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	12/05/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the residents right to receive services in the facility with reasonable accommodation of needs for 3 (Resident #101, Resident #102, and Resident #104) of 6 residents reviewed for accommodation of needs in that: The facility failed to reasonably accommodate residents' needs by failing to provide a working communication system that was easily at reach, that would allow Resident #101, Resident #102, and Resident #104 the ability to safely call staff for assistance. This failure could place residents at risk of not having a means of directly contacting caregivers in an emergency or when they need support for daily living.The findings included: Review of Resident #101's face sheet dated 10/02/25 reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnosis that included pneumonia (infection of the lungs), down syndrome (genetic condition caused by an extra copy of chromosome 21), need for assistance with personal care, unsteadiness on feet, and muscle weakness. Review of Resident #101's quarterly MDS assessment dated [DATE] reflected a BIMS score of 03 indicating severe cognitive impairment. Review of Resident #101's care plan last reviewed 07/24/25 reflected a focus on Resident #101 is high risk for increased falls and fractures as evidence by gait/balance problems, poor communication/comprehension, unaware of safety needs with intervention that included be sure the call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all request for assistance. An additional focus was observed that reflected Resident #101 had an actual fall with no injury r/t poor balance, unsteady gait (08/22/24, 09/16/24, 09/20/25) with interventions that included, resident will be reeducated on using call light. Replaced push call light with a touch sensor call light. Review of Resident #102's face sheet dated 10/02/25 reflected a [AGE] year-old male admitted to the facility on [DATE] with a diagnosis that included congestive heart failure (condition that affects the hearts ability to pump blood), mental disorder, unsteadiness on feet, lack of coordination, and abnormalities of gait and mobility. Review of Resident #102's quarterly MDS assessment dated [DATE] reflected a BIMS score of 05 indicating severe cognitive impairment. Review of Resident #102's care plan last reviewed 07/24/25 reflected a focus, Resident #102 have had an actual fall with no injury- poor balance, unsteady gait, fall was witnessed on: 02/26/25, 03/02/25, 03/04/25, 03/10/25, 03/11/25, 08/21/25) with interventions that included, call light in reach, instructed to use call light for assistance, answer call lights in a timely manner. Review of Resident #104's face sheet dated 10/02/25 reflected an [AGE] year-old female admitted to the facility on [DATE] with a diagnosis that included dementia (decline in cognitive function), difficulty in walking, unqualified visual loss in both eyes, and muscle weakness. Review of Resident #104's quarterly MDS assessment dated [DATE] reflected a BIMS score of 08 indicating moderate cognitive impairment. Review of Resident #104's care plan last reviewed 07/24/25 reflected a focus, ADL self-care performance deficit r/t disease process, weakness, confusion, fatigue, pain in all joints, and blind in both eyes interventions included encourage resident to use bell to call for assistance. Additionally, another focus was observed for Resident #104 is high risk for increased falls and fractures as evidence by confusion, gait/ balance problems, vision/hearing problems, general weakness, recent falls with interventions that included be sure the residents call light is within reach and encourage the resident to use it for assistance as needed' the resident needs prompt response to all requests for assistance and resident needs a safe environment with: a working and reachable call light. An observation on 09/30/25 at 08:56 AM in Resident #101's room, Resident #101 was observed asleep in bed, and his call light pad was observed on the floor approximately 3 feet away. An observation on 09/30/25 at 10:13 AM in Resident #102's room, he was observed in bed resting, his bed was placed on the floor due to high fall risk, the call light at this time was observed hanging over the light fixture located directly over the bed approximately 3-4 feet above the resident not in reach. An observation and interview on 09/30/25 at 10:25 AM in Resident #104's room, she was observed in her wheelchair at bedside, she stated that if she needs assistance, she needs to use her call light to call for help to be able to transfer over to her bed or to be able to use the bathroom. Resident #104 stated that she needed to call for staff in that moment to get to bed and did not know where her call light was. Resident #104 was blind in both eyes and was observed feeling around her bed for her light, she stated she did not know where her light was. Resident #104's call light was observed tucked in a closed nightstand drawer, not in reach or accessible to her. In an interview on 09/30/25 at 10:38 AM with CNA B she stated that Resident #104 was blind and has a routine of where her call light is placed in order for her to find it. CNA B stated Resident #101 was special

