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	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brenham Healthcare Center	1303 Hwy 290 E Brenham, TX 77833

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 6 residents (Residents #1) reviewed for care plans. The facility failed to have a comprehensive person-centered care plan for Resident #1 to address his refusal of medications. This failure could place residents at risk of not receiving care and services to meet individualized medical and nursing needs.Findings include: Record review of Resident #1's face sheet, dated [DATE], revealed a seventy-year-old male who was admitted to the facility on [DATE]. His admitting diagnoses included acute kidney failure (a sudden, often reversible, drop in kidney function occurring within hours or days), pain in left hand, traumatic brain compression with herniation (elevated intracranial pressure often from traumatic hemorrhage or swelling-forces brain tissue through rigid intracranial structures). Record review of Resident #1's care plan revealed a focus dated [DATE] of Resident #1 had impaired cognitive function or impaired thought processes related to cognitive loss (a reduction in mental capabilities such as memory, reasoning, attention, and executive function) and required assistance with decision making with intervention dated [DATE] to administer medications as ordered and monitor/document for side effects and effectiveness and a focus dated [DATE] of Resident #1 refused to eat 1 spoonful of pudding with medication and wanted the whole container with 1 pill with intervention dated [DATE] monitor/document for side effects and effectiveness. A review of Resident #1's care plan reflected no care plan or interventions for Resident #1's refusal to take medications. Record review of Resident #1's MDS (clinical assessment to determine resident's strength and needs) dated [DATE] Nursing Home Comprehensive Section C - Cognitive Patterns revealed a score of 6 indicating severe cognitive issues. Record review of the MARS for February and [DATE] reflected Resident #1 refused medications on the following days: - fluticasone Propionate Nasal Suspension 50 MCG/ACT on [DATE], [DATE], [DATE], and [DATE]. - Lidoderm Patch 5% on [DATE], [DATE], [DATE], [DATE], [DATE] [DATE], [DATE], [DATE], [DATE], and [DATE]. -Sodium Chloride Nasal Solution 0.65 % on [DATE] at 8:00 AM and 2:00 PM, [DATE] at 8:00 AM and 2:00 PM, on [DATE] at 8:00 AM and 2:00 PM, and on [DATE] at 8:00 AM and 2:00 PM. -Atorvastatin Calcium 40 MG tablet on [DATE], on [DATE] and on [DATE]. -Melatonin 5 MG on [DATE], [DATE], and on [DATE]. -Seroquel 100 MG on [DATE] and on [DATE]. -Apixaban 5 MG tablet on [DATE], at 5:00 PM on [DATE] at 8:00 AM and 5:00 PM and on [DATE] at 5:00 PM. - gabapentin 300 MG capsule on [DATE] at 5:00 PM, [DATE] at 5:00 PM, and on [DATE] at 5:00 PM. -lamotrigine 200 MG tablet on [DATE] at 5:00 PM, and on [DATE] at 5:00 PM. -levetiracetam 500 MG tablet on [DATE] at 5:00 PM, [DATE] at 5:00 PM, and on [DATE] at 5:00 PM. -Seroquel 100 MG tablet on [DATE] at 8:00 AM and 5:00 PM -sevelamer carbonate 800 MG tablets on [DATE] at 2:00 PM, on [DATE] at 2:00 PM and 8:00 PM, on [DATE] at 3:00 PM, and on [DATE] at 9:00 AM and 3:00 PM. During an interview on [DATE] at 2:17 PM, Resident #1 said he got all his medication except for the ones he did not like because they made him (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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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	feel sick and they tasted terrible. He said staff told him he would feel better if he took his medication, but he said he would get better on his own without taking the medication. He said his pain was there for a reason and the pain was telling him something was wrong and said the medication covered up the pain when there were severe problems. During an interview on [DATE] by phone at 3:09 PM, LVN A said a care plan stated the individual residents' care and their needs. LVN A said a care plan contained resident medication, the type of care they needed, and the residents' likes and dislikes. LVN A said if residents refuse medication, the refusal should be in the care plan. She said she was not sure who was responsible for the care plans. LVN A said she thought it was the RN supervisor but did not know her name. LVN A said it was important to care plan medication refusals because you wanted to keep up with how many times a resident refused a medication because if a resident took too little of their medication, it would affect the resident. LVN A said when Resident #1 refused medication staff had to go back and offer him different ways to take the medication. LVN A said Resident #1 would sometimes take medication with pudding, but he usually only wanted to take it with chocolate pudding, and he wanted to eat the entire container of pudding. LVN A said Resident #1 usually did not refuse to take medication from her but sometimes he did refuse. LVN A said there had been a couple of times Resident #1 spit out the medication she tried to administer to him. She said that after trying three times to get Resident #1 to take his medication and he still refused, she would document the refusal either in the progress