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	02/19/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. 44317 Based on interviews and record reviews, the facility failed to manage and maintain a system that assures a full, complete, and separate accounting, according to accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf and failed to ensure the individual financial record was available to the residents through quarterly statements and upon request, for 1 of 5 residents (Resident #1) and 1 of 1 facility reviewed for trust funds. The facility failed to have a complete accounting or access to resident's trust funds from 01/01/25 and still did not have access on 02/19/25. The facility failed to provide a trust fund stated for Resident #1 upon request on 02/18/25. This failure placed residents whose trust fund accounts were managed by the facility at risk of misappropriation or not having access to funds and needs not being met. Findings included: During a telephone interview on 02/19/25 at 12:04 PM, Resident #1's FM stated she had requested a trust fund statement on 02/18/25 to conduct business for the resident. She stated the BOM told her the facility did not have access to the trust fund accounts at the time so she could not provide a current statement. During an interview on 02/19/25 at 12:49 PM, the ADM stated the facility had a change of ownership and the accounts had all been frozen and as of late January 2025, and they did not have access to the accounts. During an interview on 02/19/25 at 12:50 PM, the BOM stated she had worked at the facility for three weeks. She stated she did not have access to the resident trust fund accounts. She stated everyone, including the lawyers, were aware that the facility did not have access to the accounts. (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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/19/24 at 2:11 PM, the ADM stated as of 01/01/25, there was still money in the trust accounts. She stated they were able to see a balance. When residents asked for money, they were able to give it to them. She stated in late January 2025, their access to the trust accounts program was taken away so they could no longer see the accounts. The ADM stated everything was at a standstill. She stated she had checks for residents but could not deposit the checks because she did not have an account to put them into. She stated the facility attorneys were aware. She stated when residents asked for money, the residents were told they were reconciling and could not give them money. She stated the facility could not complete Medicaid applications or get paid. A policy regarding trust funds was requested but was not provided prior to exit. During an interview on 02/19/25 at 3:50 PM the ABOM/MA stated she did not have access to the trust fund accounts as of 01/01/25. She stated the accounts were closed but the former Owner sent statements out on 01/31/25. She stated a family member had asked for a statement on 02/18/25, but she was only able to provide the balance as of 01/31/25. She stated not having access to their funds could prevent residents from getting money for the things they needed. Review of the facility policy, Resident Rights revised December 2016, reflected in part, 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: . q. access personal and medical records pertaining to him or herself; r. manage his or her personal funds, or have the facility manage his or her funds .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44317 Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 3 residents (Residents #1) reviewed for medications and pharmacy services The facility failed to ensure Resident #1 received her physician ordered medications routinely when it was not documented whether Depakote (a medication used for stabilizing mood) and Potassium (a mineral used to maintain the blood level of potassium that can be depleted by other medications) were administered on 02/04/25, 02/07/25, 02/12/25, and 02/16/25. This failure could place residents at risk of not receiving the intended therapeutic benefit of the medication or care to maintain their highest practicable physical, mental, and psychosocial well-being. Findings included: Review of Resident #1's face sheet, printed 02/19/25, reflected a [AGE] year-old female originally admitted to the facility on [DATE] and recently readmitted on [DATE]. Her diagnoses included transient cerebral ischemic attack (short periods of symptoms like a stroke), dementia, diabetes, and hypertension (high blood pressure). Review of Resident #1's quarterly MDS assessment dated [DATE], reflected a BIMS score of 14 which indicated intact cognition. Review of Resident #1's comprehensive care plan revised on 01/19/25 reflected she was on diuretic therapy with an intervention of monitoring labs including the potassium level. The care plan did not address the Depakote. Review of Resident #1's Order Summary Report for active orders as of 02/19/25 reflected in part: 05/09/24 Depakote Sprinkles oral capsule delayed release sprinkle 125 mg give 1 capsule by mouth two times a day for severe mood disorder with psychotic features. 