STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675799	A. Building B. Wing	12/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brenham Nursing and Rehabilitation Center	400 E Sayles St 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 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44174 Based on interview and record review, the facility failed to ensure residents had a discharge summary that included a recapitulation of the resident's stay that included, but was not limited to diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results for three (Resident #10, Resident #42 and Resident #95) of five residents reviewed for discharge summaries. The Discharge Summary for Resident #10, Resident #42 and Resident #95 did not have a completed nursing discharge summary to include a complete recapitulation of the residents' stay and a plan for discharge needs such as transportation arrangements, appointments with primary care physicians, groceries and supplies at home for residents discharged to the community. This failure could place residents discharged from the facility at risk for incorrect, incomplete, or misleading information recorded regarding their stay. Findings included: Review of Resident #10's face sheet dated 12/06/2022 revealed Resident #10 was a [AGE] year-old male admitted to the facility on [DATE] with a diagnoses of End Stage Renal Disease (disease in which the kidneys no longer function, and the patient requires dialysis to clean the blood), diabetes mellitus, high blood pressure, partial paralysis of the right side related to a previous stroke, history of repeated falls, and unsteadiness of feet with other lack of coordination. Review of Resident #10's EMR as 12/06/2022 revealed Resident #10 did not have a discharge summary that included a recapitulation of the resident's stay that included, but was not limited to diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. In an interview on 12/07/2022 at 11:27 AM, the SW stated she completed a discharge summary for Resident #10. She stated the nursing staff would complete the discharge summary that would include the required clinical information. (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 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/07/2022 at 11:30 AM, LVN F stated the discharge summary was still in the process of being completed. She said she had 14 days from the date of discharge to complete the process. She said Resident #10 was given a discharge summary by the nurses upon discharge with his clinical information. She said there may have been a computer glitch on the day he was discharged and the summary was not put in to the EMR. She said they would look for the nursing discharge summary. In an interview on 12/07/2022 at 11:56 AM, LVN G stated the nursing discharge summary was not completed for Resident #10. She said there was a discharge summary completed on paper due to computer issues but it was not Resident #10. She stated nursing staff should have completed the nursing discharge summary in the EMR to include the clinical information. In an interview on 12/07/2022 at 2:04 PM, the Administrator stated the discharge summaries were completed for Resident #10 by the social worker and physician. When asked where the discharge summary that was given to Resident #10 upon discharge to include the clinical information required by the facility policy, he said the facility just started the new process of completing the nursing discharge summary and it was not fully rolled out which accounted for why Resident #10 did not have a nursing discharge summary completed. The Administrator provided a copy of Resident #10's therapy discharge record as the discharge summary . He stated it showed Resident #10's current functioning status at discharge. In an interview on 12/08/2022 at 12:30 PM LVN D said they do a paper discharge assessment and then the nursing notification of discharge in the EMR. She said nursing staff were to complete the discharge summary and notice. The SW did their own discharge summary. If she did not have the answers to some of the questions in the discharge summary she would consult with the appropriate discipline. For instance, regarding the question about how a resident would obtain groceries once home, she would ask the SW if the resident did not know the answer. In an interview on 12/08/2022 at 12:32 PM the DON stated the nursing discharge summary was new and the process of completing it was not fully rolled out. She stated the requirements in the facility policy were addressed by the SW discharge summary and met the requirement. She said in addition the charge nurse at time of discharge was to print medication review and give remaining meds to resident to discharge home. When