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	08/12/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 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 that the residents' environment remained free of accidents or hazards as possible for 1 of 5 residents' (Resident #29 and Resident #70) bathrooms reviewed for environment.The facility failed to maintain and ensure all chemicals were labeled appropriately and put away appropriately out of Resident #29 and #70's shared bathroom.This failure could place residents at risk for injury.The findings included:1. Record review of Resident #29's face sheet dated 08/12/25 revealed she was a [AGE] year-old female with an admission date of 09/16/2019. Pertinent diagnoses included Alzheimer's Disease (progressive decline in memory, thinking, and behavior), cognitive communication deficit (difficulty in communication which arises from impaired cognitive functions), and Unspecified Dementia (a group of symptoms affecting memory, thinking, and social abilities).Record review of Resident #29's Annual MDS assessment dated [DATE] revealed a BIMS score of 03, indicating severely impaired cognition.Record review of Resident #29's care plan initiated 07/10/25 revealed Resident #29 needed a structured environment in a secure unit related to cognitive deficit.2. Record review of Resident #70's face sheet dated 08/12/25 revealed she was an [AGE] year-old female with an admission date of 01/29/25. Pertinent diagnoses included Unspecified Dementia (a group of symptoms affecting memory, thinking, and social abilities) and Depression (a mood disorder described as feelings of sadness, loss, or anger which interfere with a person's everyday activities). Record review of Resident #70's Quarterly MDS dated [DATE] revealed a BIMS score of 06, indicating severely impaired cognition. Record review of Resident #70's care plan initiated 06/30/25 revealed Resident #70 needed a structured environment in a secure unit related to cognitive deficit.In an observation on 08/10/25 at 11:25 AM an unlabeled bottle with a clear liquid in the bottom of it was observed hanging on the handrail of Resident #29 and Resident #70's bathroom. The liquid had a very strong, chemical like odor. In an interview on 08/10/25 at 11:26 AM HA-I stated she had not known where the bottle came from or how it got there. She stated she was unsure if it belonged to the residents or the housekeeping staff. HA-I stated she did not think there should be a bottle with chemicals in the residents' rooms or bathrooms, especially unlabeled bottles. In an interview on 08/10/23 at 11:27 AM LA-J, who was assisting with housekeeping that day, stated she had not known what was in the bottle or where it came from. She stated she had not left it there and was not sure who had. She stated it smelled strong and if it was chemicals, it could have harmed the residents if they had ingested it or gotten it on their skin. In an interview on 08/10/23 at 11:31 AM ES stated he was unsure where the bottle came from, but he thought a resident's family member may have brought it in. He opened the bottle and stated it had a very strong chemical scent like bleach. He stated chemicals in the facility were supposed to have a label on them, and they were not supposed to be left in residents' rooms or bathrooms because if a resident was to drink it, it could harm them. He stated the facility did not have a specific policy on labeling chemicals or keeping them out of residents rooms.Record review of the facility's Safety Data Sheet, Disinfectant/Detergent Cleaner, no date identified, revealed 2. Hazards Identification: Hazard Statement: causes severe skin and eye burns; Harmful if swallowed; Harmful in contact with skin. Precautionary Statement: Store locked up.

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	676083	A. Building B. Wing	08/12/2025

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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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	676083	A. Building B. Wing	08/12/2025

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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 revealed based on a resident's comprehensive assessment, the facility must ensure that a resident maintained acceptable parameters of nutritional status, such as usual body weight or desirable body weight range, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise for 1 of 5 Residents (Resident #35) whose records were reviewed for weight loss. Nursing staff failed to follow physician orders to weigh Resident #35 weekly for four weeks, effective 07/17/25. This deficient practice could affect residents at risk for losing weight and result in unplanned weight loss and a decline in the resident's overall health.The findings were:Record review of Resident #35's admission record dated 08/12/25 reflected a [AGE] year-old-female with an admit date of 07/17/25. Her relevant diagnoses included pneumonia (an infection that inflames air sacs in one or both lungs, which may fill with fluid), dysphagia-oropharyngeal phase (difficulty swallowing that originates in the mouth and throat), sepsis (when chemicals released in the bloodstream to fight an infection trigger inflammation throughout the body), and Alzheimer's disease (a progressive disease that destroys memory and other important mental functions). Record review of Resident #35's initial MDS assessment dated [DATE] reflected