

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  12/18/2025
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 - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</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 - 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 ensure the resident had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for 1 of 3 residents (Resident #1) reviewed for resident rights. The facility failed to ensure Resident #1 had her call light within reach on 12/18/2025. This failure could put residents at risk of being unable to contact staff in the event of an emergency or when assistance was needed with daily care. Findings include: Review of Resident #1's face sheet dated 12/18/2025 reflected a [AGE] year-old female admitted on [DATE] with diagnoses of unspecified dementia (significant memory and thinking problems), unspecified macular degeneration (the area of the eye responsible for sharp vision breakdown which causes vision loss), weakness, and generalized anxiety disorder (mental health condition marked by excessive uncontrollable worry about everyday things). Review of Resident #1's quarterly MDS dated [DATE] reflected a BIMS score of 7 (severe impairment). Further review reflected Resident #1 required supervision or touching assistance (helper provides verbal cues and steadying) for chair/bed-to-chair transfers. Review of Resident #1's care plan with revision date of 07/31/2025 reflected Resident #1 had an ADL self-care performance deficit related to weakness. Interventions included to encourage Resident #1 to use the call bell for assistance. Review of care plan dated 07/31/2025 reflected Resident #1 was a high risk for falls with interventions to ensure the resident's call bell was within reach and encourage the resident to use it for assistance when needed. Interventions also included that the resident needed prompt response to all requests for assistance. During an interview and observation on 12/18/2025 at 10:49 AM it was revealed that CNA B exited Resident #1's room. Resident #1 laid in bed and with her call light on the floor between the wall and head of her bed. Resident #1 stated that she got herself in and out of bed. Resident #1 stated that staff told to ask for help, but she forgets. Resident #1 stated she could not reach her call light. Observation on 12/18/2025 at 11:57 AM revealed Resident #1's call light on the floor between her wall and headboard as she laid in bed. Observation on 12/18/2025 at 2:46 PM revealed Resident #1's call light on the floor between her wall and headboard as she laid in bed. Observation on 12/18/2025 at 3:31 PM revealed Resident #1's call light on the floor between her wall and headboard as she laid in bed. During an interview on 12/18/2025 at 1:00 PM, LVN A stated that Resident #1's fall interventions were to encourage her to use her call light if she needed anything and to ensure her call light was within reach. LVN A stated she usually worked overnight and that during the night Resident #1 did not use her call light. During an interview on 12/18/2025 at 1:23 PM CNA C stated that fall prevention interventions included to ensure a resident had their call light in place. During an interview on 12/18/2025 at 2:18 PM, LVN D stated that residents who were at risk of falling had interventions in place to ensure their call light is within reach. During an interview on 12/18/2025 at 2:41 PM, CNA B stated she usually worked from 6:00 am to 6:00 PM. CNA B stated that she usually worked on the hall with Resident #1. She stated that rounds were done at least every two hours. CNA B stated fall prevention included to ensure the resident had their call light within reach. During a subsequent interview on 12/18/2025 at 3:22 PM, CNA B stated that when she checked on Resident #1, she checked Resident #1's brief, fixed her bed, checked her clothes to ensure they were clean and CNA B stated she had been in Resident #1's room throughout her shift because Resident #1 had been asleep most of the day. CNA B stated she laid Resident #1 down around 45 minutes ago and that Resident #1 had not turned on her call light today (12/18/2025). CNA B stated it was important for residents to have their call light in case they fell or needed something they could not reach, if they were scared to get out of bed because they may fall, or if they needed to be changed or needed care provided. At 3:24 PM, CNA B observed Resident #1's call light on the floor between her wall and headboard and stated that it was not within reach of Resident #1. CNA B stated she had just been in Resident #1's room. During an interview on 12/18/2025 at 3:28 PM, LVN E stated fall interventions included to ensure the resident had their call light within reach and that this was important so that the resident could get hold of staff and have their needs taken care of. LVN E stated if the call light was on the floor behind the bed, that would not be considered in reach of the resident. During an interview on 12/18/2025 at 3:49 PM, the DON stated that fall prevention included to ensure residents had call lights within reach. The DON stated that staff were expected to round and check on residents at least every two hours. The DON stated that it was important for residents to have call lights within reach in case they needed assistance they would have been able to contact staff. The DON</p>		