04/24/24 Potassium Chloride ER oral tablet extended release 10 mEq give 1 tablet by mouth two times a day, give with/after food with full glass of water/juice (8oz) Do not crush. Review of Resident #1's February 2025 MAR reflected in part, the Depakote and Potassium had blanks, no signature, or initials to indicate administration for one dose of each medication on 02/04/25, 02/07/25, 02/12/25, and 02/16/25 . Review of Resident #1's progress notes for 02/01/25 through 02/19/25, reflected no notes that indicated if the Depakote and Potassium were administered or not. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/19/24 at 2:11 PM, a policy for medication administration was requested from the ADM. During an interview on 02/19/25 at 2:26 PM CNA/MA A stated meds were documented when given. She stated if a resident refused a medication, she would notify the nurse. She stated adverse outcomes of not giving a medication depended on the medication. Missing some medications could result in more behaviors or depression. During an interview on 02/19/25 at 2:38 PM LVN B stated she did not usually work with Resident #1 and was not aware of blanks on the MAR. She stated she was aware that Resident #1 refused medications at times. She stated meds were documented when given. If a resident refused a medication, she made several attempts to administer. If the resident continued to refuse, she notified the doctor and the family then documented in the progress notes. If medications were refused or not administered as ordered, the resident could have different negative effects. She stated if blood pressure meds were not given the resident could have uncontrolled blood pressure. She stated not giving diabetic medications could lead to unstable blood sugars. During an interview on 02/19/25 at 2:54 PM, the ADON stated she expected the physician's orders to be followed. She stated she expected medications were documented when administered. During an interview on 02/19/25 at 3:50 PM, the ABOM/MA stated she worked in the business office but sometimes worked as a medication aide. She stated she was the medication aide for Resident #1. She stated the resident had taken her medications and she documented the meds as given at the time of administration. She stated, If it is not documented, it did not happen. She stated she did not know why there were blanks on the MAR. She stated if a resident refused a medication, she would try again then notify the nurse. She stated she would document the notes that the nurse was notified. During an interview on 02/19/25 at 4:13 PM, the ADM stated she expected medications to be administered, by all the corrects - the correct medication, the correct dose, the correct resident and so on. She stated she expected the nurse or medication aide to document the medication administration or the reason it was not given. She stated if a medication was not given, the doctor was notified. Review of the received policies, Destroying Medications Policy, Discontinued Medications Policy, Drug Regimen Review Policy, Gradual Dose Reduction Policy, Holding Medications Policy, Labeling Medications Policy, Medication Errors and Drug Reactions Policy, Medication Reconciliation Policy, Medication Self-Administration Policy, Medications - Leave of Absence, Discharge Policy, Prevention of Opioid Overdose and Death Policy, PRN Psychotropic Medications Policy, Receiving and Recording Medication Orders Policy, Resident-Centered Medication Pass Policy, and Schedule for Medication Administration Policy, all undated, reflected they did not address staff administering or documenting medications.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44317 Based on observations, interviews, and record reviews, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for all residents, staff, and other individuals providing services and conducted following accepted national standards for 1 (Resident #2) of 3 residents reviewed for infection control. The facility failed to ensure Enhanced Barrier Precautions (EBP) were implemented or used when CNA C, without wearing PPE, transferred Resident #2 to his wheelchair. The facility failed to have signage that reflected PPE was required for high contact care with Resident #2. This deficient practice could place residents at risk for infection and cross-contamination. Findings included: Review of Resident #2's face sheet printed on 02/19/25, reflected a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included osteomyelitis (an infection in the bone), dependence on renal dialysis (a procedure used to remove extra fluid and waste from the body when the kidneys do not function properly), pressure ulcer of sacral region (area at the bottom end of the spine) - stage 4 (a wound extending into deep tissue including muscle), and diabetes. Review of Resident #2's admission MDS assessment dated [DATE], Section C (Cognitive Patterns) reflected a BIMS score of 15 indicating intact cognition. Section GG (Functional Abilities) reflected he required substantial/maximal assistance for chair/bed-to-chair transfers. Section H (Bladder and Bowel) reflected he had an indwelling catheter and an ostomy (an opening through the abdomen into the colon). Section M (Skin Conditions) reflected he had a stage 4 pressure ulcer. Review of Resident #2's current order summary report dated 02/19/25 reflected in part: 01/27/25 Cleanse wound to sacrum NS, pat dry with 4x4's, apply calcium alginate, cover with bordered foam dressing daily and PRN if soiled or becomes dislodged every dayshift for stage 4 pressure ulcer. 