

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 06/10/2025
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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 1 of 4 residents (Resident #1) reviewed for rights.</p> <p>The facility failed to ensure Resident #1 was not put in two briefs by CNA B on 06/07/2025.</p> <p>This failure could place residents at risk for decreased quality of life, decreased self-esteem and diminished dignity.</p> <p>Findings include:</p> <p>Review of Resident #1's face sheet dated 06/10/2025 reflected an [AGE] year-old female admitted on [DATE] with diagnoses of unspecified dementia (loss of memory, language, problem-solving and other thinking abilities that interfere with daily life), chronic kidney disease, stage 4 (severe kidney damage, loss of kidney function and where kidneys struggle to filter waste and fluid from the body), and, other lack of coordination (difficulties with movement or balance).</p> <p>Review of Resident #1 unspecified MDS assessment dated [DATE] Resident #1 had memory problem and skills for daily decision making were severely impaired. Review reflected Resident #1 required partial/moderate assistance (helper does less than half the effort) for toileting hygiene. Further review reflected Resident #1 was always incontinent of urine and bowel. Resident #1 had no skin conditions at the time of MDS assessment.</p> <p>Review of Resident #1 care plan dated 05/14/2025 reflected Resident #1 had a history of UTIs with interventions to encourage fluids, and monitor for signs or symptoms of UTI. Further review of care plan dated 06/07/2023 reflected Resident #1 was at risk for skin breakdown with intervention that all staff were to be aware of resident's skin fragility.</p> <p>Review of Resident #1 skin assessment note dated 06/08/2025 by ADON A reflected Resident #1's skin was warm and dry, with skin color within normal limits.</p> <p>During an attempted interview on 06/12/2025 at 2:15 PM, Resident #1 answered questions with garbled words and smiled. Resident nodded to questions that were open-ended. Resident was observed clean and free of odors. Resident was not interviewable.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/07/2025 FM stated Resident #1 was found wearing two briefs at one time on 06/07/2025 between 4:30 pm and 5:00 pm, FM stated they were concerned because Resident #1 had a history of UTIs. FM stated a CNA (could not recall who) that also passed medications stated she (CNA) put two briefs on Resident #1 because she was being combative. FM stated Resident #1 had stage 4 kidney disease. FM stated she believed this was the fourth time she observed Resident #1 to have an additional brief.</p> <p>During an interview on 06/10/2025 at 1:09 PM, LVN C stated she worked 06/07/2025 from 6:00 am to 6:00 PM. LVN C stated that she (LVN C) passed medication and the medication aide worked as a CNA on 06/07/2025. LVN C did not recall who that CNA was. LVN C denied putting two briefs on any resident. LVN C stated putting more than one brief on a resident could cause skin breakdown. LVN C if a resident urinated heavily staff changed those residents when they needed to be changed. LVN C stated the aides were good about changing residents and rounding. LVN C stated she constantly rounded.</p> <p>During an interview on 06/10/2025 at 1:47 PM, CNA B stated she worked 06/07/2025. CNA B stated normally residents do not have more than one brief on. CNA B stated she put two briefs on Resident #1. CNA B stated Resident #1 was combative and CNA B put two briefs on to prevent Resident #1 from urinating through the first brief so when CNA B went back to change Resident #1, CNA B would not have to struggle with Resident #1. CNA B stated she observed Resident #1 scratch and pinch LVN C but did not experience this. CNA B stated Resident #1 urinated heavily and she put the brief on to prevent Resident #1 from wetting through the first brief before she (CNAB) could get back to change Resident #1 while she assisted other residents. Later in the interview CNA B stated she helped another aide put the brief on and that it was CNA F that put the second brief on Resident #1. CNA B stated that putting two briefs on a resident could only cause harm if the resident was not changed timely. CNA B stated she changed Resident #1 frequently, so she did not believe it was an issue. CNA F stated the LVN C was not aware two briefs were put on Resident #1.