a BIMS score of 10, which indicted her cognition was moderately intact. Record review of Resident #35's care plan assessment indicated:Problem: [Resident #35] had a nutritional problem or potential nutritional problem r/t diet restrictions.Interventions: in part included to monitor/record/report to MD prn s/sx of malnutrition, muscle wasting, significant weight loss (date initiated 07/31/25). Record review on 08/11/25 at 1: 20 p.m., of Resident #35's physician order effective 07/17/25 reflected weigh weekly for 4 weeks, then monthly and PRN one time a day every 7 day(s), and Med Plus 2.0 (nutritional drink) effective 08/09/25 three times a day for supplement to meet caloric intake, give 90 ml.Record review on 08/11/2025 at 1:22 p.m., of Resident #35's weight history on her electronic medical record reflected:07/18/2025 107.4 lbs. 08/02/2025 102.0 lbs. In an interview on 08/10/25 at 1:15 p.m., Resident #35 said she liked the food being served in the facility and for the most part would eat all that was served. She said she would get assistance with her meals. During an interview on 08/11/25 at 2:43 p.m., RN D said Resident #35 had been admitted for IV therapy due to pneumonia. She said Resident #35 had an order for weekly weights due to being a new admit and the facility's restorative aide was responsible to take her weights. She said Resident #35 also had an order for a nutritional supplement Med Pass 2 which was given to her 3 times a day. She said it was to meet her caloric intake. During an interview and observation on 08/11/25 at 3:12 PM, the ADON A said it was the facility's policy to monitor new admits weight for 4 weeks upon admission and monthly or PRN thereafter. He said it was his responsibility as a ADON to ensure all residents who required daily, weekly, or monthly weights were weighed. He said Resident #35 was a new admit and had an order for weekly weights effective 07/17/25. He said the facility's restorative aide was tasked with the responsibility to weigh residents. ADON said once a week, he would provide the restorative aide with a paper list of residents that needed to be weighed. He said the restorative aide would log the resident's weight on the paper list and at the end of the week, she would give it back to him. He said at that time he would review their weights, make necessary changes, and enter their weight on the resident's electronic medical record. He said Resident #35 was supposed to have been weighed on 07/18/25, 07/25/25, 08/01/25, and on 08/08/25. The ADON A was observed as he checked a binder he had on his desk with paper list provided by the restorative aide and said the only weights recorded for Resident #35 were for 07/18/25 and 08/01/25. ADON A said the negative outcome for Resident #35 not being weighed per physician's order could have been that the facility might have missed if she had lost weight and possibly not meeting her nutritional and diuretics needs. During an interview on 08/11/2025 at 3:30 p.m., CNA E said she was responsible to weigh all residents. She said newly admitted residents were weighed weekly for 4 weeks after admission and monthly or as needed. CNA E said it was ADON A's responsibility to give her a weekly list of residents that required to be weighed. She said once she was done weighing the residents, she would give the list back to ADON A. She said once she handed over the list to ADON A, she did not know what he did with the list. She said she did not recall if Resident #35 was supposed to be weighed weekly. An interview on 08/12/2025 at 8:45 a.m., the DON, said new admits were supposed to be weighed weekly for 4 weeks and monthly or prn thereafter. He said it the responsibility of ADON A to ensure all residents were weighed according to their physician's order. He said a negative outcome for any resident not being weighed according to their physician order would be that the

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	08/12/2025

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that a resident who needs respiratory care was provided such care, consistent with professional standards of practice for 1 of 5 residents (Resident#2) reviewed for oxygen in that: The facility failed to ensure Resident #2's oxygen was administered at the correct setting of 2 liters per minute on 08/10/2025 as ordered by the physician. This deficient practice could place residents who receive respiratory care at an increased risk of developing respiratory complications and a decreased quality of care. The findings included: Record review of Resident 2's electronic admission record dated 08/10/2025 reflected an [AGE] year-old male with an admission date of 04/15/2025 and with an initial admit date of 04/24/2024. Pertinent diagnoses included Nonspecific Abnormal Findings of Lung Field, Dementia, Congestive Heart Failure, Chronic Kidney Disease, Muscle Wasting and Atrophy (loss of muscle tissue), Type 2 Diabetes Mellitus, Dysphagia (difficulty swallowing), and Hypertension (high blood pressure). Record review of Resident #2's Quarterly MDS assessment, dated 06/12/2025 reflected BIMS score of 11, which indicated his cognition was moderately impaired. Record review of Resident #2's person-centered care plan, revised date 05/08/2025 reflected Resident #2 had risk for altered respiratory status/difficulty breathing related to. hypoxia. Intervention included Oxygen settings: O2 as ordered. Record review of Resident #2's physician