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	03/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brenham Healthcare Center	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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 17141 Based on observations, interviews, and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received necessary services to maintain good nutrition, grooming, personal and oral hygiene for three (Resident #1, #3, and #7) of five residents reviewed for ADLs. The facility failed to provide showers to Residents #1, #3, and #7 in compliance with their shower schedules. This deficient practice could place residents at risk of a decline in hygiene, at risk of skin breakdown, level of satisfaction with life, and feelings of self-worth. Findings included: 1. Review of Resident #1's, undated, face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included chronic obstructive pulmonary disease (disrupted airflow causing difficulty breathing), acquired absence of left leg above knee (amputation), major depressive disorder (depressed mood), diabetes mellitus II (disease characterized by high blood sugar), and chronic pain syndrome. Review of Resident #1's quarterly MDS assessment, dated 3/8/25, reflected a BIMS score of 15, which indicated intact cognition. Section GG (Functional Abilities and Goals) reflected he required substantial/maximal assistance with showering. Review of Resident #1's care plan, revised on 5/2/24, reflected he had an ADL self-care performance deficit related to a need for assistance with ADLs. Review of Resident #1's POC/showering tasks in his EHR, from 2/7/25 - 3/8/25 (30 days), reflected showers were to occur every Monday, Wednesday, and Friday. There were no showers documented during these dates. During an observation and interview on 3/8/25 at 10:36 am, Resident #1 revealed he did not get three showers a week. He stated he usually got a shower when he had wanted one but sometimes they would say there was not enough staff. Resident #1 was noted to have stains and what appeared to be dried food on his face and clothes. Resident #1's fingernails had a dark brown or black substance underneath the nails . (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Some	2. Review of Resident #3's, undated, face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #3 had diagnoses which included diabetes mellitus II (disease characterized by high blood sugar), muscle weakness, morbid obesity (a body weight greater than 80 pounds above ideal weight), unspecified asthma (airway swelling causing narrowing with breathing difficulties), hypertension (high blood pressure), and chronic pain. Review of Resident #3's quarterly MDS assessment, dated 12/13/24, reflected a BIMS score of 14, which indicated intact cognition. Section GG (Functional Abilities and Goals) reflected she was dependent on 2 or more staff assistance with showering. Review of Resident #3's care plan, revised on 1/17/24, reflected she had an ADL self-care performance deficit related to a need for assistance with ADLs due to dependence on the assistance of one staff to provide a shower three times weekly and as needed. Review of Resident #3's POC/showering tasks in her EHR, from 2/7/25 - 3/8/25 (30 days), reflected showers or bed baths were to occur every Tuesday, Thursday, and Saturday. There were 2 showers/bed baths documented during these dates. During an interview on 3/8/25 at 10:36 am, Resident #3 revealed she did not get showers. She stated she had gotten bed baths at times, she thought she had gotten a bed bath a few days ago. Resident #3 stated she did not believe there was usually enough staff on duty to give her a shower because it could be difficult having to use the mechanical lift to transfer . 3. Review of Resident #7's, undated, face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE], with a readmission on 1/23/25. Resident #7 had diagnoses which included convulsions (sudden involuntary muscle contractions), ataxic gait (uncoordinated abnormal walking pattern), and bipolar disorder with psychotic features (mood swings with hallucinations and/or delusions). Review of Resident #7's admission MDS assessment, dated 3/3/25, reflected a BIMS score of 15, which indicated intact cognition. Section GG (Functional Abilities and Goals) reflected he required supervision and/or touching assistance from staff with showering. Review of Resident #7's care plan, revised on 1/27/25, reflected he had an ADL self-care performance deficit related to a need for assistance with ADLs with an intervention of one staff supervision with bathing three times weekly and as needed. Review of Resident #7's POC/showering tasks in his EHR, from 2/7/25 - 3/8/25 (30 days), reflected showers or bed baths were to occur every Tuesday, Thursday, and Saturday. There were 2 showers/bed baths documented during these