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	01/20/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility for two (Resident #1 and Resident #3) of five residents reviewed for transfer and discharge rights, in that: The facility failed to: provide documentation that Resident #1 and Resident #3s' RPs received sufficient preparation and orientation when Resident #1 and Resident #3 were discharged . provide documentation that Resident #1 and Resident #3 were safely discharged . Resident #1's transfer discharge report recorded no facility name of where Resident #1 was transferred. Resident #3's discharge report recorded he was transferred to an acute care hospital. Both residents were discharged in the care of a non-profit placement agency with no facility destination communicated to the Residents RPs.discharge Resident #1 and Resident #3 to a known provider (NF or group home) and provide clinical information to ensure continuity of care for both residents.This failure could place residents at risk of not receiving care and services to meet their needs upon discharge.Findings included: Review of Resident #1's face sheet dated 01/16/26 reflected a 74-year-female who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including schizoaffective disorder, bipolar type (a mental health condition characterized by a combination of schizophrenia (a serious mental disorder affecting how a person thinks, feels, and behaves, leading to symptoms like hallucinations, delusions, and disorganized thinking) symptoms and mood disorder symptoms, specifically mania and sometimes depression), CHF (a chronic condition where the heart can't pump blood efficiently, leading to fluid buildup in the lungs and body), and major depressive disorder (a mood disorder causing persistent sadness and a loss of interest in daily activities, which can interfere with work, sleep, and eating) Record review of Resident #1's MDS (clinical assessment to determine resident's strength and needs) Quarterly Assessment Section C - Cognitive Patterns dated 01/06/26 revealed a BIMS score of 8, indicating moderate cognitive impairment. Record review of Resident #1's care plan, start dated 12/13/25, last revised 01/07/26, Resident #1 discharged date 01/07/26 reflected no discharge planning. Review of Resident #3's face sheet dated 01/16/26 reflected an 82-year-male who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dementia (a progressive, irreversible syndrome characterized by a decline in cognitive abilities-memory, language, and problem-solving-severe enough to interfere with daily life, caused by damage to brain cells), traumatic subdural hemorrhage (medical emergency where blood collects rapidly between the dura mater and the brain surface, usually caused by a severe head injury), and paranoid schizophrenia (a chronic mental health condition marked by intense, irrational suspicion, persecutory delusions, and auditory hallucinations). Record review of Resident #3' MDS (clinical assessment to determine resident's strength and needs) Quarterly Assessment Section C - Cognitive Patterns dated 11/01/25 revealed no record of Resident #3's BIMS score. Record review of Resident #3's care plan start date 07/27/25, last (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
	676355	A. Building B. Wing	01/20/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revised 10/19/25, Resident #3's discharged date 01/07/26 reflected no discharge planning. Record review of Resident #3's progress note dated 01/01/26, late entry, brief interview for mental status should not be conducted, resident was rarely/never understood. Resident #3 was unable to complete brief interview for mental status. BIMS summary score 99, severely impaired. Record review of Resident #1's progress note follow-up to 01/05/26 effective date 01/06/26 made by the DON reflected attempted to call RP r/t pending discharge. No answer, VM left to call facility back. Record review of Resident #1's progress note effective 01/06/26 created date 01/07/26 made by agency LVN D reflected patient discharged from facility today in wheelchair van. Patient alert and oriented X3 (a medical assessment of a person's mental status, meaning they are awake (alert) and know who they are (person), where they are (place), and the approximate time (time), but not necessarily the situation). No signs or symptoms of distress noted at time of discharge. Respirations even and unlabored. Vital signs stable. Patient transferred safely into wheelchair van without incident. All prescribed medications sent with resident at discharge. Discharge instructions reviewed prior to departure. Patient left facility in stable condition. Record review of Resident #1's progress noted dated 01/07/26 made by the ADM reflected spoke with [Resident #1's Emergency Contact #2] regarding the resident's location. [Resident #2's Emergency Contact] was advised to speak with [name] about the transfer. [Resident #1's Emergency Contact #2] was also informed that facility had left messages for [Resident#1's RP] concerning the transfer but had been unable to make contact. [Resident #1's Emergency Contact #2] stated that [Resident#1's RP] was difficult to reach and did not (note ended). Record review of Resident #3's progress noted dated 09/24/25 made by the DON reflected, Attempted to call RP to notify of possible placement found closer to her in [city]. No answer, VM left to call back. Will reattempt at later date/time. Record review of Resident #3's progress note date 09/25/25 made by the ADM reflected, Administrator completed a follow-up call with the resident's [RP] regarding placement options to the [city] or [city] area. [RP] stated she is open to any location within the [city] region. An email was sent to [RP] at [email] with the address of a potential home at [address]. Record review of Resident #3's progress note dated 01/06/26 made by the DON reflected, attempted to notify the RP of pending transfer to another facility. No answer, VM left to call facility back. Record review of Resident #3's progress note dated 01/07/26 made by the DON reflected, Resident [RP] called back to this nurse, given information at this time r/t residents transfer to [name of non-profit placement agency]. RP requested address/phone number. Given at this time. No further issues voiced. Review of transfer discharge report dated 01/06/26 for Resident #1 reflected blood pressure pulse, temperature, respirations readings dated 01/05/26, no behavior, ambulation, bladder, bowel, or feeding information provided, date of transfer 01/06/26 transfer/discharge to nursing home no name of nursing home entered. Review of transfer discharge report dated 01/06/26 for Resident #3 reflected no primary contact, blood pressure and pulse readings dated 01/04/26 and temperature and respirations readings dated 01/03/26, no behavior, ambulation, bladder, bowel, or feeding information provided, date of transfer 01/06/26 transfer/discharge to acute care hospital. Records review of handwritten physician telephone orders dated 01/05/26 for Resident #1 reflected, may transfer to another facility Records review of handwritten physician telephone orders dated 01/05/26 for Resident #3 reflected, may transfer to another