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	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brenham Nursing and Rehabilitation Center	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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 6 residents (Residents #1) reviewed for care plans. The facility failed to have a comprehensive person-centered care plan for Resident #1 to address his discharge. This failure could place residents at risk of not receiving care and services to meet individualized, behavioral, medical and nursing needs. Findings included:Record review of Resident #1's face sheet, dated 05/27/2026, revealed an eighty-two-year-old female who was admitted to the facility on [DATE] with a diagnosis that included hemiplegia (severe or complete paralysis of one entire side of the body), nontraumatic intracerebral hemorrhage in hemisphere, cortical (bleeding within the cerebral cortex not caused by an injury), and dementia (a decline in cognitive abilities-such as memory, reasoning, and language-severe enough to interfere with daily life). Record review of Resident #1's MDS (clinical assessment to determine resident's strength and needs) dated 05/13/2026, Nursing Home Comprehensive Section C - Cognitive Patterns revealed a score of 6 indicating severe cognitive issues. Record review of Resident #1's care plan revealed a focus dated 04/28/2025, discharge planning has been discussed with family. Discharge to the community is not expected.Date Initiated: 06/30/2025 Record review of Resident #1's MDS Nursing Home discharge date d 04/24/2026 reflected Section A - Identification Information reflected Type of discharge - planned. Record review of Resident #1's progress notes dated 04/25/2026 reflected Resident #1 discharged from the facility. Vital signs were stable. During an interview on 05/24/2026 at 12:17 PM the Administrator said the facility should have care planned for Resident #1's discharge beginning 04/02/2026 because Resident #1 was wandering and exit seeking. The Administrator said he told Resident #1's family that the facility was not the best placement for him and gave the family suggestions for facilities that had locked units. During an interview on 05/25/2026 at 2:06 PM with the facility SW, she said she said she did not care plan for Resident #1's discharge. The SW said the care plan should have been changed when it was decided he was going to be discharged to another facility. The SW said a care plan as where they documented what need the resident needed including their goals and interventions. The SW said she was responsible for care planning Resident #1's discharge. She said a possible negative effect of not care planning for a resident's discharge was that the staff would not know what was going on and with the resident and there is a possibility that the discharge would not go smoothly and thing would get missed. During an interview on 05/25/2026 at 2:24 PM with the Administrator, he said the SW and the LT MDSC would be responsible for care planning a resident's discharge. The Administrator said a care plan was a snapshot of a resident's abilities and disabilities. The Administrator said it was important to care plan a discharge so everyone would understand the end goal. The Administrator said a possible negative effect of not care planning for a resident's discharge would be that something might be left off or there might be a misstep for the resident. Attempted interview on 05/25/2026 at (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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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2:27 PM of the LT MDSC. Left a VM and sent a text message. Record review of facility policy Care Plan Revisions Upon Status Change dated 10/23/2022 revealed 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. Policy Explanation and Compliance Guidelines: 1. The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change. 2. Procedure for reviewing and revising the care plan when a resident experiences a status change: a. Upon identification of a change in status, the nurse will notify the MDS Coordinator, the physician, and the resident representative, if applicable. b. The MDS Coordinator and the Interdisciplinary Team will discuss the resident conditions and collaborate on intervention options. c. The team meeting discussion will be documented in the nursing progress notes. d. The care plan will be updated with the new or modified interventions. e. Staff involved in the care of the residents will report resident responses to new or modified interventions. f. Care plans will be modified as needed by the MDS Coordinator or other designated staff member. g. The Unit Manager or other designated staff members will communicate care plan interventions to all staff involved in the resident's care. h. The Unit Manager or other designated staff member will conduct an audit on all residents experiencing a change in status, at the time the change in status is identified, to ensure care plans have been updated to reflect current resident needs. 3. The MDS Coordinator will determine whether a Significant Change in Status Assessment is warranted. If so, the assessment will be completed according to established procedures

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed the facility failed to ensure the resident environment remained as free of accidents and hazards as is possible for one resident (Resident #2) of six reviewed for mechanical lift transfers.The facility failed to ensure Resident #2 received adequate supervision and assistive devices to prevent accidents as CNA B failed to transfer Resident #2 with a mechanical lift (assistive device) with another staff to assist as required. This failure puts residents at risk for harm, injury and decreased quality of life.Findings included:Review of Resident #2 face sheet dated 05/19/2026 revealed Resident #2 was a [AGE] year old female admitted to the facility on [DATE] with a diagnoses of previous history of a stroke, dementia (decline in mental ability affecting memory, thinking and communication), heart failure (serious chronic condition where the heart cannot pump enough oxygen rich blood to meet the body's demands), high blood pressure and chronic kidney disease stage 3 (disease from moderately damaged kidneys functioning at 30%-59% of their normal capacity with a history of kidney cancer. Review of Resident #2 MDS assessment dated [DATE] revealed Resident #2 had a BIMS score of zero to indicate severely impaired cognition. The functional abilities section GG was blank regarding Resident #2's functional limitations and abilities. Review of Resident #2 Care Plan dated 01/26/2026 revealed Resident #2 required total assist with transfers with mechanical lift by two to move between surfaces and as necessary.During an interview on 05/22/26 at 11:26 AM Resident #2 Family Member stated she had video of Resident #2 being transferred with only one staff using the mechanical lift. She stated she did not feel it was safe for Resident #2 to be transferred with the mechanical lift with only one staff member. She stated she notified the DON and wrote a grievance about her concern. She stated she was not sure what was done with the complaint. Review of a video dated 4/22/26 at 8:28 PM revealed CNA B transferred Resident #2 via mechanical lift from Resident #2's wheelchair to her bed. There were no other staff in the room and no other staff assisted with the transfer. Resident #2 was transferred without injury.During an interview on 05/22/26 at 12:30 PM, the DON stated it was facility policy for residents to be transferred using two staff members if a resident was being transferred using the mechanical lift. She stated she had not seen the video in which Resident #2 was transferred via mechanical lift with the only staff member being CNA B. She stated using only one person for the transfer with a mechanical lift put residents at risk for injury or harm as a result of an unsafe transfer. She stated all staff were trained to use two people when using the mechanical lift to transfer residents. During an interview on 05/27/26 at 12:30 PM CNA C stated she used the mechanical lift to transfer residents with another staff member at all times. If no one was available she would wait until someone was available rather than transferring a resident by herself with the mechanical lift. She said transferring a resident with only one staff member with a mechanical lift could put the resident at risk for injury. During an interview on 05/27/26 at 12:45 PM CNA D stated she and another staff member would use the mechanical lift to transfer residents. She stated she would not use the mechanical lift to transfer a resident unless there was another staff member to assist with the transfer. She stated a resident could be injured if a transfer with a mechanical lift was done incorrectly. Review of Mechanical Lift Policy dated 08/11/22 revealed The portable lift requires 2 people assist, that have completed competency training on the lift.