notes or the MAR. She said she was an agency nurse and there were a lot of agency nurses at the facility. LVN A said she had access to the care plans but had not looked at them. LVN A said the facility did not ask her to look at the resident care plans. LVN A said it might be important to look at resident care plans because care plans gave an overall look at what the residents liked. LVN A said it would be very helpful for a new person at the facility to look at resident care plans to learn the residents' wants and needs. During an interview on [DATE] by phone at 10:07 AM, the interim part time DON said she helped at the facility on weekends when she could because the facility DON died about two weeks ago. The DON said she helped with care plans and assessments but was not completely responsible for care plans. The DON said RN A was responsible for the care plans. She said she attempted to give Resident #1 his medications the other day and Resident #1 refused the medications. The DON said she did not remember the name of the medications Resident #1 refused. The DON said initially Resident #1 refused the medication because she did not have chocolate pudding. The DON said later she tried to give Resident #1 the medication and offered him chocolate pudding, and he spit out the medication. The DON said medication refusal was something that should be care planned. The DON said everything a resident did had to go in the care plan. The DON said her definition of a care plan was an outline of care with the focus on that individual resident. The DON said a care plan should allow you to see everything about a resident. The DON said it was important that the nurses had access to the care plan. The DON said agency nurses should especially have access to care plans because agency staff did not know any of the residents. The DON said a nurse could miss a resident change in condition if they did not look at the residents' care plans. The DON said a possible negative effect of not documenting in a care plan that a resident refused medications was that you would not know the effects of the resident not taking the medications. She said if medication refusal was on going it could affect the residents negatively. The DON said it was hard to get the nurses to document resident information because the whole building was staffed with agency and that could lead to a system breakdown with documentation. During an interview on [DATE] by phone at 11:34 AM, RN A said she was responsible for resident care plans at the facility. RN A said a care plan was an overall view of the residents and should include the residents' diagnoses and the level of care the residents' need. RN A said a care plan should be updated to provide a full picture of residents' needs. RN A said medication refusals should be care planned. She said she finds out about what needs to be included in a care plan in the 24-hour report and from the nurses telling her information. She said she mostly gets the information from the nurses. RN A said she was not sure if Resident #1 refused his medications. She said Resident #1 would (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	initially refuse his medication but if you gave it to him in pudding he would take it. RN A said it would be important to care plan medication refusal because it could affect the residents' diagnosis, health, or have an impact on the residents' disease process. During an interview on [DATE] by phone at 11:58 AM, the MD said he did not remember if he was told that that Resident #1 refused his medications. The MD said that if a resident repeatedly refused their medication he would like to know. The MD said the facility should definitely care plan that Resident #1 was refusing medication. During an interview on [DATE] at 2:18 PM, LVN B said a care plan was for resident safety needs including the way residents take their medication. LVN B said a care plan outlined all the way that residents need to stay healthy. LVN B said everyone was responsible for care plans. She said that if she saw something that needed to be added to the care plan, she told the supervisor and brought it up in morning meeting. LVN B had heard Resident #1 multiple times yell and say he did not want his medication. She said Resident #1 was not her resident and she did not give him medications. LVN B said refusals of medications should be care planned so you could know that the resident refused the medication to take different measures and interventions for ways that the resident might take the medication. Attempted phone interview on [DATE] at 4:00 PM, with AN C left a voice mail and sent a text message. During an interview on [DATE] by phone at 4:15 PM, AN B said Resident #1 would refuse to take his medication if he did not have pudding but sometime Resident #1 would still refuse to take his medication if he had pudding. AN B said she had not been told to look at resident care plans, but she had skimmed through them. AN B said her definition of a care plan was what you do for the residents if they had a fall. She said care plans showed the interventions necessary for a resident. AN B said if a resident refused medication, it should be care planned and could include interventions to help get the residents to take