facility Record review Resident #1's Discharge Instruction Form dated 01/06/26 reflected no information, no questions completed. Record review Resident #3's Discharge Instruction Form dated 01/06/26 reflected no information, no questions completed. During a telephone interview on 01/16/26 at 3:09 pm with the ED of a non-profit placement agency that provided placement for seniors and the homeless, she stated she told the facility she would take Resident #1 and Resident #3to the hospital for evaluation (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	01/20/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and then she would find placement for them depending on the needs of the residents. The ED of the non-profit placement agency said she informed the facility she was going to take both residents to the hospital. The ED of the non-profit placement agency said she knew Resident #1 was having mental health issues and intended to find placement for Resident #1 at a behavioral hospital first then placement for Resident #1 after Resident #1 was discharged from the behavioral hospital. The ED of the non-profit placement agency said Resident #1 had a mental health episode while in the care of the ED of the non-profit placement agency. The ED for the non-profit placement agency said the police were called and Resident #1 was taken to a hospital in [city] for emergency mental health services and was not placed in a facility at that time. The ED of the non-profit placement agency had placement for Resident #3 at a group home and Resident #3 went to the group home for one day. The ED of non-profit placement agency then found placement at another group home where the owners spoke Spanish, Resident #3's primary language. The ED of a non-profit placement agency said both residents had their medications when they discharged , and Resident #3 only had the clothing that was on his back and neither Resident #1 nor Resident #3 had any of their belongings. Resident #3 left only with the clothing he was wearing. During a telephone interview on 01/16/26 at 3:37 pm with Resident #1's Emergency Contact #2, she said LVN A told her that the owner of the facility said the nursing home could not keep Resident #1 and they had to let her go. During an interview on 01/16/26 at 4:50 pm with the ADM, she said Resident #1 eloped from the facility and was placed on 1:1 (dedicated, individualized care where one staff person was assigned to a single patient) and the facility could no longer do 1:1 care. The ADM said she would not tell the resident that she could not return to the facility from the hospital because that would be like a dump thing. She said they did not plan for Resident #1 to discharge. The ADM said Resident #1's discharge was a sudden discharge and there would not be a discharge summary. The ADM said she did not inform the Ombudsman of either of the discharges because she only needed to notify the Ombudsman of resident discharges if a resident was going to be removed from the facility for non-payment. The ADM said they could not handle Resident #1's needs and the facility needed to find Resident #1 placement and Resident #1 did not want to be at the facility. During an interview on 01/16/26 at 7:38 pm with the ADM, she said the place where they sent Resident #1 and Resident #3 was a personal care home and residents received the same care residents received in a skilled nursing facility. The ADM said she did not know any more details about the place where they sent Resident #1 and Resident #3. She said she learned about the place where they sent Resident #1 and Resident #3 through her DON, and she did not know a whole lot about the place and did not know many homes they had. She said when Resident #1 and Resident #3 left the facility, they were both going to a personal care home. During an interview on 01/16/26 at 7:49 pm with the DON, she said she did not know anything about the place where they sent Resident #1 and Resident #3. She said she was under the impression it was a nursing home. The DON said as far as she was concerned, they discharged the residents properly. The DON said they had discussed for months with Resident #3's RP about Resident #3 discharging. She said the facility used a transfer liaison to place both residents. During a telephone interview on 01/17/26 at 2:00 pm with the NP, she said that the facility MD stated he gave a verbal discharge order over the phone to the DON for Resident #1 for a discharge because of elopement issues and he gave a verbal discharge order over the phone to the DON for Resident #3 because he had a lot of behavior issues and it was not safe for him to live at the facility. The MD said the facility found safe placement for the residents. During a telephone interview on 01/17/26 at 2:46 pm with Resident #1's Emergency Contact #1 she said she did not have a meeting with the facility about Resident #1's discharge. She spoke to nurse LVN A who told her that the facility needed to find a place (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	01/20/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for Resident #1 because Resident #1 was acting up again. Resident #1's Emergency Contact #1 said Resident #1 escaped the facility, went to the bank, and created a scene then went to the ER. Resident #1's Emergency [NAME] #1 stated the facility picked Resident #1 up from the ER and attempted to send Resident #1 to a psychiatric hospital, but the psychiatric hospital would not take Resident #1. Emergency Contact #1 stated the facility did not tell Emergency Contact #1 where they were taking Resident #1 when Resident #1 was discharged . Emergency Contact #1 stated she thought Resident #1 was taken to a shelter. She said it was hard to remember what happened with Resident #1 because Resident #1 was back-and-forth with different hospitals and facilities during that time. Resident #1's Emergency Contact #1 stated to her understanding Resident #1 was now in [name of skilled nursing facility]. Resident #1's Emergency Contact #1 said Resident #1's Emergency Contact #2 spoke to [ED of the non-profit placement agency]. Resident #1's Emergency Contact #2 told Resident #1's Emergency Contact #1 that the person at the non-profit placement agency told Emergency Contact #2 they were going to take Resident #1 to a behavioral hospital because Resident #1 said she was going to kill people. During an interview on 01/17/26 at 3:49 pm with the DON she said the BOM met a placement representative at a marketing event and the BOM informed the facility team that she had possible placement for Resident #1 and Resident #3. The BOM forwarded Resident #1 and Resident #3 clinicals to the placement agency, and they said they would accept both residents. The DON said both residents were transported to the [non-profit placement agency] by medical transport. During a telephone interview on 01/17/26 at 4:06 pm with the BOM she said she met the ED of the non-profit placement agency at a marketing event. The BOM told the ED of the non-profit placement agency the facility was looking for placement for Resident #1 and Resident #3. The BOM said she sent the residents' clinicals to the ED of the non-profit placement agency who said she was able to take