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	04/25/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46708 Based on observation, interview, and record review the facility failed to develop, a comprehensive care plan of each resident that included measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs for one (Resident #1) out of five residents reviewed for care plans, in that: The facility failed to develop a comprehensive care plan that indicated Resident #1 emptied his own colostomy bag. This failure placed residents at risk of not having their individualized needs met in a timely manner, create infection control issues, and could result in injury, a decline in physical well-being. Findings included: Review of Resident #1's face sheet dated 04/25/25 reflected a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including osteomyelitis (a bone infection usually caused by bacteria, that can spread from other infections in the body through the bloodstream or directly into a wound or fracture), functional quadriplegia (the complete inability to move due to severe disability or frailty caused by a medical condition, without any damage to the brain or spinal cord), and dependence on renal dialysis (occurs when an individual's kidneys are no longer functioning properly and require regular dialysis treatment to filter blood and maintain bodily function). Review of Resident #1's most recent MDS, dated [DATE], reflected a BIMS score of 15, indicating intact cognition. Section H - Bladder and Bowel reflected ostomy (a surgically created opening on the abdominal wall that allows waste products (stool or urine) to exit the body). (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's care plan reflected a focus initiated 01/09/25 of Resident #1 has an alteration in gastro-intestinal status colostomy related to disease process and has a behavior which he [requests] frequent colostomy changes which can result in skin breakdown with a goal dated 01/09/25 of Resident #1 will remain free from discomfort, complications or signs and symptoms of gastro-intestinal alterations through review date and interventions of discuss with the resident/family caregivers any concerns/fears issues related to gastro-intestinal distress dated 01/09/25, intervention for behavior: Resident #1 will be educated on the risk with requesting frequent colostomy changes dated 03/07/25 and intervention obtain and monitor lab/diagnostic work as ordered dated 01/09/25. Resident #1 had a care plan focus initiated on 01/08/25 of Resident #1 had an ADL self-care performance deficit related to the disease process of amputation of toes, right foot, disease process multiple myeloma (a blood cancer where plasma cells, a type of white blood cell, grow abnormally and produce too much of an abnormal antibody called M protein) and quadriplegia (paralysis of all four limbs) with a goal initiated on 01/08/25 of Resident #1 will maintain current level of function of ADLs and interventions dated 01/08/25 of bathing/showering Resident #1 was able to assist with washing upper torso and face. Review of Resident #1's EMR TAR reflected that the last time Resident #1 received ostomy care was on 04/24/25 on the 2nd nursing shift which began at 6:00 pm. Observation and interview on 04/25/25 with Resident #1 at 11:53 pm revealed Resident #1, after showing the surveyor his colostomy bag, which was fully inflated and had dark smudge marks all over the outside, Resident #1 took a white garbage bag from the right side of his bed, and explained, at times, he took care of his own colostomy bag. Resident #1 did not put on his call light. He explained that he emptied the colostomy by wrapping the white trash bag around the colostomy bag, opening the white trash bag, and pushing on the colostomy bag. After this process was completed, Resident #1 explained he then tossed the white trash bag with any feces in it onto the floor to the left side of his bed and staff would periodically come into his room and pick up the white trash bag to discard it. Resident #1 said staff was aware that he emptied his own colostomy bag. He said staff also emptied it. Interview on 04/25/25 with LVN A at 2:29 pm revealed Resident #1 would empty his colostomy bag himself. She said staff told him to use the call light to ask for help, but he still emptied it by himself. She stated when he was done with the bag he used to gather the contents of the colostomy, he would put it on the floor by his bed and the contents of the bag would splatter on the floor. She said it was a daily behavior with Resident #1. LVN A revealed this was an infection control issue and everyone was aware of this behavior, and she felt he would not stop this behavior. LVN A said she had access to review care plans, but she did not create care plans. She said the care plans had interventions to provide ways to deal with resident behaviors. She said they had morning meetings where Resident #1's behavior of him emptying his own colostomy bag was discussed. She said Resident #1's behavior of self-emptying his colostomy bag and discarding the unsealed trash bag on the floor with feces leaking onto the floor of his room should have been documented in his care plan. Interview on 04/25/25 with CNA B at 3:14 pm revealed Resident #1 was not supposed to empty his own colostomy bag, but he did anyway. She said staff told him constantly every day not to do it because it got very messy. She said Resident #1 did not tie the top of the plastic bag he used when emptying the contents of the colostomy bag and he threw the bag on the floor, and it spattered, and the contents went everywhere. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/25/25 with the ADON at 4:15 pm revealed Resident #1 took care of his colostomy bag himself and it was an infection control problem. She said she discussed with him not emptying the bag himself, but letting the staff empty the bag. The ADON said she had pictures of him sitting in the nurses' station removing his colostomy bag. She said she was sure that this was something that should be care planned. She said a care plan provides a plan of care for resident care with measures and interventions. She said a care plan identifies resident problems and provides interventions on the steps and ways to address the problem. She said she provided an intervention of giving Resident #1 a tall trash can located on the left side of Resident #1's bed so he could deposit his trash in a trash can and not on the floor. The ADON said resident behaviors should be documented in the care plan and Resident #1's behavior of emptying his own colostomy bag was discussed in morning meetings and she was surprised that this behavior was not in his care plan. Interview on 04/25/25 with the DON at 4:45 pm revealed that the care plan was a document that described from A - Z resident care and it told the story of the resident. She said that if you did not have a care plan in place that had all the resident's issues included, there would be a lack care and service to the resident in the area that was not care planned. She said the MDS coordinator was responsible for the care plans, but the MDS coordinator was not a floor nurse and would not have seen this issue. She said she had heard about the problems with Resident #1 emptying his own colostomy bag, but the issues had not been discussed in the care plan. Review of facility policy Using the Care Plan Policy Statement dated August 2006 reflected care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident. Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Completed care plans are placed in the resident's chart and/or in a 3-ring binder located at the appropriate nurses' station. The Nurse Supervisor uses the care plan to complete the CNAs daily/weekly work assignment sheets and/or flow sheets. CNAs are responsible for reporting to the Nurse Supervisor any change in the resident's condition and care plan goals and objectives that have not been met or expected outcomes that have not been achieved. Other facility staff noting a change in the resident's condition must also report those changes to the Nurse Supervisor and/or the MDS Assessment Coordinator.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46708 Based on interview and record review, the facility failed to provide the necessary services to maintain personal hygiene for 1 (Resident #1) of 6 residents reviewed for ADLs. The facility failed to provide Resident #1 with adequate showers/baths. Resident #1 received three (3) showers/baths in March 2025 and no showers/baths in April 2025. This failure could place residents who required assistance for bathing at risk of not receiving care and services to meet their needs. Findings included: Review of Resident #1's face sheet dated 04/25/25 reflected a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including osteomyelitis (a bone infection usually caused by bacteria, that can spread from other infections in the body through the bloodstream or directly into a wound or fracture), functional quadriplegia (the complete inability to move due to severe disability or frailty caused by a medical condition, without any damage to the brain or spinal cord), and dependence on renal dialysis (occurs when an individual's kidneys are no longer functioning properly and require regular dialysis treatment to filter blood and maintain bodily function). Review of Resident #1's most recent MDS, dated [DATE], reflected a BIMS score of 15, indicating intact cognition. Review of Resident #1's care plan reflected a focus initiated 01/09/25 of Resident #1 has an alteration in gastro-intestinal status colostomy related to disease process and has a behavior which he [requests] frequent colostomy changes which can result in skin breakdown with a goal dated 01/09/25 of Resident #1 will remain free from discomfort, complications or signs and symptoms of gastro-intestinal alterations through review date and interventions of discuss with the resident/family caregivers any concerns/fears issues related to gastro-intestinal distress dated 01/09/25, intervention for behavior: Resident #1 will be educated on the risk with requesting frequent colostomy changes dated 03/07/25 and intervention obtain and monitor lab/diagnostic work as ordered dated 01/09/25. Resident #1 had a care plan focus initiated on 01/08/25 of Resident #1 had an ADL self-care performance deficit related to the disease process of amputation of toes, right foot, disease process multiple myeloma (a blood cancer where plasma cells, a type of white blood cell, grow abnormally and produce too much of an abnormal antibody called M protein) and quadriplegia (paralysis of all four limbs) with a goal initiated on 01/08/25 of Resident #1 will maintain current level of function of ADLs and interventions dated 01/08/25 of bathing/showering Resident #1 was able to assist with washing upper torso and face. Record review of Resident #1's shower log from 03/01/25 through 04/25/25 reflected the following: 1. Resident #1 skin monitoring: comprehensive CNA shower review dated 03/11/25 indicated bath given to Resident #1. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #1 skin monitoring: comprehensive CNA shower review dated 03/17/25 indicated bath given to Resident #1. 3. Resident #1 skin monitoring: comprehensive CNA shower review dated 03/21/25 indicated bath given to Resident #1. Interview on 04/25/25 with Resident #1 at 11:53 am reflected he had four (4) bed baths in the 90 days he had been at the facility. He said it made him feel dirty and that the facility staff did not care about him. Interview on 04/25/25 with CNA C at 3:30 pm reflected she had assisted Resident #1 was resident care and said he received his showers, but he preferred more of a wipe down to a shower. She said his showers were scheduled in the morning, but sometimes he would be at dialysis, and they would let the evening staff know that he did not get a shower and the evening staff would bath him. She said that sometimes Resident #1 refused his bath, but this refusal would be recorded on the shower sheet, but sometimes she would forget to do this. She said that if a resident did not have a bath over a period of time, their skin could go bad, they could smell, and they could be uncomfortable. Interview on 04/25/25 with LVN A at 2:29 pm revealed the CNAs were responsible for giving showers and recording on a shower sheet when the resident received a shower or if the resident refused a shower. She said that Resident #1 preferred a bed bath. She said that Resident #1 did refuse showers often, but there should be a shower sheet for each time that Resident #1 refused a shower. The negative effect of a resident not getting a shower was bad odor, possible skin breakdown and the resident could get upset because they might not feel well because they are unclean. She said it is the responsibility of the team, everyone on the staff, to make sure residents got their shower. Interview on 04/25/25 with the ADON at 4:15 pm revealed they have a shower schedule that includes the CNAs filling out shower sheets when residents have a shower or, when residents refuse a shower. She said that regardless of if a resident has a shower or not, documentation was required on the shower sheet for that resident's shower day and time for details of if the resident had a shower, the type of shower or bath that was given and to record if the resident refused a shower. The ADON said it was the responsibility of the charge nurse to make sure that resident showers were both being done and had the proper documentation. She said there should have been shower sheets that indicated if Resident #1 refused his preferred bed bath over a shower. The ADON said the negative effect of residents not getting their showers was possible skin breakdown. Interview on 04/25/25 with CNA B at 3:14 pm revealed she worked with Resident #1 and said he prefers bed baths and had not gotten his bed baths because he was at dialysis on Mondays, Wednesday, and Fridays. She said the facility policy was to fill out a resident shower sheet even when the resident refused a shower. The CNA was supposed to inform the nurse when the resident refused a shower and the nurse would try and convince the resident to take a shower and if the resident still refused, to inform the residents family. When CNA B was told that there were 3 shower sheets for Resident #1 for all of March 2025 and from 04/01/25 through 04/25/25 she said she did not know what could have happened to the shower sheets. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/25/25 with the DON at 4:45 pm revealed there were no shower sheets from January 2025 or February 2025 because the facility was acquired, and the former owners took the shower sheets for those two months. The DON said the ADONs were responsible for making sure that the showers were done. She stated the CNAs gave did a shower sheet that should document if the resident had a shower, what type of a shower or bath the resident had and if the resident refused the shower. She said the shower sheets should be accurate and document if a resident refused a shower. She said if a resident did not have a shower, there should still be a shower sheet. She said that if a resident did not receive a shower, the CNA should notify the ADON and the ADON should try and encourage the resident to get a shower, or a bath and the nurse should document in the resident progress notes that the resident did not get a shower and why. She said that was was absolutely a problem that the shower sheets reflected that Resident #1 only received 3 showers from 03/01/25 through 04/25/25. She said negative effect of a resident not receiving a shower was that the residents' skin could breakdown. Review of the Activities of Daily Living (ADLs), Supporting Policy Statement dated March 2018 reflected residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming, and oral care).