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| 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 02/21/2026 |
| 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 0603</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> | <p>Protect each resident from separation (from other residents, his/her room, or confinement to his/her room).</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to protect the resident's right to be free from involuntary seclusion for 1 of 5 residents (Resident #1) reviewed for involuntary seclusion. The facility failed to ensure Resident #1 was not secluded when Resident #1 was placed in a vacant bathroom that was 60 degree Fahrenheit for approximately 5 hours. CNA A and LVN B knew Resident #1 was in the bathroom when the Surveyor found Resident #1 alone and cold. These failures resulted in an Immediate Jeopardy (IJ) situation on 02/21/2026. The IJ template was provided to the facility on [DATE] at 5:20 AM. While the IJ was removed on 02/21/2026, the facility remained out of compliance at a severity level of no actual harm at a scope of isolated due to staff needing more time to monitor the plan of removal for effectiveness. This failure could place residents at risk of injury and isolation, leading to a decreased quality of life, severe emotional distress and trauma leading to distrust of staff. Findings include: Review of Resident #1's face sheet, dated 02/21/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE] with the following diagnoses profound intellectual disabilities (the most severe classification of cognitive impairment, typically characterized by an IQ below 20-25- a standardized score derived from tests designed to measure human mental abilities, such as reasoning, logic, memory and problem solving - profound limitations in self-care and mobility), anxiety disorder (a chronic mental health condition marked by excessive, persistent, and uncomfortable worry about everyday things such as: health work, and family that's hard to control and interfere with daily life), major depressive disorder (a serious mental health condition characterized by persistent, intense feelings of sadness, worthlessness, and a loss of interest in activities), contracture of muscle in left and right hand (a chronic, often permanent stiffening and shortening of skin, tendons, muscles, forcing fingers into a bent, flexed, or claw-like position), stiffness of right and left hands (a reduced range of motion, tightness, or difficulty moving fingers and joints, often accompanied by pain and swelling), muscle wasting and atrophy, not elsewhere classified in right and left shoulder (involves the loss of muscle mass in the rotator cuff- a group of muscles surrounds a persons shoulders- often causing visible shoulder sagging, weakness, and limited mobility), and lack of coordination (a muscle control problem causing jerky, unsteady, or clumsy movements due to an inability to orchestrate voluntary muscle actions. Review of Resident #1's Annual MDS Assessment, dated 12/10/2025, reflected Resident #1 was unable to complete BIMS assessment. She was assessed to have poor short- and long-term memory recall. Resident #1's decision making ability was severely impaired. She did have behavioral symptoms daily not directed toward others (verbal/ vocal symptoms like screaming, disruptive sounds). This behavior significantly interfere with the resident's participation in activities or social interactions. Resident #1 significantly disrupt care or living environment. Resident #1 was assessed to enjoy doing things in groups of people , snacks between meals, and staying up past 8:00 pm. She had functional limitation in Range of Motion with</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
| FORM CMS-2567 (02/99) Previous Versions Obsolete | Event ID: 675799 | Facility ID: 675799 If continuation sheet Page 1 of 8 |

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| <p>F 0603</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> | <p>she did not recall the last time she saw Resident #1. She stated she stayed on 200 hall majority of her shift. CNA H stated she was not familiar with Resident #1 except she did make loud weird sounds and could be disruptive to other residents. She stated she did not know any other information on Resident #1. CNA H stated she had never witnessed Resident #1 propelling herself when she observed her in the common area across from the 100 and 200 nurses desk. She stated if she witnessed any resident being abused or neglected she would report it immediately to the administrator. She stated the administrator was the abuse coordinator. She stated she did not know who was assigned to Resident #1 on 02/20/2026 from 6am to 6pm. Interview on 02/21/2026 at 6:35 am CNA I stated she did work 100 and part of 200 hall on 02/20/2026 during the 6am to 6 pm shift. She stated she did not know who was assigned to Resident#1 on 2/20/2026 during the day shift. CNA I stated she did not recall the last time she saw Resident #1. She stated when it was near supper time it was a busy time of assisting residents to the dining room passing out trays in dining room. She stated the meal trays had not come on the hall prior to her clocking out around 6:00 pm. CNA I stated Resident #1 does prefer to sit in the common area most of the time. She stated she did not prefer to be laid down in bed. CNA I stated she preferred to sleep in her wheelchair, and she been informed by nurses and other CNAs (did not state the nurses and CNAs names when asked) of Resident #1 staying in her wheelchair at night in the common area and would not go to bed. She stated she had observed many mornings when she arrived to work at 6:00 am Resident #1 would be sitting in the common area across