STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676355	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brenham Healthcare Center	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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46708 Based on interview and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one (Resident #1) of three residents reviewed for quality of care. The facility failed to obtain daily weights and report weight gain for Resident #1 who had a diagnosis of CHF to ensure there was no fluid overload in accordance with medical provider's order dated [DATE]. The facility failed to timely and accurately obtain Resident #1's labs in accordance with medical providers orders dated [DATE]. While at the facility on [DATE] Resident #1 suffered shortness of breath and altered mental status. Resident #1 was taken by EMS to the hospital on [DATE] and was diagnosed with sepsis. Resident #1 died at the hospital on [DATE]. An IJ was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 5:42 pm. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of pattern and a severity level of no actual harm because of the facility's need to evaluate the effectiveness of the corrective system. This failure could place residents at risk of not receiving care and services identified to meet their needs. Findings include: Review of Resident #1's face sheet dated [DATE] reflected an [AGE] year-old male who was originally admitted to the facility on [DATE] with diagnoses that included combined systolic and diastolic heart failure (systolic failure is a problem with the heart's pumping action, while diastolic failure is a problem with the heart's filling phase) and chronic respiratory failure with hypoxia (the body isn't getting enough oxygen due to impaired lung function). Review of Resident #1's care plan focus, goal, and interventions dated [DATE] revealed: Focus reflected regular diet, no added salt, 2000 ml fluid restriction. (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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Goal reflected Resident #1 will have adequate nutrition and fluid intake throughout the review date. Interventions reflected weight every month and PRN - report 5% loss/gain to MD and responsible party. Review of Resident #1's MDS dated [DATE] reflected a BIMS score of 10, indicating moderate cognitive impairment, he used a wheelchair, and had an active diagnoses of congestive heart failure and respiratory failure. American Heart Associate on managing heart failure symptoms reflected, Your body and your heart can often respond to effects of heart failure so that you never notice any symptoms. Your heart compensates for added strain by working harder. However, as heart failure worsens, your heart can gradually become less able to keep pumping blood to the body. Additionally, when a situation worsens by small degrees over time, you might not even notice the trend. Your sense for what ' s normal can become altered. Review of social services progress note dated [DATE] reflected Resident #1 was a full code (a medical directive indicating that a patient wishes to receive all possible life-saving measures in the event of a medical emergency, such as cardiac or respiratory arrest). Review of Resident #1's orders beginning [DATE] DC [DATE] revealed, Daily weights: Notify PA/MD for weight gain > 3lbs in one day or 5lbs in one-week every day shift monitoring Review of Resident #1's nurses note by LVN A dated [DATE] revealed resident was with a therapist and became short of breath. Vital signs reflected O2 saturation (a measure of oxygen in the blood) levels between ,d+[DATE]%, suggesting decreased oxygenation and intervention needed. Resident assessment revealed altered mental status and difficulty keeping eyes open. EMS arrived and transported resident to the ER at 11:52 am. Review of Resident #1's MD order dated [DATE] reflected weigh daily and record. Review of Resident #1's weights from his admission on [DATE] until discharge [DATE]: [DATE] 10:40 am 167.5 lbs. standing [DATE] 4:15 pm 167.0 lbs. standing [DATE] 10:12 am 167.1 lbs. wheelchair [DATE] 12:45 pm 167.5 lbs. wheelchair [DATE] 10:43 am 167.3 lbs. wheelchair [DATE] 6:52 am 167.3 lbs. wheelchair [DATE] 11:12 am 167.0 lbs. sitting (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	[DATE] 1:22 pm 167.2 lbs. wheelchair [DATE] 1:08 pm 167.0 lbs. wheelchair [DATE] 1:50 pm 167.3 lbs. wheelchair [DATE] 7:39 pm 167.4 lbs. wheelchair [DATE] 12:14 pm 175.5 lbs. sitting Review of PA progress notes, located in the miscellaneous tab in of Resident#1's electronic medical records, PA encounter date [DATE] revealed, Patient seen today in person at [nursing facility] for evaluation and coordination of care. Staff reported noncompliance with 02 and is high risk for falls. Orders for labs, meds., etc., were faxed earlier this week were apparently not received so I provided a copy to the DON today. Review of copy of Resident #1's orders dated [DATE] included in PA progress notes encounter dated [DATE] reflected a stamp reading orders faxed on [DATE] to the facility. Order dated [DATE] reflected lab order to check: CBC (a common blood test that provides information about the different types of cells in the blood) CMP (a routine blood test that measures various substances in the body to assess overall metabolism and organ function) TSH (assess the function of the thyroid gland, which produces hormones that regulate metabolism) Digoxin (measure the amount of digoxin (a medication used to treat congestive heart failure)) Thiamine (measure the amount of thiamine (vitamin B1)) Folic Acid (measure the amount of folic acid (a B vitamin)) Review of Resident #1's hospital history of present illness from [DATE] reflected Resident #1 had a diagnosis of dementia and chronic mixed heart failure and came from his nursing facility with altered mental status and shortness of breath. He was seen at the facility by gerontology (the study of aging people and people who are aging) and had increased in water weight. EMS was called, vitals were notable for hypotension (a condition where the blood pressure is significantly lower than normal), hypoxia (a condition where there is an inadequate supply of oxygen to the body's tissues), and hypothermia (a life-threatening condition that occurs when the body loses heat faster than it can produce it, resulting in a dangerously low body temperature). He was transferred to another hospital due to altered mental status and concern for ability to protect airway and was intubated. CT scan (Computerized tomography a noninvasive medical examination or procedure that uses specialized X-ray equipment to produce cross-sectional images of the body) demonstrated bilateral pleural effusion (a condition where excess fluid accumulates in the pleural spaces on both sides of the lungs), volume overload (a condition where there is an excessive amount of fluid in the body, particularly in the bloodstream), and cystitis (a bladder infection) and was on minimal vent settings. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #1's hospital records from [DATE] reflected principal problem: septic shock (a life-threatening condition that occurs when an infection spreads throughout the body and causes a dangerously low blood pressure). Review of Nursing Home Documentation Form dated [DATE] by PA reflected Resident #1 seen today in person at [facility name] for evaluation and coordination of care. Documentation reflected history of present illness - Resident #1 seen for follow up. There was a delay in getting lab results that the MD ordered on [DATE]. The CMP (comprehensive Metabolic Panel, a routine blood test that measures various substances in the blood to assess overall metabolism and organ function) was not done and the DON was aware it needed to be added. The facility had not done a daily weight in X7 days. The weight was 4 lbs. higher than last week so ordered additional dose of Lasix (medication for the treatment of edema associated with congestive heart failure). A review of Resident #1's lab results dated [DATE] reflected collection date [DATE] and test results for CBC, Digoxin, TSH, Thiamine, Folic Acid, and Free T4. The lab results do not reflect results for CMP. The CBC reflected that out of 22 panels (a lab analysis of a blood sample that measures the levels of various substances in the blood) checked in the CBC, 13 panels had an outcome outside of normal range, either low or high. RBC (red blood cell count) - Low 3.98, normal range 4.63 - 6.08 Hemoglobin (a protein found in red blood cells that is responsible for transporting oxygen from the lungs to the body's tissues and carbon dioxide from the tissues back to the lungs) - Low 12, normal range 13.7 - 17.5 Hematocrit (a medical test that measures the percentage of red blood cells in the blood) - Low 36.6, normal range 40.1 - 51.0% Platelet (small colorless call fragments in the blood that play a crucial role in blood clotting) - Low 80, normal range ,d+[DATE] RDW (Red Cell Distribution Width - measures the variation in size of red blood cells) - High 15.7%, normal range 11.6 - 14.4% Neutrophil % (a type of white blood cell (leukocyte) that play a crucial role in the immune system) - High 82. 2%, normal range 34.0 - 67.9% Lymphocyte# (a white blood cell that helps the body fight infection and disease) Low 0.49, normal range 1.32 - 3.57 Monocyte# (white blood cells that play a crucial role in the immune system) Low .23, normal range 0.30 - 0.82 Basophil% (a type of white blood cell (leukocyte) that play a crucial role in the immune system) Low 0.0%, normal range 0.2 - 1.2% Basophil# (a type of white blood cell (leukocyte) that play a crucial role in the immune system) Low 0.00, normal range 0.01 - 0.08 (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of Resident #1's electronic medical record from [DATE] through [DATE] reflected no notation of any communications to Resident #1's MD, PA, or family about of Resident #1's labs, collected 20 days after MD lab order. Interview on [DATE] with the PA at 12:48 pm revealed orders were written for labs for Resident #1 on, she thought, [DATE] and when Resident #1 was admitted to the hospital, they only had partial lab results. She said every week when she was at the facility, she verbally told the DON and the ADM that she needed the lab work for Resident #1. The facility did not have the results for the CMP blood test ordered on [DATE] that referred to Resident #1's level of calcium (an essential mineral that plays a vital role in maintaining strong bones, teeth, and other bodily function). The PA revealed that had they known the results of Resident #1's calcium level in a timely manner, they might have been able to reverse Resident #1's medical condition. The PA revealed Resident #1 was diagnosed at the hospital with sepsis (a lift-threatening condition that occurs when the body's immune system overacts to an infection) and his calcium level could have contribute to sepsis in addition to the fluid overload that was not discovered or reported to the PA or MD because the facility was not weighing Resident #1 in accordance with the MD orders. Interview on [DATE] with RN D at 10:37 am revealed it was important to weigh someone with congestive heart failure to make sure you could accurately keep a record of their fluid accumulation. If a resident accumulated too much fluid it could cause respiratory and circulatory issues and their medication might not be therapeutic. It was important to weight residents in accordance with the MD orders. If the order stated to do weights regularly you weighted residents regularly according to the MD order. If the resident had an increase or a loss in weight the MD needed to be informed to see if the resident needed a change in medication. When Resident #1 first admitted to the facility his weight should have been taken and documented for a baseline. Someone from the nursing staff, the CNA or a licensed nurse should have weighted and recorded the weight in accordance with the MD order to make sure it was accurate and consistent. A negative outcome of not weighing a resident who had congestive heart failure would be not knowing if there was fluid overload. Residents should be weighted the same time every day in accordance with the MD orders and they should be weighted the same way, either consistently standing, mechanical, or using a wheelchair, using the same scale. If they have congestive heart failure, you really wanted to encourage them to be weighted the same way. If a MD orders labs, you want to get it processed when it was received. The negative outcome of not getting labs processed would be not providing medication that was therapeutic. There is potential for harm if labs are not ordered and reported to the MD. Residents could be hospitalized or die if lab work is not handled properly. Interview on [DATE] with the Resident #1's MD on 12:28 pm revealed he did not know if Resident #1's complete labs were received. He stated it is hard to monitor chronic conditions without lab work and felt that not having the lab work could have contributed to Resident #1's death. The MD stated that Resident #1 suffered from dementia and could not let people know when things were really wrong. He said Resident #1 had heart failure and he wrote an order to do daily weights for Resident #1. The weights were necessary because they were needed to have some objective way to monitor and follow Resident #1's congestive heart failure and not doing the weights could have possibly contributed to heart failure. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on [DATE] with the ADM at 4:32 revealed the former DON and the former ADON were responsible for the lab tracking and there was no documentation in the daily lab tracking form. She said she could not locate the notebook that was supposed to contain the lab tracking. She said not tracking labs was a problem because it could cause harm to a resident. She stated when labs were not tracked, someone could drop the ball, and something could be missed. The ADM felt the ADON was not trained properly by the DON, and everything was falling by the wayside. She said she wanted to terminate the DON, but she had to make sure she had someone else to take her spot. She said as a nurse you have to follow up and follow through and this was not happening for either weights or labs. Interview on [DATE] with the PA at 1:34 pm revealed the facility not weighing Resident #1 daily contributed to his decline and hospitalization . Facility policy Lab management dated [DATE] reflected it is the policy of this community to provide or obtain laboratory services to meet the needs of its residents. The community is responsible for the timeliness of the services. The community must notify the attending physician of the lab results. Procedure All labs require a physician order. 1. The Designated Clinical Officer will be responsible to monitor lab orders to ensure that all ordered labs have been drawn as ordered by the physician. 2. Lab tracking is to be documented daily on the lab tracking form. 3. Ensure that all labs ordered have been collected with results communicated to MD/family in a timely manner. Proof of notification to be included on lab report sheet and slash or in the nurse's notes. 4. Lab personnel will be responsible to report to the charge nurse all labs that have been drawn or not drawn that day. Lab draws that cannot be drawn that day will be communicated to the physician and reordered if necessary. 5. The designated clinical officer will be responsible to notify the lab when a lab result is not received in a timely manner. 6. If issues are identified with the lab provider process. The designated clinical officer is to contact lab company immediately for corrective action. Quality assurance plan to be developed by lab provider to prevent recurrence of identified issue issue(s). 7. If issue with community process is identified, provide immediate staff in service and re-education regarding the importance of labs and their impact on residents. 8. Lab tracking process is to be monitored during scheduled QAPI meeting. The CDO must periodically check lab tracking book on a random basis to ensure the director of clinical office slash designee is compliant with the process. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	9. Ensure lab provider conducts a lab audit per contract and provides community with access to routine labs and frequency. 10. The attending physician will be notified promptly of lab results. 11. Lab results will be maintained in the resident's clinical record. Facility policy Nutrition Management dated [DATE] reflected the purpose of this policy is to establish facility guidelines on how and when the facility obtains and documents residents weights. The policy is also to ensure that residents with significant weight loss or weight gain are rapidly identified to ensure that the resident maintains the highest quality of life and wellness in the facility. Procedure Resident weights Based on resident's comprehensive assessment, the facility must ensure that a resident: 1. Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. Obtaining Resident weights When obtaining resident weights: It is best practice to use the same scale each time to weight the residents. Ensure that the resident is weighed, if possible, during the same time of the day Ensure that the resident has the approximate amount of clothing each time they are weighed New Admissions - The resident's height and weight should be obtained upon admission. The ADM was notified on [DATE] at 5:42 PM that an IJ had been identified and an IJ template was provided. The following POR was approved on [DATE] at 4:42 PM: The POR included: F684: The facility failed to weigh Resident #1 daily as ordered. The facility failed to obtain ordered labs. Action: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	DON/ADON in serviced administrative staff and nursing staff regarding policy and procedures for weight tracking and management and methods for obtaining weights in supine, seated, standing in wheelchair or use of mechanical lift with signature response for comprehension. [DATE]. The resident's height and weight will be obtained upon admission, documented by nursing staff in electronic medical records and lab binder. The resident is then weighed at least weekly for at least 4 weeks [DATE]. The resident's weight will be obtained upon re admission, documented in EMR and weight binder by nursing staff. The resident is then weighed at least weekly for at least 4 weeks with discussion for completion during the morning meeting with administrative staff, DON/ADON [DATE]. The residents will have a monthly weight obtained. All monthly weights will be entered into PCC by the 10th of every month by DON/ADON with daily discussion for completion during the daily morning meeting [DATE]. Nursing staff will notify Physician, resident, and family of the weight loss/gain and documented in EMR [DATE]. Nursing staff will monitor residents' eating habits and documented in residents EMR by nursing staff. [DATE]. Weekly weights will be obtained for at least 4 weeks and documented by nursing staff in EMR [DATE]. Initiation of the Weight Surveillance Form for at least 4 weeks or all resident's weight has stabilized [DATE]. Any planned weight loss will be care planned and noted in the clinical record. The physician, dietitian, and nursing staff will collaborate in a planned weight loss [DATE]. Dietitian recommendations will be implemented or if needed, sent to the physician immediately upon receipt [DATE]. If the physician has not responded within 72 hours, a call will be placed to the physician's office on [DATE]. DON/ADON completed a 100% lab audit to ensure all labs ordered have been collected with results indicating no other residents to have labs that were ordered and not completed [DATE]. Start Date: [DATE] Completion Date: [DATE] Responsible: DON/designee will monitor and track residents' weight loss of 5% or greater with immediate notification sent to dieticians and physicians for recommendations and documented in EMR [DATE]. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	DON/ADON will maintain a current list of residents and a communication form will be provided to the dietary manager to notify them of extra assistance, encouragement, substitute meals, or supplements or any weight loss identified. The dietary manager will document in residents' EMR followed by a consultation call to Registered dietician for further instructions. Follow up during the morning meeting to ensure completion [DATE]. DON/ADON will in-service administrative staff, dietary management and staff regarding procedure with communication slips concerning weight loss, diet changes, new admits and readmits with documentation placed in residents EMR. Signature page completed to reflect comprehension. The Medical Director immediately made aware of IJ for noncompliance via telephone. Surveyor Monitoring: During interviews on [DATE] from 8:39 AM - 3:21 PM the activities director, social worker, one agency LVN, one RN, and 4 LVNs (from different shifts) all stated they were in-serviced by the DON or the ADON or designee regarding policy and procedures for weight tracking and management and methods for obtaining weights. The nurses stated they will notify physician, resident, and family of the weight loss/gain and document in the EMR. The resident's height and weight will be obtained upon admission, documented by nursing staff in the electronic medical records and lab binder. The resident will then be weighed at least weekly for at least 4 weeks and if the residents have a re-admission their weight will be obtained upon re admission, documented in EMR and weight binder by nursing staff. The resident will again be weighed at least weekly for at least 4 weeks with discussion for completion during the morning meeting with administrative staff, DON/ADON. The nursing staff will notify physician, resident, and family of any weight loss/gain and it will be documented in the EMR. The nursing staff will monitor residents' eating habits and document in residents EMR. Weekly weights will be obtained for at least 4 weeks and documented by nursing staff in EMR. They were in-serviced on the initiation of the Weight Surveillance Form regarding resident weight stabilization. Any planned weight loss will be care planned and noted in the clinical record. The physician, dietitian, and nursing staff will collaborate in a planned weight loss. Dietitian recommendations will be implemented or if needed, sent to the physician immediately upon receipt. If the physician has not responded within 72 hours, a call will be placed to the physician's office. The administrative staff, dietary management and staff were in-serviced regarding procedure with communication slips concerning weight loss, diet changes, new admits and readmits with documentation placed in residents EMR. In an interview on [DATE] with the ADM at 12:30 pm the ADM confirmed that: The DON/designee will monitor and track residents' weight loss of 5% or greater with immediate notification sent to dieticians and physicians for recommendations and documented in EMR [DATE]. The DON/ADON will maintain a current list of residents and a communication form will be provided to the dietary manager to notify them of extra assistance, encouragement, substitute meals, or supplements or any weight loss identified. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Completion Date: [DATE] Responsible: The DON/designee will be responsible for monitoring lab orders to ensure that all ordered labs have been drawn as ordered by the physician [DATE]. The ADON/designee will be responsible for notifying the lab when a lab result is not received in a timely manner [DATE]. If issues are identified with the lab provider process, DON is to contact lab company immediately for corrective action [DATE]. The Administrator will check lab tracking books monthly via signature page of lab binder to ensure DON/designee is compliant with the laboratory monitoring and management tracking process [DATE]. QA plan to be developed by Administrator /DON to prevent recurrence of identified issues(s) [DATE]. Surveyor Monitoring: During interviews on [DATE] from 8:39 AM - 3:21 PM the activities director, social worker, one agency LVN, one RN, and 4 LVNs (from different shifts) all stated they were in-serviced by the DON or the ADON or designee to report all lab results to MD/NP immediately, to report abnormal lab results to MD/NP/DON or designee, to document labs in each resident EMR, and to document in the Lab tracking binder that will be located at each Nurse's station. The staff stated they understood that Proof of notification is needed and is to be included on the lab report sheets via signature, date, time and route of notification is to be documented in the nurse's notes beginning [DATE]. Staff further said they were in-serviced that lab draws that cannot be drawn that day will be communicated to the physician immediately, documented in residents EMR and checked daily by DON/ADON for completion of results. In an interview on [DATE] with the ADM at 12:30 pm the ADM confirmed that: The DON/designee will be responsible for monitoring lab orders to ensure that all ordered labs have been drawn as ordered by the physician beginning [DATE]. The ADON/designee will be responsible for notifying the lab when a lab result is not received in a timely manner beginning [DATE]. That if issues are identified with the lab provider process, DON, currently the ADM, is to contact lab company immediately for corrective action beginning [DATE]. The Lab tracking binder will be located at each Nurse's station. The Administrator will check lab tracking books monthly via signature page of lab binder to ensure DON/designee is compliant with the laboratory monitoring and management tracking process [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676355	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/01/2025
NAME OF PROVIDER OR SUPPLIER: Brenham Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1303 Hwy 290 E Brenham, TX 77833	

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] at 12:37 pm the surveyor reviewed completed lab audit to ensure all labs ordered have been collected with results indicating no other residents to have labs that were ordered and not completed [DATE]. On [DATE] at 1:02 pm the surveyor observed the lab tracking binder located at the nurse's station. On [DATE] at 1:10 pm the surveyor reviewed the QA plan to be developed by Administrator DON to prevent recurrence of identified issues(s) that began [DATE]. Interview on [DATE] with the facility medical director at 8:39 am stated he was informed of the immediate jeopardy. The ADM was notified on [DATE] at 4:30 PM that the IJ had been removed. While the IJ was removed, the facility remained at a level of no actual harm at a scope of pattern that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.

