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	08/19/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the residents were free from physical abuse for one (Resident #1) of four residents reviewed for abuse.The facility failed to ensure Resident #1 was not slapped by LVN A on 07/23/25.An Immediate Jeopardy (IJ) situation was identified on 08/15/25. While the IJ was removed on 08/17/25, the facility remained out of compliance at a scope of isolated that with a potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk of injury, hospitalization, trauma, and psychosocial injury.Findings included:Review of Resident #1's face sheet dated 08/15/25 reflected an [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including dementia (term for a decline in mental ability, affecting memory, thinking, and daily functioning), traumatic subdural hemorrhage (a dangerous collection of blood that forms between the brain's outer covering (dura) and the brain itself, often resulting from a severe head injury) and schizophrenia (a chronic mental disorder now understood as schizophrenia, marked by prominent, often persistent, delusions and hallucinations). Review of Resident #1's care plan dated 07/25/25 reflected a focus of Resident #1 had a behavior problem related to low frustration tolerance (an individual's difficulty in managing and accepting frustrating situations, leading to negative emotional reactions and difficulty coping with everyday challenges) with the following interventions dated 07/25/25:1. Assist the resident to develop more appropriate methods of coping and interacting2. Encourage the resident to express feelings appropriately3. Explain all procedures to the resident before starting and allow the resident time to adjust to changes4. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed.5. Minimize potential for the resident's disruptive behaviors by offering tasks which divert attention6. Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes.A review of Resident #1's care plan dated 07/25/25 reflected a focus of Resident #1 at risk for impaired communication with intervention dated 07/25/25 Spanish speaking.Review of Resident #1's Optional State Assessment MDS dated [DATE] reflected no BIMS score, Section A - Identification Information preferred language Spanish, Section E - Behavior Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) behavior of this type occurred 1 to 3 days.Review of Resident #1's BIMS assessment dated [DATE] reflected Incomplete - Requires Further Assessment 99.0.A review in TULIP reflected on 07/25/2025 at 12:08 am the facility reported to HHSC:Resident/Client Information Resident # 11. Pertinent Medical Diagnosis: unspecified dementia, unspecified severity, without behavioral 06/19/2025 principal diagnosis (67) admission disturbance, psychotic disturbance, mood disturbance, and anxiety, paranoid schizophrenia2. Is special supervision required? If so, please specify: No special supervision required.3. Level of cognition: BIMS SCORE 04. Is there a history of similar or prior incidents, if so please specify: No Incident Details:1. Date/Time the incident occurred: 07/24/25 nurse cannot give definitive time frame states it was around 6:30 pm or after 2. Date/Time you first learned of incident: 7/24/25 at 9:49 pm3. Brief narrative summary of the reportable incident: The Charge Nurse reported that while attempting to administer medication, the resident bit her hand, prompting a reflexive response in which she slapped the resident in the face. The nurse stated the action was unintentional. She further stated that she immediately reported the incident to the Assistant Director of Nursing (ADON). However, the ADON stated that the Charge Nurse only reported the bite incident and did not disclose that the resident had been slapped.4. Witnesses name and title: Charge Nurse states that the incident was witnessed by another CNA [CNA B]. The administrator interviewed the CNA who reports that she didn't see the incident, but that the Charge Nurse showed her the bite mark and admitted to slapping the resident. Assessment Details:1. The date and time of the assessment: 07/24/25 (no time given)2. Name and title of person who completed the assessment: [Agency Nurse]3. Results of the assessment include the extent of injuries. Provide details of any physical harm, pain, or mental anguish including serious bodily injury, or other injuries including but not limited to measurements, location, color of bruises, scratches, lacerations, fractures, changes in residents' behavior that is different from the normal baseline: The resident was assessed by the licensed nurse on duty. No visible injuries were observed upon assessment-no redness, swelling, bruising, or open skin noted on the face or surrounding areas. Alleged Perpetrator # 21. LVN A 2. Was the alleged perpetrator removed, suspended or terminated? Suspended

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure alleged violations were thoroughly investigated for one (Resident #1) of four residents reviewed for abuse.The facility failed to ensure the facility conducted a thorough investigation when Resident #1 was slapped by a facility nurse on 7/23/25. The facility did not notify law enforcement, did not take statements from witnesses and other staff working at the same time as the incident, did not interview Resident #1 in his native language, did not complete a trauma-based assessment, and did not notify Resident #1's responsible party.An Immediate Jeopardy (IJ) situation was identified on 08/15/25. While the IJ was removed on 08/19/25, the facility remained out of compliance at a scope of isolated that with a potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems.This failure could place residents at risk of additional exposure for abuse and neglect.Findings included:Review of Resident #1's face sheet dated 08/15/25 reflected an [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including dementia (term for a decline in mental ability, affecting memory, thinking, and daily functioning), traumatic subdural hemorrhage (a dangerous collection of blood that forms between the brain's outer covering (dura) and the brain itself, often resulting from a severe head injury) and paranoid schizophrenia (a chronic mental disorder now understood as schizophrenia, marked by prominent, often persistent, delusions and hallucinations). 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