STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676355	A. Building B. Wing	01/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Brenham	1303 Hwy 290 E 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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44671 Based on observations, interviews, and record reviews, the facility failed to ensure residents received services in the facility with reasonable accommodations of each resident's needs for 3 of 6 residents (Residents #1, #2, & #3) reviewed for resident rights. The facility failed to ensure Residents #1, #2, and #3' call light was within reach on 01/26/25. This failure could affect residents who needed assistance with activities of daily living and could result in needs not being met. Findings included: Record review of Resident #1's admission record dated 01/26/25 documented a [AGE] year-old male admitted on [DATE]. Resident #1 had diagnoses which included: epilepsy (nerve cell activity in the brain disturbed causing seizures) and recurrent seizures(episodes of abnormal brain activity that occur more than once). Record review of Resident #1's Quarterly MDS assessment, dated 12/23/24, revealed the resident had a BIMS score of 15 indicating the resident was cognitively intact. Record review of Resident #1's care plan, dated 01/27/25, revealed Resident #1 was care planned for ADL self-care performance deficit r/t disease processes, impaired balance, toilet use, and transfer. Observation on 01/26/25 at 11:30 a.m., revealed Resident #1's call light was lying on the floor, under the middle of the bed, and out of her reach. During an interview on 01/26/25 at 11:30 a.m., Resident #1 stated that the call light was always on the floor and staff did not make sure it was within each when they would come in to assist. Resident # 1 stated he could not recall how long the call light had been under the bed or when the last time staff had come in to assist him. Resident # 1 stated that he would just wait until staff came in the room to let them know he needed assistance. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's admission record dated 01/26/25 documented a [AGE] year-old male admitted on [DATE]. Resident #2 had diagnoses which included: congestive heart failure(heart does not pump blood as well as it should), chronic kidney disease(waste built up in kidneys), and anxiety(feelings of worry, anxiety, or fear). Record review of Resident #2's Quarterly MDS assessment, dated 12/06/24, revealed the resident had a BIMS score of 10 indicating the resident was moderately impaired. Record review of Resident #2's care plan, dated 11/01/24, revealed Resident #1 was care planned for assistance with ADL's performance deficit r/t disease processes, toilet use, and transfer. Observation on 01/26/24 at 12:47 a.m., revealed Resident #2's call light was hanging on the right side of his bed not in reach. During an interview on 01/26/24 at 12:47 a.m., Resident #2 stated that his call light was always not in reach. Resident #2 stated he would wait until staff come in to tell them what he needed. Resident # 2 was not able to recall when the last time staff had assisted him or how long the call light had been out of reach. Record review of Resident #3's admission record dated 01/26/25 documented a [AGE] year-old male admitted on [DATE]. Resident #3 had diagnoses which included: down syndrome(abnormal cell division result in extra genetic), kidney failure(loss of ability to remove waste and balance fluids), and respiratory failure(unable to maintain levels of oxygen and carbon dioxide in the body). Record review of Resident #3's Admission MDS assessment, dated 01/15/25, revealed the resident had a BIMS score of 03 indicating the resident was severely cognitively impaired. Record review of Resident #3's care plan, dated 11/01/24, revealed Resident #3 was care planned for ADL self-care performance deficit r/t disease processes, down syndrome, impaired balance, limited mobility, and musculoskeletal impairment. Observation on 01/26/24 at 1:30 p.m., revealed Resident # 3's call light was under the bed located at the foot of the bed not in reach. During an interview on 01/26/24 at 1:30 p.m., Resident # 3 shrugged his shoulders when asked the location of his call light. Resident # 3 was not able to provide how long his call light had been on the floor or when the last time staff had assisted him. During an interview on 01/26/25 at 3:42 p.m., CNA A stated CNAs should make rounds at least every two hours or as needed. CNA A stated that CNAs should be looking to see if a resident call light is in reach and clamped to their pillow. CNA A stated if a resident's call light was not within reach, the resident would not be able to communicate with staff if they have a medical emergency and may become worse. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/26/25 at 4:04 p.m., CNA B stated rounds were made every two hours or as needed. CNA B stated it was expected for CNAs to make sure call lights were in reach. CNA B stated if call lights were not in reach a resident need would not get met. During an interview on 01/26/25 at 5:32 p.m., the ADON stated it was expected for all staff that entered a resident's room to make sure the call light was in reach so residents could notify staff that they needed assistance. The ADON stated if a resident's call light was not in reach, then the resident's needs would not have been met. An interview on 01/27/25 at 5:32 p.m., the ADM stated it was everyone's responsibility to ensure call lights were always within reach of the resident. The ADM stated that if a call light was not within reach, then a resident's needs would not be met. The ADM stated that it was expected for call lights to be always within reach of the residents. Review of the facility's Call Light, Use of policy not dated , reflected, Purpose-Respond promptly to resident's call for assistance Ensure call system is in proper working order Procedure when providing care to resident, be sure to position the call light conveniently for the resident to use. Tell the resident where the call light is and show him/her how to use the call light.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44671 Based on interview and record review the facility failed to have assessments that accurately reflected the status for 3 of 6 residents (Residents #1, #2, & #3) of five residents reviewed for assessment accuracy. The facility failed to ensure Resident #1, #2, & #3 functional abilities were accurate in their MDS as it did not reflect self-care abilities. This deficient practice could result in errors in care and treatment. Findings included: Record review of Resident #1's admission record dated 01/26/25 documented a [AGE] year-old male admitted on [DATE]. Resident #1 had diagnoses which included: epilepsy (nerve cell activity in the brain disturbed causing seizures) and recurrent seizures(episodes of abnormal brain activity that occur more than once). Record review of Resident #1's Quarterly MDS assessment, dated 12/23/24, revealed the resident had a BIMS score of 15 indicating the resident was cognitively intact. The functional abilities section for self-care was not marked on the type of assistance needed for Resident #1. Record review of Resident #1's care plan, dated 01/27/25, revealed Resident #1 was care planned for ADL self-care performance deficit r/t disease processes impaired balance, toilet use, and transfer. Record review of Resident #2's admission record dated 01/26/25 documented a [AGE] year-old male admitted on [DATE]. Resident #2 had diagnoses which included: congestive heart failure(heart does not pump blood as well as it should), chronic kidney disease(waste built up in kidneys), and anxiety(feelings of worry, anxiety, or fear). Record review of Resident #2's Quarterly MDS assessment, dated 12/06/24, revealed the resident had a BIMS score of 10 indicating the resident was moderately impaired. The functional abilities section for self-care was not marked on the type of assistance needed for Resident #2. Record review of Resident #2's care plan, dated 11/01/24, revealed Resident #1 was care planned for assistance with ADL's performance deficit r/t disease processes intolerance, toilet use, and transfer. Record review of Resident #3's admission record dated 01/26/25 documented a [AGE] year-old male admitted on [DATE]. Resident #3 had diagnoses which included: down syndrome(abnormal cell division result in extra genetic), kidney failure(loss of ability to remove waste and balance fluids), and respiratory failure(unable to maintain levels of oxygen and carbon dioxide in the body). (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #3's Admission MDS assessment, dated 01/15/25, revealed the resident had a BIMS score of 03 indicating the resident was severely cognitively impaired. The functional abilities section for self-care was not marked on the type of assistance needed for Resident #3. Record review of Resident #3's care plan, dated 11/01/24, revealed Resident #3 was care planned for ADL self-care performance deficit r/t disease processes, down syndrome, impaired balance, limited mobility, and musculoskeletal impairment. During an interview on 01/27/25 at 5:57 p.m., the MDS Coordinator stated she started as MDS Coordinator on 01/16/25. The MDS Coordinator stated she could not speak on why the previous MDS Coordinator did not check to make sure those assessments were completed thoroughly. The MDS Coordinator stated she would be responsible to make sure all MDS are completed and accurate. The MDS coordinator stated if the MDS was not completed the resident would not have met their goal. During an interview on 01/27/25 at 6:15 p.m., the ADM stated it was expected for the MDS Coordinator to make sure the MDS was completed. The ADM stated not having MDS completed the residents would not have completed their goals. Review of the facility's Resident Assessment Instrument Process not dated, reflected Purpose to gather data in order to develop comprehensive, individualized care plans that meet the medical, nursing, mental, psychosocial needs of each resident. Each care plan will describe services furnished to attain or maintain the resident's highest practical physical, mental and psychosocial well-being.