dates. During an observation and interview on 3/8/25 at 12:05 pm (prior to lunch being served) Resident #7 was observed to be wearing a dark T-shirt and sweatpants with multiple circular holes and multiple stains of unknown origins on the shirt and upper thigh areas of the pants. Resident #7's hair was noted to be disheveled and appeared oily. Resident #7 stated he did not know how long he had been wearing the clothes or when he last showered. He reported the stains were mostly from coffee and food . (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/8/25 at 4:30pm, CNA A stated she worked for an agency and this was her first time to work at this facility. She stated she was given an assignment of the rooms she was to work but did not know who she was supposed to bathe or shower. She stated when she had time she gave bed baths to residents that seemed to need them. CNA A stated she was not able to give a bed bath to all the residents she was assigned. She had not known who was scheduled for a shower, but they all seemed to be lacking on hygiene and appeared not to have been recently bathed, so she had been doing all she could . During an interview on 3/8/25 at 4:48 pm, RN B stated showers were not something that the nurses checked to ensure they were completed. The CNAs verbally let the nurse know when there were any skin issues noted during peri care or showers. RN B stated she did not check staffs' documentation in POC and did not know of being given shower sheets by staff. She stated each resident has an assigned shift and day to receive showers and the CNAs know the schedule . During an interview on 3/9/25 at 2:27pm, CNA C stated she knew they were supposed to be documenting in the POC and when she gave a shower she did document. There had been a few times when the system was not working so they could not get in the POC. CNA C stated there also were times that they were short staffed, and they could not get all the showers done, but if someone looked to need one they tried to get it done . During an interview on 3/9/25 at 2:38pm, CNA D stated she knew they were to be documenting in the POC but since the new company took over there was a problem with the tablets they used to document, so she did not have a method to document. CNA D stated she knew the schedule for the residents to be showered as it was based on the bed, they were assigned whether it was A bed or B bed . During an interview on 3/9/25 at 2:00pm, the ADON stated there used to be a binder for shower information including the shower schedule and shower sheets to fill out. She stated she was not able to locate the binder and only found one loose shower sheet for the previous 30 days. The ADON stated there had not previously been anyone assigned to oversee showers that she knew of but they were currently putting a system in place . During an interview on 3/10/25 at 1:40pm, the ADM stated she was in the process of assigning someone to monitor showers, to ensure they were occurring. The scheduled showers should be occurring three times a week per the shower schedule and as needed. The ADM stated they currently have angel rounds on weekdays and if they see a resident that looks disheveled or dirty they would request one from the CNA or nurse for the resident . During an interview on 3/10/25 at 2:00pm, the facility Owner stated that showers were to be given per the schedule and as requested. He stated the ADON should be monitoring the process to ensure it was happening . A policy regarding hygiene and/or an admission packet including services offered was requested several times on 3/9/25 and 3/10/25, neither were provided at the time of exit.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17141 Based on interviews, and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate administering of all drugs and biologicals) to meet the needs of each resident for 3 of 5 residents (Resident #1, #3, and #7) reviewed for pharmacy services. The facility failed to have a system, medication error reports or monitoring in place to address multiple blank areas in Residents'#1, #3, and #7's medication administration records. This failure could place residents at risk of missed doses of medications resulting in exacerbation or deterioration in health conditions. Findings included: 1. Review of Resident #1's, undated, face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included chronic obstructive pulmonary disease (disrupted airflow causing difficulty breathing), acquired absence of left leg above knee (amputation), major depressive disorder (depressed mood), diabetes mellitus II (disease characterized by high blood sugar), and chronic pain syndrome. Review of Resident #1's quarterly MDS assessment, dated 3/8/25, reflected a BIMS score of 15, which indicated intact cognition. Review of Resident #1's care plan, revised on 5/2/24, reflected he had a focused