's Progress Note written by LVN J, dated 10/28/2024 at 11:18 AM revealed, As per NP (NP S), new order for Haldol Decanoate 50mg IM Q month for aggression behavior. Record review of Resident #3's Progress Note on 10/28/2024 at 11:19 AM written by LVN J revealed, Orders - Administration Note: This order is outside of the recommended dose or frequency. Haldol Decanoate Intramuscular Solution 50 MG/ML (Haloperidol Decanoate) Inject 50 mg intramuscularly one time a day every 1 month(s) starting on the 28th for 1 day(s) for 50mg IM Q month - The frequency of monthly is below the usual frequency of every 28 days. No indication for use on the physician's order. Record review of Resident #3's Progress Note dated 10/29/2024 at 08:18 PM written by LVN K, revealed Administered monthly haloperidol. Record review of Resident #3's October 2024 MAR revealed there was no physician's order for Haldol Decanoate Intramuscular Solution 50 MG/ML (Haloperidol Decanoate) Inject 50 mg intramuscularly one time a day every 1 month(s) starting on the 28th for 1 day(s) for 50mg IM Q month - The frequency of monthly is below the usual frequency of every 28 days, nor was there an indication for use on the order. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of resident #3's care plan, dated 11/19/2024, revealed: FOCUS: o The resident uses antipsychotic medications (HALDOL) r/t AGITATION Date Initiated: 11/19/2024 Revision on: 11/19/2024. GOALS: o Resident will have no injuries related to medication usage Date Initiated: 11/19/2024 Target Date: 12/31/2024. INTERVENTIONS/TASKS: o psych consult Date Initiated: 11/19/2024 Revision on: 11/19/2024 LN o Discuss side effects of medications with resident/RP Date Initiated: 11/19/2024 LN o Keep environment free of clutter and safety hazards Date Initiated: 11/19/2024 LN o Monitor behaviors. Notify MD of new or worsening behaviors Date Initiated: 11/19/2024 LN SS o Monitor vital signs as ordered by MD and PRN Date Initiated: 11/19/2024 LN o Monitor/document/report PRN any adverse reactions of antipsychotic medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person. Date Initiated: 11/19/2024 LN. During an interview on 06/26/2025 at 10:25 AM PA N stated when she talked with MD O about Resident #3 and the Haldol order, MD O said he was not familiar with the Haldol order for Resident #3, and he would not have ordered Haldol to him. PA N stated NP S (the one who ordered Haldol for Resident #3, was no longer working at the doctor's office). During an interview on 06/26/2025 at 01:14 PM LVN P stated for an antipsychotic to be given to a resident, the LVN needed to make sure she had a consent form, the correct diagnosis, the right reason, the right time, the right route, the right patient, and the right documentation. She stated if all those were not checked, a medication error could happen. During an interview on 06/26/2025 at 01:48 PM LVN K stated he could not recall if he had administered the Haldol injection to Resident #3 on 10/29/2024 or not. He stated he had just started working as a nurse and at the facility (October 2024). LVN K stated Resident #3 did not have behaviors. In an interview on 06/26/25 at 05:33 PM, the DON stated all orders must be complete. If the orders were not complete, they needed to be fixed by confirming with the doctor. The DON stated he had seen Resident #3's Haldol order had been given by NP S to LVN J on 10/28/2024, (LVN J no longer worked at the facility), and LVN K had written in the Progress Notes he had administered the Haldol on 10/29/2024 although the order was not on the MAR so it could not be checked off on the MAR. The DON stated the order should be checked by the nurse before the Haldol was administered. A review of the facility's policy Medication Administration dated 10/24/2022 revealed the following: Policy Explanation and Compliance Guidelines: 10. Review MAR to identify medication to be administered. 11. Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time. (continued on next page)

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	07/15/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	17. Sign MAR after administered. 18. If medication is a controlled substance, sign narcotic book.

