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	02/19/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to properly store, prepare, and distribute food in accordance with professional standards for food service safety for 1 of 1 kitchen.The facility failed to properly store, label, and date all food items located in the facility's walk-in refrigerator, freezer and in the dry food pantry area on 02/17/2026, 02/18/2026 and 02/19/2026 . The facility failed to properly seal food product bags in the walk-in refrigerator to prevent exposure to air on 02/17/2026. The facility failed to properly seal food product containers in the dry food area on 02/18/2026.The facility failed to discard outdated food items located in the dry food pantry area on 02/18/2026 and 02/19/2026 . These failures could place residents who received meals from the kitchen at risk of foodborne illnesses.Observation during the initial tour of the kitchen on 02/17/2026 beginning at 9:00 AM revealed the following:Refrigerator:1 storage bag that appeared to be leftover ham, no name, no discard/use by date5 open 1-gallon containers of salad dressings, no open date, no discard/use by date1 large pack of [NAME] open to air, no opened date, no discard/use by dateFreezer:1 storage bag no name, appeared to be french fries, no name, no discard/use by date1 storage bag no name, appeared to be sweet potato fries, no name label, no discard/use by date Observation/Interview during the follow up tour of the kitchen on 02/18/2026 beginning at 11:13 AM, revealed the following:Refrigerator-1 sandwich with no name, labeled 2/16, discard date of 2/181 sandwich with no name, no dates.1 container of 3 unknown items in storage bags, no names. It showed a use by date of 2/13/26 on side and showed a Prep and use by date of 2/19/26. Interview conducted with DM, he was asked to identify the items in the container with the 3 unknown items. He first stated he did not know, then stated, Looks like old breakfast. DM asked the Regional Dietary Consultant and she stated she was not sure herself, and cConsultant went to ask [NAME] J. [NAME] J stated it was pureed eggs, pureed sausage, and pureed cream of wheat for the next day. [NAME] J stated she forgot to place the item name on the bags., sShe stated they are for tomorrow's breakfast which is the 19th.1 container of cooked scrambled eggs, no name, 2/19/26 incorrect Prep date1 container of cooked cream of wheat, no name, 2/19/26 incorrect Prep date1 container of parmesan cheese, with Prep date of 2/8, no use by dateDry food storage area:1 bag of opened walnuts, no use by date1 large box of snack crackers and bars, the best by date was 01/28/20261 Large container of opened flour with prep date of 02/01/26, no discard/use by date1 large container of open cornmeal, with prep date of 02/01/26, no discard/use by date1 large container of sugar open to air , with prep date of 02/01/26, no discard/use by dateObservation during the final tour of the kitchen on 02/19/2026 beginning at 3:05 PM, revealed the following:Dry food storage area:1 large box of snack crackers and bars, the best by date was 01/28/20261 Large container of opened flour with prep date of 02/01/26, no discard/use by date1 large container of open cornmeal, with prep date of 02/01/26, no discard/use by dateInterview conducted with the DM on 02/19/2026, at 3:10 PM. The DM stated he has worked at the facility for 4 to 5 months. He stated he became the DM as of Monday. According to the DM, all heated and cooked foods must be consumed or disposed of within a 3-day period. The DM further stated cooked foods must be labeled with the date of prep, the product name, (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	and the discard date which is calculated as 3 days from the cooking date. The DM stated processed foods must be labeled with the product name, the date received, and a discard date set 5 days after receipt. The DM stated his position is responsible for training on all dietary procedures. He further noted that the Cooks on duty are tasked with daily checks to identify and remove expired food items. When addressing the risks of serving expired food products, the DM stated the harm level depended on the specific food item. He stated food could grow salmonella or other harmful bacteria, that could result in residents being at risk of illness that can lead to hospitalization or death .Interview conducted with Regional Dietary Consultant on 02/19/2026, at 3:39 PM. Regional Dietary Consultant stated the DM is new to the role, having held the position for only a few days. The Regional Dietary Consultant stated that she arrived at the facility on the same day as the surveyors. The Consultant stated the specific protocols for managing leftovers and open products are that theleftover items must be labeled on the day they become leftovers and must be used within a 72-hour window. She stated all items must be labeled with the product name. The Dietary Consultant stated that prepackaged food products have a manufacturer's use by date. The consultant stated that staff should label the item with the date it was opened. The consultant stated a resident could potentially become seriously ill if they received expired food.Interview conducted with DON on 2/19/2026 at 4:21 PM. The DON stated she is familiar with the facility's protocols regarding labeling, dating, and the discarding of food items. She stated items should be labeled with the date open, the name of the product, and the discard date. The DON stated she expects all dietary staff to discard expired items. The DON stated the risks to residents depend on the type of food. She stated that different food can cause different interactions.Interview conducted with Administrator on 2/19/2026 at 4:38 PM. The Administrator stated he has been with the facility for 9 years. He stated he expects all his dietary staff to follow the food labeling policy. He stated the food in the kitchen should have the name, open date, and throw out date within 72 hours. The Administrator stated a resident could become ill if they ate expired food items. Record review of the facility's policy dated October 1, 2018, with revision date June 1,2019, named food storage, revealed [in part] Policy: To ensure that all food served by the facility is of good quality and safe for consumption, all food will be stored according to the state, federal and US Food Codes and HACCP guidelines.Procedure:1. Dry storage roomsd. To ensure freshness. store opened and bulk items in tightly covered containers. All containers must be labeled and dated.e. Provide scoops for items stored in bins, such as sugar, flour. rice and other items. Store scoops covered in a protected area near the food containers. Wash and sanitize scoops weekly or as needed.f. Where possible, leave items in the original cartons placed with the date visible.g. Use the first-in, first-out (FIFO) rotation method. Date packages and place new items behind existing supplies, so that the older items are used first.2. Refrigerators d. Date, label and tightly seal all refrigerated foods using clean. nonabsorbent, covered containers that are approved for food storage. e. Use all leftovers within 72 hours. Discard items that are over 72 hours old.3. Freezers d. Do not line shelves with foil or paper. Do not over stock the freezer and leave space between items to further improve air circulation. e. Store frozen foods in moisture-proof wrap or containers that are labeled and dated.A record review of the 2022 U.S. Food and Drug Administration Food Code reflected the following:Food items in the refrigerator(s) are covered/sealed, labeled, dated, and shelved to allow air circulation.Food items in the freezer(s) are covered/sealed, labeled, dated, and shelved to allow air circulation.Food is discarded on or before the expiration date.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to ensure that each resident had the right to self-determination and the right to make choices about aspects of life in the facility that were significant to the residents for 3 of 5 residents (Resident #39, Resident #40, and Resident #104) whose care was reviewed.The facility failed to honor Resident #39 and Resident #40's request to eat at an earlier time because they preferred to dine in their room.The facility failed to provide Resident #104 who prefers to dine in her room, with a method of choosing her meal selections from the available daily menu.The facility failed to provide 6 confidential residents menus for their rooms per their request.This failure could place residents at risk of diminished feelings of self-worth and/or diminished quality of life. Record review of Resident #39's MDS Assessment, dated 11/10/2025, reflected he was a [AGE] year-old male, admitted [DATE] with a BIMS score of 10, which indicated moderate cognitive impairment. The resident's diagnoses included hypertensive chronic kidney disease with stage 1-4 (kidney damage caused by long-term high blood pressure), cancer, gout (painful inflammatory arthritis), and muscle wasting and Atrophy of right and left shoulder (nerve damage).Record review of Resident #40's MDS Assessment, dated 12/20/2025, reflected she was a [AGE] year-old female, admitted [DATE] with a readmission of 9/17/2025 with a BIMS score of 12, which indicated moderate cognitive impairment. The resident's diagnoses included unspecified dementia (impaired thinking, severe memory loss), age related osteoporosis with current pathological fracture (fragile fracture related to bone loss) and hyperlipidemia (high levels of cholesterol in