the medications. She said the DON would be responsible for care plans, but the DON passed away. During an interview on [DATE] by phone at 4:43 PM, AN F said she was an agency nurse and she worked at the facility one time and did not know about Resident #1 refusing medications. Attempted phone interview on [DATE] at 4:47 PM, with AN D left a voice mail and sent a text message. Attempted phone interview on [DATE] at 5:10 PM, with AN E left a voice mail and sent a text message. During an interview on [DATE] at 5:41 PM, the Administrator said she did not have any full-time employees for the nursing floor staff and most of her CNAs and nurses were not employed with the facility, but through an agency. Resident #1 will take his medications if he is given chocolate pudding. The Administrators definition of a care plan was it reflected how to care for a resident and included what the residents liked and what they did not like. The Administrator said it was a blueprint of who the resident was. The Administrator said if a resident was refusing medications, it should be care planned and there should be an intervention in place for the medication refusal. The Administrator said RN B was responsible for care plans and she got the information for the care plans in the morning meetings and she did clinicals with each of the nurses. The Administrator said a possible negative effect of not care planning medication refusals would be there would be no interventions for how to handle a residents' refusal to take medications. Review of the care plan policy titled Using the Care Plan, undated, reflected the care plan shall be used in developing the residents' daily care routines and will be available to staff personnel who have responsibility for providing care or services to the residents. Policy Interpretation and Implementation 1. Completed care plans are placed in the residents' chart and/or in a 3-ring binder located at the appropriate nurses' station. 2. The Nurse Supervisor uses the care plan to complete the CNAs daily/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 residents' condition must be reported to the MDS Assessment Coordinator so that a review of the residents' assessment and care plan can be made. 6. Documentation must be consistent with the resident's care plan. 7. Information contained on the care (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	plan and other documents used by the nursing staff shall be maintained in a confidential manner in accordance with established facility policy.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for three of eight residents (Resident #1, Resident #2, and Resident #3) reviewed for ADL care. The facility failed to ensure Resident #1, Resident #2, and Resident #3's fingernails and toenails were clean and free from debris. This failure could place residents who required assistance with ADLs at risk for unmet care needs.Findings included: Resident #1 Record review of Resident #1's face sheet, dated [DATE], revealed a seventy-year-old male who was admitted to the facility on [DATE]. His admitting diagnoses included acute kidney failure (a sudden, often reversible, drop in kidney function occurring within hours or days), pain in left hand, traumatic brain compression with herniation (elevated intracranial pressure often from traumatic hemorrhage or swelling-forces brain tissue through rigid intracranial structures). Record review of Resident #1's care plan revealed a focus dated [DATE], Resident #1 has impaired visual functioning and was at risk for decrease in ADLs and injuries related to blindness. Record review of Resident #1's MDS (clinical assessment to determine resident's strength and needs) dated [DATE] Nursing Home Comprehensive Section C - Cognitive Patterns revealed a score of 6 indicating severe cognitive issues. Observation on [DATE] at 2:50 PM, Resident #1's left and right foot reflected extremely thick, yellow and brown discolored toenails that extended past the tip of his toes. The toenails were brittle, curved, distorted and were growing outward away from the nail bed. The skin on Resident #1's left and right feet reflected extremely dry, flaking skin with layered thick skin on the right heel. All skin on bottom and top of Resident #1's feet were rough with yellowish skin patches on the heels and soles. The skin was ashy and grey in color with two small red scabs on the left big toe about 1/4th inch apart from each other. Observation on [DATE] at 2:50 p.m., Resident #1's left- and right-hand reflected fingernails approximately 3/4th inch growth past the tips of his fingers and had vertical layers of brown and black discoloration inside the nails that appeared to be dirt. Record review of Resident #1's shower sheet bed bath dated [DATE] reflected CNA (CNA unknown) visual assessment did not indicate dryness, abnormal color, abnormal skin, hardened skin and Resident #1 did not need his toenails cut signed by charge nurse (charge nurse unknown). Record review of Resident #1's shower sheet bed bath dated [DATE] reflected CNA (CNA unknown) visual assessment did not indicate dryness, abnormal color, abnormal skin, hardened skin and Resident #1 did not need his toenails cut signed by charge nurse (charge nurse unknown). Resident #2 Record review