both residents. The BOM said the facility had permission from the families of the residents. The BOM said the facility told the RP of Resident #3 that the facility could no longer meet Resident #3's needs at the facility. The BOM said she spoke with the ED of the non-profit placement agency the other day and Resident #3 was doing fine, and his RP was happy with his placement. The BOM said no one had communicated with Resident #1's family because of Resident #1's behavioral issues. Resident #1 did not want to get out of the car when she was with the ED of the non-profit placement agency and the police was called. During a telephone interview on 01/17/26 at 4:27 pm with the ED of the non-profit placement agency she said [the non-profit placement agency] was her business. The ED of the non-profit placement agency stated that she received the clinical information for Resident #1 and Resident #3 and advised the facility she could locate placement for the residents. The ED of the non-profit placement agency advised that both residents would need to be medically evaluated prior to placement. The ED of the non-profit placement agency said the DON, who was responsible for the discharges, was aware that the two residents were being sent to the hospital for evaluation before she would be able to accept them for placement. The ED of the non-profit placement agency told the ED once the residents were medically cleared, she would then be able to arrange placement for them. The ED for the non-profit placement agency said Resident #3 was initially placed; however, staff at that location did not speak Spanish and he was located a second home that was Spanish-speaking. The ED of the non-profit placement agency stated Resident #1 had not yet been placed because she was having a mental crisis and said she was going to kill herself. The ED for the non-profit placement agency said the police issued a mental health warrant. Resident #1 was sent to a hospital in [city] because the behavioral hospital did not have an open bed. The ED of the non-profit placement agency stated the [city] hospital should be contacting her soon. The ED for the non-profit placement agency stated both residents were sent with their medicaions but (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	01/20/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #3 only had three days of blood pressure medicaions and she was able to get him more. During a telephone interview on 01/17/2026 at 5:16 pm with Resident #1's Emergency Contact #2 she said the last she heard Resident #1 was at [name of skilled nursing facility]. Resident #1's Emergency Contact #2 said the facility said they were sending her away because they could not tolerate Resident #1's aggressiveness. LVN A told her the facility could not let Resident #1 stay at the facility. Resident #1's Emergency Contact #2 said she wanted Resident #1 to be moved to an area closer to them. Resident #1's Emergency Contact #2 said Resident #1's RP did not want to be responsible for Resident #1 but neither Emergency Contact #1 nor Emergency Contact # 2 were able to be Resident #1's RP. During a telephone interview on 01/17/26 at 5:56 pm with Resident #3's RP, she said the facility did not notify her the day Resident #3 left the facility. She stated she found out later when she was trying to call the facility, and no one answered, so she sent a text to a nurse (name of nurse unknown). The nurse said Resident #3 was discharged to another facility. She stated she asked the nurse for the location in a text and the nurse did not respond. Resident #3's RP stated that during the December 2025 care plan meeting, facility staff only discussed Resident #3's likes and dislikes. She stated that during the meeting, the facility did not indicate they wanted Resident #3 to leave. She stated the facility had mentioned discharge several times in the past when Resident #3 was acting different, but then stopped discussing it for months at a time. The RP said during the December 2025 care plan meeting staff discussed that Resident #3 urinated on the floor. The RP stated she told staff that Resident #3 likely did not receive his medications properly and that could have contributed to the behavior. She stated that after she made the comment, the Administrator told her they were discharging Resident #3 to a group home. The RP said she had previously informed the facility that Resident #3 could not go to a group home because of a prior incident at a group home that was still under investigation. The RP said the ADM told her the facility was privately owned and, because it was privately owned, they did not have to keep Resident #3 at the facility. Resident #3's RP said the facility did not notify her on the day Resident #3 left the nursing facility. She stated she was only provided with the phone number of the location where he was sent. She said that when Resident #3 was on his way in the van for the non-profit placement agency to take him to a group home he was instead dropped off at a hospital. Resident #3's RP said the hospital contacted her at approximately 2:30 a.m. because the hospital refused to treat Resident #3 without consent. The RP stated she traveled to the hospital and arrived at approximately 5:00 a.m. Resident #3 was treated and discharged from the hospital, and she had spoken with Resident #3 and the place where he was now was taking good care of him. During an interview on 01/17/26 at 6:36 pm with the DON she stated the non-profit placement agency transported Resident #1 and Resident #3. The DON was asked if she knew what type of facility the non-profit agency was, and she said she thought it was a nursing home. During a telephone interview on 01/17/26 at 6:56 pm with the ED of the non-profit placement agency she said her agency did not arrange for the transportation for Resident #1 and Resident #3. She said the hospital sent the transport and the ED of the non-profit placement agency said she informed the DON transportation resource was a hospital and that both residents needed to be checked out medically before she could accept them. During an interview on 01/18/2026 at 4:10 pm with the DON she said she and the ADM were responsible for making sure the facility discharge policy was followed. The DON said she, the ADM, and the BOM were involved in the discharge for Resident #1 and Resident #3. She said the members of the IDT were the DON, the assessment nurse, the MDS coordinator, the rehabilitation director, the dietary director, and the administrative staff. She said the IDT team was involved in the discharges for Resident #1 and Resident #3 because it was discussed in the morning meetings, but it was not an official IDT (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	01/20/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	meeting, but everyone knew they were going to be discharged and the BOM got involved with finding placement. The DON said there was no documentation for the IDT meeting for the resident discharges. She said they had a care plan meeting by phone with Resident #3's RP and discussed his discharge during this care plan call. She said they did not have a care plan meeting with Resident #1's RP because they could not reach