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure any drug regimen irregularities reported by the Pharmacist Consultant were acted upon, for 1 (Resident #3) of 5 residents whose medications were reviewed. The facility failed to act on the facility's Pharmacy Consultant recommendations for Resident #3 ' s Haldol order for 1. An approved psychiatric diagnosis and 2. To have an informed consent on file. This failure could place residents receiving antipsychotic medications at risk for adverse consequences and could cause a decline in their physical, mental, and psychosocial condition. The findings were: Record review of Resident #3's admission record dated 06/17/2025, revealed an admission date of 08/15/2024, and a re-admission date on 11/25/2024, with a diagnoses which included dementia (a group of thinking and social symptoms that interferes with daily functioning) without behavioral disturbance, psychotic disturbance (delusions and hallucinations), mood disturbance, and anxiety, and traumatic subdural hemorrhage (a type of bleeding near the brain that can happen after a head injury) with loss of consciousness of 30 minutes or less. Record review of Resident #3's admission MDS, dated [DATE], revealed a BIMS of 01, indicating severe cognitive impairment. There were no potential indicators of psychosis, and no behavioral symptoms were indicated. Active diagnoses included: traumatic brain dysfunction (an impairment in the normal functioning of the brain caused by an outside force, usually a violent blow to the head), and dementia. Resident #3 was not receiving an antipsychotic. Record review of the Pharmacy Consultant letter titled All Recommendations dated between 01/25/2025 and 02/27/2025 for Resident #3 revealed: Recommendations By Routing: Nursing Please ensure approved psych diagnosis has been documented to support continued use. Record review of the Pharmacy Consultant letter titled All Recommendations dated between 01/29/2025 and 01/30/2025 for Resident #3 revealed: Recommendations By Routing: Nursing An informed consent was not found in resident medical record for: Haldol – requires standardized antipsychotic consent form. (continued on next page)

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review on 06/17/2025 of Resident #3's medical record did not reveal a consent for the antipsychotic Haldol (ordered 10/28/2024) until 02/22/2025. Record review on 06/17/2025 of Resident #3 ' s medical record revealed there had been no evaluations completed for the administration of Haldol (an antipsychotic) from 10/28/2024 through 06/17/2025. In an interview on 06/25/2025 at 03:38 PM Resident #3's RP stated she had gone to the facility sometime around February to sign a consent for a medication they wanted to give Resident #3. She said they told her it was for sleep because he woke up in the night and because he walked around. In an interview on 06/26/25 at 10:25 AM PA N stated she was the one who discontinued Resident #3 ' s Haldol order on 06/19/2025. She said she spoke to MD O about the Haldol order for Resident #3, and they wanted Resident #3 to evaluated by psychiatric services. PA N stated she did not see on the notes where Resident #3 had been evaluated. PA N stated before giving Haldol a resident would have to be evaluated by psych first. In an interview on 06/26/2025 at 01:14 PM LVN P stated for an antipsychotic to be given to a resident, the LVN needed to make sure she had a consent form (signed), the correct diagnosis, the right reason, the right time, the right route, the right patient, and the right documentation. In an interview on 06/26/25 at 02:16 PM LVN Q stated she called PA N (on 06/18/2025) to have Resident #3 ' s Haldol discontinued on 06/19/2025 due to checking the chart with resident had no behaviors and no evaluation. LVN Q stated she received an order for psychiatric services to come evaluate Resident #3. In an interview on 06/26/25 at 05:33 PM the DON stated, to administer an antipsychotic, an evaluation needed to be done, and a consent must be signed prior to giving the antipsychotic. The DON stated he had seen the consent for the Haldol for Resident #3 had been signed in February 2025 and the order had been given by NP S to LVN J on 10/28/2024, (LVN J no longer worked at the facility). The DON stated the consent should have been signed by the RP. Record review of facility ' s policy General Policy & Procedures, Subsection: Consultant Pharmacist Service Requirements dated 10/01/2019, revealed: Procedure B. Communicating to the responsible prescriber and the facility leadership potential or actual problems detected and other findings relating to medication therapy orders as well as recommendations for changes in medication therapy and monitoring of medication therapy at least monthly. 7.A. A written or electronic report of findings and recommendations resulting from the activities as described above is given to the administrator and/or director of nursing at least monthly. Record review of facility's policy Use of Psychotropic Medication(s) dated 03/05/1025 revealed: Policy: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It is the intent of this policy to ensure that residents only receive psychotropic medications when other nonpharmacological interventions are clinically contraindicated. Policy Explanation and Compliance Guidelines: 5.The indications for initiating, maintaining, or discontinuing medication(s), as well as the use of nonpharmacological approaches, will be determined by evaluating the resident ' s physical, behavioral, mental, and psychosocial signs and symptoms in order to identify and rule out any underlying medical conditions, including the assessment of relative benefits and risks, and the preferences and goals for treatment. 7. The resident ' s medical record shall include documentation of this evaluation and the rationale for chosen treatment options. 13.Residents who receive an antipsychotic medication will have an Abnormal Involuntary Movement Scale (AIMS) test performed on admission, every six months, with a significant change in condition, change in antipsychotic medication, PRN or as per facility policy. Record review of the facility's policy Nursing Facility Residents' Rights, dated November 2021, revealed, Participation in Your Care You have the right to: -Have any psychoactive medications prescribed and administered in a responsible manner as mandated by the Texas Health and Safety Code, 242.505, and to refuse to consent to the prescription of psychoactive medications.

