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	12/08/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. (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 0578 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 the right for a resident to refuse or discontinue treatment for 1 of 5 Residents (Resident #1) whose records were reviewed for resident rights. The DON, failed to stop Depakote after Resident #1's RP requested the medication be stopped immediately on [DATE]. This deficient practice could affect any resident and could result in residents believing their right to refuse a medication does not matter. The findings were: Record review of Resident #1's admission Record, dated [DATE], revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks), and dementia, unspecified (a condition in which a person loses the ability to think, remember, learn, make decisions, and solve problems. Symptoms may also include personality changes). Record review of Resident #1's [DATE] Quarterly MDS revealed Resident #1 had a BIMS score of 99, which indicated Resident #1 could not complete the assessment. Resident #1 had unclear speech, was rarely/never understood others and was rarely/never able to be understood by others. Resident #1 was always incontinent of his bowels and bladder. Resident #1 required substantial/maximal assistance with eating. Resident #1 was dependent on toileting hygiene, showers/baths, and personal hygiene requiring the assistance of two or more helpers. Review of Resident #1's physician orders for [DATE] revealed the following orders: Start Date [DATE] End Date [DATE] Depakote Oral Tablet Delayed Release 250 MG (Divalproex Sodium) Give 1 tablet by mouth two times a day for MOOD [AFFECTIVE] DISORDER. Review of Resident #1's physician order for Start Date [DATE] End Date [DATE] revealed the following order: Start Date [DATE] End Date [DATE] Depakote Oral Tablet Delayed Release 250 MG (Divalproex Sodium) Give 1 tablet by mouth two times a day for MOOD [AFFECTIVE] DISORDER. Review of Resident #1's [DATE] MAR revealed he received Depakote 250 mg Oral Tablet Delayed Release two times a day from [DATE] through [DATE]. The morning dose on [DATE], was refused by Resident #1 and the evening dose was not taken due to Resident #1's unresponsiveness and his being sent to the hospital where he expired. Review of Resident #1's progress note dated [DATE] at 03:46 pm revealed DON A wrote Nursing Note Skilled nurse received a call from Resident #1's RP, who stated she never gave consent for Depakote and expressed concern that Resident #1 appears very sleepy. She requested that the medication be discontinued immediately. After reviewing the chart, I explained to her that verbal consent had been obtained from her over the phone. RP further stated that she does not want any physician other than PCP to prescribe medications for Resident #1 and that she had not given consent for any other providers to see him. I reminded her that she had previously provided consent to myself and the facility administrator, and that due to the patient's behaviors, psychiatric services were initiated with consent on file. The medication in question is Depakote 250 mg PO BID for mood disorder. I contacted PCP's office to obtain discontinuation orders; however, the office was closed for the weekend. I then called the on-call line and spoke with NP J, who advised that the medication is helping manage the patient's documented behaviors and recommended not discontinuing until PCP is consulted directly. This information was communicated to RP, who has been informed of the plan. We will await further orders from PCP on Monday. continue poc. During an interview on [DATE] at 09:05 am DON B stated when the RP told them to stop a medication, they would stop the medication even if they could not reach the physician to notify. DON B stated the resident or RP's wishes would be honored and they would put the medication on hold. She said the nurses were alerted to the medication hold and also notified during their daily meeting of the hold on the medication. She said the medication would show as on hold on the MAR. The DON stated she had not seen a policy for what to do when a resident or RP told them to stop a medication. During an interview on [DATE] at 10:13 am ADON E stated if the RP requested the medication be stopped, they would notify the RP they had to notify the doctor, and the doctor had to stop the medication. He said if the doctor said it was ok to stop the medication, they would stop it, but the doctor may say to leave the medication in place and the resident could refuse. ADON E stated if the doctor said to continue the medication, they would continue the medication and relay that information to the family. ADON E stated he did not think there was a policy on stopping medication at RP request. During an interview on [DATE] at 10:33 am Administrator D stated they did not have a policy on stopping medications when an RP requested a medication be stopped. During an interview on [DATE] 01:32 pm Resident #1's RP stated in August there was a Care Plan meeting that she and two family members

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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 interviews and record reviews, the facility failed to ensure review and revision of comprehensive care plans for 1 resident (Resident #1) of 5 residents reviewed for comprehensive care plan revisions in that: The facility failed to review and revise Resident #1's comprehensive person-centered care plan to address the initiation of Depakote, an antiseizure medication used for mood disorder. This deficient practice could affect residents and place them at risk of not receiving appropriate interventions to meet their current needs.The findings were: Record review of Resident #1's admission Record, dated 11/26/2025, revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks), and dementia, unspecified (a condition in which a person loses the ability to think, remember, learn, make decisions, and solve problems. Symptoms may also include personality changes). Record review of Resident #1's 07/22/2025 Quarterly