Resident #1's RP. The DON stated the facility [non-profit placement agency] should have said if they could not meet the needs of the residents. The DON said she did not recall a conversation with Resident #3's RP that she did not want Resident #3 to go to a group home. The DON said Resident #3's discharge was already in the works when she began working for the facility in August of 2025 and they were trying to find placement for Resident #3. The DON said Resident #1's placement was spontaneous, and the DON said Resident #1 kept calling 911 and Resident #1 said she did not want to be at the facility any longer. The DON said the facility discharge policy was not followed for Resident #1 because the facility could not get in touch with the RP and one of the Emergency Contacts did not want anything to do with Resident #1 because Resident #1 cursed her out. She said she spoke with Resident #3's RP about placement and the RP was well aware they were seeking placement when Resident #3 arrived at the facility. The DON said the RP offered to look for placement in an area closer to her, the DON said it was part of the care plan meeting. She said the facility found placement for Resident #3 in September, but the Resident #3's RP did not follow back up with them. The DON said the discharge planning was not followed when discharging Resident #1 because the RP did not answer or respond to the facility when the facility tried to reach him. The DON stated a potential harm to a resident if discharge was not followed was that it could cause emotional issues or trauma to the resident. During an interview on 01/18/26 at 4:55 pm with the ADM she said the DON was responsible for making sure the facility discharge policy was followed however, as the ADM she was responsible for everything. The ADM said the DON was the sole person who was over the discharge for Resident #1. The ADM said the DON spearheaded the discharge of Resident #1 completely. The ADM said Resident #3's discharge was collective, like an IDT. The ADM said the administrative department were the members of the IDT team. She said Resident #3's discharge started in September of 2025 and was not a rush. The ADM said she did not find out about Resident #3 leaving until the day before he left and the ADM said she thought that was fast. The ADM said the IDT team was not involved in Resident #1's discharge because with her elopement, it happened fast. The ADM said she assumed the DON decided to use the same placement she found for Resident #3 for Resident #1. The ADM said the IDT involvement was not documented for either of the discharges. The ADM said the discharge for Resident #3 was always an ongoing conversation. The ADM said there was a break in the period of time it was discussed and in January 2026 the DON said they had placement for Resident #3. The ADM said they should have called and discussed the placement with Resident #3's RP. The ADM said Resident #3's RP was called on 01/06/26 and they did not get a response. The progress note from the DON said Resident #3's RP was provided the information on 01/07/26 and the RP did not ask questions and was okay. The ADM said the DON informed her that Resident #3's RP was aware of the discharge planning and the ADM found out recently that the RP was aware of the actual discharge date and location. The ADM said Resident #1's discharge happened so quickly after her elopement. The ADM said she spoke with Resident #1's RP in December of 2025 about looking for placement. During a telephone interview on 01/20/26 at 12:34 pm with Resident #1's RP he said the facility was having multiple issues with Resident #1 and he stated Resident #1 had left the facility a couple of times. The RP stated Resident #1 called 911 and said people at the facility were trying to kill her. Resident #1's RP stated he knew Resident #1 was going to be discharged from the facility eventually. He stated he did not participate in an IDT or discharge (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	01/20/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	meeting. The RP stated he did not know the current location of resident and the last he heard she moved to [name of skilled nursing facility]. During a telephone interview on 01/20/26 at 1:40 pm with LVN D who said she was an agency nurse and had picked up shifts at the facility beginning December of 2025. She said she was the nurse who completed the discharge with Resident #1 and Resident #3. LVN D said the paperwork was left with her that day and she was told the residents were discharged . LVN D said a transport company picked up both residents together and she provided the driver with a report on each resident. She said she notified the DON, ADM, and the RP for Resident #3 and she spoke to an emergency contact for Resident #1. LVN D said she was not part of the discharge meeting for residents.Record review of facility discharge planning process, undated, revealed purpose - ensure that there is a discharge planning process in place that addresses each resident's goals and needed, including caregiver support and referrals to local contact agencies, as appropriate, and involved the resident and if applicable, the resident representative and the interdisciplinary team in developing the discharge plan. Discharge planning begins on admission. Procedure: The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must: Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. Involve the interdisciplinary team in the ongoing process of developing the discharge plan. The discharge plan is part of the comprehensive care plan. Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. Address the resident's goals of care and treatment preferences. Document that a resident has been asked about their interest in receiving information regarding returning to the community. If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. If discharge to the community is determined to not be feasible, the facility must document who made the determination and why or residents who are transferred to another SNF or who are discharged to a HHA, IRF or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF or LTCH standardized patient assessment data, data on quality measures and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized resident assessment data, data on quality measures and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. Document and complete on a timely basis based on the resident's needs and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. Discharge planning must identify the discharge destination and ensure it meets the resident's health and safety needs, as well as preferences. If a resident wishes to be (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	01/20/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discharged to a setting that does not appear to meet his/her post-discharge needs, or appears unsafe, the facility must treat this situation similarly to refusal of care and must: Discuss with the resident, (and/or his or her representative, if applicable) and document the implications and/or risks of being discharged to a location that is not equipped to meet his/her needs and attempt to ascertain why the resident is choosing that location; document that other, more suitable, options or locations that are equipped to meet the needs of the resident were presented and discussed; document that despite being offered other options that could meet the resident's needs, the resident refused those other more appropriate settings; determine if a referral to Adult Protective Services or other state entity charged with investigating abuse and neglect is necessary. The referral should be made at the time of discharge.