blood).Record review of Resident # 104's MDS Assessment, dated 02/03/2026, reflected she was a [AGE] year-old female, admitted [DATE] with a readmission of 06/25/2024 with a BIMS score of 14, which indicated cognitively intact. The resident's diagnoses included chronic obstructive pulmonary disease (incurable respiratory condition primarily caused by smoking), morbid (severe) obesity due to excess calories, diabetes mellitus (high blood sugar) and depression (mood disorder, loss of interest).Interview conducted with Resident # 104 on 02/17/2026, at 10:16 AM. Resident #104 stated she had concerns of the food not being good and not receiving a menu to select an alternative meal choice as she had previously. She stated she does not go all the way to the dining room to view the chalkboard for posted meal options. Resident #104 further stated that the facility staff will always provide an excuse when she inquiries about not receiving a menu.Interview conducted with Resident # 40 on 02/17/2026, at 11:07 AM. Resident #40 stated her and Resident #39's food is late because they are served after the dining hall.Interview conducted with Resident #39 and Resident #40's family member on 02/17/2026, at 11:08 AM. The family member stated she was informed by facility staff that the residents could receive their meals earlier if they would eat in the dining room. The family member further expressed concerns regarding the lack of information provided to Resident #39 who received a ground diet. Family member stated that Resident #39 is unable to identify the specific food items served on his tray. The family member stated the facility should list the item on the tray ticket or at least have staff explain the meal to the residents. The family member stated Resident #39 would like to know what he is eating.Interview conducted with Resident # 40 on 02/17/2026, at 1:28 PM. Resident #40 stated she was waiting for her lunch tray. She reported that she did not understand why she was served last, explaining that she prefers to eat in her room. She stated that as the DON walked by, the DON said, I was looking for you [Resident #40] in the dining room. Resident #40 replied, What? I do not know why she said that. I do not ever eat in the dining room. Resident #40 further stated that she has been told she should consider eating in the dining room if she wants to receive her meal earlier; however, she reported that she does not feel it is best for her and Resident #39, as they prefer privacy. She stated, [Resident #39] is [AGE] years old, and it is not convenient for us to go to the dining room. When asked by the surveyor whether she had spoken with the (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administrator regarding the concern, Resident #40 stated that he would likely tell her again to eat in the dining room if she wanted her food earlier.During a confidential group interview on an undisclosed date at an undisclosed time, 6 of 7 residents voiced that they have requested individual menus for their rooms, but the facility has failed to provide them. The group stated the menu in the dining room is frequently inaccurate. The group further stated that they would like the menus so they can choose what each of them wanted to eat.Interview conducted with Administrator on 2/18/2026, at 12:42 PM. The Administrator was asked how residents who do not attend the dining room are made aware of the available menu options. The Administrator stated that staff verbally inform residents in the morning of the meal for the day. He reported that if a resident wants something different, they may notify the aides. The Administrator further stated that the menu is posted in each hallway near the nurses' stations. The Administrator was advised that the menus had not been posted on either day the surveyors were present. The Administrator then stated that the facility encourages all residents to come to the dining room to eat. He acknowledged that residents have the right to eat in their rooms and know what they are eating. The Administrator stated that he would speak with the DM to ensure copies of the menus are provided to residents.Interview conducted with CNA D on 2/19/2026, at 2:56 PM. CNA D stated she has been employed at the facility since April of last year. CNA D stated she does not know the scheduled mealtimes for the units. CNA D reported that Resident #40 has complained about meals not arriving in a timely manner. She stated she encourages Resident #40 to attend the dining room for meals; however, the resident prefers to remain in her room to eat. CNA D further stated that Resident #104 has also complained about late mealtimes, but she prefers to stay in her room as well. CNA D stated menus are not provided in the residents' rooms. She stated that she has not been told to provide the menu information to the residents in the mornings. CNA D stated sometimes a resident may ask and she would tell them the information. Record review of the facility policy Resident Rights, received 02/19/2026, undated, revealed the following [in part]: Statement of Resident RightsYou, the resident, do not give up any rights when you enter a nursing facility. The facility must encourage and assist you to fully exercise your rights. Any violation of these rights is against the law. It is against the law for any nursing facility employee to threaten, coerce, intimidate or retaliate against you for exercising your rights. If anyone hurts you, threatens to hurt you, neglects your care, takes your property, or violates your dignity, you have the right to file a complaint with the facility administrator or with the Texas Department of Human Services by calling 1-800-458- 9858.You have a right to:(1) all care necessary for you to have the highest possible level of health;(2) safe, decent and clean conditions;(3) be free from abuse and exploitation;(4) be treated with courtesy, consideration, and respect;(5) be free from discrimination based on age, race, religion, sex, nationality, or disability and to practice your own religious beliefs;(6) privacy, including privacy during visits and telephone calls.(7) complain about the facility and to organize or participate in any program that presents residents' concerns to the administrator of the facility;Sec 102.003 Rights of Elderly IndividualsAn elderly individual has all the rights, benefits, responsibilities, and privileges granted by the constitution and laws of this state and the United States, except where lawfully restricted. The elderly individual has the right to be free of interference, coercion, discrimination, and reprisal in exercising these civil rights.An elderly individual has the right to be treated with dignity and respect for the personal integrity of the individual without regard to race, religion, national origin, sex, age, disability, marital status, or source of payment. This means that the elderly individual:has the right to make the individual's own choices regarding the individual's personal affairs, care, benefits, and services; (2) has the right to be free from abuse, neglect, and exploitation; and (3) if protective measures are required, has the right to designate a guardian or representative to ensure the right to quality stewardship of the individual's affairs.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interviews, and record review the facility failed to provide a private space for residents' confidential resident group meeting during the survey for seven of seven residents reviewed for resident council. The facility did not provide a private space for resident council meeting. This failure could place residents, who attended confidential resident group meeting, at risk of not being able to exercise their rights of being able to voice their grievances in private without uninvited staff being present.Findings included:During an observation on 02/18/2026 at 10:15 am the Regional Dietary Consultant opened the door from the kitchen and leading into the dining room during the residents' confidential group meeting with the surveyor. She walked 2 or 3 steps into the dining room while the residents were voicing concerns about dietary. The residents would not voice any of their concerns after the Regional Dietary Consultant entered the dining room. During an interview on 02/18/2026 at 10:20 a.m., all the residents in the residents' confidential resident group meeting stated they did not feel comfortable voicing their concerns any further during the meeting. They stated there was a possibility the lady from dietary may come back in the meeting area and may hear what they had to say about dietary. They all stated they were expected to have privacy during all their resident council meetings and today they did not have privacy and had concerns if the lady (Regional Dietary Consultant) heard what they were saying about the kitchen. The residents in the group stated their meetings was never interrupted during their monthly Resident Council meetings. The group stated this was against their resident rights and that lady (Regional Dietary Consultant) needed to respect the residents and their rights to voice their opinions in privateDuring an interview on 02/18/2026 at 10:30 a.m., the Regional Dietary Consultant stated she did not enter the dining room. She stated what was expected of me now do you (speaking to surveyor) want me to be in-service on this what is it you are wanting from me. She stated she was in-serviced on resident rights. She stated she took maybe two steps into the dining room when the residents were meeting but that was not interrupting