of Resident #2's face sheet, dated [DATE], revealed a seventy-three-year-old male who was admitted to the facility on [DATE] and re-admitted on [DATE]. His admitting diagnoses included chronic diastolic (congestive) heart failure (occurs when the left ventricle becomes stiff and cannot relax to fill with enough blood, leading to high pressure and fluid buildup), morbid (severe) obesity due to excess calories (defined as being 100 pounds or more over ideal body weight), and chronic kidney disease (the long-term, irreversible loss of kidney function, often caused by diabetes or high blood pressure). Record review of Resident #2's care plan revealed a focus dated [DATE], Resident #2 was a risk for skin breakdown related to immobility with interventions dated [DATE] of inspect skin with morning, evening, and shower during activities of daily living and document each incident of bruising, skin tear, or other skin problems noted and tailor interventions to prevent further occurrence. Record review of Resident #2's MDS (clinical assessment to determine resident's strength and needs) dated [DATE] Quarterly Assessment Section C - Cognitive Patterns revealed a score of 4 indicating severe cognitive issues. Observation on [DATE] at 9:16 a.m., Resident #2's left and right foot reflected extremely thick, yellow and brown discolored toenails that extended past the tips of his toes and were brittle, curved, distorted and growing outward away from the nail bed. Resident #2's left and right feet reflected extremely dry, flaking skin with layered thick skin on both feet extending up to (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #2's shins on both feet with the skin on legs resembling fish scales. Resident #2's skin appeared as if the skin was cracking. Observation on [DATE] at 9:16 am of Resident #2's left and right-hand reflected fingernails approximately 3/4th inch growth past the tip of Resident #2's fingers, brittle with uneven jagged edges and a dark brown appearance on the interior that appeared to be dirt. Record review of Resident #2's podiatry records dated [DATE] reflected Toenails: Right: nail dystrophy (abnormal changes in the shape, color, texture, or growth of fingernails or toenails, often resulting in brittleness, thickening, pitting, or discoloration commonly caused by fungal infections, trauma, skin conditions like psoriasis or eczema, or systemic diseases), nail thickening (common condition caused by fungal infections, trauma, aging, or underlying conditions like psoriasis and diabetes. It causes nails to turn yellow, brittle, and become difficult to trim. Treatments include antifungal medications, proper trimming, filing, or professional podiatry care to reduce discomfort), elongated toenails (often resulting from neglect, trauma, or conditions like Onychogryphosis (ram's horn nails), can curl, thicken, and cause pain, infections, or difficulty wearing shoes. These nails, common in seniors, can harbor bacteria and require specialized trimming or surgical removal. Regular foot hygiene and inspection are crucial for prevention), discolored toenails (often result from fungal infections (yellow/brown), trauma (black/blue), or bacterial infections (green), and thickened dystrophic nail(s) with subungual debris (commonly indicate onychomycosis (fungal infection) or a chronic skin condition like psoriasis. This condition involves yellow-brown discoloration, crumbling, and separation from the nail bed (onycholysis) due to keratin debris buildup. Treatment requires antifungal medication, specialized podiatry care, or managing underlying inflammation). Toenails: Left: nail dystrophy, nail thickening, elongated toenails, discolored toenails, and thickened dystrophic nail(s) with subungual debris. Impression/plan - Follow up in 2 months Record review of Resident #2's shower sheets dated [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE] reflected CNA (CNA unknown) visual assessment did not indicate dryness, abnormal color, abnormal skin, hardened skin and Resident #2 did not need his toenails cut signed by charge nurse (charge nurse unknown). Resident #3 Record review of Resident #3's face sheet, dated [DATE], revealed a sixty-seven-year-old male who was admitted to the facility on [DATE] and re-admitted [DATE]. His admitting diagnoses included hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting left dominant side (indicates weakness or paralysis of the left side of the body), contracture of the left shoulder (the joint capsule or surrounding muscles tighten, causing significant pain and loss of motion, frequently resulting from prolonged immobility, injury, or conditions like diabetes), and contracture of the left elbow (a stiffening of the elbow joint, resulting in a loss of range of motion of greater than 30 degrees). Record review of Resident #3's care plan revealed a focus dated [DATE], Resident #3 had an ADL self-care performance deficit related to his disease process that required extensive assistance with ADLs and an intervention dated [DATE] personal hygiene/oral care, Resident #3 required extensive assist x1 staff. Record review of Resident #3's MDS (clinical assessment to determine resident's strength and needs) dated [DATE] Quarterly Assessment Section C - Cognitive