order dated 06/23/2025, reflected oxygen at 2 LPM via nasal cannula every shift for shortness of breath. During an observation of Resident #2 on 08/10/2025 at 12:28 p.m. the oxygen level setting on the oxygen concentration machine was at 3 LPM via nasal cannula. Observed Resident #2 with O2 tubing via nasal cannula in bed with head of the bed slightly elevated. No signs of respiratory distress noted. In an interview on 08/10/2025 at 12:29 p.m. with Resident #2, he stated that he did not know what the oxygen level settings was supposed to be at. He stated that he was feeling well. He stated he did not remember seeing the nurse checking the oxygen machine, but that she had been in his room that morning. Resident #2 stated if he needed anything, he used his call light. In an interview on 08/10/2025 at 12:30 p.m. LVN K, stated she was the nurse for Resident #2. LVN K confirmed that the O2 setting was set at 3 LPM. She stated the oxygen setting was supposed to be at 2 LPM per physician orders. She stated that she checked Resident #2's oxygen setting that morning, and it was at 2 LPM. LVN K stated that he had a nebulizer treatment that morning, and did not know who might have moved it. She stated that she checked the oxygen setting periodically throughout her shift. LVN K stated the negative outcome of the oxygen setting being high was that it could increase the CO2 and cause respiratory distress. In an interview on 08/10/2025 at 5:08 p.m. with the DON, stated that the charge nurses assigned to that hall were responsible for checking the O2 setting. He stated that the nurses were to check the setting once per shift. The DON stated they were to follow oxygen settings on physician orders. The DON stated that the negative outcome depended on the patient's diagnosis but for Resident #2 it would be hyperoxygenation (excessive oxygen in the lungs or other body tissues). He stated that they did not have an Oxygen Administration Policy. Record review of the facility's policy subject titled, Medication Administration, date implemented 10/24/22 revealed:Policy Explanation and Compliance Guidelines:14. Administer medications as ordered in accordance with manufacturer specifications. Record review of the Respiratory Care Critical Element Pathway revealed:Oxygen: Oxygen machine set at the correct Liters.

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	676083	A. Building B. Wing	08/12/2025

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were secured and stored in accordance with currently accepted professional principles and standards for 1 of 4 medication carts (400 Hall Med-Aide Medication Cart) reviewed for storage. The facility failed to ensure the 400 Hall Med-Aide medication cart was locked and secured. This failure could place the residents at risk of gaining access to unlocked medications that were not prescribed to them. Findings included: In an observation on 08/10/25 at 11:34 AM, the med-cart which belonged to the 400 Hall Med-Aide was noted to be unlock, and the Med-Aide was noted to be off the unit. In an interview on 08/10/25 at 11:37 AM Med-Aide-C stated she knew she was supposed to lock her medication cart when she was away from it. She stated if the cart was left unlocked anyone could have gotten into it and taken medication which did not belong to them, and it could have made them sick, or even caused death. In an interview on 08/12/25 at 11:04 AM the DON stated nurses and med-aides should always lock their med-carts when they walk away from them. If a med-cart was left unlocked anyone could have taken anything out of it creating a drug diversion or causing possible harm to the resident if ingested. In an interview on 08/12/2025 at 3:04 PM ADON-B stated nurses were supposed to lock the med-carts when they were not in use, and med-carts should not be left unlocked because residents could get into it and ingest medications which did not belong to them. Depending on the medication ingested, the resident could have had side effects of dizziness, lethargy or even death. In a record review of the facility's Medication Administration: Medication Carts and Supplies for Administering Med policy, dated 10/01/19, revealed 2. The medication cart is locked at all times when not in used. 3. Do not leave the medication cart unlocked or unattended in the resident care areas.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident received food prepared in a form designed to meet individual needs for 1 of 8 residents (Resident #100) reviewed for pureed diet needs. The facility failed to provide Resident #100 with her regular pureed diet (that was prescribed for individuals who have difficulty chewing or swallowing food) as designated on her meal ticket on 08/10/25. This deficient practice could place residents at risk for poor food intake, weight loss, and not having their nutritional needs met. Record review of Resident #100‘s face sheet dated 11/23/21 reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. Diagnoses included Stroke, Muscle wasting, and dysphasia (difficulty swallowing). Record review of Resident #100‘s quarterly MDS assessment dated [DATE] reflected the resident had active diagnoses including non-traumatic brain dysfunction, Alzheimer’s, Aphasia (difficulty speaking), dysphasia (difficulty swallowing), and disturbances of salivary secretion (dry mouth). Resident #100‘s BIMS score of 99 indicated severe cognitive impairment. She was dependent on staff or required