STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675799	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brenham Nursing and Rehabilitation Center	400 E Sayles St Brenham, TX 77833

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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 - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 47065 Based on observation, interview and record review the facility failed to provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for 1 of 4 residents (Resident #1) reviewed for pharmaceutical services. The facility failed to provide antibiotic medication to Resident #1 from 05/17/24 through 05/21/24. On 05/21/24, the facility sent Resident #1 to the ER by EMS. On 05/22/24, Resident #1 was admitted to the hospital for higher level of care. The noncompliance was identified as PNC. The IJ began on 05/21/24 and ended 05/24/24. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk of not receiving their medications, hospitalization , infection or death. Findings include: Record review of Resident #1's Admission Record, dated 05/17/24, reflected a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1 had diagnoses which included unspecified fluid overload (A condition in which the liquid portion of the blood (plasma) is too high) and hepatic encephalopathy (The loss of brain function when a damaged liver doesn't remove toxins from the blood). Record review of Resident #1's Admission MDS assessment, dated 04/17/24, reflected she had a BIMS of 14, which indicated she was cognitively intact. Record review of Resident #1's Discharge MDS assessment, dated 05/21/24, reflected she had active diagnoses which included unspecified fluid overload and hepatic encephalopathy. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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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 - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's Hospital Records, dated 05/17/24, reflected Resident #1 was required to start taking Rifaxmin 200 MG tablet, commonly known as Xifaxan, last time they were given the medication was at 400 MG on 05/17/24 at 1:57 p.m., indications for impaired brain function due to liver disease, and instructions included taking 2 tablets 400 mg by mouth 3 times daily for same indications. There were also instructions to take antibiotics exactly as prescribed, do not skip doses or stop taking antibiotics even if you feel better, and antibiotics only work for bacterial infections. Record review of Resident #1's Order Summary Report, as of 05/21/24, reflected she was required to take two Rifaximin 200 milligram tablets by mouth three times a day for hepatic encephalopathy that was verbally ordered and started on 05/17/24. Record review of Resident #1's MAR, from 05/18/24 through 05/21/24, reflected Resident #1 received Rifaximin 200 milligram tablets by mouth three times a day on 05/17/24 at 4:00 p.m. and 8:00 p.m, 05/18/24 at 4:00 p.m. and 8:00 p.m., 05/19/24 at 8:00 p.m., 05/20/24 at 8:00 p.m., and 05/21/24 at 8:00 p.m. Resident #1 did not receive the Rifaximin 200 milligram tablets by mouth three times a day on 05/18/24 at 8:00 a.m., 05/19/24 at 8:00 a.m. and 4:00 p.m., 05/19/24 at 8:00 a.m. and 4:00 p.m., 05/20/24 at 8:00 a.m. and 4:00 p. m., and 05/21/24 at 8:00 a.m. and 4:00 p.m. Record review of Resident #1's EMAR Progress Notes, from 05/18/24 through 05/21/24, reflected the following: -A note on 05/18/24 at 5:41 p.m., on 05/19/24 at 9:58 a.m., and on 05/19/24 at 5:07 p.m., Rifaximin Oral Tablet 200 Note MG Give 2 tablet by mouth three times a day for hepatic encephalopathy waiting on pharmacy. -A note on 05/20/24 at 11:27 a.m., Rifaximin Oral Tablet 200 Note MG Give 2 tablet by mouth three times a day for hepatic encephalopathy on order. -A note on 05/20/24 at 4:55 p.m., Rifaximin Oral Tablet 200 Note MG Give 2 tablet by mouth three times a day for hepatic encephalopathy on order nurse aware. -A note on 05/21/24 at 8:23 a.m., Rifaximin Oral Tablet 200 Note MG Give 2 tablet by mouth three times a day for hepatic encephalopathy spoke to the pharmacy and the nurse is aware of this situation -A note on 05/21/24 at 4:34 p.m., Rifaximin Oral Tablet 200 Note MG Give 2 tablet by mouth three times a day for hepatic encephalopathy unavailable. Record review of Resident #1's Admission and Discharge Report, from 03/05/24 through 06/05/24, reflected Resident #1 was discharged to the hospital on 05/21/24. An observation of the medication room on 06/05/24 at 3:02 p.m. revealed there was no Rifaximin 200 MG available or listed as an available medication in the emergency medication kit. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 06/05/24 at 12:09 p.m., Resident #1 revealed she would never return to the facility because staff found her on the floor on 05/21/24. Resident #1 stated she could not remember anything about how she ended up on the floor and could only remember waking up in the hospital. Resident #1 stated staff administered medications to her. Resident #1 stated she could not remember what medications she received and did not receive. Resident #1 also stated she did not know if she received any discontinued medications during her stay at the facility. Resident #1 did not have any additional information to provide and advised to speak with her POA . During an interview on 06/05/24 at 12:29 p.m., Resident #1's POA revealed Resident #1 had poor liver function. The POA stated staff did not administer certain medications to Resident #1. The POA explained staff should have administered the same medications Resident #1 was administered in the hospital. The POA stated on 05/21/24, the facility called the ER to pick up Resident #1 because her pneumonia levels were high. The POA also stated they spoke with the ADM on 05/23/24 about Resident #1's hospitalization . The POA stated Resident #1 had the capacity to make decisions for herself and knew she needed to take her medication. Attempted interview with CMA A on 06/05/24 at 12:54 p.m. was unsuccessful. A voicemail and call back number was left. CMA A did not return the call. Attempted interview with LVN B on 06/05/24 at 12:56 p.m. was unsuccessful. A voicemail and call back number was left. LVN B did not return the call. During an interview on 06/05/24 at 12:58 p.m., CMA C revealed they were trained and in-serviced on medication administration. CMA C stated they learned to notify a nurse whenever a residents' medication was unavailable. CMA C also stated they did not know Resident #1 received her medication on 05/17/24 and ran out on 05/17/24 because she did not work on 05/17/24. CMA C stated she notified LVN D, who told them they called the Pharmacy to send Resident #1's medication. CMA C also stated they did not know Resident #1 received any medication from the emergency kit on 05/18/24 because they did not know what medications were available . During an interview on 06/05/24 at 1:11 p.m., the SW revealed on 05/21/24, they had a care plan meeting with Resident #1's family and Resident #1. The SW stated the nurses monitored Resident #1's fluid and the DON and the ADON evaluated Resident #1. The SW explained the ADON notified the MD and the MD recommended to send Resident #1 out to the ER. The SW stated Resident #1 made all her own decisions, had the capacity to make decisions for herself, and had a POA. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 06/05/24 at 1:19 p.m., LVN D revealed they were trained and in-serviced on medication administration. LVN D stated they learned to notify the pharmacy whenever a residents' medication was unavailable. LVN D also stated on 05/18/24, CMA C informed them Resident #1's medication was not refilled. LVN D stated she did not make a progress note of contacting the pharmacy and physician when they notified them on 05/18/24, did not know why they did not make a progress note, and thought it was because they might have been busy. LVN D stated they notified the Pharmacy and determined Resident #1's medication was on back order, which they explained meant there was a local shortage on the particular medication. LVN D stated they also notified the Physician that the medication was on back order, the Physician did not give them any new orders, and the Physician did not provide them with any instruction or direction on 05/18/24. LVN D also stated they did not notify anyone else about Resident #1's medication backorder. LVN D stated they were supposed to notify the ADON and DON if the Physician did not give any direction or instruction. LVN D also stated they did not notify the ADON and DON because the day was probably busy. LVN D stated residents' health could be affected if the resident went long periods of time without medication if the medication was on back order. LVN D stated they were in-serviced on proper protocol to take when a medication was unavailable at the facility. LVN D explained they learned to contact the pharmacy, have the pharmacy STAT order the medication if the pharmacy had the medication, document contacting the pharmacist, each person they spoke to and new order given, and notify the ADON, the DON and the physician for alterative medication recommendations . During an interview on 06/05/24 at 1:59 p.m., the Physician revealed they were not informed by the facility on 05/18/24 about the facility still waiting on the Pharmacy to send Resident #1's medications. The Physician stated the facility might have informed the on-call physician on 05/18/24. Physician explained on-call physicians worked during the weekends and weekdays after 6:00 p.m. Physician went on to explain they worked on weekdays until 6:00 p.m. The Physician stated there were no on-call physician notes. The Physician stated they would work with the Pharmacy to find an alternative medication if they were notified that a medication was on back order. The Physician also stated Rifaximin did not need to be administered daily, but it depended on the resident's condition. The Physician stated the facility could wait one or two days to administer antibiotics to a resident, but it depended on the resident's condition. The Physician also stated they were not working when Resident #1 was sent to theER on [DATE] . During an interview on 06/05/24 at 3:03 p.m., the DON revealed Resident #1 was readmitted to the facility on [DATE]. The DON stated they trained staff to notify the Pharmacy about medications unavailable at the facility and notify the MD if the MD wanted to change or continue to use the medication unavailable. The DON also stated they expected CMAs to document medications unavailable and notify a nurse if a medication was unavailable. The DON stated they expected nurses to notify the pharmacy and the MD when determining a resident's medication was unavailable. The DON also stated they in-serviced staff about documentation, notifying the physician and pharmacy, and medication availability. The DON stated staff did not notify them or the ADON about Resident #1's medications being unavailable from 05/18/24 through 05/21/24. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 06/05/24 at 3:40 p.m., the ADON revealed Resident #1 came from the hospital on 05/16/24, 05/17/24, or over the weekend (05/18/24-05-19/24), but they were not at the facility. The ADON stated Resident #1 went out to the hospital after the weekend. The ADON stated Resident #1 was on antibiotics during her admission. The ADON stated Resident #1 also had fluid overload prior to her admission. The ADON stated they expected CMAs to alert a nurse if a resident's medication was unavailable. The ADON stated the facility had an emergency kit. The ADON stated they expected nurses to call the pharmacy if a resident's medication was unavailable. The ADON stated they also expected nurses to contact the Physician if the pharmacy indicated the resident's medication was unavailable or backordered. The ADON also stated the physician gave instructions to the nurses and nurses followed the instructions. The ADON stated they expected nurses to document notifying the pharmacy or MD whenever a resident's medication was unavailable. The ADON explained nurses could notify them and the DON if a resident's medication was unavailable. The ADON stated they were not sure if a resident could be affected if a resident did not receive medications according to orders. The ADON stated nurses did not notify them or the DON about medication unavailability. The ADON stated they did not know how the DON learned of staff waiting on the pharmacy for Resident #1's medications that resulted in reeducation for the staff. The ADON stated on 05/21/24, Resident #1 fell and went to the hospital. The ADON stated she did not observe Resident #1 before EMS took her to the hospital. The ADON also stated the Pharmacy would notify the nurses if a medication was in the emergency kit. The ADON stated staff (she could not remember who) informed her and the DON that they contacted the MD (did not indicate who nor did staff indicate who) and did not mention if the MD gave any special instructions or medication changes. The ADON also stated residents must be on antibiotics to ensure they did not develop any infections and improve. The ADON stated residents could catch an infection if they were not consistent with their antibiotic orders. Attempted interview with the Pharmacy on 06/05/24 at 4:03 p.m. was unsuccessful. The Pharmacy was advised to email the Pharmacy Director, which was completed. The Pharmacy did not respond to the email and did not call back. During an interview on 06/05/24 at 4:08 p.m., the ADM revealed they were still looking for a policy related to following physician's orders. During an interview on 06/05/24 at 4:17 p.m., LVN E revealed they were trained and in-serviced on medication administration. LVN E stated they learned to notify the pharmacy whenever a residents' medication was unavailable. LVN E also stated Resident #1's medication might have been in the emergency kit . LVN E stated they could not recall that they administered Resident #1's medication on 05/17/24 and 05/18/24 and believed they might have misdocumented on the MAR. LVN E stated residents were given antibiotics for specific diseases and must have full treatment for antibiotics. LVN E stated residents could be affected if they did not receive medication according to their orders. LVN E stated they were trained to call the pharmacy or physician if a medication ran out. LVN E stated they did not document contacting the pharmacy or physician about Resident #1's medication unavailability. LVN E stated they reached out to the physician if the resident needed a substitute or change in medication. LVN E stated they called the physician whenever the pharmacy did not have medications unavailable. LVN E stated they could not recall why they documented administering Resident #1's medications despite Resident #1's medications being unavailable . LVN E stated they must contact the physician so the resident's order could be put on hold or start on the medication when the pharmacy brought out medication or ordered a substitute. LVN E stated they could not recall if they contacted the pharmacy or physician regarding Resident #1's orders. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 06/05/24 at 4:34 p.m., the DON revealed the ADON and them reviewed residents' clinicals during morning meetings. The DON stated the ADON and them reviewed residents' medications and history and physical records to make sure assessments were in place. The DON also stated they could not recall what happened on 05/20/24 that caused them to overlook Resident #1's medications during Resident #1's clinical review. The DON stated staff were expected to reach out to the physician for a substitution or discontinuation if a medication was back ordered. The DON stated staff could also call a pharmacist and the pharmacist could give a list of medications that could be interchanged with medication on backorder or recommend another medication if a medication was on backorder. During an interview on 06/05/24 at 5:24 p.m., the DON revealed they did notice the ADON and them missed Resident #1's medication during Resident #1's clinical review. The DON stated they initiated a cart and MAR audit for admissions and readmissions and contacted the pharmacy for medications that were missing or not ordered or reordered and STAT medications ordered after Resident #1 went to the hospital. The DON also stated the former DON and ADM were aware of the backordered medications. The DON stated they were not aware of the back-order medication list before stepping into the position. The DON stated they noticed a change occurred and Resident #1's family filed a grievance with the ADM about Resident #1 going to the hospital. During an interview on 06/05/24 at 5:30 p.m., the ADM revealed the hospital notified the facility that Resident #1 was diagnosed with Hepatic Encephalopathy. The ADM stated he and the DON, at the time, discussed the medication backorder list, forwarded the pharmacy communication about the medication backorder list to the MD, the MD acknowledged it, reviewed residents' medications, determined there were no residents who had medications on the back-order list, and communicated the backorder list with staff. The ADM stated they reviewed in-services with staff and had no in-services related to communicating with staff about backordered medications, which they then provided to staff. During an interview on 06/05/24 at 6:16 p.m., Resident #1's POA revealed hospital staff informed them Resident #1 was diagnosed with Hepatic Encephalopathy in the hospital. The POA stated Resident #1 was at another rehabilitation center at the time of the interview and left the hospital on 05/28/24. The POA stated staff did not inform them about anything related to Resident #1's medications, ordering Resident #1's medications, or about the back order of Resident #1's medications. During an interview on 06/06/24 at 11:16 a.m., the DON revealed none of the backordered medications were supposed to be available in the emergency kit. The DON stated staff could contact a pharmacist for a medication recommendation to inform the physician with. The DON also stated they contacted pharmacy if the facility could add a similar medication to the emergency kit, but the pharmacy was not sure because the medication was on back order. The DON stated on 06/05/24, they reached out to the Pharmacy about adding a medication similar to the backorder medication and were waiting to hear back. Attempted interview with the on-call Physician's on 06/06/24 at 1:30 p.m. The Physician on-call Agency advised to speak with their information technology department to determine who the on-call physicians were between 05/17/24 and 05/21/24, which was attempted. A voicemail and call back number was left. The information technology department did not return the call. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 06/06/24 at 2:37 p.m., The Physician revealed a vital medication was if someone had an infection and needed to take antibiotic or if someone had surgery and needed to take pain medication. The Physician stated Rifaximin was not considered vital despite hospital discharge paperwork which indicated do not skip antibiotics or stop taking antibiotics for Resident #1. The Physician also stated it was hard to determine if medications were vital because Resident #1 was skilled and not long-term. The Physician stated they attended QAPI meeting in May 2024, but could not recall what was discussed. The Physician stated they might have been notified of medications not available following Resident #1, but they could not recall . Record review of an email thread between the ADM, the former DON, and the Pharmacy, dated 03/26/24, reflected the Pharmacy notified the facility that Xifaxan 200 MG was a backordered drug and on shortage that could affect the facility's residents. The Pharmacy also suggested the facility inform the prescribing physician so that an alternative therapy could be evaluated. The ADM notified the Physician on 03/26/24. Record review of an email thread between the Pharmacy and the ADM, dated 06/05/24, reflected the Pharmacy notified the facility that Xifaxan 200 MG tablets were on backorder since the beginning of the year (January 2024) and the Pharmacy tried ordering it on 06/04/24 and the manufacturer was not producing the medication. Record review of an email thread between the Pharmacy and facility, dated 06/06/24, reflected the Pharmacy informed the facility the following, Ekit inventory is determined largely based on average usage of a medication as well as sensitivities regarding initiation of therapy. There are physical limitations of available space that must be factored into deciding what medications are and aren't included in the kit. Ekits are not intended to be a full-service dispensing option. Medications unavailable in the ekit are provided via a standard delivery schedule and if a medication is needed sooner than that would be available can be expedited. Xifaxan 200mg is currently