

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675799	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/23/2025
NAME OF PROVIDER OR SUPPLIER  Brenham Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  400 E Sayles St Brenham, TX 77833	

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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884</b></p> <p>Based on observations, interviews, and record review the facility failed to ensure the residents received services in the facility with reasonable accommodation of each resident's needs for 1 (Resident # 2) out of 5 residents reviewed for call lights.</p> <p>The facility failed to ensure Resident # 2's call light was within reach.</p> <p>This failure could affect all residents who needed assistance and could result in needs not being met.</p> <p>Findings included:</p> <p>Record review of Resident #2's face sheet, dated, 01/23/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #2 had diagnoses which included muscle wasting and atrophy (loss of muscle a not elsewhere classified, in multiple sites (wasting or thinning of your muscle mass), need for assistance with personal care (required help with basic daily living activities such as: bathing, dressing, eating and personal hygiene), unsteadiness on feet, lack of coordination ( the inability to control the movement of one's body).</p> <p>Record review of Resident #2's Quarterly MDS, dated [DATE], reflected the resident had a BIMS score of 10, which indicated his cognition was moderately impaired. Resident #2 required partial to moderate assistance (helper does less than half the effort) with toileting hygiene, dressing, personal hygiene, and showers. Resident #2 was dependent on staff for bed-to-chair transfer and chair to bed transfer. He required substantial/maximal assistance ( helper does more than half the effort) for all other transfers and bed mobility such as: lying to sitting on side of bed, sit to lying, and sit to stand.</p> <p>Record review of Resident #2's Comprehensive Care Plan, with a completion date 12/02/2024, reflected Resident #2 had an ADL self-care performance deficit. Interventions: Resident #2 required assistance by one staff to turn and reposition in bed, dressing, personal hygiene, and toileting. Resident #2 required mechanical lift by two staff for transfers. Encourage Resident #2 to use bell to call for assistance. Resident #2 was at risk for impaired mobility. Resident #2 was at high risk for falls. Interventions: Be sure the call light is within reach and encourage the resident to use the call light for assistance as needed. Resident #2 needs prompt response to all requests for assistance.</p> <p>(continued on next page)</p>