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	01/20/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that each resident received adequate supervision for 2 of 7 residents (Resident #1 and Resident #2) reviewed for accidents hazards and supervision.The facility failed to provide adequate supervision to prevent the elopement of Resident #1. On 1/05/2026, Resident #1 exited the facility without staff supervision. Resident was later located by a security guard employed at a local credit union about 0.50 miles from the nursing facility, after crossing a busy frontage road. Resident #1 was found 1 hour and 49 minutes later after leaving facility.The facility failed to change the door code that overrode the Wander Guard system, despite Resident #2 being identified as an elopement risk and knowing the door code.An IJ was identified on 1/19/2026. The IJ template was provided to the facility on [DATE] at 12:16 AM. While the IJ was removed on 1/20/2026, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with the potential for more than minimal harm that is not an Immediate Jeopardy, due to facility's need of more time to monitor the plan of removal for effectiveness.This failure could place residents at risk of experiencing accidents, injuries, and/or death. Record review of Resident #1's electronic face sheet, dated 1/17/2026, reflected a [AGE] year-old female admitted to the facility on [DATE] and readmission on [DATE] with diagnoses of type II diabetes mellitus (high blood sugar levels), congestive heart failure (heart unable to pump enough blood), hypertension (elevated blood pressure), acute kidney failure, major depression, and schizoaffective disorder, bipolar type (presence of both mood disorder symptoms({manic} and psychotic features{hallucinations}).Record Review of Resident #1's MDS assessment dated [DATE] reflected Resident #1 was assessed to have a BIMS score of 8 which indicated she had moderate cognitive impairment. Record Review of Resident #1's comprehensive care plan, dated 1/18/2026, reflected it was updated to identify an elopement by Resident #1 who was an elopement risk/wanderer initiated on 01/05/2026.Record Review of Resident #1's progress notes dated 01/05/2026 reflected Resident #1 was missing from the facility after an inside search revealed she was not located within the facility; the ADM was notified by the local hospital at 10:05 AM that Resident #1 was in the ER and had been transported from a local credit union for evaluation and possible treatment. ER staff administered an injection to the resident to stabilize her behavior. Resident #1 was brought back to the facility by ADM and DON.Record Review of the facility's Incidents By Incident Type provided on 01/17/2026 for the months of 11/17/2025-01/17/2026 reflected Resident #1 had an elopement incident on 01/05/2026 at 9:05 AM.Record review of Resident #2's electronic face sheet dated 1/18/2026, reflected a [AGE] year-old male admitted to the facility on [DATE] and readmission on [DATE] with diagnoses of hemiplegia and hemiparesis affecting left dominant side (weakness and partial paralysis on one side), dysphagia (difficulty in swallowing), and contracture of left shoulder and left elbow (loss of range of motion).Record Review of Resident #2's MDS assessment dated [DATE] reflected Resident #2 was assessed to have a BIMS score of 11 which indicated he had moderate cognitive impairment. Record Review of Resident #2's comprehensive care plan, dated 1/18/2026, reflected a focus area that Resident #2, goes outside and sits at the front entrance of facility often without alerting staff of my whereabouts, initiated on 12/07/2025 and an additional focus area stated Resident #2 is an elopement risk/wanderer and is at risk for possible injury r/t impaired safety awareness initiated on 01/05/2026. Interventions 1. Assess for fall risk. Monitor Resident #2's whereabouts at all times q shift wander guard in place with double checks to make sure it is functioning.Observation of facility 01/17/2026 at 9:49 AM, revealed the facility had a coded door lock at the main entrance. The front of the building included a covered patio area. The (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	01/20/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	facility was located adjacent to a busy feeder road in front of the parking lot, and the road along the side of the facility led to a heavily trafficked business area that was frequently visited by the public.Observation of Resident #2 at approximately 1:55 PM who was a high elopement risk was sitting outside on the patio alone, unsupervised.In an interview conducted on 1/18/2026 at 3:13PM, the ADM stated LVN A notified her on 1/05/2026 when she was about to conduct her morning rounds that Resident #1 was not in her room during the morning check following breakfast. ADM stated she immediately searched the entire facility but was unable to locate Resident #1 in any of the residents' rooms, elsewhere in the building, or on the facility grounds. ADM further stated that she searched the surrounding neighborhoods by driving in her personal vehicle, while the business manager also searched for the resident in her personal vehicle. The ADM stated that at approximately 10:05 a.m., the local hospital contacted her and reported that the resident was at the hospital ER. She stated she then went to the hospital to pick up Resident #1. ADM stated upon reviewing the surveillance cameras, Resident#1 exited the facility at 8:16 a.m. using the door code. ADM stated she had no knowledge of Resident #1 knowing the door code, she stated Resident #1 must have obtained the code from her boyfriend, Resident #2 who knew the door code.In an interview conducted on 1/18/2026 at 3:20 PM. LVN A stated she last observed Resident #1 shortly after 6:00 AM on 1/05/2026 when the resident refused her Accu-Checks. LVN A further stated she saw Resident #1 again at approximately 7:40 AM as LVN walked to the breakfast room. After Breakfast, LVN A stated CNA B notified her that Resident #1 was not in her room when staff attempted to retrieve the breakfast tray and noted resident had not eaten her breakfast. LVN A stated that she immediately notified the ADM that Resident #1 was missing. The ADM then began making rounds, and staff initiated a search of the entire building for Resident #1. LVN A stated that the ADM and business office personnel left the facility in their personal vehicles to search for the resident. LVN A stated that Resident #1 was later found at a local credit union and was transported to the hospital by EMS. An attempted interview on 1/17/2026 at 2:37 PM and on 1/18/2026 at 11:52 AM with Resident#1's RP, no answer, left voicemail to return call to surveyor.In