areas of pain, use of an antidepressant medication (for depression), anticoagulant medication (inhibits blood from becoming thicker), amputation related to blood clot, antiplatelet medication (inhibits platelets from forming together), hypertension (high blood pressure), history of constipation (less than 3 bowel movements a week), hyperlipidemia (high levels of fat particles in the blood), hypothyroidism (decreased thyroid hormone), and seizures. Review of Resident #1's February 2025 MAR revealed the following blank areas in the sections where the nurse put their initials indicating the medication was given. -2/4 for amlodipine 10 mg one time a day for hypertension, to be administered at 9:00am. Lisinopril Tablet 20 mg one tablet a day for hypertension at 9:00am. Bupropion 300 mg one time a day for depression to be given at 9am. Tradjenta 5 mg one time a day for diabetes (high blood sugar) at 9am. Apixaban 5mg two times a day for DVT (blood clot) to be given at 9am and 5 pm. The 9am initial area was blank. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Docusate Sodium 100mg to be given two times a day for constipation to be given at 9am and 5pm. The 9am initial area was blank. Keppra 750mg two times a day for seizures to be given at 9am and 5pm. The 9am initial areas were blank. Metformin 500mg two times a day to be given at 9am and 5pm. The 9am initial area was blank. -2/7 Apixaban 5mg two times a day for DVT to be given at 9am and 5 pm. The 5pm initial area was blank. Docusate Sodium 100mg to be given two times a day for constipation to be given at 9am and 5pm. The 5pm initial area was blank. Keppra 750mg two times a day for seizures to be given at 9am and 5pm. The 9am initial areas were blank. Metformin 500mg two times a day to be given at 9am and 5pm. The 5pm initial area was blank. -2/16 Oxycodone 10 mg one time a day for pain to be given at 4:00pm. Apixaban 5mg two times a day for DVT to be given at 9am and 5 pm. The 5pm initials area was blank. Docusate Sodium 100mg to be given two times a day for constipation to be given at 9am and 5pm. The 9am and 5pm initial areas were blank. Keppra 750mg two times a day for seizures to be given at 9am and 5pm. The 5pm initials areas were blank. Metformin 500mg two times a day to be given at 9am and 5pm. The 5pm initials area was blank. -2/28 for Atorvastatin Calcium tablet 20 mg one time a day for Hyperlipidemia at 6:00pm. Apixaban 5mg two times a day for DVT to be given at 9am and 5 pm. The 5pm initials area was blank. Docusate Sodium 100mg to be given two times a day for constipation to be given at 9am and 5pm. The 5pm initials area was blank. Keppra 750mg two times a day for seizures to be given at 9am and 5pm. The 9am initial areas were blank. Metformin 500mg two times a day to be given at 9am and 5pm. The 5pm initials area was blank. During an interview on 3/8/25 at 10:36 am, Resident #1 stated he did not have concerns regarding his medications as far as he knew he was getting them. (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident #3's, undated, face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #3 had diagnoses which included diabetes mellitus II (disease characterized by high blood sugar), muscle weakness, morbid obesity (a body weight greater than 80 pounds above ideal weight), unspecified asthma (airway swelling causing narrowing with breathing difficulties), hypertension (high blood pressure), and chronic pain. Review of Resident #3's quarterly MDS assessment, dated 12/13/24, reflected a BIMS score of 14, which indicated intact cognition. Review of Resident #3's care plan, revised on 1/17/24, reflected she had focused areas of pain, use of an antidepressant medication, anticoagulant medication, hypertension, chronic atrial fibrillation (irregular heartbeat), hyperglycemia (high blood sugar), hyperlipidemia (high levels of fat particles in the blood), insomnia (persistent problems with falling or staying asleep), and asthma. Review of Resident #3's February 2025 MAR revealed the following blank areas in the sections where nurse put their initials indicating the medication was given. 2/12- Junuvia 50 mg one time a day at 6am for diabetes. Initials space was blank. Levothyroxine Sodium 25 mcg one time a day at 8am for low thyroid hormone. Initials space was blank. 2/16- Polyethylene 17GM /scoop two times a day at 9am and 5pm for constipation. Initials space was blank for 5pm. Pregabalin 150 mg three times a day at 8am, 2pm, and 8pm. Initials space was blank for 2 pm. Tramadol 50mg three times a day at 9am, 3pm, and 9pm. Initials space was blank for 3pm. 2/25- Insulin Glargine Max SoloStar solution 300 unit/ml, inject 45 units at 8pm for diabetes. Initials space was blank. Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) one vial two times a day for wheezing. Initials space was blank for 5pm. Lyumjev Kwikpen 100 units/IM solution to be given 4 times a day per sliding scale (determined by blood sugar reading to be taken prior to administration) to be given at 7am, 11:30am, 4:30pm, and 8pm. Initials space was blank for 4:30pm and 8pm, a blood sugar level was not recorded for either time. 2/28- Insulin Glargine Max SoloStar solution 300 unit/ml, inject 45 units at 8pm for diabetes. Initial space was blank. Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) one vial two times a day for wheezing. Initial space was blank for 5pm. Lyumjev Kwikpen 100 units/IM solution to be given 4 times a day per sliding scale (determined by blood sugar reading to be taken prior to administration) to be given at 7am, 11:30am, 4:30pm, and 8pm. Initials space was blank for 8pm, a blood sugar level was not recorded. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/8/25 at 10:36 am, with Resident #3 she stated there were times that she did not get her medications, it was infrequent and usually only if there were computer problems or new staff. 3. Review of Resident #7's, undated, face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE], with a readmission on 1/23/25. Resident #7 had diagnoses which included convulsions (sudden involuntary muscle contractions), ataxic gait (uncoordinated abnormal walking pattern), and bipolar disorder with psychotic features (mood swings with hallucinations and/or delusions). Review of Resident #7's admission MDS assessment, dated 3/3/25, reflected a BIMS score of 15, which indicated intact cognition. Review of Resident #7's care plan, revised on 1/27/25, reflected he had focused areas of a history of seizures and a history falls with fractures. Review of Resident #7's February 2025 MAR revealed the following blank areas in the sections where the nurse put their initials indicating the medication was given. 2/12 Carafate 1GM to be given every eight hours for GERD (stomach contents flow back up into the esophagus causing irritation to the lining). The initials space for 6am was blank. 2/16 Clobazam oral suspension 2.5 MG/ML, give 4ML two times a day at 9am and 5pm for seizures. Initials space was blank for 5pm. Carafate 1GM to be given every eight hours for GERD. The initials space for 2pm was blank. Sodium Chloride 1GM to be given three times a day at 8am, 2pm, and 7pm for hyponatremia. The initials space for 2pm was blank. 2/28 Clobazam oral suspension 2.5 MG/ML, give 4ML two times a day at 9am and 5pm for seizures. Initials space was blank for 5pm. Lactulose oral solution 10GM/15ML give 30 ML two times a day at 9am and 5pm for hyperammonemia. Initials space was blank for 5pm. During an interview on 2/9/25 at 5:41 am LVN E stated he was not aware of medication error reports they were to fill out. If he made a medication error, he would report it to the DON or the ADON . During an interview on 2/9/25 at 12:09pm LVN F revealed she did not leave blank spots in the MARs, she puts the reason a medication was not given. LVN F stated if she made a medication error, she would report it to the DON that the error was made. She did not know of any report they were to fill out . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/10/25 at 2:00pm with the facility ADON she stated they did not have any medication error reports filled out during the previous 3 months and she was unable to find a blank medication error report. She stated there should not be any blank areas in the MAR. There was a legend for things like the medication was not available, the resident was in the hospital, the medication was refused. The nurse should be putting a number from the legend to document the reason. She stated as far as she knew there had not been anyone monitoring the MARs for issues. She stated she would implement looking at the MARs in the morning meetings. The ADON stated they would need to train nurses about the use of medication error reports and have the reports checked for any patterns . During an interview on 3/10/25 at 1:40 pm with the ADM she stated there has been an issue with newly hired DON's quitting causing gaps in nursing leadership. The ADM stated she did not know the reason for the uninitialed medications in the MAR. A system has not been put in place as it should have been to monitor medications. Blank spaces in the MAR would be a medication error. It would be the DONs responsibility to monitor and ensure medications had been given. They currently do not have a medication error report but were in the process of setting up a system to utilize the reports and nursing staff would receive in-services regarding using the reports and no blank areas were to be left in the MAR. The ADM stated there should be an explanation for any time a resident did not receive their medications . During an interview on 3/10/25 at 12:36 pm with the facility MD revealed he did not know as he was unable to remember if he was told of specific