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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46708 Based on interview and record review, the facility failed to obtain laboratory services to meet the needs of its residents for 1 (Resident #1) of three residents reviewed for laboratory services. The facility failed to collect Resident #1's blood specimen as ordered by the physician on 11/12/24 until 12/02/24. The CBC results reflected multiple out of range readings and did not include a CMP test. Resident #1 suffered shortness of breath and altered mental status. Resident #1 was taken by EMS to the hospital on 12/03/24 and was diagnosed with sepsis. An IJ was identified on 01/29/25. The IJ template was provided to the facility on [DATE] at 5:37 pm. While the IJ was removed on 02/01/25, the facility remained out of compliance at a scope of pattern and a severity level of actual harm because of the facility's need to evaluate the effectiveness of the corrective system. This failure could place residents at risk of a delay in receiving the necessary interventions to treat their medical condition(s). Findings Included: Review of Resident #1's face sheet dated 01/29/25 reflected an [AGE] year-old male who was originally admitted to the facility on [DATE] with diagnoses that included combined systolic and diastolic heart failure (systolic failure is a problem with the heart's pumping action, while diastolic failure is a problem with the heart's filling phase) and chronic respiratory failure with hypoxia (the body isn't getting enough oxygen due to impaired lung function). Review of Resident #1's MDS dated [DATE] reflected a BIMS score of 10, indicating moderate cognitive impairment, he used a wheelchair, and had an active diagnoses of congestive heart failure and respiratory failure. Review of Resident #1's care plan focus, goal, and interventions dated 11/06/24: Focus reflected regular diet, no added salt, 2000 ml fluid restriction. Goal reflected Resident #1 will have adequate nutrition and fluid intake throughout the review date. Review of Resident #1's care plan Focus dated 11/06/24: I have an activities of daily living self-care performance deficit related to the disease process - confusion. Review of social services progress note dated 11/06/24 reflected Resident #1 was a full code (a medical directive indicating that a patient wishes to receive all possible life-saving measures in the event of a medical emergency, such as cardiac or respiratory arrest). (continued on next page)

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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #1's nurses note by LVN A dated 12/03/24 revealed resident was with a therapist and became short of breath. Vital signs reflected O2 saturation (a measure of oxygen in the blood) levels between 88-90%, suggesting decreased oxygenation and intervention needed. Resident assessment revealed altered mental status and difficulty keeping eyes open. EMS arrived and transported resident to the ER at 11:52 am. Review of PA progress notes, located in the miscellaneous tab in of Resident#1's electronic medical records, PA encounter date 11/14/24 revealed, Patient seen today in person at [nursing facility] for evaluation and coordination of care. Staff reported noncompliance with 02 and is high risk for falls. Orders for labs, meds., etc., were faxed earlier this week were apparently not received so I provided a copy to the DON today. Review of copy of Resident #1's orders dated 11/12/24 included in PA progress notes encounter dated 11/14/24 reflected a stamp reading orders faxed on 11/13/24 to the facility. Order dated 11/12/24 reflected lab order to check: CBC (a common blood test that provides information about the different types of cells in the blood) CMP (a routine blood test that measures various substances in the body to assess overall metabolism and organ function) TSH (assess the function of the thyroid gland, which produces hormones that regulate metabolism) Digoxin (measure the amount of digoxin (a medication used to treat congestive heart failure)) Thiamine (measure the amount of thiamine (vitamin B1)) Folic Acid (measure the amount of folic acid (a B vitamin)) Review of Resident #1's hospital history of present illness from 12/03/24 reflected Resident #1 had a diagnosis of dementia and chronic mixed heart failure and came from his nursing facility with altered mental status and shortness of breath. He was seen at the facility by gerontology (the study of aging people and people who are aging) and had increased in water weight. EMS was called, vitals were notable for hypotension (a condition where the blood pressure is significantly lower than normal), hypoxia (a condition where there is an inadequate supply of oxygen to the body's tissues), and hypothermia (a life-threatening condition that occurs when the body loses heat faster than it can produce it, resulting in a dangerously low body temperature). He was transferred to another hospital due to altered mental status and concern for ability to protect airway and was intubated. CT scan (Computerized tomography a noninvasive medical examination or procedure that uses specialized X-ray equipment to produce cross-sectional images of the body) demonstrated bilateral pleural effusion (a condition where excess fluid accumulates in the pleural spaces on both sides of the lungs), volume overload (a condition where there is an excessive amount of fluid in the body, particularly in the bloodstream), and cystitis (a bladder infection) and was on minimal vent settings. (continued on next page)

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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Nursing Home Documentation Form dated 12/03/24 reflected Resident #1 see today in person at [facility name] for evaluation and coordination of care. Documentation reflected history of present illness - Resident #1 seen for follow up. There was a delay in getting lab results that the MD ordered on 11/12/24. The CMP (comprehensive Metabolic Panel, a routine blood test that measures various substances in the blood to assess overall metabolism and organ function) was not done and the DON was aware it needed to be added. The weight was 4 lbs. higher than last week so ordered additional dose of Lasix (medication for the treatment of edema associated with congestive heart failure). Review of Resident #1's hospital records from 12/03/24 reflected principal problem: septic shock (a life-threatening condition that occurs when an infection spreads throughout the body and causes a dangerously low blood pressure). A review of Resident #1's lab results dated 12/03/24 reflected collection date 12/02/24 and test results for CBC, Digoxin, TSH, Thiamine, Folic Acid, and Free T4 . The lab results do not reflect results for CMP. The CBC reflected that out of 22 panels (a lab analysis of a blood sample that measures the levels of various substances in the blood) checked in the CBC, 13 panels had an outcome outside of normal range, either low or high. RBC (red blood cell count) - Low 3.98, normal range 4.63 - 6.08 Hemoglobin (a protein found in red blood cells that is responsible for transporting oxygen from the lungs to the body's tissues and carbon dioxide from the tissues back to the lungs) - Low 12, normal range 13.7 - 17.5 Hematocrit (a medical test that measures the percentage of red blood cells in the blood) - Low 36.6, normal range 40.1 - 51.0% Platelet (small colorless call fragments in the blood that play a crucial role in blood clotting) - Low 80, normal range 163-337 RDW (Red Cell Distribution Width - measures the variation in size of red blood cells) - High 15.7%, normal range 11.6 - 14.4% Neutrophil % (a type of white blood cell (leukocyte) that play a crucial role in the immune system) - High 82. 