Patterns revealed a score of 11 indicating moderate cognitive issues. Observation on [DATE] at 8:00 am of Resident #3's left and right foot reflected toenails extended past the tips of toes with the big toenails approximately 1/4th inch past tip of toe and remailing nails overly long curved towards the big toe and the little toenails curved upwards away from the nail bed. Observation on [DATE] at 8:00 am of Resident #3's left and right hands reflected fingernails overly long and extended past fingertips, jagged and uneven yellow in color with no apparent dirt under nails. During an interview on [DATE] at 2:37 PM, Resident #1 said his nails fingernails were long, and it was not okay with him that his nails were long. Resident #1 said he wanted them to be clipped. Resident #1 said he thought a podiatrist was going to trim them. He said his fingernails looked like fangs and they were very dirty underneath. Resident #1 said he said he thought he asked a nurse to cut his nails but could not remember the name of who he asked. During an interview on [DATE] at 2:50 PM Resident #3 said his fingernails were too long and he had spoken to (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	someone about cutting them, but he cannot remember who, but he thought it was about two weeks ago. He said his nails being long bothered him because his nails caught on his clothes and he poked himself in the face with the long fingernails. Resident #3 said that staff do not want to cut his nails. He said a podiatrist needs to cut his finger and toenails he had not seen a podiatrist for a long time.During an interview on [DATE] at 3:09 PM, LVN A said when shown a photo of Resident #1's finger and toenails, said that Resident #1's finger and toenails should be cut. She said that nails left uncut could cause skin infections and lead to skin fungus. LVN A said Resident #1's feet had a lot of dryness and scaliness. She said that if finger and toenails were too long residents could scratch themselves from the overly long nails which could lead to skin tears and infection. LVN A said that when she looked at Resident #1's toenails she thought skin tears could happen easily. LVN A said Resident #1's toenails were curving backwards. LNV A said when Resident's toenails were in the condition of Resident #1's, typically a pediatrist would address Resident #1's nails. LVN A said the CNAs usually took care of clipping fingernails and Resident #1's fingernails were long. LVN A said the condition of Resident #1's finger and toenails should be documented a skin assessment. During an interview on [DATE] at 2:50 PM, Resident #2 said it did not bother him that his toenails were not trimmed because he said he did not have any feeling on his feet and he was fine with his fingernails being long.During an interview on [DATE] by phone at 10:07 AM, the interim part time DON said she helped at the facility on weekends when she could because the facility DON died about two weeks ago. She said when a nurse conducted a skin assessment, they did a head-to-toe assessment that included the feet and nails. She said it was her expectation that if a resident had really dry cracked flaky skin it should be on the skin assessment and if toenails need to be cut it needed to be charted on the progress notes and the residents' name needed to be added to the list of people the podiatrist needed to see. The DON said finger and toenails should be trimmed by a CNA when they were long and if the resident was diabetic, a nurse needed to trim the finger and toenails. She said if finger and toenails were in bad condition the facility needed to set up an appointment for the residents to see the podiatrist. The DON said, when she saw the photos of Resident #1 and Resident #2's toenails, oh my gosh, she was not aware of it and the finger and toenails needed to be cut. The DON said the finger and toenails were dirty and the residents needed to see the podiatrist. She said she was not aware that residents' nails were in this condition, and it was an infection control issue because the residents' nails were dirty and the entire facility needed all residents to have a skin assessment. The DON said she was just trying to help at the facility because the former DON died. The DON said they needed to talk to a doctor about Resident #1 and Resident #2's feet. The DON said feet should be documented in skin assessment because it was part of the skin. The DON said Resident #1 and Resident #2s' fingernails were dirty and if they put their fingers in their mouths the residents could get an infection and have an upset stomach. The DON said some areas of the feet were red and that could indicate an infection and be painful. The DON said the residents could scratch themselves and could scratch a wound with their nails that could get infected because of the dirt under their nails. She said that the condition of the residents' nails was unacceptable from an infection control level, from a dignity level because the fingernails were so long. The DON said it was her expectation when nurses were doing a head-to-toe skin assessment that this should have been addressed earlier so the facility could catch infections and problems. She said it was her expectation that agency nurses communicated with