shifts or times when medications were not given. He stated he knew he has been contacted before regarding an error but did not realize there were no medication error reports. Review of the Texas Health and Human Services, Evidence-Based Best Practices for Medication Management in LTC provided by the facility as their policy, revised 01/2024, revealed the policy included the following: Overview Medications are an important aspect of care provided to people living in the nursing facilities (NFs). Treatment with medications is directed toward achieving various health and quality of life-desired outcomes, such as reducing or eliminating symptoms, or preventing or treating a disease process. And Maintain a communication and reporting system to notify facility leadership/staff and families of pharmaceutical service issues for people living in the facility (e.g., medication errors, side effects, adverse drug events, etc.)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17141 Based on interviews and record review the facility failed to ensure residents were free of any significant medication errors for 1 of 5 residents (Resident #1) reviewed for significant medication errors. The facility failed to ensure Resident #3 received her prescribed medication ipratropium-albuterol solution for asthma. Resident #3 did not receive scheduled doses from order given on 11/13/24 through 2/13/25. This failure could place residents at risk of complications from deterioration in health, and hospitalization s. Findings included: Review of Resident #3's, undated, face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #3 had diagnoses which included diabetes mellitus II (disease characterized by high blood sugar), muscle weakness, morbid obesity (a body weight greater than 80 pounds above ideal weight), unspecified asthma (airway swelling causing narrowing with breathing difficulties), hypertension (high blood pressure), and chronic pain. Review of Resident #3's quarterly MDS assessment, dated 12/13/24, reflected a BIMS score of 14, which indicated intact cognition. Review of Resident #3's care plan, revised on 11/26/24, reflected she had a focused area for asthma related to congestive heart failure and another focus area for an ineffective breathing pattern related to Asthma. Interventions include Give nebulizer treatments and oxygen therapy as ordered. Initiated on 9/29/23 and Administer medications, respiratory treatments, and Oxygen as ordered. Review of Resident # 3's Pulmonologist Progress/Visit Note, dated 11/13/24, provided by Resident #3's FM, reflected the visit was a 6-month follow-up visit. Resident #3's diagnoses listed included asthma. Current medications on the Pulmonologist listed included ipratropium- albuterol solution 0.5-2.5 (3) mg/ml. The treatment plan for Resident #3's moderate persistent asthma, without complications included continuing ipratropium- albuterol solution 0.5-2.5 (3) mg/ml two times a day for 30 days with 6 refills. Review of Resident #3's EHR revealed there was not a copy of the pulmonologist visit included in the record. Review of Resident #3's Progress Notes from 1/1/25 through 3/8/25 revealed the following: 11/13/24- notes Resident #3 is out for an appointment. 2/14/25- Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/ML 1 vial inhale orally two times a day for Prophylaxis; Wheezing. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/9/25-RP stated that the Pulmonologist gave an order for Ipratropium-Albuterol PRN, and was discontinued, and she want it back in the system for the resident. MD notified, new order given for Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/ML 1 vial inhale orally every 8 hours as needed for S.O.B./Wheezing. Review of Resident #3's MARs revealed they included following: November 2024 and December 2024 - have a section of the MAR which included- take 3ml nebulization everyday prn for wheezing or shortness of breath every 8 hours as needed. No name of medication was included. All days for both months were blank indicating not given. January 2025- has a section of the MAR which included- take 3ml nebulization everyday PRN for wheezing or shortness of breath every 8 hours as needed. No name of the medication was included. All days were blank until 1/10/25 when the order was discontinued. Feburary2025-on 2/9/25 a prn order was added for Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/ML 1 vial inhale orally every 8 hours as needed for S.O.B./Wheezing. On 2/14/25 Ipratropium-Albuterol Solution 0.5-2. 5 (3) MG/ML 1 vial inhale orally two times a day for Prophylaxis; Wheezing. Review of Resident #3's Physician Order Summary revealed orders listed for ipratropium-albuterol solution dated as follows: -7/26/24- ipratropium- albuterol solution 0.5-2.5 (3) mg/ml one applicator full, inhale orally every 24 hours PRN for S.O.B. -8/5/24- ipratropium- albuterol solution 0.5-2.5 (3) mg/ml vial inhale orally every 3 times a day for asthma. -2/9/25- ipratropium- albuterol solution 0.5-2.5 (3) mg/ml vial inhale orally every 8 hours PRN for S.O.B. -2/14/2025- ipratropium- albuterol solution 0.5-2.5 (3) mg/ml vial inhale orally two times a day for prophylaxis; wheezing. During an interview on 3/8/25 at 9:40am with Resident #3 revealed she was relieved that she gets scheduled nebulizer treatments. Resident #3 stated she had been nervous when there was not a nebulizer machine in her room. Resident #3 denied she had problems with her breathing while she was not receiving treatments. (continued on next page)