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident's drug regimen was free of unnecessary drugs for 1 (Resident #3) of 5 residents reviewed for medications. The facility failed to have an adequate indication for the use of the medication Haldol (an antipsychotic) for Resident #3 before administering the medication with a black box warning. This failure could put residents at risk of harm from adverse reactions or harmful side effects. The findings included: Record review of Resident #3's admission record dated 06/17/2025, revealed an admission date of 08/15/2024, and a re-admission date on 11/25/2024, with a diagnoses which included dementia (a group of thinking and social symptoms that interferes with daily functioning) without behavioral disturbance, psychotic disturbance (delusions and hallucinations), mood disturbance, and anxiety, and traumatic subdural hemorrhage (a type of bleeding near the brain that can happen after a head injury) with loss of consciousness of 30 minutes or less. Record review of Resident #3's admission MDS, dated [DATE], revealed a BIMS of 01, indicating severe cognitive impairment. There were no potential indicators of psychosis, and no behavioral symptoms were indicated. Active diagnoses included: traumatic brain dysfunction (an impairment in the normal functioning of the brain caused by an outside force, usually a violent blow to the head), and dementia. Resident #3 was not receiving an antipsychotic. Record review of Resident #3's Progress Note written by LVN J, dated 10/28/2024 at 11:18 AM revealed, As per NP (S), new order for Haldol Deconate 50mg IM Q month for aggression behavior. Record review of Resident #3's Progress Note Orders - Administration Note on 10/28/2024 written by LVN J revealed This order is outside of the recommended dose or frequency. Haldol Decanoate Intramuscular Solution 50 MG/ML (Haloperidol Decanoate) Inject 50 mg intramuscularly one time a day every 1 month(s) starting on the 28th for 1 day(s) for 50mg IM Q month - The frequency of monthly is below the usual frequency of every 28 days. Record review of Resident #3's October 2024 MAR revealed no order for Haldol Decanoate Intramuscular Solution 50 MG/ML (Haloperidol Decanoate) Inject 50 mg intramuscularly one time a day every 1 month(s) starting on the 28th for 1 day(s) for 50mg IM Q month - The frequency of monthly is below the usual frequency of every 28 days. Record review of Resident #3's Progress Note dated 10/29/2024 at 08:18 PM written by LVN K, revealed Administered monthly haloperidol. Record review of Resident #3's Order Summary dated 11/01/2024 revealed an order for Haldol Decanoate Intramuscular Solution 50 MG/ML (Haloperidol Decanoate) Inject 50 mg intramuscularly one time a day every 1 month(s) starting on the 28th for 1 day(s) for 50mg IM Q month - The frequency of monthly is below the usual frequency of every 28 days with an order date of 10/28/2024 and a start date of 12/15/2024. (continued on next page)

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of resident #3's care plan, dated 11/19/2024, revealed: FOCUS: o The resident uses antipsychotic medications (HALDOL) r/t AGITATION Date Initiated: 11/19/2024 Revision on: 11/19/2024. GOALS: o Resident will have no injuries related to medication usage Date Initiated: 11/19/2024 Target Date: 12/31/2024. INTERVENTIONS/TASKS: o psych consult Date Initiated: 11/19/2024 Revision on: 11/19/2024 LN o Discuss side effects of medications with resident/RP Date Initiated: 11/19/2024 LN o Keep environment free of clutter and safety hazards Date Initiated: 11/19/2024 LN o Monitor behaviors. Notify MD of new or worsening behaviors Date Initiated: 11/19/2024 LN SS o Monitor vital signs as ordered by MD and PRN Date Initiated: 11/19/2024 LN o Monitor/document/report PRN any adverse reactions of antipsychotic medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person. Date Initiated: 11/19/2024 LN. Record review of Resident #3's December 2024 MAR revealed an order for Haldol Decanoate Intramuscular Solution 50 MG/ML (Haloperidol Decanoate) Inject 50 mg intramuscularly one time a day every 1 month(s) starting on the 28th for 1 day(s) for 50mg IM Q month and checked off as administered on 12/19/2024. Record review of Resident #3's physician's orders revealed no indication for use for the antipsychotic Haldol from 10/28/2024 through 06/18/2025. Record review of Resident #3's physician's order for Haldol dated 11/25/2024 written by MD O revealed a black box warning Increased mortality of elderly patients with dementia-related psychosis. Haloperidol is not approved for the treatment of dementia-related psychosis. During an interview on 06/25/25 at 02:25 PM CNA R stated when he first met Resident #3, he was walking and walking. CNA R stated