maximal assistance for all ADL’s and required moderate assistance with eating. She utilized a manual wheelchair and could not self-propel. She was always incontinent of bladder and bowel. Record review of Resident #100' s Order Summary Report revealed Dietary Order for Regular Diet, Pureed texture, Nectar Thickened Liquids consistency, Fortified Foods with all meals. Order date 10/29/2024 and Start date 10/20/2024. Record review of Resident #100‘s care plan reflected a problem as “The resident has potential nutritional problem r/t current diet: Regular diet, Pureed texture, Nectar thickened liquids consistency, Fortified foods with all meals. Date initiated: 10/10/21 Revision on: 08/10/25. Goal: The resident will maintain adequate nutritional status through review date. Date initiated: 12/10/21. Revision on: 10/02/23. Target date: 10/09/25. Interventions included Monitor/document/report as needed and s/sx of dysphagia: Pocketing, choking, coughing, drooling, holding food in mouth…Date initiated: 06/18/25. Provide and serve diet as ordered. Date initiated: 06/18/25. Provide, served diet as ordered. Monitor intake and record every meal. Date initiated: 12/10/21. Problem: The resident has unplanned/unexpected weight loss r/t Poor food intake. Date initiated: 08/10/25. Goal: The resident will consume (100%) two of three meals/day. Date Initiated: 08/10/25 Revision on: 08/10/25 Target Date: 10/09/25. Interventions: Give the resident supplements as ordered. Alert nurse/ dietitian if not consuming on a routine basis. Date Initiated: 08/10/2025. Monitor and evaluate any weight loss. Determine percentage lost and place interventions for weight loss per dietician/physician. Date Initiated: 08/10/25. Monitor and record food intake at each meal. Date Initiated: 08/10/25. Offer substitutes as requested or indicated. Date Initiated: 08/10/25. Revision on: 08/10/25. (continued on next page)

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	676083	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 08/10/25 at 12:24 pm in the dining room revealed Resident #100 was coughing after taking bites of her food. Her meal plate had chopped carrots, mashed potatoes, and cut up chicken. Her tray ticket indicated Regular Diet, Pureed Texture, Fluids-Nectar. RN F reviewed her meal ticket and said Resident #100 was provided the wrong food texture. RN F said Resident #100 required a regular diet with pureed texture and nectar thick liquids and not mechanical altered. She said Resident #100‘s plate had mechanical altered food. She said she checked the resident’s tray on the cart prior to delivering it to her. She said she saw “regular” (diet) on the tray card but overlooked where it read “pureed” texture. She said she should have taken the tray of mechanical textured food back to the kitchen immediately. She said she should have had an “order listing” (a list of all resident’s tray cards) to go by. She said the kitchen had the same one (list). She said Resident #100 should have a refusal form in her chart in the electronic health record under “miscellaneous”. RN F said Resident #100 had been refusing her pureed diet. She said Resident #100 was edentulous (no teeth) and did not want to wear dentures. She said the diet, refusal, having no teeth and not wanting dentures should all be in Resident #100‘s care plan. RN F said nurses were responsible for getting the refusal forms signed, verbally or a physical signature by the resident. She said if the resident was not able to sign or verbalize, then a nurse signed the form to verify with families or the resident, if the resident had a BIMS score of 10 or greater but was not sure about the BIMS score. In an interview with ADON-A, on 08/10/25 at 12:27 pm, he said Resident #100’s tray card showed pureed but Resident #100 had a mechanical altered plate she was choking on. He said meal trays were checked by the nurses. He would not say what the outcome or dangers could be if a resident had the wrong texture diet. In an interview with CK on 08/12/25 at 11:45 am, she said the “tray line” was responsible for getting the food correct on the trays from the kitchen. She said once the trays went on the carts, the nurses were responsible to check the trays before serving the residents. She said if there was a tray that did not have the right diet on it, she would correct it right away. She said sometimes the trays were mixed up on the carts. Kitchen policies, in-services, and the RD’s presence was requested at this time. The RD was not available for interview throughout the survey. In-services were not received. Record Review of the facility’s kitchen policy revised 06/01/19, titled, “Tray Service” revealed under “Policy: The facility believes that accurate tray service and adequate portion sizes are essential to the residents' well-being and safety. The facility will ensure that diets are served accurately and in the correct portions and that resident preferences are met. Under Procedure: 3. For tray line service, Nutrition & Foodservice staff will check each resident's tray card prior to service to ensure that preferences and dislikes are honored, the correct diet is served, portion sizes are accurate and appropriate substitutions provided. 6. The Nutrition & Foodservice Manager or consultant (RD) will conduct in-services with the Nutrition, Foodservice as needed to ensure all serving staff are familiar with portion sizes and therapeutic and mechanically altered diets.