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure the comprehensive assessment accurately reflected the resident's status for 3 (Resident #05, Resident #22, and Resident #30) of 4 Residents reviewed for accuracy of assessments. The facility failed to ensure the MDS dated [DATE] was updated to reflect an active pressure wound for Resident #5. The facility failed to ensure the MDS dated [DATE] was updated to reflect there was no dialysis for Resident #22. The facility failed to ensure MDS dated [DATE] was updated to reflect an active pressure wound for Resident #30. This failure could place residents at risk of inaccurate assessments and not receiving appropriate care according to their status. Findings include: Review of Resident #5's face sheet dated 10/01/25 reflected that she was a [AGE] year-old female admitted [DATE] with diagnoses of anxiety, muscle wasting, seizures, lung clot, and repeated falls. Review of Resident #5's latest MDS quarterly assessment dated [DATE] reflected a BIMS of 03, indicating the resident was severely cognitively impaired. The MDS also reflected that she was at risk for a pressure ulcer but that she did not have a pressure ulcer. Review of Resident #5's care plan initiated 9/5/25 and last revised 9/25/25 reflected there was a care plan focus for a pressure ulcer Stage 3. Review of Resident #5's progress note reflected a nursing note dated 09/05/25 that stated, New skin Issue. Location: Sacrum.Pressure ulcer staging: Stage 3 Pressure ulcer/ injury. Wound measurements were documented as 7x7x02 and a wound dressing was ordered. Review of Resident #5's orders reflected an order to cleanse sacral area with wound cleanser and apply dressing every shift for wound healing. Review of Resident #5's physician's wound consult reflected on 9/1/25 the physician staged the sacral wound as a Stage 3 Pressure Wound. Review of Resident #5's physician's wound consult reflected the sacral Stage 3 Pressure Wound was resolved on 9/29/25. Review of Resident #22's face sheet dated 10/02/25 reflected that he was a [AGE] year-old male admitted [DATE] with diagnoses of heart failure, Diabetes Type 2, Obesity, high blood pressure, and vascular (blood vessels) disease. The face sheet did not indicate any diagnosis related to End Stage Kidney Disease or dialysis. Review of Resident #22's latest Quarterly MDS assessment dated [DATE] reflected a BIMS of 14, indicating the resident was cognitively intact. The MDS also reflected that he was on dialysis during his admission. Review of Resident #22's care plan last revised 09/13/25 reflected there was no focus care plan area for dialysis. Review of Resident #22's orders on 10/2/25 reflected that there had never been an order for dialysis. Review of Resident #30's face sheet dated 10/02/25 reflected that he was a [AGE] year-old male admitted [DATE] with diagnoses of bone infection, lung disease, difficulty swallowing, and high blood pressure. Review of Resident #30's latest Quarterly MDS assessment dated [DATE] reflected a BIMS of 11, indicating the resident was moderately cognitively impaired. The MDS also reflected that he was at risk for a pressure ulcer but that he did not have a pressure ulcer. Review of Resident #30's latest care plan last revised 09/25/25 reflected there was a care plan focus for Unstageable pressure injury to left heel measuring 0.5x0.7 (depth was not measurable) which was identified on 9/15/25. Review of Resident 30's physician's wound consult notes reflected on 9/15/25 the physician indicated there was an Unstageable Deep Tissue Injury of the right heel caused by pressure. Review of Resident 30's wound physician's consult notes reflected on 9/29/25 the physician indicated there was an Unstageable Deep Tissue Injury of the right heel caused by pressure. Review of Resident 30's orders reflected on 9/16/25 an order was given to cleanse right and left heel with normal saline, pat dry, and apply skin preparation daily. Review of the facility resident matrix (CMS-802) dated 09/30/25 reflected Resident #5, and Resident #30 were not marked for current/ active pressure ulcers. Resident #22 was marked for Dialysis. In an interview on 10/2/25 at 09:00 AM with LVN-A she stated that Resident #05 had a recently healed pressure ulcer and that the wound had been open and being treated with wound care orders over the last month. In a telephone interview on 10/02/25 at 01:00 PM with MDS Coordinator, she stated that the MDS should be updated within 14 days after a change in condition (pressure ulcer) and the MDS should reflect accurate information regarding the residents. She stated the negative outcome if the MDS is not current and correct could be the Matrix (802) would not be correct and the management team would not have accurate information to plan care. She stated that Resident #22 was never on dialysis, and she had just corrected hist MDS. She was not aware that Residents #05 and #30 had pressure ulcers. She stated the reason it was not correct was due to human error and lack of team communication. She stated she was responsible to keep MDS current. In an interview on 10/02/25 at 01:05 PM with the DON she stated the MDS should reflect current, correct information on residents. She