an interview conducted on 1/18/2026 at 3:53 PM CNA B stated she had worked for the facility since June of last year. CNA B stated she last observed Resident #1 on 1/05/2026 approximately 7:50 AM in her restroom when she dropped off the resident's breakfast tray. CNA stated when she came back to pick up breakfast tray around 8:40 AM, Resident #1 was not in her room, and she notified the LVN.In an interview conducted on 1/18/2026 at 4:08 PM, the DON stated that Resident #1 somehow knew the door code and exited the facility on January 5, 2026. The DON further stated the resident had previously been a good resident who socialized and was pleasant to be around. The DON stated that Resident#1 experienced a change in behavior beginning in December. DON stated Resident #1 has a history of bipolar and schizoaffective disorder.In an interview conducted on 1/18/2026 at 6:25 PM Resident #2 said that he did not give Resident #1 the door code. He stated that Resident #1 may have observed him entering the code on a prior occasion. Resident #2 stated that Resident #1 was his girlfriend. He further stated that he had not provided the door code to any other person in the facility. Resident #2 stated that he was expected to notify nursing staff when he goes outside; however, he stated that at times he has not notified nursing staff but has informed front office staff instead.In an interview conducted on 1/18/2026 at 7:11 PM, EMS personnel stated EMS was dispatched to the Credit Union on 1/05/2026 at 9:24 am. He stated Resident #1 was transported from the Credit Union to the local hospital ER at 9:52 AM.Review of the video footage dated 1/05/2026 and time stamped 8:15 am provided by the facility revealed Resident #1 walking in the front living room area of the facility unattended and at 8:16 am on 1/05/2026 revealed resident leaving out the front door of facility unmonitored.Record Review of the (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	01/20/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	hospital report dated 1/05/2026 reflected Resident #1 was found in an altered mental status upon arrival to the hospital, brought in by EMS after being found in altered mental status at the Credit Union. Report further stated Resident #1 was here yesterday for similar circumstances for her psychosis. Resident #1 was released back to the nursing facility staff at 10:35 AM.In an additional interview and observation with ADM on 1/18/2026 from 10:00 PM-10:12PM, ADM revealed there was no policy for residents with high elopement risk having knowledge of the Master door code. The ADM stated that the master door code had not been changed since she began working at the facility in 2024. She stated that the door code had not been changed because doing so would result in a significant financial cost, as all door codes would need to be updated. The ADM stated that Resident #2 cannot be kept confined to the building and was expected to notify nursing staff when he wishes to go outside. She stated that she had previously sat outside with Resident #2 and that he has never wandered off. When asked how the Wander Guard system functions, the Administrator stated that when an individual with a Wander Guard device approaches the door, a small red person icon appears on the keypad, and the door will not open. She stated that most of the Wander Guard devices at the facility are visual only and do not alarm. She further stated that Resident #2's Wander Guard device does not alarm. The ADM stated that although Resident #2 has a Wander Guard device, his knowledge of the door code overrides the Wander Guard system. When asked why Resident #2 has a Wander Guard device if he knows the door code, the ADM stated that the Wander Guard serves as a second layer of protection because the resident likes to sit outside. She further stated that Resident #2 knew the door code prior to her employment at the facility. The ADM demonstrated the wander guard device using the wheelchair belonging to Resident #2, the door did not open but with the code entered the door opened. Review of Elopement Policy effective date of 11/01/2019: Policy StatementTo safely and timely redirect patients/residents to a safe environment. A prompt investigation and search will be conducted if a patient/resident is considered missing. Elopement drill will be held quarterly.Procedure1. Once it has been established that a patient/resident is missing, the following staff members are notified immediately: The charge nurse, Executive Director of Operations, Director of Clinical Operations, and social service designee, responsible party and the primary care physician. Complete the missing resident profile. Make note of the outside temperature.2. The DCO or designee organizes and institutes an immediate and thorough search of the center and surrounding grounds. Conduct a headcount of each unit. Including but not limited to a search of the area outside the nearest exit to the patient's/resident's room or the exit where he/she Was last seen, and the entire unit where the patient/resident resides or was last seen, the remainder of the facility, all rooms, closets - including storage facilities - bathrooms and grounds, extending beyond the fence line. Check all offices and any locked doors to ensure none were left unlocked.3. The entire search process of the facility and grounds, from the time the patient/resident is missing, should be completed within 30 minutes.4. if the search fails to locate the missing patient/resident within 2 hours from the time the. Patient/resident is found to be missing, the Administrator and/ or designee contacts the appropriate community agencies (Local Law Enforcement) and update the patient's/resident's legal representative. Staff will provide the police with all physical identifying information including but not limited to physical appearance, height, weight, age, sex, and clothing. If known.5. The search is continued. Two staff members search the surrounding streets by car for a two (2) mile radius around the facility.6. When the patient/resident is located, the nurse completes a head-to-toe assessment. The social service designee assesses the patient/resident for emotional distress. The charge nurse reports any findings to the DCO The DCO notifies the EDO or designee and notifies the appropriate community agencies, attending physician, and (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	01/20/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	patient's/resident's legal representative.7. If a resident is not located during a search of the facility, facility grounds, and immediate vicinity, and there are circumstances that place the resident's health, safety, and/or welfare at risk, a report to HHSC must be made as soon as the facility becomes aware the resident is missing and cannot be located. Examples include, but are not limited to: A resident requires medications that, if not taken as scheduled, place the resident at risk of serious illness or death or both; Extreme weather conditions exposed the resident to potential freezing, heat prostration, or drowning from flooding; A resident is confused or otherwise incapable of assessing potential danger; There is suspicion of foul playAn