</p> <p>During an interview on 06/10/2025 at 1:57 PM, CNA F stated she worked 06/07/2025. CNA F stated she worked as a hospitality aide and observed that when staff tried to assist Resident #1 she swung her hands. CNA F stated she used to be a CNA at the facility but she now she was a hospitality aide. CNA F stated as a hospitality aide she did not help with care and made bed, passed out ice. CNA F stated she did not assist with care to Resident #1 and if a resident needed care she would get a CNA to provide the care.</p> <p>During an interview on 06/10/2025 at 4:47 PM, ADON A stated there was a skill check off completed with all CNAs. She stated that the check off included peri-care, hand washing and answering call lights. ADON A stated staff have been educated that it was never okay for a resident to wear two briefs at one time and that it was not accepted. ADON A stated skin was the biggest organ and that once it was broken it could cause multiple problems. ADON A stated she was unsure if it could cause breakdown because she had never seen a resident put in more than one brief at a time. ADON A stated that staff was educated verbally about putting more than one brief on at a time and it was not a formal or written in-service. ADON A stated there have not been any reports of staff that found residents with more than one brief on. ADON A stated she completed a skin assessment for Resident #1 on 06/08/2025 and there were no alterations in Resident #1's skin or redness. ADON A stated skin assessment included observation from the resident's heels to head. ADON A stated that included looking under any skin [NAME], private or groin area of a resident.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with ADON K she stated skills were checked off monthly. ADON K stated during the skills check, showers, peri-care, bathing and feeding was reviewed. ADON K stated CAN B was a medication aide as well as a CNAADON K stated no residents wore two briefs and it was not allowed. ADON K stated wearing two briefs caused problems and there was not a need for more than one brief at a time. ADON K stated it was discussed in a morning meeting with staff that the facility did not allow double briefing. ADON K stated it could have caused irritation. ADON K stated she has not seen any resident with more than one brief and had not received any report about a resident having more than one brief on at a time.</p> <p>During an interview on 06/10/2025 at 5:08 PM, the ADM stated the DON or an ADON were responsible to assess the skills of floor staff. ADM stated the DON quit yesterday (06/09/2025). The ADM stated an assessment of skills was completed if a need was brought up, but she believed the staff tried to complete an assessment monthly. The ADM stated that prior to being put on the floor, newly hired CNAs completed three days of training and their skills were observed by the DON or ADON. The ADM stated that staff were educated recently on peri-care and she believed the DON did a hands on review with staff as well as return demonstration. The ADM stated it was never okay for a resident to wear more than one brief at a time. The ADM stated that a whole lot of things could happen such as skin issues or infection. The ADM stated that was why the facility had two-hour check and change if needed that staff was required to do. The ADM stated that it had never been brought to her attention that a resident had more than one brief on at a time. The ADM stated that some residents wore a line but never two briefs. The ADM stated it was grounds for automatic termination. The ADM stated it was also a dignity issue. The ADM stated the residents could have also felt uncomfortable.</p> <p>Review of facility in-service dated 04/29/2025 over topic perineal care reflected in-service was completed with all staff and reviewed perineal care was to maintain skin health, prevent infections and provide comfort.</p> <p>Review of facility in-service dated 05/05/2025 with topic of Peri-Care Training reflected it was completed with nursing staff.</p> <p>Review of facility in-service dated 05/18/2025 with topic of peri care reflected it was completed with staff.</p> <p>Review of facility policy titled Activities of Daily Living (ADLs), Supporting with revision date of March 2018 reflected residents who are unable to carry out activities of daily living independently will receive services necessary to maintain good groom and personal hygiene.</p> <p>Review of facility policy titled Resident Rights with revision date of December 2016 reflected Employees shall treat all residents with kindness, respect and dignity. Further review of the facility policy reflected:</p> <p>1. Federal and state laws guarantee certain basic rights to all residents of this facility.</p> <p>These rights include the resident's right to:</p> <p>a. a dignified existence;</p> <p>b. be treated with respect, kindness and dignity.</p>		