2%, normal range 34.0 - 67.9% Lymphocyte# (a white blood cell that helps the body fight infection and disease) Low 0.49, normal range 1.32 - 3.57 Monocyte# (white blood cells that play a crucial role in the immune system) Low .23, normal range 0.30 - 0.82 Basophil% (a type of white blood cell (leukocyte) that play a crucial role in the immune system) Low 0.0%, normal range 0.2 - 1.2% Basophil# (a type of white blood cell (leukocyte) that play a crucial role in the immune system) Low 0.00, normal range 0.01 - 0.08 (continued on next page)

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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of Resident #1's electronic medical record from 11/12/24 through 12/03/24 reflected no notation of any communications to Resident #1's MD, PA, or family about of Resident #1's labs, collected 20 days after MD lab order. Interview on 01/28/25 with the PA at 12:48 pm revealed orders were written for labs for Resident #1 on, she thought, 11/13/24 and when Resident #1 was admitted to the hospital, they only had partial lab results. She said every week when she was at the facility, she verbally told the DON and the ADM that she needed the lab work for Resident #1. The facility did not have the results for the CMP blood test ordered on 11/12/24 that referred to Resident #1's level of calcium (an essential mineral that plays a vital role in maintaining strong bones, teeth, and other bodily function). The PA revealed that had they know the results of Resident #1's calcium level in a timely manner, they might have been able to reverse Resident #1's medical condition. The PA revealed Resident #1 was diagnosed at the hospital with sepsis (a lift-threatening condition that occurs when the body's immune system overacts to an infection) and his calcium level could have contribute to sepsis in addition to the fluid overload. She said because the facility was so poor with keeping track of resident labs, she would physically hand the nurses orders for a lab (unable to specifically detail resident names or dates). Interview on 01/31/25 with Resident #1's MD on 12:28 pm revealed he did not know if Resident #1's complete labs were received. He stated it is hard to monitor chronic conditions without lab work and felt that not having the lab work could have contributed to Resident #1's death. The MD stated that Resident #1 suffered from dementia and could not let people know when things were really wrong. He said he repeatedly had to ask for lab work and ask when they were going to draw the specimen for the lab work. He said he would go to the facility and specifically have to ask them to follow through with lab orders (at the time of the interview, he did not have access to resident records and did not have specifics). He said he had waited up to 3 weeks for lab work on stat lab orders. He said he had to beg for labs to be done. He said, it is a very disorganized facility. Interview on 1/29/25 with RN D at 10:37 am revealed the negative outcome of not getting labs processed would be not providing medication that was therapeutic. There is potential for harm if labs are not ordered and reported to the MD. Residents could be hospitalized or die if lab work is not handled properly. Interview on 01/31/25 with RN D at 8:57 am revealed there was no system for labs. The lab tracking was missing, and they thought it went with the former DON and they had to recreate a new one. He said that there are some labs that are signed and scanned into the resident electronic medical record, but the tracking book had been gone for about 2 weeks. He said the DON was responsible for the tracking book. He said nurses were told to, put the labs on the shelf until she picked them up in the morning. He said nursing staff did not have control of the lab book and it was not available to the nurses. He felt it was a failure in the system and the negative impact of this was that they could not keep account of the labs. He said the problem was the labs were not put in a system and that is why labs were missed. He said there were no lab communications put in the electronic medical record and this is how the ball got dropped. He said the facility needed to cross check the lab book and the electronic medical record. He said clearly there was a lack of organization with the labs and it was the responsibility of the nursing staff to keep up with the labs but there was no system set up by the DON, so it was ineffective. He said there was absolutely no follow up or follow through with the DON. (continued on next page)

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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 01/31/25 with the ADM at 4:32 pm revealed the former DON and the former ADON were responsible for the lab tracking and there was no daily lab tracking documentation. When asked for lab orders for Resident #1 and other residents, the ADM said she was unable to produce them. She said she could not locate the notebook that was supposed to contain the lab tracking. She said she thinks maybe the former DON took the lab tracking binder with her when she left but has no proof of this. The ADM said the former DON stopped working for the facility on 01/18/25. She told the surveyor she was able to produce records from the lab they contracted with that reflected resident labs were processed, but no resident lab orders were provided. She said not tracking labs was a problem because it could cause harm to a resident. She stated when labs were not tracked, someone could drop the ball, and something could be missed. The ADM felt the ADON was not trained properly by the DON, and everything was falling by the wayside. She said she wanted to terminate the DON, but she had to make sure she had someone else to take her spot. She said as a nurse you have to follow up and follow through and this was not happening. In an interview on 02/01/25 with the ADM at 12:36 she stated when the former DON left, she did not have DON supervision and she felt like that was a problem. She was told by the former DON that there were systems in place but, hindsight is 20 20 and she now found out that this was not the case at all. The ADM verbally reprimanded the DON and told her that things were being