the meeting. The Regional Dietary Consultant stated if the residents were unhappy with her opening the door and stepping into the dining room for a few seconds, it was their right to meet privately. The Regional Dietary Consultant would not respond to any further questions of how interrupting the Resident Group was violation of their resident rights for privacy.During an interview on 02/18/2026 at 10:45 a.m., the Regional Dietary Consultant requested to continue interview with the Administrator. The Administrator was present, and she continued to ask what did surveyor want to do give her in-services on resident rights. What was expected for her to do now. And she stated she was in serviced on resident rights but did not recall the date. She stated, Am I going to get the facility a citation? The Regional Dietary Consultant would interrupt when questions were asked about her entering the dining room. She stated she opened door and took a step and returned to the kitchen. During an interview on 02/19/2026 at 10:20 a.m., the Activity Director stated she placed signs on both dining room doors. She stated she wrote on the signs do not disturb resident group in progress. She stated she went into the kitchen and reported to all dietary staff not to enter the dining room until after the resident group with surveyor was finished. She stated the Regional Dietary Consultant was in the kitchen when she reported not to enter the dining room until after the resident group meeting. The Activity Director stated the resident had rights to meet in privacy and anytime they had a resident council meeting the residents did meet in private. She stated no one was to enter the room when resident council was in progress. The Activity Director stated the only time other staff could be int the resident council meeting was if the staff was invited by the residents. She stated the residents may not feel comfortable voicing their opinions or concerns if they thought the meeting would not be private.During an interview on 02/19/2026 at 8:51 a.m., the Administrator stated the resident council group should be able to meet in a private area, and staff could not attend unless invited. He stated if the resident council did not have a private area to meet there was a potential staff who could overhear what the residents were saying, and the residents may feel uncomfortable (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to voice their opinions. He stated it was against resident rights not to have a private area to meet during a survey and during their monthly resident council meeting. He stated the Regional Dietary Consultant did not follow resident rights by entering the dining room even if it was only for a few seconds.Record review of the policy titled, Facilities Resident Rights, not dated, reflected, An elderly individual is entitled to privacy while attending to personal needs and a private place or receiving visitors or associating with other individuals unless providing privacy would infringe on the rights of other individuals. This right applies to medical treatment, written communications, telephone conversations, meeting with family, and access to resident council.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility failed to ensure storage of drugs and biologicals used in the facility for 2 of 8 medication carts and 1 of 2 medications rooms observed for medication storage and labeling. The facility failed to ensure expired medications were removed from the medication carts and rooms. The facility failed to ensure loose medications were removed from the medication carts. This failure could place residents who received medications at risk of not receiving the intended therapeutic effect of the medication. This failure could place residents who received medications at risk of receiving the wrong dose of medication.Findings included: During an observation on 02/18/2026 at 11:43 a.m., the 100 hall medication cart revealed two bottles of Losartan 50 mg with the expiration date of 01/03/2026 and one white, round medication tablet which was loose in the cart. During an observation on 02/18/2026 at 12:29 p.m., the 100/200 hall medication room revealed one bottle of B-50 Vitamin Supplement with the expiration date of 11/2025 and one loose pink, round medication tablet. During an interview on 02/18/2026 at 11:51 a.m., the Medication Aide stated they were supposed to check the medication's expiration date prior to placing them in the medication cart. During an interview on 02/19/2026 at 5 p.m., the DON stated the expectation was for staff to check the expiration dates for medications prior to storing them in the medication carts and medication rooms. She stated, loose pills happen especially with blister packs.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to make sure that its menus documented any substitutions made to the menus on 4 of 4 halls reviewed for food and nutrition services.The facility failed to place the correct weekly menu in the dining hall on 2/18/2026 for lunch and dinner meals. This failure could place residents who eat food from the kitchen at risk of not knowing what was on the menu so they could request an alternate meal timely. Observation on 02/17/26 at 1:07 PM revealed the menu board for halls 300/400 did not display the breakfast, lunch, or dinner menu.Observation on 02/17/26 at 1:15 PM revealed the menu board for halls 100/200 did not display the breakfast, lunch, or dinner menu.Observation on 02/18/26 at 8:00 AM revealed the menu board for halls 100/200 did not display the breakfast, lunch, or dinner menu.Observation on 02/18/26 at 11:11 AM revealed incorrect facility's weekly menu on the wall in the dining room, as it displayed week 5.Observation/Interview on 2/18/2026 at 11:25 AM. Surveyor observed chicken being prepared for lunch instead of pork and veggie stir fry listed on menu on dining room wall. Regional Dietary Consultant stated she made meal substitutions for this week. She brought out a meal substitution approval form, no approval signatures noted on form. Consultant stated the menu was changed to what the residents preferred to eat.Observation on 2/18/26 at 6:30 PM, surveyor noted residents were served Beef Stroganoff over pasta , the posted menu in the dining room displayed turkey loaf with buttered corn.Observation on 02/19/26 at 8:18 AM, revealed the menu board for halls 300/400 did not display the breakfast, lunch, or dinner menu.Observation on 02/19/26 at 12:51 PM, revealed the menu board for halls 100/200 did not display the breakfast, lunch, or dinner menu.Record review of Resident # 104's MDS Assessment, dated 02/03/2026, reflected she was a [AGE] year-old female, admitted [DATE] with a readmission of 06/25/2024with a BIMS score of 14, which indicated cognitively intact. The residents' diagnoses included chronic obstructive pulmonary disease (incurable respiratory condition primarily caused by smoking), morbid (severe)obesity due to excess calories, diabetes mellitus (high blood sugar) and depression (mood disorder, loss of interest).Interview conducted with Resident # 104 on 02/17/2026, at 10:16 AM. Resident #104 stated she had concerns of the food not being good and not receiving a menu to select an alternative meal choice as she had previously. She stated she does not go all the way to the dining room to view the chalkboard for posted meal options. During a confidential group interview on an undisclosed date at an undisclosed time, 6 of 7 residents voiced that they have requested individual menus for their rooms, but the facility has failed to provide them. The group stated the menu in the dining room is frequently inaccurate. The group further stated that they would like the menus so they can choose what each of them wanted to eat.Interview conducted on 2/18/2026 at 1:18 PM, Resident #82 stated lunch has not come yet and she does not know what they are having, she stated they never get a copy of the menu. Resident #82 stated she was told the dining room has two menus. She stated the facility doesn't seem to care anything about them; and that they have changed.Interview conducted with Administrator on 2/18/2026, at 12:42 PM. The Administrator was asked how residents who do not attend the dining room are made aware of the available menu options. The Administrator stated that staff inform residents in the morning of the meal for the day. He reported that if a resident wants something different, they may notify the aides. The Administrator further stated that the menu is posted in each hallway near the nurses' stations. The Administrator was advised that the menus had not been posted on either day the surveyors were present. The Administrator then stated that the facility encourages all residents to come to the dining room to eat. He acknowledged that residents have the right to eat in their rooms and know what they are eating. The administrator stated that he would speak with the DM to ensure copies of the menus are provided to residents.Interview conducted with the DM on 02/19/2026, at 3:10 PM. The DM stated he has worked at the facility for 4 (continued on next page)

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	675799	A. Building B. Wing	02/19/2026