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	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with 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
	676083	A. Building B. Wing	08/12/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interviews and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for storage, preparation and sanitation. 1.The facility failed to ensure the juice gun nozzle, coffee maker, cabinets, drinking glasses, pitchers, and utensils were clean. 2.The facility failed to ensure the area under a prep sink was free from water damage and debris. 3.The facility failed to ensure the underside of the shelf on the stove, directly above cooking food, was kept clean. 4.The facility failed to ensure dirty utensils were not kept in a clean drawer. 5.The facility to ensure dry storage items were not left on the floor. 6.The facility failed to ensure spices were not left open to air when not in use. 7.The facility failed to ensure leftovers in refrigerator #2 were labeled and dated. These failures could place residents who received meals and/or snacks from the kitchen at risk for food contamination and food borne illness. Findings included: Observation and initial tour of the kitchen on 08/10/25 at 11:10 am revealed the inner nozzle of the juice gun was clogged with a thick, red substance. The dripper of the coffeemaker had a thick, layered dark brown substance coating the opening. The cabinets below and in front of the coffee maker was stained from the countertop to the floor with a thin brown substance. 75 of 120 drinking glasses (4 full trays) and 7 plastic pitchers were stained and/or caked on the inside bottoms and up the sides with a removable white and/or light brown substance. The drinking glasses and pitchers were on clean racks. The drinking glasses did not have a dry mat between them and the trays. The area under a prep sink appeared to have water damage and a large amount of small, round, black fuzzy spots, dirt, stains, and debris. There were 2 metal spatulas with deep crevasses in the melted handles and a dirty hand-held lime juicer in a clean utensil drawer. The underside of the shelf above the stove was covered with a dark brown/black gritty substance that was directly over cooking food. Five sleeves of Styrofoam cups were on the floor near a large working water purifier in the dry storage room. There were 5 of 12, 16-ounce containers of spices open to air. There was a covered half-size holding pan with leftovers in refrigerator #2 that was not labeled or dated. In an interview with DA-1 on 08/10/25 at 11:10 am, she said the plastic glasses and pitchers were dry and on clean racks to be used for service. She said the substance in the drinking glasses was removable and could be stained by lemonade, tea, juice, or milk. She said the removable substance in the glasses could cause cross contamination and make residents sick. She said she would not drink from the glasses. She said she had been trained on sanitation and cleanliness of the kitchen but could not remember the last training or in-service she had. She said the juice gun was cleaned every shift. She said she had not cleaned the juice gun, did not know who was responsible for cleaning it, or when it was last cleaned. In an interview with DA-2 on 08/10/25 at 11:15 am, she said the plastic glasses and pitchers were dry and on clean racks to be used for service. She said the substance inside the drinking glasses was humidity. She said she would not drink from the glasses after removing some of the white substance with her finger. She said she did not know what the substance was. She said it could come off in the drinks and make residents sick. She said she had been trained on sanitation and cleanliness of the kitchen but could not remember the last training or in-service she had. She said she did not know how often the juice gun was cleaned or supposed to be cleaned, or who was responsible for cleaning it. In an interview with the FPS on 08/10/25 at 11:30 am, she said she had worked at the facility for 4 years. She said all the drinking glasses and pitchers were clean and dry. She said the white substance inside the glasses did not come off. When asked to try to remove some of the white substance by this surveyor, she did so with her fingernail then flicked it aside. She said she was not sure what the white substance was and today was the first time she had ever seen it (the heavy white build-up) before. She said they served juice, tea, lemonade, and milk to the residents in the same glasses. She said she would drink from the glasses and proceeded to do so but was stopped by this surveyor before the glass touched her lips. She said she did not know what the stuff was under the prep sink, and she had never looked there before. She said the spices were open to air because they (the cooks) used them for breakfast service. She said spices should not be left open to air because debris or anything in the air could contaminate them and if consumed, could make residents sick and alter the flavor of the food. She said she held an in-service last week on the topics of labeling and storage. In-services, the registered dietician, cleaning schedules, and facility policies for cleaning schedules and sanitization were requested at this time. In an interview with the CK on 08/10/25 at 11:45 am, she said all items in the refrigerators and freezers should be labeled and dated. She said she should have closed the spices when she was done cooking. She said she put the unlabeled leftovers that were in the holding pan in