missed, but here we are now. The negative impact of not having systems in place is it could cause harm to the residents. The ADM said not having followed through with the labs could have potentially caused harm to Resident #1. The ADM said it was embarrassing that an MD had to come to the facility and ask for the labs. The ADM was responsible for making sure the DON was doing her duties and the DON not doing her duties was a detriment to the residents. It is a big detriment because nursing is the core of the nursing home. She said she had several conversations with the DON about accountability. She said she did not know that labs were not getting done. In morning meetings, it was not reported to her that labs were not getting done. Facility policy Lab management dated 08/01/21 reflected it is the policy of this community to provide or obtain laboratory services to meet the needs of its residents. The community is responsible for the timeliness of the services. The community must notify the attending physician of the lab results. Procedure All labs require a physician order. 12. The Designated Clinical Officer will be responsible to monitor lab orders to ensure that all ordered labs have been drawn as ordered by the physician. 13. Lab tracking is to be documented daily on the lab tracking form. 14. Ensure that all labs ordered have been collected with results communicated to MD/family in a timely manner. Proof of notification to be included on lab report sheet and slash or in the nurse's notes. 15. Lab personnel will be responsible to report to the charge nurse all labs that have been drawn or not drawn that day. Lab draws that cannot be drawn that day will be communicated to the physician and reordered if necessary. (continued on next page)

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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	16. The designated clinical officer will be responsible to notify the lab when a lab result is not received in a timely manner. 17. If issues are identified with the lab provider process. The designated clinical officer is to contact lab company immediately for corrective action. Quality assurance plan to be developed by lab provider to prevent recurrence of identified issue issue(s). 18. If issue with community process is identified, provide immediate staff in service and re-education regarding the importance of labs and their impact on residents. 19. Lab tracking process is to be monitored during scheduled QAPI meeting. The CDO must periodically check lab tracking book on a random basis to ensure the director of clinical office slash designee is compliant with the process. 20. Ensure lab provider conducts a lab audit per contract and provides community with access to routine labs and frequency. 21. The attending physician will be notified promptly of lab results. 22. Lab results will be maintained in the resident's clinical record. The ADM was notified on 01/29/25 at 5:42 PM that an IJ had been identified and an IJ template was provided. The following POR was approved on 01/31/25 at 4:42 PM: Removal Plan On 1/29/25 an abbreviated survey was initiated at the community. On 1/29/2025 the surveyor provided an Immediate Jeopardy (IJ) Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate threat to residents' health and safety. F770: The facility failed to obtain ordered labs. Resident #1 is an [AGE] year-old male with a DX of chronic respiratory failure with hypoxia. 01/29/2025 Action: DON/ADON completed a lab audit to ensure all labs ordered have been collected with results indicating no other residents to have labs that were ordered and not completed 1/29/25. Report all lab results to MD/NP immediately, report abnormal lab results to MD/NP/DON or designee and documented in each resident EMR 1/29/25. Lab tracking binder will be located at each Nurse's station. DON/ADON will perform lab audits to ensure all labs that are ordered are placed in the lab tracking binder. (continued on next page)

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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Proof of notification to be included on the lab report sheet via signature, date, time and route of notification and documented in the nurse's notes 1/29/25. Lab draws that cannot be drawn that day will be communicated to the physician immediately, documented in residents EMR and checked daily by DON/ADON for completion of results. 1/29/25. Lab results will be maintained in the resident's clinical record via Electric Medical Record integration documentation system 01/29/2025. Administrator/DON and ADON will in-service charge nurses on laboratory monitoring and management with signature for comprehension. Agency and PRN staff will be in- serviced prior to the start of shift in addition to the binder placed at nurses' station with lab policy and procedures 1/30/25. Start Date: 01/29/2025 Completion Date: 01/31/25 Responsible: The DON/designee will be responsible for monitoring lab orders to ensure that all ordered labs have been drawn as ordered by the physician 1/29/25. The ADON/designee will be responsible for notifying the lab when a lab result is not received in a timely manner 1/29/25. If issues are identified with the lab provider process, DON is to contact lab company immediately for corrective action 1/29/25. The Administrator will check lab tracking books monthly via signature page of lab binder to ensure DON/designee is compliant with the laboratory monitoring and management tracking process 1/29/25. QA plan to be developed by Administrator /DON to prevent recurrence of identified issues(s) 1/29/25. Surveyor Monitoring: The surveyor monitored the POR from 02/01/25 from 8:39 AM - 3:21 PM as followed: the activities director, social worker, one agency LVN, one RN, and 4 LVNs (from different shifts) all stated they were in-serviced by the DON or the ADON or designee to report all lab results to MD/NP immediately, to report abnormal lab results to MD/NP/DON or designee, to document labs in each resident EMR, and to document in the Lab tracking binder that will be located at each Nurse's station. The staff stated they understood that Proof of notification is needed and is to be included on the lab report sheets via signature, date, time and route of notification is to be documented in the nurse's notes beginning 1/29/25. Staff further said they were in-serviced that lab draws that cannot be drawn that day will be communicated to the physician immediately, documented in residents EMR and checked daily by DON/ADON for completion of results. In an interview on 02/01/25 with the ADM at 12:30 pm the ADM confirmed that: (continued on next page)