MDS revealed Resident #1 had a BIMS score of 99, indicated Resident #1 could not complete the assessment. Resident #1 had unclear speech, was rarely/never understood others and was rarely/never able to be understood by others. Resident #1 was always incontinent of his bowels and bladder. Resident #1 required substantial/maximal assistance with eating. Resident #1 was dependent on toileting hygiene, showers/baths, and personal hygiene requiring the assistance of two or more helpers. Record review of Resident #1's psychiatric note dated 07/26/2025 at 09:00 am written by APNP L revealed an order for Depakote 250 mg twice a day. Record review of physician's orders revealed on 07/26/2025 at 10:20 am an order given by PCP for Depakote Oral Tablet Delayed Release 250 MG (Divalproex Sodium) Give 1 tablet by mouth two times a day for MOOD [AFFECTIVE] DISORDER. Order was discontinued on 08/02/2025. Record review of physician's orders revealed on 08/02/2025 at 05:40 am an order given by PCP for Depakote Oral Tablet Delayed Release 250 MG (Divalproex Sodium) Give 1 tablet by mouth two times a day for MOOD [AFFECTIVE] DISORDER. Order was discontinued on 10/07/2025. Record review of Progress Note for Resident #1 written by LVN G on 07/26/2025 at 10:16 am revealed APNP L ordered Depakote 250 mg twice a day by mouth. Record review of Progress Note for Resident #1 written by MDS H on 08/21/2025 at 05:46 pm revealed NURSING - Plan of Care Note Note Text : CARE PLAN MEETING HELD WITH RP, (and family members) VIA TEAMS MEETING. ADMINISTRATOR, DON, ADON'S AND CARE MANAGEMENT PRESENT. DISCUSSED WTIH FAMILY DECREASE IN BEHAVIORS. DISCUSSED MEDICATION INTERVENTIONS IN PLACE FOR MOOD DISORDER (DEPAKOTE)FAMILY AWARE PATIENT 1 TO 1 WITH RESIDENT WILL BE DISCONTINUED TOMORROW. FAMILY ALSO AWARE THAT PATIENT DOES CONTINUE TO REFUSE ADL CARE AND BECOMES AGITATED WITH INCONTINENT CARE. During an interview on 12/05/2025 at 04:45 pm ADON E stated if a medication needed a consent, it would be care planned. He said Depakote did not need labs since it was being given therapeutically for mood. ADON E stated best practice would be the nurse who gets the order for a medication (Depakote for mood disorder), would be the one who put it in the care plan, but any nurse could do that. During an interview on 12/05/2025 at 04:50 pm DON B stated Depakote would not need labs to check levels if the Depakote was being given for moods. She said if the Depakote were being given for seizures, there would be labs also ordered by the doctor. DON B stated if Depakote were ordered on a Saturday, the nurse who received the order would be the one who care planned the medication after the consent was signed. She said on Monday, the medication would be discussed at the morning meeting with the IDT. Record review of facility's Care Plan Revisions Upon Status Change Policy, dated 10/24/22, revealed:Policy:The purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change.Policy Explanation and Compliance Guidelines:1. The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change.2. Procedure for reviewing and revising the care plan when a resident experiences a status change:c. The team meeting discussion will be documented in the nursing progress notes.d. The care plan will be updated with the new or modified interventions. Record review of facility's Psychoactive Medication Management Policy, not dated, revealed:Upon noting an order for psychoactive medication on admission or initiation of therapy:5. Care plan the targeted behavior and for why the resident is receiving the medicationForms and Timing of Completion:5. Care Plan - upon initiation of medication.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan, for 1 resident (Resident #1) of 5 residents reviewed for quality of care, in that: The facility failed to consult with Resident #1's physician concerning the discontinuation of Depakote at RP's request. These failures placed residents in the facility at risk for not receiving care according to professional standards.The findings were:Record review of Resident #1's admission Record, dated [DATE], revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks), and dementia, unspecified (a condition in which a person loses the ability to think, remember, learn, make decisions, and solve problems. Symptoms may also include personality changes). Record review of Resident #1's [DATE] Quarterly MDS revealed Resident #1 had a BIMS score of 99, indicated Resident could not complete the assessment. Resident #1 had unclear speech, was rarely/never understood others and was rarely/never able to be understood by others. Resident #1 was always incontinent of his bowels and bladder. Resident #1 required substantial/maximal assistance with eating. Resident #1 was dependent on toileting hygiene, showers/baths, and personal hygiene requiring the assistance of two or more helpers. Review of Resident #1's [DATE] MAR revealed he received Depakote 250 mg Oral Tablet Delayed Release two times a day from [DATE] through [DATE]. The morning dose on [DATE], was refused by Resident #1 and the evening dose was not taken due to Resident #1's unresponsiveness and his being sent to the hospital where he expired. Review of Resident #1's progress note dated [DATE] at 03:46 pm revealed DON A wrote I contacted PCP's office to obtain discontinuation orders; however, the office was closed for the weekend. We will await further orders from PCP on Monday ([DATE]). Review of Resident #1's progress notes dated [DATE] revealed DON A had no follow-up note concerning the discontinuation orders for Depakote at the RP's request. During an interview on [DATE] at 11:32 am, OM I stated she believed she called to follow-up with the facility on [DATE] concerning Resident #1 because she had not heard from DON A and was notified at that time Resident #1 was found unresponsive on [DATE], CPR was initiated, then he had been sent out to the hospital, and expired on [DATE]. Record review of facility's Charge Nurse job description not dated revealed:Essential functions: Communicate with resident's point of contact when they ask for a status update or if there is a change in condition.