Immediate Jeopardy was identified on 01/19/2026 and the Administrator was notified of the Immediate Jeopardy on 01/19/2026 at 12:16 AM and was given a copy of the IJ template and a Plan of Removal (POR) was requested. The facility's Plan of Removal for the Immediate Jeopardy was accepted on 01/19/2026 at 7:12 p.m. and reflected the following: Plan of removalProblem: F689 Accidents/Supervision Immediate Action:On 1/19/2026 an abbreviated survey was initiated at the community. On 1/19/26 the surveyor provided an Immediate Jeopardy (IJ) Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate jeopardy to resident health and safety. F689 The facility must ensure that each resident receives adequate supervision to ensure they are free from accidents and hazards related to elopement.1. Action: Weekly Elopement Risk assessments for all residents completed to ensure ongoing evaluation and implementation of appropriate preventive interventions. Due to Resident #1's demonstrated knowledge of the door access code, the facility implemented a universal reset of the master door code to immediately reduce the risk of unauthorized exit and elopement. A facility-wide in-service will be completed by the Administrator and Maintenance Director addressing the importance of door code security and that any known or suspected door code breach must be reported immediately to the Maintenance Director and/or Administrator with signature acknowledgment obtained to verify understanding. Start Date: 1/19/2026.Completion Date: 1/19/2026Responsible: The DON/Designee is responsible for ensuring the task being implemented and maintained.2. Action: The facility implemented a camera monitoring system at the nursing station to enhance supervision of residents and monitor exit activity. In the event door codes are compromised/breached, only the Maintenance Director and Administrator are authorized to initiate and implement immediate code changes to ensure continued security and resident safety.Start Date: 1/19/2026.Completion Date: 1/19/2026.Responsible: This task will be monitored continuously and daily by the assigned Charge Nurse on duty during all shifts to ensure ongoing compliance, effectiveness, and resident safety. Education on camera monitoring and reporting procedures will be included as a required component of the new hire orientation process/policy change.3. Action: The Director of Nursing to be in-serviced on the operation, monitoring expectations, and response procedures related to the camera monitoring system, with signature acknowledgment obtained to verify understanding.Start Date: 1/19/2026Completion Date: 1/19/2026.Responsible: The Administrator has received training from the Chief Executive Officer of the facility to ensure proper oversight and compliance with the camera monitoring system.4. Action: Charge nurse staff/Agency to be in-serviced on the operation, monitoring expectations, and response procedures related to the camera monitoring system prior to start of shift with signature acknowledgment obtained to verify understanding. Education on door code security and reporting procedures will be included as a required component of the new hire orientation process.Start Date: 1/19/2026Completion Date: 1/19/2026Responsible: The Director of Nursing responsible for ensuring the task is implemented and maintained.5. Action: The facility contacted the door system manufacturer to request and coordinate the immediate change of all access and exit door codes. This action was taken to enhance residents' safety and ensure secure (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	01/20/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	access control. The Maintenance Director and Administrator will maintain sole possession of the master door code and all instructions for code changes in the event door codes are compromised/breached,Start Date: 1/19/2026Completion Date: 1/19/2026Responsible: The Maintenance Director and Administrator will maintain sole possession of the master door code and all instructions for code changes. In the event door codes are compromised/breached, only the Maintenance Director and Administrator are authorized to initiate and implement immediate code changes to ensure continued security and resident safety. 6. Action: The Administrator and Maintenance Director initiated facility-wide in-service addressing the importance of door code security and that any known or suspected door code breach must be reported immediately to the Maintenance Director and/or Administrator with signature acknowledgment obtained to verify understanding.Start Date: 1/19/2026Completion Date: 1/19/2026Responsible: The Administrator and Maintenance Director have received training from the Chief Executive Officer facility addressing the importance of door code security and that any known or suspected door code breach must be reported immediately.Monitored the POR on 01/19/2026 and 01/20/2026 as follows: Record Review of the POR Binder included:-Elopement assessments of all 26 residents completed-The Importance of Door Code Security In-Service: Door Access Code Security & Elopement Prevention training presented by Chief Executive Officer to ADM and Maintenance Director-Proper Oversight and Compliance with the Camera Monitoring System presented by Chief Executive Officer to ADM and Maintenance Director-The Importance of Door Code Security In-Service: Door Access Code Security & Elopement Prevention training of 20 signed staff signatures presented by the ADM and Maintenance Director with start date 1/19/26 and continuing.-Proper Oversight and Compliance with the Camera Monitoring System presented by the ADM to the DON, and 1 LVN, start date 1/19/2026-Proper Oversight and Compliance with the Camera Monitoring System presented by the DON to 3 Charge Nurses, start date 1/19/2026Email receipt of service request response on 1/19/2026, from the facility security systems company indicated to resolve breach of code issue among the residence we'll dispatch tech to change default master code and user code on all requested keypads.Door alarm code receipt of purchase dated 1/20/2026In an interview conducted on 1/20/2026 at 10:59 AM, a Representative from the security system company stated he was there in the process of changing the facility's door code. He stated that the facility would be able to change the door codes going forward and that he had provided the facility with instructions on how to change the codes. He further stated that while he was working on the system, the door was secure.Interviews conducted on 01/20/2026 with 3 nurses and 4 CNAs who work from 6 AM-6 PM and 6PM-6AM between 11:55 AM -2:57 PM [LVN A, LVN C, LVN D, CNA B, CNA E, CNA F, and CNA G] revealed all had been in-serviced on The Importance of Door Code Security In-Service: Door Access Code Security & Elopement Prevention training, they all demonstrated knowledge of the importance of not disclosing the door code and to report immediately to ADM or maintenance director if someone compromised the code.Interviews conducted on 01/20/2026 with 4 other staff from the two shifts between 1:23 PM-2:01 PM (Cook, Dietary aide, Housekeeping, and Laundry Aide) revealed facility staff had been in serviced on The