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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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to 5 months. He stated he became the DM as of Monday. The DM stated that he the DM or Dietary Supervisor, is responsible for posting the breakfast, lunch, and dinner menus in the dining hall and on the units. He reported that if he is not present, he directs the cook to post the menus. He stated that menus are expected to be posted first thing in the morning. The DM stated he does not know why the menus had not been posted on the units. He reported that the previous Dietary Manager walked out recently. The DM acknowledged that he did not post the menus that morning because he was behind and stated he had been working double shifts. He further stated that he understands this is not an excuse for the menus not being posted.The DM stated that residents need to know what they are going to eat so they can determine whether they want to request an alternative meal.Interview conducted with Regional Dietary Consultant on 02/19/2026, at 3:39 PM. Regional Dietary Consultant stated the DM is new to the role, having held the position for only a few days. The Regional Dietary Consultant stated that she arrived at the facility on the same day as the surveyors. The Regional Dietary Consultant stated that the Dietary Manager is responsible for posting the breakfast, lunch, and dinner menus in the dining hall and on the units. She reported she does not know why the menus were not posted on the units. The consultant stated the facility has some issues to work through, as the previous Dietary Manager left and they are in the process of training new staff. She stated they can only continue to educate staff and do the best they can for the residents. She acknowledged that residents have the right to know what is being served.When asked about menus not matching the meals being served, the consultant stated that the meal served that day did match the menu. She reported that she corrected the menu posted on the wall after identifying an error that morning. The Regional Dietary Consultant stated the Nutrition Consultant can sign off on substitutions upon next visit to facility.On 2/19/2026 at 10:54 AM, a policy was requested from the administrator on Notification of menu changes and Residents access to the availability of menus. The administrator responded, We do not have a policy on that. We have posted menus as well as the alternate menu, and we accommodate as needed and when we are notified of preferences of the residents. Review of facility policy dated October 1, 2018, named Alternate Food Choices and Substitutions and Honoring Preferences revealed: Policy: The facility believes that adequate nutrition is essential to each resident's well being and good health. An alternate entree and vegetable will be offered at each meal. The facility also supports resident choice and allowing residents to choose foods by honoring their food preferences. Other substitutions will also be available in the event a resident does not choose the main meal or the alternate. Procedure: 1.^^Residents will be informed on admission that there is an alternate for each meal and will also be informed of substitutions which are available on a daily basis.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide each resident at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care for 7 (Resident #11, Resident #30, Resident #39, Resident #40, Resident #79, Resident #82, and Resident # 104) of 7 residents reviewed for timely meals on hall 200. The facility failed to provide lunch according to the lunch meal service schedule on 02/17/26 to Residents #39, #40, and #82.The facility failed to provide breakfast according to the breakfast meal service schedule on 02/18/26 to Residents #30 #39, #40, #79 and #82.The facility failed to provide lunch according to the lunch meal service schedule on 02/18/26 to Residents #30 #39, # 40, #79, #82 and #104.The facility failed to provide dinner according to the dinner meal service schedule on 02/18/26 to Residents #11 #30, #39, # 40, #79, #82, and #104.The facility failed to provide breakfast according to the breakfast meal service schedule on 02/19/26 to Residents #11, #30, # 39, #40, #79, #82, and #104. This deficient practice could place residents at risk of increased hunger, low blood sugar levels, increased stress levels, slowed metabolism rates, and malnutrition. Review of an undated document provided by the Administrator, titled [Facility] Resident Dining Hours and Locations, revealed: Breakfast- 7:00 AM: Dining room [ROOM NUMBER]:20 AM: 100 Hall 7:30 AM: 400 Hall 7:40 AM: 300 Hall 7:50AM: 200 HallLunch-11:50 AM: Dining room [ROOM NUMBER]:20 PM: 100 Hall 12:30 PM: 400 Hall 12:40 PM: 300 Hall 12:50 PM: 200 HallDinner-5:00 PM: dining room [ROOM NUMBER]:20 PM: 100 Hall 5:30 PM: 400 Hall 5:40 PM: 300 Hall 6:00 PM: 200 HallObservation/Interview on 2/17/2026 at 1:25 PM in resident's room on 200 hall, Resident # 82 stated lunch had not been served yet and she was still waiting.Observation/Interview on 2/17/2026 at 1:28 PM in residents' room on 200 hall, Resident #39 and #40 had not received their lunch meal. Resident #40 stated she was waiting for her lunch tray. She reported that she did not understand why she was served last, explaining that she prefers to eat in her room. She stated that as the DON walked by, the DON said, I was looking for you [Resident #40] in the dining room. Resident #40 replied, What? I do not know why she said that. I do not ever eat in the dining room. Resident #40 further stated that she has been told she should consider eating in the dining room if she wants to receive her meal earlier; however, she reported that she does not feel it is best for her and Resident #39, as they prefer privacy. She stated, [Resident #39] is [AGE] years old, and it is not convenient for us to go to the dining room. When asked by the surveyor whether she had spoken with the Administrator regarding the concern, Resident #40 stated that he would likely tell her again to eat in the dining room if she wanted her food earlier. Observation/Interview on 2/18/2026 at 8:01 AM, Resident #39 and Resident #40 were in their room. Resident #40 was shaving Resident #39, and she stated breakfast had not arrived.Observation/Interview on 2/18/2026 at 8:04 AM, Resident #30 and Resident #79 were in their room. Resident #30 stated breakfast has not arrived.Observation/Interview on 2/18/2026 at 8:05 AM, Resident #11 and Resident #82 were in their room. Resident # 82 stated her breakfast has not come. She stated her roommate Resident #11 received her breakfast early today because she has dialysis. Resident #82 stated, the breakfast does not come this early.Observation/Interview on 2/18/2026 at 1:18 PM, Resident #82 stated lunch has not come yet. She stated the facility doesn't seem to care anything about them; and that they have changed.Observation/Interview on 2/18/2026 at 1:20 PM, Resident #79 and Resident #30 were in their room, and lunch had not been served. Resident #30 stated, no food yet, this is ridiculous. Advised her food cart just entered floor 200.Observation on 2/18/2026 at 1:21 PM, food cart entered hallway 200.Observation on 2/18/2026 at 1:22 PM, food was served to Resident #104 .Observation on 2/18/2026 at 1:24 PM, food was taken to Resident #39 and Resident #40's room. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation/Interview on 2/18/2026 at 1:25 PM with Resident #82 who stated she now had her food. Observation on 2/18/2026 at 6:23 PM, food was served to Resident #104.Observation/Interview on 2/18/2026 at 6:24 PM, Resident #11 and Resident #82 were in their room. DON came into room and said Resident #11's call light was on. Resident #82 stated the food is not here, and she was advised it was on the hallway. Resident #82 stated, they must have saw you come in because it's never this early in the evening.Observation/Interview on 2/18/2026 at 6:25 PM, Resident #39 and Resident #40 were in their room, and stated they are waiting to eat. Food was delivered to the room at 6:28 PM.Observation/Interview on 2/18/2026 at 6:29 PM, Resident #30 and Resident #79 were in their room. Food was delivered at 6:31 PM by DON. Resident #30 stated, the food is coming out sooner, soon State leave it will go back to later times. On 2/18/2026 at 6:36 PM, an interview was attempted with the evening cook. The DM was present; he stated the evening cook left the facility a few days prior. He stated the swing cook is on vacation and will return tomorrow. DM stated he was working a double shift.Observation/Interview on 2/19/2026 at 8:21 AM, Resident #11 and Resident #82 were in their room. The residents stated they have not received breakfast. Resident #82 stated, breakfast is not here and it's almost 8:30 AM. Trays were served to the room at 8:43 AM. Resident #82 stated, the tall nurse never pass out trays.Observation on 2/19/2026 at 8:45 AM, breakfast was delivered to Resident #39 and Resident #40 in their room.Observation on 2/19/2026 at 8:48 AM, breakfast was delivered to Resident #30 and Resident #79 in their room.Observation /Interview on 2/19/2026 at 8:49 AM, Resident #104 had her breakfast. She stated it was just delivered after 8:30 AM. Resident #104 stated that a long time ago she received copies of the menu. She stated that meals are frequently served late and that this occurs often. She reported that weekends are worse. She stated that breakfast may be served around 10:00 a.m., lunch around 2:00 p.m., and supper around 7:00 or 8:00 p.m. She reported that she brings in snacks from outside the facility. When asked whether she has filed a grievance regarding the meal concerns, she stated that it is no use.During a confidential group interview on an undisclosed date at an undisclosed time, 6 of 7 residents voiced that breakfast meals are not delivered to the 100 and 200 hallways until 8:20 