her and let her know when there were any skin or nail issues. The DON said the three residents' feet and nails need to be reviewed by an MD. During an interview on [DATE] by telephone at 11:34 AM, RN A she said she made the skin assessment schedule for the residents. She said a skin assessment involved a head-to-toe assessment and she looked at the residents to see if there were scabs, skin breakdown, abrasions or bruises and she would look at residents' feet and in between their toes. She said if the resident had long toenails and fingernails she would check if the resident was diabetic and if a resident was diabetic the podiatrist would clip the residents' nails. She said if a resident's skin was extremely flaky, she would document this in her skin assessment.During (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	an interview on [DATE] by telephone at 12:19 PM, LVN C said she was an agency nurse, and she had done a skin assessment for Resident #2 and saw he had really long finger and toenails, but she did not chart this. She said the shower sheets have a section that asks if the residents needed their nails clipped. She said a nurse could have cut his fingernails and toenails, but she did not talk to him about it. LVN C said she did not talk to him about it because she did not work with him a lot and he did not request his finger or toenails be cut. She said the expectation at the facility was either to document that finger and toenails needed to be cut, to do it herself or pass it along to someone else that it needed to be done. She said she did not remember if she documented that Resident #2 needed his finger and toenails to be cut, and she did not remember telling anyone. She said that Resident #2's toenails were so long they could grow back into his skin or cause ingrown toenails. She said it was important to trim nails because it could be painful. LVN C said Resident #2's heels were thick and scaly, and she said she knew this was documented. She said she worked the night shift from 6:00 PM until 6:00 AM and the day shift usually did more for Resident #2 and Resident #2 was particular about what he wanted and was very vocal with his needs. She said if Resident #2 wanted his nails trimmed, he would have called them to do it. She said Resident #2's finger and toenails were so long he could scratch himself and have had an infection control issue. LVN C said Resident #2 might have had a skin infection because his skin was in such bad shape. LVN C said several residents had longer toenails but she did not remember their names. She said she thought she might have worked at the facility about 20 times. She said she saw Resident #1's feet but did not think they were as bad and Resident #2's. During an interview on [DATE] at 2:28 PM, LVN B said the CNAs needed to report to the nurses if residents' finger and toenails needed to be trimmed. LVN B said if nails needed to be cut it needed to be checked on the shower sheets by the CNAs to let the nurses know. She said she did skin assessments and she looked over residents from head to toe including the finger and toenails. LVN B said she was told nurses do not cut toenails, that only the podiatrist cuts toenails. LVN B said she was never told that she needed to cut resident toenails, only fingernails. She said that Resident #2 cannot cut his own toenails. LVN B said if toenails get long, they could get infected and could break and cause damage to the skin. She said if someone had long toenails, the resident's name would be added to a list of residents who needed to been seen by the podiatrist. She said the podiatrist came to the facility every 3 months. During an interview on [DATE] by phone at 2:33 PM, the podiatrist said he came every 2 - 3 months to the facility to cut the nails for diabetic residents. He said when he was at the facility, sometimes a resident would be added to the list of residents he needed to see, and he would see that person also. The podiatrist said he saw Resident #2 in December, about 3 months ago. The podiatrist viewed a photo sent to him by the surveyor of Resident #2's feet. The podiatrist said Resident #2 had a callous on a heel and the toenails were long and thick and needed to be trimmed. The podiatrist said a possible negative effect of not having toenails trimmed was ingrown toenails, infection, and it could be painful. The podiatrist said that if residents were walking and callous were present and not trimmed or paired, residents could get ulceration or wounds. The podiatrist said that looked like Resident #2 needed a good bath with a brush to scrub off the lose and flaky skin and then have lotion applied. The podiatrist said that it looked like Resident #2 had ichthyosis (skin condition characterized by dry, scaly skin resembling fish scales the disorder causes dead skin cells to accumulate, creating thick, tile-like, or flaky patches (often white, gray, or brown) on the surface, commonly affecting arms and legs). During and interview on [DATE] at 5:41 PM, the Administrator said she did not have any full-time employees for nursing floor staff and most of her CNAs and nurses were not employed with the facility, but through an agency. She said it was the responsibility of the CNAs to see if residents needed nails to be clipped. The Administrator said CNAs were the first point of contact, then the charge nurses would need to clip toenails. She said a nurse can clip toenails and it was her expectations that that the CNAs should let the nurse know and that nurses should clip toenails. She said when you gave a resident a shower you could see if residents needed to have their finger and toenails clipped. She said it was false that the nurses do not (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	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brenham Healthcare Center	1303 Hwy 290 E Brenham, TX 77833