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	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections for 3 of 5 residents (Resident #97, Resident #111 ,) reviewed for infection control practices. 1.The facility failed to ensure proper contact precautions for infections of ESBL and MRSA were followed for Resident #97 to prevent cross-contamination and possible infection. 2.The facility failed to ensure proper contact isolation precautions were followed for Resident #9 to prevent cross-contamination and spread of infection. 3.The facility failed to ensure proper Enhanced Barrier Precautions (EBP) were followed for Resident #111 when checking blood sugar and administering insulin. These failures could place residents at risk for cross contamination, infection, and improper wound healing. Findings included: 1.Record review of Resident #97's face sheet, dated 08/12/25, revealed a [AGE] year-old-male with an original admission date of 07/29/25. Current diagnoses included Encounter for Surgical Aftercare Following Surgery on the Skin and Subcutaneous Tissue, Abscess of Tendon Sheath (typically occurs due to an infection within the sheath surrounding a tendon), and Cellulitis of the Left Lower Limb (a bacterial infection which affects the skin and soft tissues underneath). Record review of Resident #97’s admission MDS assessment dated [DATE], revealed a BIMS score of 15, intact cognition. MDS also revealed Active Diagnoses: Encounter for Surgical Aftercare Following Surgery on the Skin, Cellulitis of Left Lower Limb, and Abscess of Tendon Sheath. Record review of Resident #97’s active physician orders with a start date of 08/12/25 revealed an order for wound care to surgical incision and drainage wound to left lateral lower leg. Another physician order with a start date of 08/10/2025 revealed monitor peripheral IV site for redness, as well as an order for contact isolation for ESBL and MRSA to left lower extremity. Record review of Resident #97’s progress note dated 08/01/25 revealed Resident #97 left on pass; Progress note dated 08/02/25 at 1:12 PM revealed Resident #97 left on pass; Progress note dated 08/02/25 at 7:09 PM revealed Resident #97 left on pass; Progress note dated 08/05/25 at 4:16 PM revealed continued to invite Resident #97 to activities; Progress note dated 08/07/25 at 8:33 PM revealed Resident #97 returned from being out on pass; Progress note dated 08/11/25 at 8:03 AM revealed Resident #97 continued to receive IV antibiotics for infection; Progress note dated 08/11/25 at 9:34 AM revealed Resident #97 continued to remain on contact isolation, but he could be out of his room as wound was contained within dressing. Progress note dated 08/11/25 at 9:51 AM revealed resident was re-educated on the importance of contact isolation to prevent the spread of infection, but wound was contained so he was allowed to step out of room but try and limit constant entering and exiting room. Progress note dated 08/12/25 at 7:57 AM revealed Resident #97 was re-educated on the importance of contact isolation. In an observation on 08/11/25 9:35 AM Resident #97 was observed entering and leaving his room twice within a 10-minute time period. He was also seen taking down his own IV antibiotic bag and carrying it across the room. Unsure what he did with it. (continued on next page)

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	676083	A. Building B. Wing	08/12/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 08/11/25 at 3:45 PM, ADON-A stated a resident on contact isolation should not be going in and out of their room and exposing other residents to cross-contamination and infection, even if the wound was contained and covered. ADON-A stated Resident #97 was educated regarding this. He stated it was also not recommended to share a room with another resident, especially if the resident was not on any precautions at all, and there were available rooms, so he was not sure why the contact isolation Resident #97 was sharing a room with another resident who was not on any precautions or isolation. In an interview on 08/11/2025 at 5:35 PM the Administrator stated ADON-B was the new ICP and was still learning as the infection control nurse. The Administrator stated Resident #97 was on contact isolation and was allowed to come and go as he pleased since his wound was contained, and he was not considered a danger to other residents. He also stated regarding CDC and best practice, Resident #97 should probably not be coming and going as he pleased, and it would be best if he was placed in a room on his own instead of exposing someone else to his infection. In regard to a specific contact isolation policy, the Administrator stated the facility did not have one, and they followed CDC guidelines and recommendations. In an interview on 08/12/2025 at 8:01 AM ADON-B stated he had been in the ICP role for approximately 1 month. He stated contact precautions included draining wounds which cannot be contained, and just because a resident had a wound with a specific organism in it did not specifically qualify them for contact precautions. He stated Resident #97’s wounds did not necessarily constitute contact precautions, and he technically could have just been placed on EBP, but ADON-B placed him on contact precautions because he had MRSA to both wounds on his leg, and he felt like he took this extra step to be cautious. ADON-B stated patients had rights, so he was allowed to come and go as he pleased, but according to CDC recommendations, the facility tried to limit how much he was coming and going in and out of his room. ADON-B stated Resident #97 was not putting other residents at risk for cross-contamination or infection because the wound was contained. ADON-B stated regarding a specific contact isolation policy, the facility did not have one, and they just followed CDC guidelines and recommendations. In an interview on 08/12/25 at 11:04 AM the DON stated they did not have a specific contact isolation policy but followed CDC guidelines and recommendations. He also stated Resident #97’s wound was contained, and they tried to limit his coming and going so as to not cause any cross-contamination. 