AM and 8:45 AM. Group members said that the food would sit in the hallways a long time before the staff pass out the meals. The group stated that the supper/dinner meal is served between 7:30-8:00 PM. The group all agreed something needed to be done about the meals.Interview conducted with the DM on 02/19/2026, at 3:10 PM. The DM stated he has worked at the facility for 4 to 5 months. He stated he became the DM as of Monday. The DM stated that any meal delays are communicated to the floor by the dietary aides. When asked whether residents are offered snacks when meals are delayed, the DM stated that, on the dietary department's side, meals have only been delayed by approximately five minutes. He stated that meal carts are delivered to the units after service in the dining room. The DM stated he is unsure whether the facility has a policy regarding timely meal service, as he has not seen one. He reported that meals are scheduled to leave the kitchen for the units immediately after the dining room is served, which he stated averages about 20 minutes. He stated that breakfast typically takes less time because fewer residents eat in the dining room. The surveyor presented the DM with the posted mealtimes for Hall 200: breakfast at 7:50 a.m., lunch at 12:50 p.m., and dinner at 6:00 p.m. The DM stated meals should never arrive late but the kitchen is currently short staffed . He reported that one cook recently left and the swing cook was on vacation. The DM stated he had never seen the specified unit mealtimes and reported he has not been trained on the designated mealtimes for the units. The DM stated the potential harm to residents is that they could lose weight if they do not accept the meal being late. The DM stated the former DM would send out the plates without being in a warmer and he has been correcting the process.Interview conducted with Regional Dietary Consultant on 02/19/2026, at 3:39 PM. Regional Dietary Consultant stated she believed the facility mealtimes are 7:00 a.m., 12:00 p.m., and 5:00 p.m. She stated that the halls are served shortly after completion of the main dining room service, which she estimated to be approximately 35 to 45 minutes after the dining room meals are served. She reported she is not aware of any specific scheduled mealtimes designated for the units. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The consultant stated she feels the facility has been serving meals on time and reported she has been impressed with the meal service times. She stated that, in her opinion, serving dinner at 7:00 p.m. would be late, whereas 6:30 p.m. would be acceptable. She further stated the facility serves approximately 120 residents and emphasized that this is a large number of individuals to serve. When asked about the potential effect delayed meals could have on residents, she stated residents would likely be upset; however, she reported she has not personally observed any late meal service. Interview conducted with DON on 2/19/2026 at 4:21 PM. The DON stated dining room mealtimes are 7:00 a.m., 12:00 p.m., and 5:00 p.m. She stated that the units are served approximately 45 minutes after the dining room service is completed. The DON reported that a list of unit's mealtimes is posted indicating when residents should receive their meals. She stated that for a 7:00 a.m. dining room meal, the units should receive breakfast at approximately 8:00 a.m. The DON stated that when she conducts rounds, residents are vocal and inform her if meals are late. She reported that if meals are running behind schedule, she would provide education and conduct in-services with staff. The DON was advised of the reported times meals have been arriving at the units. She was also informed that the evening meal was late on the previous night while she was present. The DON acknowledged that the meal was late and stated she would ensure the Administrator is made aware.Interview conducted with Administrator on 2/19/2026 at 4:38 PM. The Administrator stated the mealtimes are 7AM for breakfast, noon for lunch, and 5PM for dinner. The Administrator stated the facility does not have a specific scheduled time for meals to be served to the units. He was reminded he provided a mealtime schedule to surveyor. He reported that the goal is to serve the entire facility within an hour and a half. He stated there were some prior complaints regarding late meal service under the previous Dietary Manager; however, he feels the concern has been rectified but described the process as a work in progress. When asked about the potential harm to residents related to delayed meal service, the Administrator stated residents could possibly feel anxious. He further stated he has not heard any recent complaints from residents regarding late mealtimes.Record review of facility grievances revealed on 12/26/2025, one resident on hall 200 complained of late trays on her hall. On 12/28/25, multiple residents complained of late breakfast, and on 1/14/2026, all residents complained of breakfast being served late on 1/14/2026. Record Review of the facility's policy named Meal Times, dated October 1, 2018, revealed: Policy: The facility provides three meals daily at regular times which are comparable to meal times in the community setting. Meals are served at the specified times except in emergency situations.Procedure:1. Meals will be served according to the state and federal regulations, with no more than fourteen hours between the evening meal and breakfast the following day.2. There will be at least a four hour interval between breakfast and lunch and between lunch and dinner.3. The Dietary Department will develop an order of service for all meals which best suits the needs of the residents. The scheduled order will be followed.4. A schedule of the meal times will be posted in all resident areas.5. Meal times may be altered according to resident preference, such as brunch or late continental breakfast, early or late lunch or other changes in order to accommodate cultural differences and preferences among the residents. Standard meals must be offered as required by the regulations above, but altered meal times should be offered as requested by the resident(s). A plan of care must be developed to document the resident's altered meal times.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the residents received services in the facility with reasonable accommodation of each resident's needs and preferences for 1 resident (Resident #114) of 8 residents reviewed for call lights. The facility failed to ensure Resident #114's soft pad call light device was within reach. This failure could place residents at risk for their needs not being met. Findings included: Record review of Resident #114's face sheet, dated 02/19/2026, revealed Resident #114 was an [AGE] year-old male, admitted [DATE], readmitted [DATE], diagnoses included hemiplegia (paralysis on one side of the body caused by brain or spinal cord injury, often resulting from stroke) and hemiparesis (a common, often stroke-related condition characterized by partial weakness or reduced motor control on one side of the body) following cerebral infarction (the death of brain tissue resulting from a prolonged lack of blood supply) affecting left non-dominant side, aphasia (language disorder caused by brain damage that impairs the ability to speak, understand, read, or write, while leaving intelligence intact), dysphagia (difficulty swallowing) dysarthria (motor-speech disorder caused by nerve or brain damage that weakens, paralyzed, or impaired coordination of the muscles used for speech), repeated falls, contracture of muscle, multiple sites, unsteadiness on feet, and gastrostomy status (presence of a surgically created opening in the stomach, usually with a feeding tube inserted for long-term nutritional support). Record review of Resident #114's Quarterly MDS Assessment, dated 01/26/2026, revealed a BIMS score of 5 which indicated severe cognitive impairment. Resident #114 was assessed as dependent on staff for the following ADLs: eating, oral hygiene, toileting hygiene, showers, dressing, and personal hygiene. Resident #114 was assessed as dependent on staff for mobility including the following: chair/bed to chair transfers, shower transfers, ability to wheel at least 50 feet and make two turns using his manual wheelchair, and the ability to wheel at least 150 feet in a corridor or similar space. Resident #114 was assessed to require substantial/maximal assistance to move from sitting on the side of the bed to lying flat on the bed. Resident #114 was assessed to require partial/moderate assistance to roll from lying on his back to left and right side, and to return to lying on his back on the bed. Resident #114 was assessed as dependent on staff for the management of his feeding tube. Resident #114 was at risk of developing pressure ulcers, so he required frequent turning and repositioning. Record review of Resident #114's comprehensive care plan, dated 01/26/2026, revealed Resident #114 had an ADL self-care performance deficit related to fatigue, hemiplegia, contractures, impaired balance, limited mobility and abnormal posture with the following interventions: The resident was totally dependent x 2 staff for bathing/showering; the resident required extensive assist x 2 staff to turn and reposition in bed; the resident used a Halo ring x 1 to maximize independence with turning and repositioning in bed; the resident required extensive assist x 1 staff to dress; the resident required extensive assist x 1 staff to eat; the resident required total