asked about the missing clinical information in the SW summary, for instance the labs and course of treatment, she said she would have to defer to the SW for that information. She said for the three residents, Resident #10, Resident #42 and Resident #95 they had the information they needed at discharge though the nursing discharge summary was not completed. Review of Resident #42's face sheet dated 12/08/2022 revealed Resident #42 was a [AGE] year-old male admitted to the facility on [DATE] with a diagnoses of pressure ulcer to right buttock stage 2, type 2 diabetes, chronic kidney disease (disease in which the kidney function decreases in time), high blood pressure, heart disease, right below the knee amputation and atrial fibrillation (fast irregular heart beat). Resident #42 was discharged to the community on 12/03/2022 from the facility. Review of Resident #42's EMR dated 12/08/2022 revealed an incomplete Nursing discharge summary with no portions of the discharge summary completed. Review of Resident #42's [FACILITY] SNF Notice of Medicare Non-coverage dated 12/02/2022 revealed Resident #42 was given the notice on 12/02/2022 that services would end 12/03/2022. It was signed by Resident #42 on 12/02/2022. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #42's Social Services Discharge from Skilled Level of Care dated 12/05/2022 revealed Resident #42 was discharged from skilled level of care to home alone on 12/02/2022. It noted home health orders were initiated and orders were received for durable medical equipment including a hospital bed through Medicare equipment. Resident #42 was noted to need a PCP appointment within one but no appointment date and time was noted. Discharge information was noted to be sent to the PCP office. Prescriptions were given to the resident upon discharge. Review of Resident #42's Nursing Notice to Resident/RP of Transfer or discharge date d 12/03/2022 revealed Resident #42 was given notice of his discharge on 12/03/2022 and discharged on [DATE] due to the resident has failed, after reasonable and appropriate notice, to pay for (or has failed to have Medicare or Medicaid pay for) this stay at the facility. The notice was not signed by Resident #42. Review of Resident #95's face sheet dated 12/08/2022 revealed Resident #95 was a [AGE] year-old male admitted to the facility on [DATE] with a diagnoses of partial paralysis following a stroke on his right side, cellulitis of the lower limbs (skin infection of the lower legs), high blood pressure, aphasia (inability to speak), heart failure, and history of repeated falls. Resident #95 was discharged to home on 11/25/2022 with home health services. Review of Resident #95's EMR dated 12/08/2022 did not reveal a Nursing discharge summary to be completed at the time of discharge for Resident #95. Review of Resident #95's [FACILITY] SNF Notice of Medicare Non-coverage dated 11/22/2022 revealed Resident #95 was given the notice on 11/22/2022 that services would end 11/24/2022. It was signed by Resident #95 on 11/22/2022. Review of Resident #95's Nursing Notice to Resident/RP of Transfer or discharge date d 11/25/2022 revealed Resident #95 was transferred home on 11/25/2022 due to the resident's health improved sufficiently that the resident no longer needs the services provided by this facility. The notice was signed by Resident #95 on 11/25/2022. Review of Resident #95's Social Services Discharge from Skilled Level of Care dated 11/28/2022 revealed Resident #95 was discharged from skilled level of care on 11/24/2022 to home with family. Home health orders were initiated but resident refused. No PCP follow-up was set up for Resident #95 following discharge. Resident #95 was given prescriptions and it was noted resident living with friend in a new town. Finding a new physician and pharmacy to set up with. Review of Resident #95's Physician discharge summary dated 11/23/2022 revealed Resident #95 He is clinically stable and has been cleared to discharge home on Friday. SW report he declined home health services, he is going to a friend's house in Houston, he reported he will need to establish new PCP in Houston. However, he did say he will see his current PCP one more time before transitioning to a new PCP. Discharge medication reconciled and 30 days supply sent to pharmacy per patient request. Staff to give him Tramadol and Coumadin. I emphasized the importance of following with PCP for Coumadin monitoring. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Discharge Process Policy dated October 2022 revealed facility will ensure a smooth discharge process to include a discharge process and documentation of recapitulation of the resident's stay that included patient diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.

