

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455477	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/23/2025
NAME OF PROVIDER OR SUPPLIER  Brazos Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  413 Garland Dr Lake Jackson, TX 77566	

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 0584  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.  (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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on observations, interviews, and record reviews, the facility failed to provide a safe, clean, comfortable, and homelike environment including but not limited to receiving treatment and support for daily living safely for 3 of 3 shower rooms (A-Hall, B-Hall, and C-Hall) reviewed for cleanliness and sanitization. The facility failed to maintain clean and organized shower rooms, maintenance leaking shower head faucet, and properly dispose of dirty briefs and used linen. These deficient practices could place residents at risk of living in an unclean and unsanitary environment which could lead to a decreased quality of life. Findings included: During an observation on 12/19/2025 at 01:12 p.m. in unlocked shower room A-Hall (across from the nurse's station) had leaking water dripping from shower head faucets. Floor and wall tiles were discolored under leaking water. During an observation on 12/19/2025 at 01:14 p.m. in unlocked shower room on B-Hall (resident's hall) were 2-open wall cabinets that were full of unorganized items consisting of loose gloves, unfolded towels, 1 of 2 personal grey bins tipped over on its side, brief wipes slightly opened exposed wipes, 3-shaving cream containers without tops, 1 of 3 leaking cream, 2 of 3 knocked over, and tops sitting to the side. Folded towels hanging halfway off edge of shelf. Atop shower table laid damp and bunched up towels at one end of table. Large clear bag of dirty bedsheets on shower room floor, shower floor was stained and discolored, 3-damp face towels rested on floor in crumpled balls, 1 of 2 trashcans overfilled, blue shaver razor resting on top of an adult brief with blood like substance, discolored shoestring laying on floor near side of can, 2 of 2 trashcans overfilled with used disposable bed protectors, back of shower chair covered with damp bed sheets, clean folded towels sitting on closed seat of toilet, foam hand/bath soap sitting on toilet back, and 1-soiled bagged adult brief on floor near door entry. During an observation on 12/19/2025 at 01:31 p.m. in locked shower room C-Hall (memory care unit) floor tile rubber protector aligning wall loose and laying on floor near floor drain exposing wall adhesive and 1-damp face towel resting on one arm of shower chair. During an observation on 12/19/2025 at 03:12 p.m. shower rooms A, B, and C Halls were in unchanged conditions as last observed on 12/19/2025 between 01:12 p.m. and 01:31 p.m. During an overheard observation on 12/19/2025 at 03:11 p.m. ADON asked a CNA (name unknown) on C-Hall/memory care who last used the showers. The CNA stated that they had not given any showers on 12/19/2025. During an interview on 12/19/2025 at 03:07 p.m. Assistant Director of Nursing (ADON) stated that the certified nursing aides (CNAs) had been responsible for the upkeep of the shower rooms. She stated infection control was the importance of keeping the shower rooms clean. She stated it also kept residents free of various illness exposure. She stated she was not aware of the leaking faucet in A-Hall's shower room. She stated the importance of keeping the faucet leak free was to safeguard buildup of water that could breed bacteria. She stated that she was not aware of shower room B-Hall and C-Hall were dirty or hand damp items within. She stated that it had been the responsibility of the CNA who last used the rooms to disinfect and remove all used items. During an interview on 12/19/2025 at 03:27 p.m. Administrator (ADM) stated that leaving the shower rooms dirty, wet and unkept placed residents at risk of dignity and respect issues. He stated the facility was the resident's home and should be upkept as such. During an interview on 12/19/2025 at 03:48 p.m. Housekeeping Supervisor (HS) stated that the dirty briefs, damp and used towels, bedsheets, and shaving razors left in the shower rooms were the responsibility of the CNAs who last used the shower rooms. She stated failing to do so, placed residents at risk for infection control issues, and dignity and respect as the facility was the residents home and should be kept up and homelike. During an interview on 12/19/2025 at 03:56 p.m. ADM stated that the leaking shower head faucet in shower room A-Hall had been addressed by the Maintenance Director and would have a list of all staff who used the showers rooms on 12/19/2025. During an interview on 12/19/2025 at 03:59 p.m. ADON stated in-service education would be provided to a hospice staff that last provided a resident a shower on 12/19/2025 in the shower room on the C-Hall. During an interview on 12/19/2025 at 04:05 p.m. HS provided a daily shower room checkoff list (DSRCL) where those who last used the shower room noted they had cleaned the room. She stated a charge nurse would then check off verifying that the cleaning tasks were performed. She stated on 12/19/2025 no shower rooms were checked off as they were being cleaned. She stated the importance of keeping the shower rooms clean was to maintain infection control and residents' dignity and respect. During an interview on 12/19/2025 at 04:40 p.m. CNA A stated that she had worked at the facility for over 2 years on a rotating 6 a.m. to 6 p.m. She stated that she had provided a shower to a resident at the beginning of her shift on 12/19/2025 in the B-Hall shower room, but had cleaned and sanitized the shower floor, shower chair</p>		