Importance of Door Code Security In-Service: Door Access Code Security & Elopement Prevention training, they all demonstrated knowledge of the importance of not disclosing the door code and to report immediately to ADM or maintenance director if someone compromised the code.Interview conducted on 01/20/2026 at 12:26 PM, DON stated that she conducted elopement assessments for all the facility residents and identified six residents as high risk for elopement. She stated that elopement assessments would be completed on those 6 residents weekly every Monday for one month and thereafter monthly on an ongoing basis. The DON stated that she discussed oversight and compliance with the camera monitoring system with the charge nurses. She stated that the camera monitor is located at the nurses' station (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	01/20/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and provides coverage of both the front and back of the building. The Administrator demonstrated to nursing staff how to operate the camera system, including how to move the camera and view different angles. The DON stated that it is the responsibility of nursing staff to utilize the camera system to maintain resident safety and prevent elopement. She stated that the camera is to be monitored continuously throughout the nursing shift. She further stated that if an issue related to camera monitoring is identified or if a resident exits the building, staff are to immediately notify the Administrator and Maintenance and inform all staff. The DON stated that she is responsible for ensuring that the charge nurses and agency staff are trained in the use of the camera system and emphasized that proper use of the system is important to resident safety.Interview conducted on 01/20/2026 at 12:54 PM, the Maintenance Director stated he has worked for the facility 14 months. He stated that he was instructed to reset all doors with a new code and that the security system company was in the process of recoding the doors. He stated that all doors remained secured while the company completed the work. The Maintenance Director stated that he set up the camera monitoring system. He stated that the camera system provides coverage of all doors throughout the building, the TV/common area, the nurses' station, the front of the building, the rear parking lot, and the back door leading to the trash area. He stated that the system includes audio capability. The Maintenance Director stated that the security system company, along with himself, the owner and ADM, has the ability to change door codes. He stated that if he becomes aware that an unauthorized individual knows a door code, he will reset the code immediately. He stated that the master door code is a default code used to change door codes and that only the owner, ADM, and Maintenance Director have access to it. The Maintenance Director stated that he provided in-service training to housekeeping and laundry staff regarding door security. He further stated that he was in-serviced by the Chief Executive Officer and the ADM on the importance of door security and the requirement to immediately report any suspected door code breach to himself and ADM. The Maintenance Director stated that he is responsible for monitoring the camera system, he has a monitor in his office, and also carries the camera application on his mobile phone for ongoing monitoring.Interview conducted on 01/20/2026 at 3:32 PM, Chief Executive Officer stated that he provided in-service training to the ADM and Maintenance Director regarding proper oversight and compliance with camera monitoring. He stated that both individuals have administrative access to the camera system and can view all areas of the facility. The Chief Executive Officer stated that charge nurses are responsible for responding when the camera system alerts, including when movement at a door causes the system to beep or highlight. He stated that staff are expected to respond appropriately to these alerts. The Chief Executive Officer stated that the ADM and Maintenance Director are responsible for monitoring the camera system and for ensuring that nursing staff are trained and actively monitoring the cameras. He further stated that he provided in-service training to the Maintenance Director regarding the importance of door security, maintaining control of door codes, and not sharing security codes to ensure resident safety.Interview conducted on 01/20/2026 at 4:54 PM, ADM stated that Resident #2 no longer knows the door code. She stated that Resident #2 will continue to wear a Wander Guard device. She stated that staff are aware that Resident #2 was high risk and has been instructed to provide increased monitoring. The Administrator stated that the facility continues to utilize agency staff and has posted open positions online. She stated that agency staff will not be provided door codes and will be let into and out of the facility by permanent staff. The ADM stated that she completed an in-service with the Chief Executive Officer regarding door security policies and monitoring of the facility's camera system. She stated that staff have been instructed not to share security codes in order to maintain resident safety. She further stated that door codes (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	01/20/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	will be changed every 30 days and upon employee termination. She reiterated that agency staff are not to have access to door codes. The ADM stated that permanent staff are responsible for allowing agency staff to enter and exit the facility and that door codes are not to be provided to family members. She stated that if it is determined that an employee shared a door code with agency staff or any unauthorized individual, the employee would be terminated. She further stated that if an agency staff member enters the facility using a door code, staff will be questioned regarding how the code was obtained. The ADM stated that when agency staff are used, the facility will attempt to assign the same individuals consistently and will provide in-service training related to camera monitoring. She stated that camera monitoring is mandatory and that the nurse on duty is responsible for continuously monitoring the cameras. The ADM stated that staff have been instructed to maintain a chart of observations of the six residents identified as high elopement risk and to document that those residents have been observed. She stated that rounding frequency has been increased and that the camera system supports this monitoring. She further stated that if a camera is not functioning properly, staff are required to immediately report the issue to the Administrator or Maintenance Director. The ADM stated that she, along with the DON/ADON, were responsible for ensuring that charge nurses are monitoring the cameras and complying with facility monitoring expectations.On 01/20/26 at 6:45 p.m., the ADM was notified the IJ was removed. While the IJ was removed on 1/20/26, the facility remained out of compliance at a severity level of no actual harm with a potential for more than minimal harm that is not immediate jeopardy and scope of isolated.