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews, 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 1 of 6 residents (Residents #39) reviewed for ADL care. 1. The facility failed to ensure Resident #39 was provided with adequate showers. These failures could place residents at risk of not receiving care and services to meet their needs.Findings Include: Review of Resident #39's face sheet dated 10/02/25 reflected a [AGE] year-old female admitted to the facility on [DATE] with a diagnosis that included need for assistance with personal care, lack of coordination, cognitive communication deficit, major depressive disorder, and hypertension (high blood pressure). Review of Resident #39's annual MDS assessment dated [DATE] reflected a BIMS score of 12 indicating moderate cognitive impairment. Section GG for functional abilities reflected that Resident #39 required partial/moderate assistance with showers. Review of Resident #39's care plan last reviewed on 09/04/25 reflected a focus on ADL self-care performance deficit r/t disease process with intervention that included bathing/showering; Resident #39 requires limited-extensive by 1 staff with bathing/showers as necessary. There was no focus on the refusal of showers or behaviors of refusing care. Review of shower binder for Resident #39s showers for the month of September 2025 reflected only 3 documented showers. 09/08/25 reflected a shower with no skin issues noted, 09/22/25 reflected a shower with no skin issues documented, and 09/25/25 reflected a shower with no skin issues noted. There were no documented showers occurring on 09/01/25, 09/03/25, 09/05/25, 09/10/25, 09/12/25, 09/15/25, 09/17/25, 09/19/25, 09/24/25, 09/26/25, or 09/29/25 based on shower schedule of Monday, Wednesday, Friday and no documented refusals of showers for the month in the shower binder. Review of Resident #39's skin assessments dated 09/23/25 and 09/30/25 both reflected no new skin issues identified- scattered red bumps were present on admission. Review of Resident #39's progress notes reflected no refusal of showers documented for the month of September 2025. In an interview on 09/30/25 at 08:44 AM with Resident #39, she stated that her shower schedule is Monday, Wednesday, and Fridays during the evening shift. Resident #39 stated she had not received a shower in a while but was not able to recall when her last shower was. She stated that when her showers are missed, she will ask the morning shower aide to get a shower and is told that if there is a cancellation they will try to fit her in but then is never pulled to get a shower. Resident #39 stated it did not make her feel good to miss her showers and she just wants to get a shower as soon as possible. The surveyor did not note a foul odor from Resident #39 during this interview. In an interview on 10/02/25 at 11:58 AM with CNA C she stated that showers are provided to residents 3 times a week and the shower schedule for the residents are posted in their rooms at their bathroom door. CNA C stated showers are documented in the shower binder and if a resident refuses a shower they were to be documented in there as well. CNA C stated she did not provide showers to Resident #39 as she was not on her schedule to shower. CNA C stated it is the nurse aides responsibility to complete showers and stated a negative outcome of no showers would be body odor or hygiene issues. In an interview, observation, record review on 10/02/25 at 12:05 PM with the DON she stated it was her expectation that showers are provided by the CNAs and that they are documented in the shower binder. The DON was observed pulling the shower binder to review showers documented for Resident #39. In a record review of the shower binder, Resident #39 was documented to have a shower 09/08/25, 09/22/25, and 09/25/25. The DON stated that Resident #39 was scheduled to receive her showers Mondays, Wednesdays, and Fridays during the 6pm to 6am shift. The DON stated this did not meet her expectations for ADL care and showers. The DON stated that it was her expectation that showers are documented every time or that a refusal is documented if the resident refuses; she stated otherwise all residents should be provided with their showers 3 times a week at a minimum. The DON stated that a negative outcome of no showers has the potential to result in dignity issues and rashes. She stated Resident #39 required minimum assistance with showers, and the last documented refusal was in June of 2025 with no recent refusals. The DON stated that in reviewing the care plan this was also not a documented behavior and Resident #39 was not known to refuse showers. The DON stated that she believed Resident #39 had received more showers than the 3 documented for the month, however, with the facility using many agency staff it was possible they were not being documented. In an interview on 10/02/25 at 12:34 PM with the ADM she stated that it was her expectation that showers are completed as scheduled 3 times a week on both the day and evening shifts