2. Record review of Resident #9’s face sheet dated 04/12/25, revealed a [AGE] year-old-female. Diagnoses included Atherosclerosis (the buildup of fats, cholesterol and other substances in and on the artery walls causing arteries to narrow and blocking blood flow) of native arteries of extremities with gangrene (when body tissue dies because it does net enough blood flow or because of a serious bacterial infection) of the right leg, need for assistance with personal care, acquired absence of the left leg below the knee, Alzheimer’s, and Diabetes. Record review of Resident #9’s quarterly MDS dated [DATE] revealed a BIMS score of 08, indicating moderate cognitive impairment. She was dependent on staff for all ADLs except eating and oral hygiene which required moderate assistance. She was always incontinent of bladder and bowel. She was receiving antidepressants, antibiotics, and opioid medications for pain control. (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	08/12/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #9’s care plan dated 04/12/25 indicated she was on EBP for wound care Date initiated and revised: 06/03/25. The resident has infection of the urine Date Initiated: 07/27/25. Goal: The resident will be free from complications related to infection through the review date of 10/15/25. Interventions: Contact Isolation precautions for MRSA to urine; Wear gowns and masks when changing contaminated linens. Place soiled linens in bags marked biohazard. …Educate the resident/family/caregivers regarding the importance of hand washing. Use antibacterial soap and disposable towels. Wash hands immediately after ADLs, care tasks, and activities. Date Initiated 08/06/25. Administer antibiotic Macrobid x7 days for UTI. Date initiated: 07/27/25. Record review of Resident #9’s progress notes dated 08/11/25 at 9:36 am revealed patient remains on contact isolation when dealing direct contact/and or in room. Patient is bedbound so ok to be with another resident since patient does not use shared toilet. Note written by ADON B. Record review of Resident #9’s progress notes dated 08/11/25 at 11:25 am revealed patient has had 6 days of antibiotic therapy for UTI MRSA to urine with one left as well as no complaints of painful urination…ok to remove contact isolation and continue on EBP. Note written by ADON B. Record review of Resident #9’s lab results for urine cultures dated 07/21/25 indicated she had e. coli and was placed on the antibiotic Cipro. Urine cultures done on 08/03/25 indicated she had MRSA and was placed on the antibiotic Macrobid. Record review of Resident #9’s physician orders dated 07/22/25 indicated she received Cipro 500 mg by mouth every 12 hours for 7 days for UTI. Macrobid 100 mg by mouth every 12 hours for MRSA for 7 days from 08/12/25-08/12/25. Observation and interview with CNA G on 08/11/25 at 9:10 am in a contact isolation room, CNA G was wearing no PPE. CNA G was wearing a short- sleeved scrub shirt. He was sitting in a chair, contacting Resident #9’s bedrail with the underside of his right arm. He said he removed her oxygen (nasal cannula) for her so she could eat better. He said he did not use gloves to remove the oxygen. He said he did not wash his hands after removing the oxygen. CNA G was observed folding his arms, touching the resident’s bedcovers, and the utensils she was using that were on her tray. CNA G was asked by this surveyor why he was not wearing PPE. He said he was not touching the patient. He said he thought she had a wound infection. Then he said he did not know. He said the last time he had training on isolation was 2 weeks ago. He said he washed his hands 20 seconds or more, before & after contacting a resident. He said he knew he should have been wearing PPE. He said his arm was leaning on the side rail and he was touching where the patient touched. During the interview, he touched his face. In an interview with HA on 08/11/25 at 9:29 am, she said she donned PPE because she was going to help CNA G turn Resident #9. HA said staff wore PPE for wound infections and for “other things” she could not elaborate about. She said she got training 2 weeks ago on isolation. She said the process for proper hand washing was 2-3 minutes then said 2-3 seconds then said 20 minutes “or something like that”. HA used ABHR and donned gloves prior to entering the contact isolation room. (continued on next page)

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	676083	A. Building B. Wing	08/12/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the DON on 08/11/25 at 4:19 pm, he said the last infection control in-service held was last month and today. He said today’s in-service was “just for continuing education”. He said CDC recommendations were to limit their (residents’) movements, and the facility could not force a resident to stay in their room if they were in isolation. He said it was preferrable to not have contact isolation patients rooming with someone without contact isolation. He said his expectations were for staff to wear PPE for all necessary precautions. In an interview with ADON B on 08/12/2025 at 8:05 am, he said the reason for PPE was to prevent the spread of infection. He said PPE was required for feeding residents in contact isolation. He said in-services