01/16/25 Foley catheter care every shift. 01/16/25 Ostomy care daily and PRN every shift. Review of Resident #2's comprehensive care plan initiated on 01/08/25, reflected in part: Special Instructions: EBP Precautions: Suprapubic Catheter, Sacral Wound, PICC line (a tube inserted through a vein in the arm to large veins near the heart to administer medication), JP Drain (a suction drain used to remove fluid near a surgical site). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Focus: Resident is on EBP, Central lines/PICC lines, chronic wound or skin opening requiring dressing change, indwelling catheter, Dialysis central port left chest wall . Goal: Resident will demonstrate effective coping mechanisms through next review date. Interventions: EBP sign will be placed inside resident room within close proximity to resident to inform staff of resident specific needs; EBP supplies (gown and gloves) will be readily available; EBP supplies will be discarded in regular trash receptacle unless soiled with blood or body fluids . An observation on 02/19/25 at 12:35 PM, revealed Resident #2 lying in bed with his eyes closed. A catheter drain bag and an IV pole were visible from the hall. No EBP sign was visible . During an observation and interview on 02/19/25 at 1:20 PM, revealed Resident #2 and CNA C were observed exiting Resident #2's room. Resident #2 stated he needed to get to the van, so he was not late for his dialysis chair time. CNA C stated she did transportation and drove residents to their appointments. CNA C stated the resident was not of EBP and she did not wear PPE when she transferred him to his wheelchair. She stated she had been trained on PPE. CNA C followed the resident towards the exit. Observation in the room revealed no EBP signage, no supply of clean PPE and no discarded PPE in the trashcan. During an interview on 02/19/25 at 2:26 PM, CNA/MA A stated she had been trained on infection control and EBP. She stated anyone with a catheter, peg tube (a tube inserted through the abdomen into the stomach for nutrition), or colostomy (a surgical opening in the colon through the abdomen, allowing waste to exit the body) required EBP. She stated a gown and gloves were required when they provided care and PPE was in the rooms. She stated they would be considered dirty to residents with catheters or tubes, and we could spread infection. During an interview on 02/19/25 at 2:54 PM, the ADON stated she had just started in her position on 02/17/25. She stated she had received training regarding EBP. The ADON stated she was not sure who was responsible for posting the EBP signs. She stated there was supposed to be a meeting with the DON and other ADON to clarify who was responsible for which duties, but the meeting had not happened yet. She stated anyone with a line, g-tube, catheter, dialysis port, Foley, or IV should have been on EBP. She stated not wearing proper PPE or following infection control procedures could cause infection. During an interview on 02/19/25 at 4:13 PM, the ADM stated the nursing administration, DON and ADONs, were responsible for EBP and infection control. She stated she expected EBP to be followed and it did not meet her expectations that EBP were not followed for Resident #2. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy, Enhanced Barrier Precautions effective 04/01/24, reflected in part, Enhanced Barrier Precautions (EBP) are a CDC guidance to reduce the transmission of multi-drug resistant organisms (MDRO) in health care settings, including nursing homes. EBP require team members to wear a gown and gloves while performing high-contact care activities with residents who are infected or colonized with a targeted MDRO, or who have open wound or indwelling medical device. 2. Determine if a resident has any wounds . Examples include pressure ulcers .Determine if any of the following indwelling medical devises are in use: urinary catheter, g-tube, tracheostomy (a surgical incision through the front of the neck into the windpipe for breathing), central lines .EBP will be implemented if any of the above wounds or invasive medical devices are present. Place signage on resident's closet door, maintain PPE in resident's room and assure all team members are aware of resident status and need for EBP during high contact care. 4. High contact resident care activities: Dressing; Bathing/Showering; Transferring . Device care or use: central line, urinary catheter; Wound care.