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

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review the facility failed to maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrated that it was not possible or resident preferences indicated otherwise for 1 (Resident #1) of 6 residents reviewed for weight loss: The facility failed to provide weekly weights for Resident #1 on 10/27/2025, 11/10/2025, 11/17/2025, 11/24/2025, 12/08/2025, and 12/15/2025. Resident #1 was noted to have weight loss on 12/01/2025 and 12/17/2025 who had gastrostomy status (refers to a patient having a surgically placed tube (G-tube) into their stomach for feeding or draining, requiring ongoing care) diagnosis. These failures had the potential to affect other residents requiring weight management, especially those who have weight loss and weight gain and who could be at risk of serious harm due to poor nutrition and weight loss. Findings Included: Record review of Resident #1's Facesheet dated on 12/19/2025 reflected she was a [AGE] year-old female who admitted to the facility on [DATE]. Her diagnosis included but were not limited to gastroparesis (chronic condition where the stomach muscles work poorly, slowing or stopping the movement of food to the small intestine), muscle wasting and atrophy (the loss or thinning of muscle tissue, leading to decreased mass and strength), Rett's syndrome (a rare genetic neurological disorder, primarily affecting females, that causes a progressive loss of motor skills, speech, and purposeful hand use), seizures (sudden, uncontrolled electrical disturbances in the brain, causing temporary changes in movement), epilepsy (chronic neurological disorder defined by recurrent, unprovoked seizures, which are sudden bursts of abnormal electrical activity in the brain), disturbances of salivary secretion (too little (xerostomia) or too much (sialorrhea) saliva, causing dry mouth, difficulty eating/swallowing, bad taste, or drooling), functional dyspepsia (chronic indigestion, causing upper belly pain, burning, fullness, or bloating without a clear cause), other dysphagia (difficulty swallowing food or liquids, caused by problems with the nerves or muscles involved in moving items from the mouth to the stomach), gastrostomy status (refers to a patient having a surgically placed tube (G-tube) into their stomach for feeding or draining, requiring ongoing care), mixed receptive-expressive language disorder (communication challenge affecting both understanding (receptive) and using (expressive) language), protein-calorie malnutrition (muscle/fat loss), and irritable bowel syndrome (chronic gut disorder causing abdominal pain, cramping, bloating, gas, and changes in bowel habits (diarrhea). Record review of Resident #1's Care Plan undated reflected Focus: Resident had potential nutritional problem related to (r/t) feeding tube, low body, mass, index (BMI), malnutrition, nothing by mouth (NPO) Feeding: Jevity (nutritional supplement and tube-feeding formula using a syringe, rather than continuously) 1.5, 237 milliliter (ml) bolus (single, large syringe dose of a substance administered over a short period) every (q) 6 hours (hrs.) water flush 60 ml before and after each bolus medications: levOCARNitine (naturally occurring amino acid derivative (creating important compounds like hormones) and a prescription medication used to prevent and treat carnitine (a naturally occurring compound, derived from an amino acid, that is crucial for energy production by transporting fatty acids into the cells) deficiency in the body), multi-vitamin infusion (MVI) Date Initiated/Created: 08/05/2023. Goal: Resident will maintain adequate nutritional status as evidenced by maintaining weight daily through review date. Date initiated: 08/05/2023 and created on 08/05/2023. Intervention/Tasks Monitor/record/report to medical doctor (MD) as needed (PRN) signs and symptoms (s/sx) of malnutrition: Emaciation (Cachexia), Record review of Resident #1's Minimum Data Set (MDS) dated [DATE] reflected that the resident was unable to answer the questions of the Brief Interview of Mental Status (BIMS). Record review of Resident #1's Physician Orders dated 03/28/2023 at 06:00 p.m. reflected medical doctor (MD) A ordered Resident #1 was to received enteral feeding (method of delivering nutrition directly into the gastrointestinal tract, typically through a tube, for individuals who cannot consume food orally) q shift and to be flushed with 10 cubic centimeter (cc) water between medications. Record review of Resident #1's Physician Orders dated 03/28/2023 at 06:00 p.m. reflected MD A ordered enteral feed q shift and monitor g-tube for swelling and drainage and notify MD of s/sx. Record review of Resident #1's Physician Orders dated 04/04/2023 at 06:00 p.m. MD A ordered enteral feed 4x a day and verify g-tube placement and to be checked for residual. Record review of Resident #1's Physician Orders dated 04/04/2023 at 03:00 p.m. Nurse practitioner (NP) A 4 ordered enteral feed q 6 hrs. with water