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	05/14/2025

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** 48606 Based on observations, interviews, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs for 1 (Resident # 1) of 7 residents reviewed for care plans. Resident #1's comprehensive care plan did not reflect her current UTI or history of urinary tract infections. Resident #1's comprehensive care plan did not reflect diagnosis of severe Sepsis after discharge from hospital on 04/17/2025. Resident # 1's comprehensive care plan did not reflect diagnosis of E-Coli and COVID -19 after discharge from hospital on 04/17/2025. This failure could place residents at risk of not receiving needed services and care to improve their health. Findings Include: Record review of Resident #1's face sheet, dated 05/05/2025, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included Dementia, (memory loss), anxiety, and hypothyroidism (thyroid gland not producing enough thyroid hormones). Record review of Resident # 1's MDS, dated [DATE], reflected Resident #1 's BIMS assessment could not be completed. The MDS did not reflect her history of UTI, Sepsis, COVID and antibiotic use. Record review of Resident #1' s care plan dated 05/12/2025 reflected Resident #1 had no care area to address urinary tract infections. Record review of Resident #1's Physician order reflected on 05/08/2025 Cipro Oral Tablet 500 MG (Ciprofloxacin HCl) Give 1 tablet by mouth at bedtime for UTI for 7 Days, and 05/06/2025 Cranberry Oral Capsule 250 MG (Cranberry Vaccinium macrocarpon) Give 1 capsule by mouth in the morning for UTI. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident # 1's diagnostic laboratory final report date 07/31/2024 reflected, enterococcus faecalis (bacteria in the intestines), Proteus mirabills (bacteria that causes urinary tract infections (UTIs) and was prescribed amoxicillin Route - PO Dosage - Asymptomatic bacteriuria (bacteria in urinary tract that make urination difficult: 500mg q8hr or 875mg q12hrs for 4-7 days. Acute uncomplicated Cystitis (Bladder infection): 500mgq8hrs Record review of Palliative Care consult notes dated 04/17/20205 reflected, assessment/ plan . admitted to the hospital for severe sepsis. Supportive and Palliative Care consulted for goals of care. Patient's quality of life has declined significantly in the past few months. Record review of Resident # 1 hospital after visit summary dated 04/13/2025 - 04/17/2025 reflected a diagnosis of severe sepsis, Atrial fibrillation with RVR (HCC) (irregular heartbeat) and E coli bacteremia (bacteria in the bloodstream) and COVID-19 (illness caused by a virus. Observation and interview on 05/14/2025 at 10:00AM revealed Resident #1 sitting in her wheelchair while in the activity room. Resident #1's name was called, and she was asked how she was feeling; however, she did not respond and began to propel her wheelchair away from Surveyor. Resident #1 was unable to provide any information. In an interview with the DON on 05/14/25 at 4:06 PM, she said all the care plans should reflect the resident's status and the care plan should have been revised to reflect her current UTI status. She stated Resident #1 is currently on an antibiotic for her UTI. She stated, they have an MDS coordinator who is responsible for all care plans, but she would start helping with care plan updates. She stated she would update Resident #1's care plan on 05/14/2025, because her MDS coordinator was not available. She stated not updating the care plan may prevent nurses and CNAs from providing needed care to the residents. She stated CNAs would need to ensure Resident # 1 is given proper perineal care and ensure she is hydrated. She stated frequent UTIs could lead to other medical problems such as sepsis (inflammation throughout the body that can lead to tissue damage, organ failure and even death). In an interview with the Administrator on 05/14/2025 at 5:00 PM, she said she was not aware of Resident #1's UTIs not being care planned. She stated their MDS coordinator and DON were responsible for resident's care plans. She stated their MDS coordinator works remotely and during their morning meetings any resident concerns to include care plans are discussed. She stated she was not sure how Resident #1's care plan was missed. She stated the risk of not having Resident #1's UTIs care planned was the staff would not know how to provide quality care which could lead to further risk of infections. An interview with MDS coordinator was attempted on 05/14/2025 at 5:15PM by phone; however, she did not answer. Record review of facility's policy on care plan dated 2001 revised August 2006 indicated title -Using the care Plan- Policy Statement The 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 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The Nurse Supervisor uses the care plan to complete the daily and weekly work assignment sheets and/or flow sheets. 3. 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. 4. 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. 5. Changes in the resident's condition must be reported to the MDS Assessment Coordinator so that a review of the resident's assessment and care plan can be made. 6. Documentation must be consistent with the resident's care plan. 7. Information contained on the care plan and other documents used by the nursing staff shall be maintained in a confidential manner in accordance with established facility policy.Based on observations, interviews, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs for 1 (Resident # 1) of 7 residents reviewed for care plans. Resident #1's comprehensive care plan did not reflect her current UTI or history of urinary tract infections. Resident #1's comprehensive care plan did not reflect diagnosis of severe Sepsis after discharge from hospital on 04/17/2025. Resident # 1's comprehensive care plan did not reflect diagnosis of E-Coli and COVID -19 after discharge from hospital on 04/17/2025. This failure could place residents at risk of not receiving needed services and care to improve their health. Findings Include: Record review of Resident #1's face sheet, dated 05/05/2025, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included Dementia, (memory loss), anxiety, and hypothyroidism (thyroid gland not producing enough thyroid hormones). Record review of Resident # 1's MDS, dated [DATE], reflected Resident #1 's BIMS assessment could not be completed. The MDS did not reflect her history of UTI, Sepsis, COVID and antibiotic use. Record review of Resident #1' s care plan dated 05/12/2025 reflected Resident #1 had no care area to address urinary tract infections. (continued on next page)

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