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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The DON/designee will be responsible for monitoring lab orders to ensure that all ordered labs have been drawn as ordered by the physician beginning 1/29/25. The ADON/designee will be responsible for notifying the lab when a lab result is not received in a timely manner beginning 1/29/25. That if issues are identified with the lab provider process, DON, currently the ADM, is to contact lab company immediately for corrective action beginning 1/29/25. The Lab tracking binder will be located at each Nurse's station. The Administrator will check lab tracking books monthly via signature page of lab binder to ensure DON/designee is compliant with the laboratory monitoring and management tracking process 1/29/25. On 02/01/25 at 12:37 pm the surveyor reviewed completed lab audit to ensure all labs ordered have been collected with results indicating no other residents to have labs that were ordered and not completed 1/29/25. On 02/01/25 at 1:02 pm the surveyor observed the lab tracking binder located at the nurse's station. On 02/01/25 at 1:10 pm the surveyor reviewed the QA plan to be developed by Administrator DON to prevent recurrence of identified issues(s) that began 1/29/25. Interview on 02/01/25 with the facility medical director at 8:39 am stated he was informed of the immediate jeopardy. The ADM was notified on 02/01/25 at 4:30 PM that the IJ had been removed. While the IJ was removed, the facility remained at a level of no actual harm at a scope of pattern that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32452 Based on interview and record review, the facility failed to promptly notify the physician of laboratory results that fall outside of clinical reference ranges for one of six residents reviewed for laboratory services. (Resident #1) The facility failed to promptly notify Resident #1's physician of her hematocrit (the ratio of the volume of red blood cells to the total volume of blood.), glucose (blood sugar level), and albumin (blood protein level) laboratory results when they did not fall within the parameters set by the reference range with the lab when her lab was drawn on 2/20/2025 and was not reviewed by Resident #1's physician until 03/06/2025. This deficient practice placed residents at risk for delay in receiving necessary interventions to treat their medical condition. Findings include: Review of Resident #1's face sheet dated 03/06/2025 reflected she was admitted on [DATE] and readmitted on [DATE] with the following diagnoses: dementia (A group of symptoms that affects memory, thinking and interferes with daily life.), Diabetes Mellitus type 2 (A condition results from insufficient production of insulin, causing high blood sugar.) and cerebral vascular accident (occurs when the blood supply to part of the brain is blocked or reduced.). Review of Resident #1's Annual MDS dated [DATE] reflected she was assessed to have a BIMS score of 10 indicating moderate cognitive impairment. Resident #1 was assessed to have anemia, and diabetes Mellitus. Review of Resident #1's comprehensive care plan reflected a focus area dated 03/13/2021: she was on an antiplatelet medication. Interventions included bleeding precautions and to monitor for signs of bleeding. Further review reflected a focus area for anemia. Interventions included to obtain, document, and notify MD of lab and diagnostic work as ordered. Further review of Resident #1's comprehensive care plan reflected she had Diabetes Mellitus and was to be free of signs and symptoms of hypo or hyperglycemia (low or high blood sugar.) Review of Resident #1's nursing progress notes reflected an entry dated 02/18/2025: MD in the facility new orders given for CMP (is a blood test that measures proteins, enzymes, electrolytes, minerals and other substances in your body.), CBC (is a blood test that measures amounts and sizes of your red blood cells, hemoglobin, white blood cells and platelets), HgA1C (measuring the glycated form of hemoglobin to obtain the three-month average of blood sugar.), lipid panel (A complete cholesterol test is a blood test. It can measure the amount of cholesterol and fats called triglycerides in blood.) and phenytoin level (seizure medication blood level). Review of Resident #1's lab results drawn on 02/20/2025 reflected she had abnormal results for her hematocrit, glucose, and albumin levels within the parameters set by the reference range with the lab. The lab was signed as received by the ADON on 2/20/2025. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676355	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/01/2025
NAME OF PROVIDER OR SUPPLIER Brenham Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's nursing progress note dated 03/03/2025 reflected this nurse called MD office to give him resident lab results but was told to fax the results to the office. In an interview on 03/06/2025 at 12:30 PM the ADON stated she signed Resident #1's lab as received on 02/20/2025 and gave it to LVN A to get it to the doctor. She stated she did not follow up on the lab to see if it was returned until 03/03/2025. She stated it should have been followed up on right away to ensure the residents gets the care they need. She stated the lab was still not back and was calling the doctor right now to see if the lab was received by his office. In an interview on 03/06/2025 at 12:49 PM LVN A stated she was not aware Resident #1's lab had not been followed up on until the ADON told her on 03/03/2025. She stated the ADON was supposed to follow up on the labs and no one told her to do that until 03/03/2025. In an interview on 03/06/2025 at 1:00 PM the Administrator stated it was her expectation that labs be followed up on right away. The Administrator stated she noticed the lab was not followed up on in her audit and sent the lab to the doctor herself on 03/03/2025. She stated she expected the nurses to follow up on the labs and to keep track, so the residents' labs are reviewed by the MD and the residents get the care they need. Review of Resident #1's nursing progress note dated 03/06/2025 at 1:39 PM reflected Lab results reviewed by medical director, no new orders at this time. Encouraged protein intake in meals TID for low albumin level. Plan of care continues as ordered. Review of the facility policy Lab Monitoring-Therapeutic levels dated 05/25/2021 reflected It is the policy of this community that physician ordered laboratory services will be provided and monitored . 4) All lab results will be reviewed by a nurse. The nurse will date and document the time the result was reviewed . Abnormal lab results will be faxed to the physician. Note any medications the resident is taking that could affect the lab value and note all treatments that have been done. The fax and original lab results will be maintained at the nurse's station until a response is received from the physician. a) Inform the next shift if you still do not have a response from the physician. b) Inform the DON regarding the abnormal lab values. c) If a reply is needed and there is no reply within 24 hours, you must call the physician's office and notify them of the anormal value. d) Chart in the nurse's notes that you spoke to the physician's office and chart if any orders were obtained. e) The physician's office is to be notified daily until there is a response .