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interviews, and record reviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for one of one kitchen reviewed for expired foods. The facility failed to ensure that outdated food items were disposed of properly in the walk-in refrigerator. The facility failed to ensure food items stored in the freezer were properly stored. The facility failed to ensure food areas were free of pests, a cockroach was observed in the walk-in refrigerator on the floor. This failure could place residents at risk for consuming hazardous expired food and developing foodborne illnesses who received food from the kitchen. Findings Included:During an observation on 09/30/25 at 7:20 AM the kitchen revealed the following:Walk-in Refrigerator:1. Jar of Ranch dressing dated 2/11/20252. Jar of Cherries dated 2/11/2025 and used by Thursday (no date)3. 2 Bottles of Hershey's Chocolate 1 dated 3/12/2025 and 2nd labeled 7/15/2025 and used by 7/22/20254. Jar of Relish dated 3/4/20255. Jar of Pickles with 2 dates 3/14/2025 and 3/19/2025Walk-in Freezer:1. Box of opened turkey franks that were opened and exposed2. Box of opened hamburger patties were opened and exposedAll jars and bottles had what appeared to be molded on the jars. The manufactured date on the bottles was not located on the jar to determine if the expiration date had passed. Observation on 09/30/2025 at 7:25 AM revealed a cockroach on the floor inside of the walk-in refrigerator located in the kitchen. Observation on 9/30/2025 at 11:40 AM revealed the cockroach was cleaned from the floor of the walk-in refrigerator. During an interview on 10/02/2025 at 10:15 AM the CK stated the in-services she received were regarding cutting boards and cooler. She stated there is no one assigned to clean and rotate the food in the refrigerator and freezer. She stated when they stock the refrigerator and the freezer, they are supposed to rotate the oldest to the front. She stated it is usually the aides or the dishwasher since she is cooking. CK stated when the food is opened, anything placed in the refrigerator/freezer, it should have an open and used by date. CK stated, if it is something she cannot close back up, she places it in a zip lock bag with an opened and used by date. CK stated food that is in the refrigerator, she goes by the date and if it is expired, she will trash it. She stated food is normally held for 3 days she believes. CK stated if a resident is given the expired food, the negative impact can be they can have an allergic reaction or get sick.During an interview on 10/02/2025 at 10:35 AM the DM stated her expectation of her staff is to come in and do their job the right way, clean and sanitized behind themselves, follow the menu, report things to her, and make sure they satisfy the residents. The DM stated everyone is responsible for cleaning and rotating food in the refrigerator and freezer. She stated once the food is opened, an opened and used date is placed on it. The cooked food should be used within 3 days. The DM stated it is her responsibility to ensure all duties of the kitchen is done. The DM stated if the resident's received food that is expired or spoiled, they can get sick. The DM stated what led to the failure of the expired and mildew being left in the refrigerator is because it hadn't been used and the staff were focused on the top 2 shelves. She stated she had not used any cherries since she had been there. Interview on 10/02/2025 at 10:35 AM The DM stated pest control comes and sprays in the kitchen once a month. The DM stated if she saw any roaches or bugs, she would let maintenance know and he would have pest control come in and spray. Interview on 10/02/2025 at 11:05 AM the Maintenance stated he has the kitchen sprayed once a month. He stated the negative effects could be health issues (sick) and hygiene. He stated the staff will notify him of any issues with roaches or bugs. During an interview on 10/02/2025 at 12:35 PM ADM stated it is the Supervisor of the kitchen responsibility to train the kitchen staff. The ADM stated the policy on expired food is to remove it from the shelves, date and label food once it is opened and place it on the shelf. ADM stated they staff should check for expired food daily. A negative impact that could have to happen to residents are they can develop health issues, traumatize residents, weight loss of residents because they don't want to eat from, the kitchen, and they can get sick. Record review of facility policy titled, Nutrition Services Food Storage and Handling Policies and Procedures undated did not provided content involving expired foods.Interview on 10/02/2025 at 12:35 p.m. The ADM stated they spray in the building once a month or as needed. She stated the negative impact that could have on a resident is they can begin to have health issues, traumatize residents, and weight loss of residents because they don't want to eat from kitchen. A pest control policy was requested but was not provided. The administrator provided their pest control log and invoices.Record review of the pest control logs provided by the ADM showed the last time pest control provided services was 8/25/2025.Review of an undated facility policy titled Nutrition Services Food Storage and Handling Policies and Procedures reflectedB. Cold Food StorageCold foods shall be stored at the proper