now, Resident #3 was very calm. CNA R stated he did not know what happened to make Resident #3 calm. During an interview on 06/25/2025 at 03:38 PM Resident #3's RP stated she had gone to the facility sometime around February to sign a consent for a medication they wanted to give Resident #3. She said they told her it was for sleep because he woke up in the night and because he walked around. During an interview on 06/26/2025 at 10:25 AM PA N stated she discontinued the order for Haldol on 06/19/2025 for Resident #3. She said she had spoken to MD O about it, and they decided they wanted Resident #3 to be evaluated by psych. PA N stated she had not seen in the notes where Resident #3 had been evaluated. PA O stated when she talked with MD O about Resident #3 and the Haldol order, MD O said he was not familiar with the Haldol order for Resident #3, and he would not have ordered Haldol to him. PA N stated NP S (the one who ordered Haldol for Resident #3, was no longer working at the doctor's office). (continued on next page)

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Brownsville Nursing and Rehabilitation Center	320 Lorenaly Dr 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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/26/25 at 03:40 PM MD O stated he did not know where that order (Resident #3's order for Haldol) came from. He said it did not come from him. He said he would not give Haldol to a nursing home patient, and he definitely would not give it once a month. MD O stated he thought there was probably an error in communication and he thought it was just nonsensical. During an interview on 06/26/2025 at 01:14 PM LVN P stated for an antipsychotic to be given to a resident, the LVN needed to make sure she had a consent form, the correct diagnosis, the right reason, the right time, the right route, the right patient, and the right documentation. During an interview on 06/26/2025 at 01:48 PM LVN K stated he could not recall if he had administered the Haldol injection to Resident #3 on 10/29/2024 or not. He stated he had just started working as a nurse, and at the facility (October 2024). LVN K stated Resident #3 did not have behaviors. In an interview on 06/26/25 at 02:16 AM, LVN Q stated she called PA N to have Resident #3's Haldol order discontinued on 06/19/2025. LVN Q stated she had checked Resident #3's chart, and he had no behaviors. She said the staff were interviewed about behaviors with Resident #3 and none were reported. LVN Q stated she received an order for psych to come evaluate Resident #3. In an interview on 06/26/25 at 03:40 PM MD O stated he did not know where that order for Haldol came from for Resident #3. He said it had not come from him. He said he would not give Haldol to a nursing home patient, and he definitely would not order for it to be given once a month. MD O stated he thought there was probably an error in communication, and he thought it was just nonsensical. In an interview on 06/26/25 at 05:33 PM, the DON stated all orders must be complete. If the orders are not complete, they need to be fixed by confirming with the doctor. To administer an antipsychotic, an evaluation needed to be done, and a consent must be signed prior to giving the antipsychotic. The DON stated he had seen the consent for the Haldol for Resident #3 had been signed in February 2025 and the order had been given by NP S to LVN J on 10/28/2024, (LVN J no longer worked at the facility), and LVN K had written in the Progress Notes he had administered the Haldol on 10/29/2024 although the order was not on the MAR so it could not be checked off on the MAR. The DON stated the consent should have been signed by the RP and checked and the order should be checked by the nurse before the Haldol was administered. The DON stated he started working at the facility two months ago. A record review of the facility's policy Use of Psychotropic Medication(s), dated 03/05/25, revealed, Policy Explanation and Compliance Guidelines: 9.Prior to initiating or increasing a psychotropic medication, the resident, family, and/or resident representative must be informed of the benefits, risks, and alternatives for the medication, including any black box warnings for antipsychotic medications, in advance of such initiation or increase. 10. The resident has the right to accept or decline the initiation or increase of a psychotropic medication. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11.The facility will document that the resident or resident representative was informed in advance of the risks and benefits of the proposed care, the treatment alternatives or other options and the preferred option to accept or decline in a format the facility deems to use (e.g., written consent form, narrative note, etc.).