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	clip nails in the facility and only the podiatrist clipped toenails. The Administrator said that to wait for the podiatrist to clip resident toenails was like handing off your work to someone else. The Administrator said toe and fingernails were too long cause it could cause skin tears, infection, and be uncomfortable for the residents. The Administrator said both finger and toenails needed to be clipped and trimmed by nurses at the facility. Record review of Activities of Daily Living (ADLs), Supporting dated [DATE] reflected that residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming, and oral care). Record review of Policy: skin integrity, undated, reflected Purpose: ensure the resident does not develop pressure ulcers/injuries unless clinically unavoidable and that the facility provides care and services consistent with professional standards of practice.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident with limited range for motion received appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion for three (Resident #1, Resident #2, and Resident #4) of 10 residents reviewed for range of motion. The facility failed to ensure:Resident #1 was wearing his prescribed left wrist splint.Resident #2 was wearing his prescribed Ace bandage.Resident #4 was wearing her prescribed left wrist splint.This failure placed residents at risk of impaired skin integrity, further decline and decrease in quality of life and quality of care. Findings include:Resident #1Record review of Resident #1's face sheet, dated [DATE], revealed a seventy-year-old male who was admitted to the facility on [DATE]. His admitting diagnoses included acute kidney failure (a sudden, often reversible, drop in kidney function occurring within hours or days), pain in left hand, traumatic brain compression with herniation (elevated intracranial pressure often from traumatic hemorrhage or swelling-forces brain tissue through rigid intracranial structures).Record review of Resident #1's care plan revealed a focus dated [DATE] Resident #1 was at risk for skin breakdown related to physical impairment (affected right hand). Resident #1 had a splint to his right hand dated [DATE] with intervention dated [DATE] monitor hand splint for any pain, swelling and good circulation and ensure right hand splint was intact. A review of Resident #1's care plan reflected no care plan or intervention for Resident #1's order dated [DATE] left hand splint must be worn at all times.Record review of Resident #1's MDS (clinical assessment to determine resident's strength and needs) dated [DATE] Nursing Home Comprehensive Section C - Cognitive Patterns revealed a score of 6 indicating severe cognitive issues.Review of Resident #1's order by MD dated [DATE] reflected left hand splint must be worn at all times.Observation [DATE] at 2:37 PM reflected Resident #1 in his bed, no splint on his left arm.Observation on [DATE] at 7:57 AM reflected Resident #1 in his bed with his left arm splint on his dresser.Resident #2Record review of Resident #2's face sheet, dated [DATE], revealed a seventy-three-year-old male who was admitted to the facility on [DATE] and re-admitted [DATE]. His admitting diagnoses included chronic diastolic (congestive) heart failure (occurs when the left ventricle becomes stiff and cannot relax to fill with enough blood, leading to high pressure and fluid buildup), morbid (severe) obesity due to excess calories (defined as being 100 pounds or more over ideal body weight), and chronic obstructive pulmonary disease (a progressive, incurable inflammatory lung disease causing obstructed airflow, commonly manifesting as chronic bronchitis or emphysema).Record review of Resident #2's care plan revealed a focus dated [DATE] Resident #2 had potential for pain and was at risk for injury from decreased ADLs with a focus dated [DATE] discuss with Resident #1 factors that precipitate pain and what may reduce it. A review of Resident #2's care plan reflected no care plan or interventions for Resident #2's order dated [DATE] to wrap Resident #2's right knee with Ace bandage during the day and remove at bedtime.Record review of Resident #2's MDS (clinical assessment to determine resident's strength and needs) dated [DATE] Quarterly Assessment Section C - Cognitive Patterns revealed a score of 4 indicating severe cognitive issues.Observation on [DATE] at 9:12 PM reflected Resident #2 in his bed with no Ace bandage on his right knee.Resident #4Record review of Resident #4's face sheet, dated [DATE], revealed a thirty-one-year-old female who was admitted to the facility on [DATE]. Her admitting diagnoses