assistance by nurse for g-tube feedings; the resident required extensive assist x 2 staff with personal hygiene and oral care; the resident required extensive assist x 2 staff for incontinent care; and the resident required mechanical lift to transfer x 2 staff for assistance. Record review of Resident #114's comprehensive care plan, dated 05/31/2024, revealed Resident #114 had a communication problem related to aphasia and dysarthria with the following interventions: Ensure/provide a safe environment: Call light in reach. Resident #114 required peg tube feedings continuous related to dysphagia with the following intervention: Nurse to administer all tube feedings and water flushes. Record review of Resident #114's comprehensive care plan, dated 10/03/2023, revealed Resident #114 was a high risk for falls related to disoriented x 1, regularly incontinent, medication use and predisposing diseases; resident also has impaired Gait/balance and impulsivity with the following interventions: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. During an observation on 02/17/2026 at 11:08 a.m., Resident #114 was lying (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in bed, and his soft pad call light device was lying face-down in the bottom of a drawer located to the left of his bed. During an interview on 02/19/2026 at 9:30 a.m., LVN C stated when a resident was in their room the call light was expected to be within reach. She stated if the resident needed nursing assistance it would be difficult for the resident to obtain that assistance. She stated a resident may attempt to move themself out of a wheelchair or bed, and the resident could fall resulting in an injury. She stated she attended an in-service on call lights, but she could not recall the date or time.During an interview on 02/19/2026 at 9:41 a.m. CNA E stated call lights were to be within the residents reach when residents were in their room. She stated some residents could not move themselves to the door to yell for help. She stated if a resident needed immediate assistance from staff, it would be difficult for them to receive help if they did not have their call light within reach. She stated the resident may attempt to locate the call light. She stated if the call light was on the floor, the resident could fall out of the wheelchair or bed. She stated it was possible the resident could sustain an injury such as a broken hip or head injury. During an interview on 02/19/2026 at 10:25 a.m., the ADON stated all call lights were to be within reach when a resident was in their room. She stated it was possible a resident may fall attempting to move themself from the bed or wheelchair to go to the bathroom. She stated a resident may have difficulty yelling for assistance. She stated the resident would not receive timely nursing care if the call light was out of their reach. She stated staff attended an in-service on placing call lights within reach of the residents, but she could not recall the date or time of the in-service.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Pre-admission Screening and Resident Review(PASARR) Level I assessment accurately reflected the resident's status for 2 of 5 residents (Resident #4 and Resident #129). The facility failed to ensure the accuracy of the PASARR Level 1 (PL1) screening for Resident # 4. The PASARR Level 1 screening did not indicate a diagnosis of mental illness, although the diagnosis (major depressive disorder, single episode, unspecified (experience major depressive episode with no history of previous depressive episodes - sadness, loss of interest in daily activities) was present upon Resident #4's admission date on 01/19/2026.The facility failed to ensure the accuracy of the PASARR Level 1 screening for Resident #129. The PASARR Level 1 screening did not indicate a diagnosis of mental illness, although the diagnosis major depressive disorder, recurrent, unspecified (person has experienced multiple, separate episodes of major depression, but there is insufficient information for a clinician to specify the severity. Symptoms: sadness and loss of interest in daily activities) was present upon Resident #129's admission date 02/11/2026.This failure could place residents at risk of not receiving a needed assessment (PASARR Evaluation), individualized care, or specialized services to meet their needs.Findings included:1. Record review of Resident #4's face sheet, dated 02/12/2026, reflected a [AGE] year-old female, admitted [DATE], with the following diagnoses: major depressive disorder, single episode, unspecified (a serious mental health condition characterized by intense feelings of sadness, worthlessness, and loss of interest in activities, lasting at least 2 weeks), insomnia (a common sleep disorder characterized by persistent difficulty falling asleep, staying asleep, or waking up too early and struggling to return to sleep, resulting in poor sleep quality and significant daytime impairment), and chronic pain (pain lasting for more than three months often persisting beyond the normal healing time of an injury or illness). Record review of Resident #4's admission MDS Assessment, dated 01/22/2026, reflected Resident #4 had a BIMS score of 15 indicating her cognition was intact. Resident #4 was assessed to have the following 7 to 11 days out of the 14-day assessment period: little interest or pleasure of doing things feeling down, depressed, or hopelessFeeling tired or having little energyResident #4 had the following symptoms 2 to 6 days out of the 14-day assessment period:Poor appetite or overeatingFeeling bad about herself or felt she was a failure or let herself or her family down.Resident #4 had diagnoses of depression. Record review of Resident #4's Comprehensive Care Plan, dated 02/02/2026, reflected Resident # 4 had a potential for nutritional problems related to diet restrictions, depression and pain. Record review of Resident #4's PASARR Level 1 Screening, dated 02/11/2026, reflected that Section C, Primary Diagnosis of Dementia, was marked no, which indicated she did not have dementia, and Mental Illness was marked as No, which indicated Resident #4 did not have a mental illness. During an interview on 02/18/2026 at 2:30 p.m., Resident #4 stated she had depression majority of the time. She stated some days she felt good and did not have depression. Resident #4 stated she felt since she was in this facility she would benefit from having someone to talk to, such as mental health person, that helped people with depression. She stated she may not want it all the time, but she thought it may help if she tried talking to someone with a professional career with helping others with depression. She stated she had not spoken to anyone about getting help with depression and no one had asked her if she needed help. 2.Record review of Resident #129's Face Sheet, dated 02/18/2026, reflected an [AGE] year-old female, admitted [DATE] with diagnoses: major depressive disorder, recurrent, unspecified, insomnia (a common sleep disorder characterized by persistent difficulty falling asleep, staying asleep, or waking up too early and struggling to return to sleep, resulting in poor sleep quality and significant daytime impairment),chronic pain syndrome (a condition characterized by persistent pain lasting longer than 3-6 months, often continuing well after an injury or illness has healed). Record review of Resident #129's MDS, dated [DATE], was in progress. Record review of Resident #129's Baseline (continued on next page)

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	675799	A. Building B. Wing	02/19/2026

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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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Care Plan, dated 02/11/2026, reflected Resident #129 used antidepressant medication. Record review of Resident #129's PASARR Level 1 Screening, dated 02/11/2026, reflected that Section C Mental Illness was marked as No, which indicated Resident #4 did not have a mental illness. Primary Diagnosis of Dementia was marked no.Interview on 02/18/2026 at 2:50 p.m., Resident #129 stated she had depression and some days it is very difficult for her to do anything. She stated some days she prefers to stay in bed but not every day. She stated being in a new place and trying to get better was difficult sometimes. She stated she had seen psychologist in the past and it did help her. She stated if there was a psychologist available and, after she met the psychologist, she may be interested in receiving counseling. Resident #129 stated no one worked in the facility had talked to her about her depression. She stated she has had depression over the past few years. Interview on 02/18/2026 at 9:05 am, MDS Coordinator LVN A stated Resident # 4 and Resident #129 had major depression as their diagnosis. She stated the PASARR did not reflect Resident #4 and Resident #129 had a mental illness. She stated the hospital had completed both of the Residents (Resident #4 and Resident #129) PASARR's prior to the residents being admitted to the facility. She stated it was the MDS Coordinators responsibility to review the PASARRs, when residents were admitted , to ensure they were coded correctly. MDS Coordinator LVN A stated Resident #4's and Resident #129's was missed. She stated there was a possibility both residents (Resident #4 and Resident #129) may benefit from services from PASARR. She stated MDS Coordinators were responsible for the PASARR's on all residents. She stated Resident #4 and Resident #129 did not have a