on a long-term manufacturer backorder and is unavailable to be added to an ekit. Record review of the facility's Order Listing Report, from 05/17/24 through 06/05/24, reflected there were no residents who had active, completed, and discontinued orders for Xifaxan 200 MG. Record review of the facility's Physician Notification Manual, dated 06/06/24, reflected staff were required to call the physician whenever there was a new presentation of data, symptoms, findings, lab work, change in condition and assessment, notify the NP immediately, notify the Physician if staff could not reach the NP, or notify on-call Physician if the situation was after hours (6:00 p.m.) or weekends/holidays. Record review of the facility's, undated, Clinical Notification Log, reflected an entry for Resident #1 that was documented by staff, reviewed, and signed by the NP on 05/21/24 which indicated Rifaximin 200 MG was on backorder and expensive and 500 MG was available but expensive. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the facility's In-Services, from 03/01/24 through 05/31/24, reflected staff were trained on Drug Shortages on 03/26/24 at unknown time, 10 staff were trained on POC Orders on 04/02/24 at unknown time, 13 staff were trained on Medication Administration on 04/25/24 at unknown time, 14 staff were trained on Reconciling New Admission Orders on 04/30/24 at unknown time, 9 staff were trained on Antibiotics on 05/08/24 at unknown time, 40 staff were trained on Documentation on 05/23/24 at unknown time, 24 staff were trained on Night Shift staff completing and signing off on MAR on 05/21/24 at unknown time, 23 staff were trained on Following Physician Orders on 05/22/24 at unknown time, and 61 staff were trained on Reconciling Medications and Admission Orders on 05/22/24 at unknown time. Record review of an email thread from the ADM, dated 06/06/24 at 1:00 p.m., reflected the facility did not have a policy on following physician's orders. Record review of the facility's Medication Availability Performance Improvement Plan reflected the MD was notified on 05/22/24, staff completed reviewing residents' current orders to identify any other residents with orders for unavailable medication on 05/22/24, completed a 100% MAR to cart audit for current residents to identify any resident whose medication (including OTCs) was not available in the facility and/or back ordered on 05/23/24, completed review and reconciliation of orders to validate medication availability for admissions and readmissions from 05/01/24 through 05/22/24, validated facility emergency kits stocks on 05/23/24 and completed reeducation on required communication in the event a medication and/or treatment was not available for a resident, prompt notification to MD/NP, DON and RP, emergency kits on 05/23/24, monitored compliance with medication availability and following physician orders by reviewing new physician orders, including admission and readmission orders daily and include checking to ensure medication was present in facility to validate medication availability, monitor compliance with staff with 10 rights of medication administration by observing medication pass and findings reported to QAPI committee monthly effective 05/24/24. Record review of the facility's Medication Administration Performance Improvement Plan reflected the MD was notified on 05/22/24, staff completed reviewing residents' current orders to identify any other residents with orders for unavailable medication on 05/22/24, completed 100% MAR to cart audit for current residents to identify any resident whose medication (including OTCs) was not available in the facility and/or back ordered on 05/23/24, reviewed and reconciled orders to validate medication availability for admissions and readmissions from 05/01/24 through 05/22/24 on 05/23/24, validated facility emergency kits stocked on 05/23/24, completed medication audit report from 05/01/24 through 05/22/24 to identify residents who refused medication and/or treatments and included validating the MD/NP notification on 05/23/24, reeducated staff on following MD orders for medication administration, notification and/or clarification with the MD with medication availability and 10 rights of medication administration, importance of refusal documentation in residents' electronic health records, use of RP and MD involvement with continued refusals and possible drug alternatives on 05/23/24, reviewed 24 hour reports, order listing report and MARs to identify physician orders not followed related to medication availability on 05/24/24, reviewed resident refusals and documentation on 05/24/24, discussed alternative medications with MD/NP, notification to the pharmacy to obtain STAT medication from the pharmacy on 05/23/24, staff reviewed new orders including admission and readmission orders to validate medication availability and ensuring the medication was present in the facility, and during daily clinical meeting on 05/24/24, monitor compliance with medication availability by reviewing new physician orders including admission and readmission orders daily, checking to ensure the medication was present in the facility, and findings reported to the QAPI committee on 05/24/24. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the facility's Medication Reconciliations Performance Improvement Plan reflected the MD was notified on 05/22/24, staff completed reviewing residents' current orders to identify any other residents with orders for unavailable medication on 05/22/24, completed 100% MAR to cart audit for current residents to identify any resident whose medication (including OTCs) was not available in the facility and/or back ordered on 05/23/24, reviewed and reconciled orders to validate accuracy of medication transcription and medication availability for admissions and readmissions from 05/01/24 through 05/22/24 completed on 05/23/24, validated facility emergency kits stocked on 05/23/24, reeducated staff on accuracy of transcription of admission and readmission orders, validating medication availability for new orders and promptly notifying MD/NP if medication was not available, use of the facility emergency kits, discussing alternative medications with the MD/NP, notifying the pharmacy to obtain STAT medication from the pharmacy on 05/23/24, reviewed new orders including admission or readmission orders to validate accuracy of order transcription and medication availability and ensuring medication was present in the facility during daily clinical meetings on 05/24/24, monitor compliance with accuracy of transcription for admit/readmit orders and medication availability by reviewing new physician orders including admission and readmission orders daily, to validate medication availability and checking to ensure the medication was present in the facility, and findings reported to the QAPI committee on 05/24/24. Record review of the facility's Resident Medication Refusals reflected the MD was notified on 05/23/24, staff completed medication audit report from 05/01/24 through 05/22/24 to identify residents who refused medication and/or treatments that included validating MD/NP notification, MD/NP was notified of any instance notification was not documented on 05/23/24, reeducated staff on the importance of refusal documentation in residents' electronic health records, use of RP and MD involvement with continued refusals and possible drug alternatives on 05/23/24, continued refusal of care needs to be communicated to the Charge Nurse and then ADM for the facility to have the ability to capture refusals in the residents care plan and seek other means of persuasion if at all possible on 05/24/24, refusals of medications communicated to the RP and MD in order to pursue drug alternatives if possible and/or to discontinue when necessary on 05/24/24, review resident refusals and documentation and findings will be reported to the QAPI Committee on 05/24/24. Record review of the facility's Ordering and Receiving Medications from Pharmacy, dated 10/01/19, reflected the following: Procedure: 12. When contacting the attending physician regarding a change in condition where it is likely the physician will order a medication, the nurse is to inform the physician of the availability of remote medications in the facility (i.e., the contents of the remote drug supply). This will facilitate timely drug administration and reduce costs to the resident. Record review of the facility's Ordering and Receiving Medications from Pharmacy policy and procedure, dated 10/01/19, reflected the following under the section, Readmission: A. The Most Original order must be faxed to the pharmacy with a face sheet and cover sheet to clarify a resident's status. B. Nurses must communicate to the pharmacy which medications need to be dispensed based on the readmission medication list. Review current medication stock to avoid duplication and the patient's pay plan upon readmission. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675799	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brenham Nursing and Rehabilitation Center	400 E Sayles St Brenham, TX 77833

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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 - Immediate jeopardy to resident health or safety Residents Affected - Some	C. Use a fax cover sheet and indicate the time that the next doses are due, for the medications that are needed. Record review of the facility's Medication Administration policy and procedure, dated 10/01/19, reflected the following: Medication Administration Guidelines: K. If a medication with a current, active order cannot be located in the medication cart/drawer, other areas of the medication cart, medication room, and facility (e.g., other units) are searched, if possible. If the medication cannot be located after further investigation, the pharmacy is contacted or medication removed from the night box/emergency kit. Documentation (including electronic): F. If a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time (e.g., the resident is not in the facility at scheduled dose time, or a starter dose of antibiotic is needed), the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record. If 3 consecutive doses of a vital medication are withheld, refused, or not available the physician is notified. Nursing documents the notification and physician response. The noncompliance was identified as PNC. The IJ began on 05/21/24 and ended 05/24/24. The facility had corrected the noncompliance before the survey began.