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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview on 01/23/2025 at 9:41 AM, revealed upon entering Resident #2's room he was attempting to reach for the call light located at the foot of the bed. The overhead bed table was over the bed with water and cup located on the overhead bed table. Resident #2 stated I have been trying to get that light to call someone. He stated I prefer my call light to be next to me where I can use it when I need help. He pointed to the halo (device on the bed for resident to help with mobility in bed) on his bed and stated this is where I like for my call light to be. Resident #2 stated I have difficulty sometimes yelling for help.</p> <p>In an interview on 01/23/2025 at 9:46 AM, CNA A entered Resident #2's room and stated Resident #2's call light was at the foot of the bed and Resident #2 was unable to reach the call light. She stated all residents call light was required to be within reach at all times when a resident was in their room. CNA A stated she did not know how the call light got at the end of the bed. She stated she was not assigned to Resident #2. She stated if a resident was unable to reach their call light and needed assistance, there was a possibility a resident may need nursing assistance. CNA A stated a resident may attempt self out of bed and fall trying to get assistance. She stated she had been in-serviced on placing call lights within resident's reach, however, she did not recall the date or time of this in-service.</p> <p>In an interview on 01/23/2025 at 2:45 PM The DON stated if a resident was in their room lying in bed or sitting in a wheelchair, the call light was expected to be within reach of resident. She stated she could not determine what may happen to a resident if the call light was not within reach and the resident needed assistance. The DON stated any staff who entered the room was expected to check the call lights of the resident and if the call light was not in reach, any staff was capable of placing call light within reach of resident.</p> <p>Record review of the facilities policy on Call Lights: Accessibility and Timely Response, dated 10/13/2022, reflected The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. The call system must be accessible to residents while in their bed or other sleeping accommodations within the resident's room.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40884</p> <p>Based on interviews and record reviews , the facility failed to ensure that the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment for 1 (Resident #1) of 5 residents reviewed for care plans.</p> <p>The facility failed to ensure Resident #1's care plan was revised to reflect recent falls on 11/10/2024, 12/31/2024 and, 01/04/2025.</p> <p>This failure could place residents at risk of not receiving appropriate care to meet their current needs.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet, dated, 01/23/2025, reflected an [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1 had diagnoses which included repeated falls, unspecified dementia, unspecified moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (a decline in mental ability that affects memory, thinking, and behavior), adult failure to thrive (a syndrome in older adults characterized by unexplained weight loss, decreased appetite, poor nutrition, and inactivity), muscle wasting and atrophy (loss of muscle and strength), not elsewhere classified, right and left shoulder, and right and left upper arm (wasting or thinning of your muscle mass), and lack of coordination (uncoordinated movement is due to a muscle control problem that causes an inability to coordinate movements).</p> <p>Record review of Resident #1's Quarterly MDS Assessment, dated 12/31/2024, reflected the resident had a BIMS score of 3, which indicated her cognition was severely impaired. Resident #1 was total dependent on staff for personal hygiene, showers, and toileting hygiene. Resident #1 required partial/moderate assistance where helper does less than half the effort with transfers, eating, and dressing. Resident #1 was assessed for falls.</p> <p>Record review of Resident #1's Comprehensive Care plan, with completion date of 12/31/2024 , reflected Resident #1 had an ADL self-care performance deficit. Intervention: Bathing, toileting, transfers, and dressing: Resident #1 required one staff assistance. Resident #1 required 1-2 staff assistance with bed mobility. Resident #1 was low risk for falls. Intervention: Be sure call light was within reach and encourage the resident to use call light for assistance as needed. Resident #1 required prompt response to all request and assistance. Review information on past falls and attempt to determine cause of falls. Record root causes. Alter remove any potential causes if possible. Resident #1 had an actual fall with no injury. She had poor balance and, unsteady gait. Intervention: Check range of motion. Ensure personal items are within reach. Fall mat in place when resident in bed. New intervention dated 12/31/2024: Room modification to ensure safety and repositioning. Resident #1 had an actual fall with no injury (date initiated 07/12/2024) Interventions: Check range of motion. Ensure personal items are within reach. Fall mat in place when resident in bed. Room modification to ensure safety and repositioning.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's fall risk assessment dated , 12/31/2025, reflected Resident #1 was high risk for falls with a score of 15. If the total score was 10 or greater, the resident should be considered high risk for potential falls. A prevention protocol should be initiated immediately and documented on the care plan. Resident #1 had 1-2 falls in the past 3 months.</p> <p>Record review of the facility's incident/accident report from 11/2024 thru 01/2025 reflected Resident #1 had a fall on the following dates:</p> <ol style="list-style-type: none"> <li>1. 11/10/2024- result of a fall with abrasion</li> <li>2. 12/31/2024- result of a fall without injury</li> <li>3. 01/04/2025 - result of a fall with laceration</li> </ol> <p>In an interview on 01/23/2025 at 1:30 PM MDS Coordinator RN stated the most current completed care plan is the one with the completion date of 12/31/2024. (Surveyor and MDS Coordinator RN was reviewing the care plans in electronic medical record at the same time to verify the care plan completed on 12/31/2024 was the most current completed care plan). She stated there was a care plan opened but it had not been completed with all the information needed to be documented on the care plan. MDS Coordinator RN stated Resident #1's care plan needed to be revised on the completed care plan dated 12/31/2024 to reflect resident fall on 01/04/2025. She reviewed Resident #1 fall risk assessments with surveyor and she stated the same care plan with completion date of 12/31/2024 needed to be revised to reflect Resident # 1's low risk for falls problem needed to be revised to reflect Resident #1 was high risk for falls and revise the interventions as needed. The MDS Coordinator, RN stated she missed the fall risk assessments for December 2024 that reflected she was high risk for falls. She stated there was a care plan opened at this time but was not completed. She stated anytime a resident had a fall with injury their care plan was expected to be revised the day of the fall. The MDS Coordinator RN stated the importance of a care plan revision after a fall or any type of incidents the interventions needed to be reassessed and make any changes to prevent further falls or incidents. She stated she was responsible for completing comprehensive care plan, revising care plans. She stated she had been in serviced on care plans but did not recall the date or time of the in-service. She stated she was expected to revise Resident #1's care plan on 12/31/2024 when she completed Resident #1's comprehensive care plan and on 01/04/2025 when she fell . She stated Resident #1's fall on 12/25/2024, 12/31/2024, and 01/04/2025 would be considered a change with Resident #1 with having three falls less than two weeks.</p> <p>In an interview on 01/23/2025 at 2:45 PM the DON stated Resident #1 care plan should have been revised on 12/31/2024 and resolved of Resident #1 had a low risk for falls and changed the care plan to Resident #1 was high risk for falls. She stated there is care plan opened but it was not completed. She stated the MDS Coordinator RN was documenting on the care plan today (01/23/2025). She stated the MDS Coordinator RN was responsible for ensuring the care plans were correct. The DON did not respond to the question of a possibility of a negative outcome if the care plan was not revised after a fall or incident.</p> <p>Record review on 01/23/2025 the facilities Care Plan Revisions upon status change, dated 10/23/2022, reflected 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.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Policy Explanation and Compliance Guidelines:</p> <ol style="list-style-type: none"> <li>1. The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change.</li> <li>2. Procedure for reviewing and revising the care plan when a resident experiences a status change. The care plan will be updated with the new or modified interventions. Care plans will be modified as needed by the MDS Coordinator or other designated staff member.</li> </ol>