primary diagnosis of Dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory). Interview on 02/18/2026 at 9:30 am, MDS Coordinator LVN B stated Resident #4 and Resident #129 PASARR was not coded correctly. She stated both of the residents (Resident #4 and Resident #129) had mental illness and on their PASARR forms it was coded they did not. She stated it was the MDS Coordinators' responsibility to review the PASARR forms when a resident was admitted and if the PASARR forms were not correct they were expected to fill out another one and make the corrections. She stated Resident #4's and Resident #129's was missed. She stated Resident #4 and Resident #129 did not have a primary diagnosis of Dementia. MDS Coordinator LVN B stated she was in serviced on the PASARR process but did not remember the date. She stated Resident #4 and Resident # 129 may benefit from PASARR services. Record review of the facilities Policy on Guide for Local Authorities and Nursing Facilities to Complete the PASARR Level 1 (PL1) Screening, dated 06/2023, reflected, The PASARR Level 1 Screening Form is designed to identify individuals who are suspected of having mental illness), intellectual disability (ID) or a developmental disability (DD). Developmental Disabilities are also referred to as related conditions. If documentation entered on the PL1 Screening Form indicates a suspicion of MI, ID, OR DD, a PASARR evaluation (PE) must be completed to confirm PASARR eligibility. The PE is designed to confirm suspicion of MI, ID, or DD and ensure an individual is placed in the most integrated residential setting receiving the specialized services needed to improve and maintain an individual's level of functioning.Section C:Primary Diagnosis of Dementia- Is there evidence that dementia is the primary diagnosis of this individual (this must be listed in the medical record as the primary diagnosis by the physician). Mental Illness- Is there evidence or an indicator this is an individual that has a Mental Illness?Examples of Mental Illness are:SchizophreniaMood Disorder (Bipolar Disorder, Major Depressive Disorder, or other mood disorder).Paranoid DisorderSevere Anxiety DisorderSchizoaffective DisorderPlease explain/define the medical diagnoses/terms in layman terms for reader comprehension as this document is an official record and available to the public upon request.Recommend updating throughout this document, per the NF handbook, the source of evidence is listed at the beginning of the sentence on the CMS 2567, such as, During an interview., During an observation. or Record review of.Recommend updating throughout this document, per the NF handbook, the source of evidence is listed at the beginning of the sentence on the CMS 2567, such as, During an interview., During an observation. or Record review of.Per the PoD, (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	we write the report after the survey ends so we are always describing something that happened in the past, hence the past tense requirement. Recommend making this edit to reflect past tense throughout the document.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for two of eight residents (Resident# 92, and Resident #127) reviewed for ADL care.The facility failed to ensure Resident #92's and Resident # 127's nails were cleaned and did not have any rough edges.This failure could place residents at risk of not receiving services or care, diminished quality of life, and decreased self-esteem.Findings included: Record review of Resident #92's face sheet, dated 02/18/2026, reflected an [AGE] year-old male, admitted [DATE], with diagnoses: hemiplegia and hemiparesis following cerebral infarction following nontraumatic intracerebral hemorrhage affecting left non-dominant side (complete or partial loss of motor function on one side of the body, caused by damage to the right hemisphere of the brain- controls the left side of the body), need for assistance with personal care (when an individual cannot independently prefer essential Activities of Daily Living due to age, illness, or disability), and lack of coordination (an inability to produce smooth, precise, and voluntary muscle movements).Record review of Resident #92's Quarterly MDS Assessment, dated 12/11/2025, reflected Resident #92 was assessed to have a BIMS score of 4 indicating cognition was severely impaired. Resident #92 did not refuse care. Resident #92 required - partial/moderate assistance (helper does less than half the effort) with personal hygiene, lower body dressing, toileting hygiene, and shower transfers. He required- substantial/ maximal assistance (helper does more than half the effort) with showers. Record review of Resident #92's Comprehensive Care Plan, dated 12/24/2025, reflected Resident #92 had arthritis in his joints. Interventions: notify physician of any significant changes. Administer medications as ordered. Resident #92 had an ADL self-care performance deficit related to weakness. Intervention: Resident #92 required limited to extensive assistance by one staff with personal hygiene.Observation and interview on 02/17/2025 at 9:45 am, revealed Resident #92 was in his room lying in bed. He had a blackish/ brownish substance underneath the middle and ring fingernails on his right hand. Resident #92's middle fingernail on his right hand was uneven around the edges. Resident #92 did not respond to questions or conversation about his nails.Record review of Resident #127's face sheet, dated 02/18/2026, reflected an [AGE] year-old male admitted to the facility on [DATE] with the following diagnoses: type 2 diabetes mellitus (the body develops insulin resistance and cannot use insulin properly, or fails to produce enough insulin, leading to high blood sugar),cognitive communication deficit (an impairment in communication skills caused by underlying disruptions such as memory, attention, and processing information- rather than a primary speech or language disorder), and other lack of coordination (the inability to produce smooth, accurate, and voluntary muscle movements, resulting in clumsy, jerky, or unsteady actions).Record review of Resident #127's five-day Medicare MDS Assessment, dated 2/16/2026, was in progress. Record review of Resident #127's Baseline Care Plan, dated 02/15/2026, reflected Resident #127 had an ADL self-care performance deficit related to weakness. Intervention: Resident #127 required extensive assistance by one staff with personal hygiene.Observation and interview on 02/17/2026 at 9:40 a.m., revealed Resident #127 was in his room lying in bed. He had a blackish/ brownish substance underneath the middle ring and fore fingernails on his right hand. He stated on Monday night (02/17/2026) he asked a staff if she would clean his nails. Resident #127 did not recall the employee's name or their position. Resident #127 stated the person stated his nails would be cleaned sometime that night or the next day. He stated he did not ask anyone else to assist him in cleaning his nails.In an interview on 02/19/2026 at 9:30 a.m., LVN M stated the nurses were responsible for residents with diagnosis of diabetes with nail care such as trimming, cleaning, filing. She stated the CNAs were responsible for all other residents' nail care. LVN M stated if a resident had brownish/blackish substance underneath their nails and if a resident swallowed the substance there was a possibility a resident may become (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ill such as stomach problems nausea and vomiting. LVN M stated if a resident refused any type of care, the nurse would document the refusal in the nurse's notes. She stated Resident #92 and Resident #127 did not refuse nail care. She stated Resident # 92 sometimes refused showers. She stated no one reported to her Resident #92 or Resident #127 refused nail care. LVN M stated she worked with Resident #92 and Resident #127 for several weeks. She stated she had been in- serviced on nail care, however, she did not recall the date. In an interview on 02/19/2026 at 9:35 am, CNA E stated the CNAs were responsible for cleaning, trimming, and filing all residents' nails except for the residents with a diagnosis of diabetes. She stated nurses were responsible for all the residents' nails with a diagnosis of diabetes. CNA E stated the residents' nails were usually cleaned on their shower days and as needed. She stated if there was a blackish substance on the residents' fingertips or underneath their nails and the resident swallowed the blackish substance there was a possibility a resident may become ill such as vomiting and diarrhea. CNA E stated she was in-serviced on cleaning, filing, and trimming residents' nails but she did not recall the date. She stated Resident #127 did refuse showers; however, she was not aware of him refusing nail care. She stated if any resident refused nail care, she reported it to the nurse. CNA E stated she was not sure where the nurse documented the refusal of nail care. In an interview on 04/24/2025 at 10:25 am, the ADON stated the nurses completed all nail care on residents except cleaning resident's nails. She stated the nurses were responsible to complete nail care such as trimming, filing, and cleaning once a week or as needed on residents with diagnosis of diabetes. The ADON stated the CNAs were responsible for nail care on all other residents. The ADON stated if a CNA noticed any concerns of a resident's nails, the CNA was expected to report any concerns to the nurse. The ADON stated if a resident had blackish substance underneath their nails there was a possibility a resident may become ill such as nausea or diarrhea depending on the type of bacteria. The ADON stated if a resident had rough edges around their nails, it was a possibility the resident may scratch themselves and develop a skin tear. She stated the nurse supervisors were responsible for monitoring the CNAs and nail care. Record review of the Facility's Policy on Activities of Daily Living (ADLs), dated 05/26/2025, reflected, A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