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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 - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, 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 3 (Resident #2, Resident#3, Resident #4) of 5 residents reviewed for accuracy and completeness of clinical records. 1.The facility failed to ensure LVN A and LVN F correctly completed Resident #4's neuro checks between 05/24/25 and 05/27/25. 2. The facility failed to ensure LVN A documented on Resident #4's electronic medical record; he had a nosebleed after the fall he sustained on 05/24/25. 3. The facility failed to ensure Resident #4's left inferior orbital wall fracture was documented on his electronic medical record. 4. The facility failed to ensure two Resident-to-Resident altercations were documented thoroughly. One altercation between residents on 11/15/2024 between Resident #3 and Resident #2, and the other altercation occurred on 03/25/2025 with Resident #2 and Resident #6.5. The facility failed to ensure the bruising of unknown origin for Resident #2 on 11/11/2024, 11/13/2024, 12/17/2024, 01/07/2025, 02/04/2025, and 03/19/2025 was thoroughly documented in the Progress Notes.6. The facility failed to ensure the unwitnessed fall on 03/10/2025 with skin tear to the bridge of Resident #2's nose was thoroughly documented.These failures could place residents at risk of not receiving adequate care and services due to inaccurate reflection of the care provided. Findings included: Record review of Resident #4's admission sheet dated 06/18/25 reflected an [AGE] year-old male with an admission date of 04/19/23 with pertinent diagnoses that included dementia (a group of symptoms affecting memory, thinking, and social abilities, which interfere with daily life), history of falling, difficulty walking, abnormalities of gait and mobility, and presence of intraocular (anything that is situated within the eyeball) lens . Record review of Resident #4's quarterly MDS assessment dated [DATE] reflected a BIMS score of 04, which indicated his cognition was severely impaired. Record review of Resident #4's quarterly care plan dated 05/26/25 reflected he was at risk for falls related to confusion and poor safety awareness (date initiated 04/19/23 and revised on 05/26/23). Resident #4's interventions in part included a safe environment with even floors free from spills and/or clutter, adequate flare free light, a working and reachable call light, and personal items within reach. Record review of Resident #4's progress notes on his electronic medical record dated 05/24/25 at 7:35 a.m., authored by LVN C reflected aide reported to this nurse resident had fell lying on left side on the floor in hallway. resident has redness to left side of cheek and skin tear to left hand. resident stated his foot caught his other foot while walking pushing wheelchair and fell. redness noted to left side of cheek, skin tear noted to back of left hand, NP notified. vs 130/74, 77, 18, 97.4 at time of assisting resident. skin tear cleansed with wound cleanser, and dry dressing applied. Record review of Resident #4's progress notes on his electronic medical record dated 05/24/25 at 9:12 a.m., authored by LVN C reflected NP gave order to send to ER for CT of head to rule out brain bleed from fall, EMS notified at 9:01 a.m. called ER and gave report to RN at 9:08 a.m. Record review on 06/19/25 of Resident #4's hospital record dated 05/24/25 reflected, he had presented to their emergency room via EMS due to a fall. His stated complaint: fall/nosebleed/left hand skin tear. The impression of cat scan performed on 05/24/25 was a left maxillary sinus anterior, medial, and lateral walls, and a left inferior orbital wall fracture which is minimally to nondisplaced. Record review of Resident #4's neuro checks on her electronic medical record reflected they were done from 05/24/25 to 05/26/25. Record review of Resident #4, 13th neuro checks on his electronic medical record were not dated, or time stamped by LVN C. Record review of Resident #4's, 16th and 17th neuro check was left blank by LVN F. In an observation and interview on 06/18/25 at 9:00 a.m., Resident #4 was observed sitting in his wheelchair in the memory unit's dining room. He did not have any visible bruising or any facial grimacing. Resident #4 closed his eyes when this surveyor started speaking to him. An interview on 06/18/25 at 9:15 a.m., LVN A said Resident #4 had sustained a fall on 05/24/25 at around 7:35 a.m., while walking down the hall of the memory unit. She said she was also in the hallway when a nurse aide reported to her Resident #4 had fallen. She said she found Resident #4 lying on his left side. She said she had immediately assessed him and the only injuries he had were a red mark on his cheek and a skin tear to his left hand. LVN A said Resident #4 told her, his foot caught his other foot while walking pushing his wheelchair and fell. She said she immediately notified his NP (no new order given) and proceeded to cleanse his wounds. She said she then proceeded to cleanse his wounds and checked his vitals. She said after his vitals were checked; she initiated the neuro checks. LVN A said during one of the 30-minute neuro checks, she noticed Resident #4