included bipolar disorder current episode manic severe with psychotic disorder (extreme manic symptoms, elevated mood, extreme energy, grandiosity, and reduced sleep-paired with breaks from reality like hallucinations or delusions), displaced segmental fracture of shaft of right femur (a severe, high-energy injury where the bone is broken in at least two places, creating a separated segment), and fracture of shaft of humerus, right arm (a break in the upper arm bone between the shoulder and elbow, often causing significant pain, swelling, and deformity).Record review of care (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	plan focus dated [DATE] reflected Resident #4 had impaired physical mobility contracture left hand (splint in place) unable to ambulate bilateral with intervention consult physical therapy per order to evaluate range of motion, fine and gross motor movements.Review of Resident #4's order by MD dated [DATE] reflected left wrist splint must be worn at all times.Observation on [DATE] at 9:32 AM reflected Resident #4 in her bed with not wearing her left wrist splint.Resident #2Record review of Resident #2's MDS (clinical assessment to determine resident's strength and needs) dated [DATE] Nursing Home and Swing Bed Tracking Section C - Cognitive Patterns revealed no BIMS score.Review of Resident #2's order by MD A dated [DATE] reflected wrap right knee with Ace wrap during the day and remove at night.During an interview on [DATE] at 3:09 PM, LVN A said she saw Resident #1 wearing his left-hand splint. He only had a left-hand splint. She said it was the responsibility of the nurses to make sure that orders were being followed and if orders were not followed things could go wrong. LVN A said if Resident #1 was not wearing his left splint, he could not be receiving the therapeutic benefits of the splint.During an interview on [DATE] at 9:32 AM, Resident #4 stated when she first came to the facility, she had a contracture on her right hand and she got therapy. She said she puts her brace on herself.During an interview on [DATE] by phone at 10:07 AM, the interim part time DON said she helped at the facility on weekends when she could because the facility DON died about two weeks ago. The DON said that if Resident #1 had an order to wear a left arm splint, he should wear it all the time and if refused to wear it, the refusal should have been care planned. The DON said if Resident #1 was not wearing the left arm splint, he was not following doctor's orders and the facility needed to contact the doctor and see if the doctor would discharge the order for wearing the left arm splint. The DON said that if Resident #2 had an order for an Ace bandage for his knee brace and was not wearing an Ace bandage on his right knee it should have been addressed. She said if Resident #4 had an order for a splint on her left arm, she should have been wearing it.During an interview by phone on [DATE] at 3:30 PM, the MD said Resident #1 should have left hand sprint that Resident #1 received from the hospital because he had a fracture of the 5th metacarpal of the left hand. The MD said it was important that Resident #1 wore the splint for comfort because it would reduce the amount of pain Resident #1 would have from the hand fracture. The MD said he cannot remember if Resident #1 was wearing his left hand splint the last time, he saw Resident #1 at the facility. |The MD said it was his impression that Resident #1 would do what Resident #1 wanted to do and if the MD was in the facility he wanted to be informed if Resident #1 was not wearing the splint. The MD said that Resident #4 needed to wear her left arm splint all the time if possible. The MD said he wanted Resident #4 to wear the splint, so her contracture would not get worse. The MD said Resident #4's hand contracture could slowly get worse over time. The MD said it was his expectation that staff make sure she wore it all the time.During an interview by phone on [DATE] at 3:39 PM, MD A said he ordered the Ace bandage for Resident #2's right knee because Resident #2 had some arthritis pain. He said the Ace bandage should be applied as needed. MD A said it was important to follow doctor's orders and if a resident had an issue with what had been ordered, the facility should let him know. He said it was a quality-of-care issue for residents to have an order in place for an Ace bandage and the Ace bandage not to be applied according to the order or the facility not to discuss the order with the MD.During an interview on [DATE] at 5:41 PM, the Administrator said if a resident had an order for an orthopedic device the resident should have worn it because not wearing it would affect the residents; quality of life. The Administrator said not wearing an orthopedic device would affect the residents' level of functioning and their mobility. The Administrator said the nurses were being lazy and not reading the doctors' orders. The Administrator said it was her expectation that doctor's orders were carried out. The Administrator said if the doctor's order could not be carried out, another intervention should have been put in place. The Administrator said information about residents' orders and refusals needed to be communicated in the daily clinical meetings.