flush 60 ml before and after each bolus. Record review of Resident #1's Physician Orders dated 06/05/2025 at 06:00 p.m. order enteral feed q night shift and cleanse g-tube stoma (surgically created opening that</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on observation, interview and record review, the facility failed to 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 3 shower rooms (A-Hall, B-Hall, and C-Hall) observed for infection control practices. The facility failed to maintain clean and organized shower rooms and avoid the development of legionella (a serious lung infection (pneumonia) caused by a bacteria, caught by inhaling mist from contaminated warm water sources like cooling towels and showers), repairing a leaking shower faucet, and not properly disposing of dirty briefs and linen. This failure could place residents at risk of cross-contamination from exposure to another's used personal items. Findings included: During an observation on 12/19/2025 at 01:12 p.m. of A-Hall's unlocked shower room (across from the nurse's station) faucet water dripping from 1 of 1 shower heads. Water accumulating on discolored floor and wall tiles near drip water. During an observation on 12/19/2025 at 1:14 p.m. of B-Hall's unlocked shower room (on resident's hall) were 2-attached wall cabinets with full of cluttered items consisting of but not limited to unfolded towels, loose gloves, 1 of 2 grey plastic bins laying sideways, unsecured brief wipes, 3-open shaving creams with no tops and cream oozing out of 1 of 3, and 2 of 3 laying sideways on shelf, all 3 shaving cream were uncovered and tops sitting on the shelf. Damp shower table was located diagonally in the room with bunched up damp towels laying at one end of the table, dirty bedsheets inside a large clear bag sat inside entry area of shower room, 3-bunched up and damp face towels sitting on floor of shower room, 2 of 2 trashcans overfull with disposable bed protectors, 1 of 1 had exposed shaving razor atop an adult brief with what appeared to be a blood like substance on brief, dirty shoestring sat on floor near backside of trashcan, damp bed sheets hung on back of shower chair, what appeared to be clean folded towel sat on closed lid of toilet seat, and on back of toilet sat foam hand/bath soap, and on the floor near entry door sat an bagged adult brief. During an observation on 12/19/2025 at 01:31 p.m. C-Hall 's (memory care unit) locked shower room revealed an unsecured rubber tile wall protector loose and laying on floor drain exposing wall and adhesive and a shower chair with a damp face towel hanging on arm. During an observation on 12/19/2025 at 3:11 p.m. Assistant Director of Nursing (ADON) asked an unknown certified nursing aides (CNA) on the C-Hall whom performed showers in that hall's shower room. That unknown CNA stated that no showers had been performed by facility staff on that day. During an observation on 12/19/2025 at 03:12 p.m. unlocked shower rooms A, B, and came were observed in the same condition as observed on 12/19/2025 at 01:12 p.m. and 01:31 p.m. During an interview on 12/19/2025 at 03:07 p.m. ADON stated that the CNAs had been responsible for shower room upkeep and cleaning, and each was to be immediately cleaned after providing a resident with a shower. She stated additionally the facility's housekeeping staff were to assure that the shower rooms were clean and were to check every 1-2 hours. She stated the importance of keeping the shower room's clean was for infection control and to keep the residents free of contact of different illnesses. She stated she had not been made aware that shower room on A-Hall's faucet had been leaking water and she would then report the leak to the maintenance director. She stated that the faucet should be properly functioning to avoid water buildup that could breed bacteria. She stated that the shower room B-Hall was to have been kept clean and it had been the responsibility of the CNAs who provided showers to do so. She stated it was unknown if the items on the cabinet shelves were used or unused, but would not want the staff to use for or on the residents. She stated that she would find out who had been responsible for the unkept shower rooms. She stated the shower chair in shower room C-Hall should not have a damp towel hanging of the arm. During an interview on 12/19/2025 at 03:27 p.m. Administrator (ADM) stated shower rooms left unkept and unclean could place residents at risk for cross-contamination. During an interview on 12/19/2025 at 03:48 p.m. Housekeeping Supervisor (HS) stated that the housekeeping staff were responsible for pulling trash from the shower rooms, but not dirty briefs. She stated that CNAs were responsible for brief disposal and if the housekeeping staff found briefs in the trash, they were to set aside for the CNAs to dispose. She stated that the risk of not properly disposing of dirty and damp towels, sheets, pulling up trash, and properly disposing of sharps posed a risk of infection control and residents could become sick. During an interview on 12/19/2025 at 03:56 p.m. ADM stated that the leaking shower head in A-Hall's shower room had been addressed by the Maintenance Director and if a plumber was needed, one would be contacted. He stated a list of the staff that performed showers in shower room B-Hall would be provided. During an interview on 12/19/2025 at 03:59 p.m. ADON stated that that the</p>		