and 1:1 education were enforced for staff who did not follow protocol. He said administrative staff knew if the staff was adhering to isolation precautions by consistent rounding or if it was brought to his attention. He said PPE policy education was done monthly and as needed. He said he did not say “policy”. He said the last in-service was yesterday and the one before that was 2 weeks ago. He said he did a 1:1 with CNA G and said CNA G told him he did not wear PPE because he thought he was not in direct contact with Resident #9. He said he told CNA G that PPE and handwashing was required on contact isolation when entering and exiting every single time to prevent spread of infection. PPE Policy was requested at that time. 3. Record review of Resident #111’s electronic face sheet dated 08/12/2025 reflected a [AGE] year-old-female with an admission date of 06/23/2025. Pertinent diagnoses included Cholecystectomy Drain (a drain placed after gallbladder surgery), Type 2 Diabetes Mellitus, Chronic Kidney Disease Stage 3A (damage to your kidneys and they aren't working as well as they should), Dependence on Renal Dialysis (dependent on a life sustaining treatment that replaces the function of failing kidneys), Absence of Right Leg Above Knee (above the knee amputation). Record review of Resident #111's MDS assessment, dated 06/23/2025, reflected she scored a 14 on her BIMS which reflected cognitively intact. Record review of Resident #111’s person-centered care plan-initiated date 07/04/2025 reflected Resident #111 had the need for Enhanced Barrier Precautions due to:… cholecystectomy tube. Intervention included Place on Enhanced Barrier Precautions…. Record review of Resident #111’s active physician orders with a start date of 08/10/2025 reflected an order for Enhanced Barrier Precautions: Use gown and gloves for high contact resident care activities for those with ……as well as those residents with wounds or indwelling medical devices every shift for cholecystectomy drain. During an observation of medication administration on 08/11/2025 at 4:16 p.m. revealed that LVN L wore gloves but did not put on a gown when she checked Resident #111’s blood sugar and administered insulin who had a drain. There was an Enhanced Barrier Precaution (EBP) (an infection control intervention designed to reduce transmission of drug-resistant organisms) sign posted on Resident #111’s door. (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	08/12/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 08/11/2025 at 4:30 p.m. LVN L stated that the residents who meet the EBP criteria were residents with IV’s, infection, or those who have wounds. She stated Resident #111 was on EBP due to having a gallbladder drain. LVN L stated that it was to her understanding that the staff was to wear gloves and gowns only when having direct contact to the site. She stated that it was important to put on proper PPE to prevent the spread of infection. She stated she received in-services for enhanced barrier precautions upon hire. In an interview on 08/11/2025 at 4:51 p.m. the DON stated EBP was ordered for residents who meet the criteria such as residents with G-Tubes, open wounds, wounds that are draining, central lines, a tracheostomy, foley catheters, or central lines. The DON stated LVN L was supposed to put on a gown and gloves when checking blood sugar and administering insulin to Resident #111. He stated that proper PPE was to be worn to make sure they did not contaminate the area and to prevent the spread of infection. The DON stated LVN L was fairly new, and training was provided on infection control and EBP. Record review of the facility’s Infection Prevention and Control Program policy, dated 05/13/23, revealed “This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infection as per accepted national standards and guidelines. 5. a. A resident with an infection or communicable disease shall be placed on transmission-based precautions as recommended by current CDC guidelines.” Record review of CDC: Transmission Based Precautions: Contact precautions are used for patients with known or suspected infections that represent an increased risk for contact transmission. Ensure appropriate patient placement in a single patient room if room was available and make room placement decisions balancing risks to other patients. Limit transport and movement of patients outside of the room to medically necessary purposes. When transport or movement in any healthcare setting was necessary, ensure that infected or colonized areas of the patient’s body are contained and covered. Remove and dispose of contaminated PPE and perform hand hygiene prior to transporting patients on contact precautions. DON clean PPE Website reviewed 08/12/25 at 12:35 PM https://www.cdc.gov/infection-control/hcp/basics/transmission-based-precautions.html Record review of the facility's policy, titled Enhanced Barrier Precautions, revised 04/5/24, reflected: Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms.” Definitions: “Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown, and gloves use during high contact resident care activities.” Policy Explanation and Compliance Guidelines: 1. “Prompt recognition of need: a. All staff receive training on enhanced barrier precautions upon hire and at least annually and are expected to comply with all designated precautions. (continued on next page)

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	676083	A. Building B. Wing	08/12/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. “Initiation of Enhanced Barrier Precautions: b. indwelling medical devices (e.g. central lines, urinary catheters, feeding tubes)”