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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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents received proper treatment and care to maintain good food health for one of nine residents (Resident #6) reviewed for foot care. The facility failed to schedule a podiatrist consultation for Resident #6 who was admitted to the facility on [DATE] with long, jagged toenails. This failure could place residents at risk of diminished quality of life by not receiving care and services to meet their needs. Findings included: Review of Resident #6's face sheet dated 02/19/2026 reflected a [AGE] year old male admitted to the facility on [DATE] with the following diagnoses: Atrial Fibrillation (A disease of the heart characterized by irregular and often faster heartbeat.), Hypertension (High pressure in the arteries and vessels that carry blood from the heart to the rest of the body), and Cachexia (complex metabolic syndrome characterized by involuntary weight loss, muscle wasting, and often fat loss, typically associated with chronic illnesses and cannot be fully reversed by conventional nutritional support.). Review of Resident #6's admission MDS assessment dated [DATE] reflected Resident #6 was assessed to have a BIMS score of seven indicating he had severe cognitive impairment. Resident #6 was assessed to not have behaviors or rejection of care. Resident #6 was further assessed to be dependent on staff for ADL assistance. Review of Resident #6's comprehensive care plan reflected a problem dated 01/23/2026 .has an ADL self-care performance deficit related debility and weakness. Interventions included .check nails cleanliness, length and trim as needed on bath day and PRN. Report any changes to the nurse. Observation on 02/18/2026 at 8:55 AM revealed Resident #6 sitting up in his wheelchair at nursing station. His sock on his left foot was off revealing his toenails to be long and jagged with the ends of some of the toenails curling over at the tips. The DON noticed and came over to the resident to put his sock back on and stated Yes his toenails were very long. In an interview on 02/19/2026 at 10:13 AM Resident #6 was in his room up in his wheelchair. Resident #6 was alert and was answered questions appropriately. Resident #6 stated he would like his toenails trimmed. When he was asked if he would let staff trim his toenails he stated he would love to have them cut. When asked if his toenails got hung on anything or scratched him he stated, surprisingly no they are pretty long. In an interview on 02/19/2026 at 10:20 AM The DON stated the social worker puts together the list for the podiatrist. She stated she tells the social worker who to put on the list. The DON stated she told the social worker to put Resident #6 on the list for the next podiatrist visit. The DON stated Resident #6 does refuse care and has refused nail care. The DON stated when asked if Resident #6 would still be added to the podiatry list even though he has refused care in the past she stated yes he would need to be added to the podiatry list. Review of the podiatry list provided by the facility on 02/19/2026 at 10:34 AM reflected the list was sent to the podiatrist on 02/16/2026 for the visit scheduled for 02/24/2026. The list did not include Resident #6. In an interview on 02/19/2026 at 10:39 AM the Treatment Nurse LVN L stated she checks residents' nails during her skin assessments for need of care. She stated she did not know why Resident #6 would not be on the podiatry list. She stated his nails were long and he should be on the list. In an interview on 02/19/2026 at 10:55 AM the Social Worker stated Resident #6 was on the podiatry list. After reviewing the list that did not include Resident #6's name she stated she still needed to get a signature from the resident. In an interview on 02/19/2026 at 11:05 AM the Social Worker stated Resident #6 had refused podiatry services on admission and presented the surveyor with the admission document. Review of Resident #6's admission paperwork dated 01/23/2026 reflected a section that for request for Podiatric services the documented reflected the resident declined podiatry care/services. Further review of the document reflected This can be changed at any time. In an interview on 02/19/2026 at 1:48 PM Social worker stated she had not re interviewed Resident #6 regarding the podiatry consult and stated she usually did not until they come and tell her the resident needed to be on the list which they just told her today (02/19/2026) that he needed to be on the list. The Social worker stated she would put him on the list (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to see the podiatrist. Request for the facility's policy for podiatry services on 02/19/2026 at 10:34 AM revealed a response from the facility Administrator that the facility did not have a podiatry policy.

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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 observation, interviews, and record reviews the facility failed to ensure the facility remained free of accidents and hazards a for one of three housekeepers (Housekeeping Cart #1) reviewed for hazards.The facility failed to ensure Housekeeping Cart #1, with chemicals inside the compartments, was locked when unsupervised. The housekeeping cart was located on 300 hall in front of biohazard room. This failure could place residents at risk for injuries, illness, and hospitalization.Findings included:Observation on 02/17/2026 at 8:55 am Housekeeping Cart #1 was located in front of biohazard room on 300 hall. The compartment where chemicals were stored was not locked. There was not a label on two bottles of the chemicals. The compartment had micro-kill bleach, disinfectant cleaner, Clorox, and two bottles filled with chemicals without a label on the bottles. Housekeeper G was not standing near the housekeeping cart. She exited the biohazard room [ROOM NUMBER]:00 a.m. and walked around the housekeeping cart and was standing beside surveyor. There were not any residents near the housekeeping cart or in the hallway on 300 hall.During an interview on 02/17/2026 at 9:00 a.m., Housekeeper G stated she did not know the name of the chemicals in the unlabeled bottles. She stated the housekeeping cart was expected to be locked anytime housekeeper walked away from the cart. Housekeeper G stated she could not see Housekeeping Cart #1 from inside the biohazard room because the door was closed. She stated there was a possibility that if a resident drank some of the chemicals the resident may become sick with stomach issues or have an allergic reaction. She stated it was possible a resident may need to be evaluated at the hospital. Housekeeper G stated all chemicals were required to have labels on the bottles. She stated she did have a key to the housekeeping cart. Observation on 02/17/2026 at 9:10 am, Housekeeper G located the key to the housekeeping cart and used the key to lock the compartment where chemicals were stored. Interview on 02/18/2026 at 1:30 p.m., the Housekeeping Supervisor stated all bottles with chemicals were expected to be labeled. She stated if a resident swallowed the chemical the nurse would not know what type of care to give the resident without knowing the name of the chemical. She stated all housekeeping carts were expected to be locked anytime the housekeeper was not standing in front of the cart. The Housekeeping Supervisor stated if a resident ingested some chemicals there was a potential for an allergic reaction, such as burning their throat, stomach and may need to be assessed at the hospital. She stated all housekeeping staff was in-service on locking housekeeping carts. She stated there was a possibility if a resident spilled chemical on their skin it may cause irritation to the skin. Interview on 2/19/2026 at 8:51 a.m., the Administrator stated he expected the housekeeping cart to be locked at all times when the housekeeper was not obtaining an item from the housekeeping cart. He stated all chemical bottles were expected to be labeled with the correct chemical name and directions how to use the chemical. The Administrator stated all housekeeping staff had been in-service on locking the housekeeping carts. He stated he checked with the nursing staff and there was not any residents who wandered on the 300 hall. He stated all the residents on 300 hall was in the facility for rehabilitation and would be discharging home when finished with their therapy. The Administrator stated if a resident drank a chemical there was a possibility a resident may become ill with nausea and vomiting. He stated there was a possibility a resident may need to be transported to the emergency room for further evaluation. Review of the Facilities Environmental Services Policies and Procedures, not dated, reflected All bleaches, detergents, disinfectants, insecticides, and other potentially hazardous substances are labeled and kept ins a safe place accessible only to employees. These items are not kept in containers that previously contained food or medicine.