from the 100 and 200 hall nurses desk. She stated she was not aware of Resident #1 or any resident being isolated against their will in a vacant room or anywhere in the facility. CNA I stated she had been in-service on abuse, neglect and resident rights. She did not remember the date of the in-services. Record review on 02/21/2026 for the nursing schedule for 02/20/2026 for 6 am to 6pm and it did not indicate who was assigned to Resident #1. Attempted interview on 02/21/2026 at 7:05 am with LVN J and she refused to interview with surveyor. Attempted interview on 02/21/2026 at 7:30 am with CNA K (she worked day shift on 2/20/2026) via phone and she did not answer the phone. Surveyor left message and CNA K did not return phone call. Attempted interview on 02/21/2026 at 7:40 am with CNA L (she worked 6am to 6pm on 02/20/2206) via phone and she did not answer the phone. Surveyor left message and CNA L did not return phone call. Reviewed the Facility Policy on Abuse, Neglect and Exploitation, dated 07/15/2025, reflected Involuntary Seclusion refers to separation of a resident from other residents or from his/her room or confinement to his/her room against the resident's will or the will of the resident's legal representative. The Administrator was notified on 02/21/2026 at 5:20 am that an Immediate Jeopardy had been identified due to the above failures and an IJ template was provided. The following POR was accepted on 02/21/2026 at 12:16 pm. Letter of Credible Allegation For the Removal of Immediate Jeopardy Attention Sir or Madam On February 21, 2026, the Facility was notified by the surveyor that immediate jeopardy had been called and the Facility needed to submit a Plan of Removal. The Facility respectfully submits this Letter for a Plan of Removal pursuant to Federal and State regulatory requirements. The alleged immediate jeopardy allegations are as follows: F603- Free from Involuntary Seclusion The facility failed to ensure that the resident was from involuntary seclusion. The facility failed to ensure Resident #1 was not placed in a vacant bathroom. Actions for Resident Involved On 02/20/2026 and by 02/20/2026, Resident #1 was removed from room [ROOM NUMBER] by the Licensed Nurse (LVN B). Resident #1 was assisted to the shower room via wheelchair and soiled clothing changed. Blankets were placed around Resident #1. Resident #1 was assessed by the Licensed Nurse (LVN B) related to abuse and neglect, as well as psychosocial status with no concerns noted. On 02/21/2026, an allegation of potential seclusion was reported to HHSC as well as Law Enforcement for Resident #1 by the</p> <p>(continued on next page)</p> | | |

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| 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 02/21/2026 |
| 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) | | |
| F 0603 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some | <p>Facility Administrator. An investigation into the incident was immediately initiated by the Facility Administrator, which included interviews with facility staff on duty on 02/20/2026. On 02/21/2026, the Licensed Nurse (LVN B) and the two Certified Nursing Assistants (CNA A and CNA C) assigned to 100 hall on the 6 pm-6 am shift on 02/20/2026 were suspended pending investigation outcome by the Facility Administrator. Identify residents who could be affected: On 02/21/2026, the Administrator and/ or designee conducted facility rounds in all rooms to observe for the presence of abuse and/or neglect, to include potential seclusion with no concerns noted. Observations included ensuring residents were present in their assigned rooms and beds, as well as observing for residents unattended in bathrooms and/or resident areas; and/or visibly noted or reporting symptoms of distress. Findings were documented on a resident room roster and facility map. On 02/21/2026 and by 02/21/2026, the Administrator and /or designee interviewed interviewable residents related to abuse and neglect, to include involuntary seclusion with no concerns noted. Interviews consisted of abuse and neglect questions and documentation on a questionnaire for each resident. On 2/21/2026 and by 2/21/2026, the Director of Nursing and/ or designee assessed residents with a BIMS score below 13 head to toe related to abuse and neglect and psychosocial status, with no concerns noted. Findings were documented in the resident's progress note. On 2/21/2026 and by 2/21/2026, the Director of Nursing and/ or designee reviewed the resident progress notes for the last 30 days to ensure concerns related to abuse and neglect, to include potential seclusion were identified. No additional concerns were identified. Progress note review was completed and documented using printed progress notes for each current resident. On 2/21/2026 and 2/21/2026, the Administrator and/ or designee completed temperature checks in all resident rooms and resident use areas. All temperatures were found to be within the required temperature of 71 - 81 degrees Fahrenheit. The audit findings were documented on an audit tool and will continue daily Monday to Friday. Action Taken/ System Change: Effective 2/21/2026, any facility staff on FMLA, Leave of Absence, non-scheduled workday or PTO will be reeducated by the Administrator and/or designee and/ or Director of Nursing and/ or designee on all reeducation detailed below prior to the start of their next scheduled shift. On 2/21/2026, the Regional [NAME] President of Operations reeducated the Facility Administrator (Abuse Coordinator) and Director of Nursing on the facility's abuse and neglect policy and procedure to include involuntary seclusion. Reeducation included examples of actions that would meet the criteria for i[TRUNCATED]</p> | | |