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	03/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brenham Healthcare Center	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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/8/25 at 6:25 pm with Resident#3's FM revealed they were concerned for Resident #3 not receiving her asthma medication as was ordered. FM stated a ride was provided for Resident #3 to see her pulmonologist on 11/13/24, the nursing staff at the time knew and when they returned the nurse was given a copy of the visit results. The Pulmonologist had continued orders for nebulizer breathing treatments. The FM stated Resident #3 had been saying for months that she was not getting her breathing treatments, but the FM assumed she was saying there still was an order but they had missed giving one of the treatments. The FM stated it never entered their mind that the order had been discontinued. The FM stated Resident #3 had the diagnosis of asthma and had been receiving nebulizer treatments for years. The FM stated in mid-February when entering Resident #3's room they heard her wheezing. The FM stated they started to turn on the call light and realized there was not a nebulizer in the room to administer a treatment. The FM stated it was then realized that the resident had not been receiving treatments at all. The FM stated Resident #3 was not going to admit she had any problems with her asthma because she did not want to get anyone in trouble . During an interview on 3/10/25 at 12:32pm with the facility MD revealed he was also Resident #3's doctor. The MD stated he was aware of Resident #3's diagnosis of asthma. He stated the treatment varies per person. The MD stated he did not know if he was the one to discontinue the nebulizer treatment or not, he was not able to remember, he might have. He also stated he did not know if he was aware of the pulmonologist visit or orders given. Review of the Texas Health and Human Services, Evidence-Based Best Practices for Medication Management in LTC provided by the facility as their policy, revised 01/2024, revealed the policy included the following: Overview Medications are an important aspect of care provided to people living in the nursing facilities (NFs). Treatment with medications is directed toward achieving various health and quality of life-desired outcomes, such as reducing or eliminating symptoms, or preventing or treating a disease process.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 17141 Based on observations and interviews, the facility failed to ensure all drugs and biologicals were stored in locked compartments and labeled in accordance with currently accepted professional principles reviewed for medications stored in 1 of 2 medication areas (medication room and closet outside of the medication room) reviewed for storage. The facility failed to keep medication in a secured area. This failure could place residents in the facility at risk of drug diversion or misuse of medications leading to harm. Findings included: During an observation on 3/9/25 at 5:40 am revealed directly to the side and in front of the medication room was a closet with the door ajar. Inside the closet were 4 large containers of liquid polyethylene glycol (laxative). During an interview on 3/9/25 at 5:41 am, LVN E revealed he had worked since 6:00pm the night before. He stated he did not know the closet contained the liquid polyethylene glycol. LVN E stated the door to the closet did have a lock on it and he did not have a key, so it was always left unlocked. He stated the bag leaning up against the medication belonged to him . During an interview on 3/9/25 at 11:30am with the facility ADM revealed that all medications whether over the counter or prescribed were to be in the medication room or on a cart in a locked area. She stated she did not know the polyethylene glycol was in the closet and did not know who put it there but it had been moved once she became aware . Review of the Texas Health and Human Services, Evidence-Based Best Practices for Medication Management in LTC provided by the facility, revised 01/2024, revealed the following: Maintain medication room, carts and boxes as/with locked and secured.