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F 0689 Level of Harm - Actual harm 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** 44174 Based on observation, interview, and record review the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for one (Resident #24) of 10 residents reviewed for accidents and hazards. The facility failed to ensure Resident #24 was supported when sitting on the edge of her bed on 11/26/2022 and Resident #24 fell and suffered a laceration to her head that required eight sutures. This failure could place residents at risk for injury and decreased quality of life. Findings included: Review of Resident #24's face sheet dated 12/08/2022 revealed Resident #24 was a [AGE] year old female admitted to the facility on [DATE] with a diagnoses of dementia (cognitive and thinking disorder that causes confusion and loss of memory), high blood pressure, history of falls, dysphagia (difficulty swallowing), muscle wasting and atrophy (disorder that causes decreased strength and coordination), contractures (tight muscles) of the left and right lower leg and history of stroke. Review of Resident #24's Physical Therapy Evaluation and Treatment dated 06/10/2020 revealed Resident #24 had fair static sitting balance and required max assistance for bed mobility and transfers. Resident #24 required maximal assistance for lying to sitting on side of bed, sit to lying, sit to stand and chair or bed to chair transfer. Review of Resident #24's care plan dated 08/11/2022 revealed Resident #24 required ETAC [NAME] assistance with 2 staff to move between surfaces as necessary (ETAC [NAME] is a turn aid with a functional design that offers safe patient turning and transfer with standing support). Resident #24 required extensive assistance by two staff to turn and reposition in bed. Resident #24 was at low risk for falls related to confusion, deconditioning, gait/balance problems, incontinence and unaware of safety needs. Interventions included anticipate and meet Resident #24's needs, ensure call light is within reach, ensure Resident #24 is wearing appropriate footwear and Resident #24 needs a safe environment . Review of Resident #24's quarterly MDS assessment dated [DATE] revealed Resident #24 had a BIMS score of zero to indicate severe cognitive impairment. Resident #24 was noted to require extensive assistance by two staff members for transfers and bed mobility. Resident #24 was not steady and only able to stabilize with staff assistance when moving from seated to standing position and moving from surface to surface in a transfer. Review of Resident CNA A's Texas Nurse Aide Performance Record dated 11/10/2022 revealed CNA A satisfactorily completed procedures for assisting with resident to sit up on side of bed, assisting resident to transfer to chair or wheelchair and safety regarding fainting and falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #24's Incident Report dated 11/26/2022 revealed Resident #24 had an unwitnessed fall with the description CNA alerted this nurse that resident had had a fall and was lying on the floor. CNA stated, I was waiting for a co-worker to come assist me and with the ETAC [NAME] to get the resident into her wheelchair, so I sat the resident up on the side of the bed and turned around to get the wheelchair when fell over onto the floor. Upon entering the room noted resident lying on her left side between her bed and bedside table, gash noted on resident's left forehead above eyebrow, copious amount of blood noted coming from laceration, resident unable to tell this nurse if she was in pain, resident noted holding head with hand, started VS monitoring and neuro checks, no deficits noted, resident able to speak, VS stable, ROM good to extremities, tried to clean wound with gauze and wound cleanser, held pressure to wound, notified DON, called 911, sent resident to ER for further evaluation. Notified RP and MD. Resident description: Resident unable to give description. Resident pain assessment was noted to have a sad, frightened, frown face and tensed, distressed and pacing body language. The report further noted Resident was sitting on the side of the bed and fell over onto the floor. Poor trunk control. Review of Provider Investigation Report dated 11/26/2022 revealed Resident #24 was investigated for an injury of unknown origin revealed the following staff interviews: CNA A: I was getting Resident #24 up for breakfast. She was sitting on the side of the bed, without any issues. I turned to get the wheelchair while I was waiting on another aide and when I turned around, she had fallen between the bed and bedside cabinet. It looked like she hit her head on the cabinet. I called for the charge nurse, who then immediately came to the room. CNA B: was asked to come help with transfer. We didn't do the transfer because Resident #24 had fallen, and they were calling EMS. LVN E: I was called to the room after a resident fall. Resident #24 was noted to be on her side between the bed and her cabinet. She had blood coming from her forehead, after attempting to clean I held pressure to the wound. We then sent her to the ER for treatment. She couldn't explain what happened, but the aide was getting her up from breakfast. Description of injury: 8 forehead sutures to close laceration measuring 3.3 cm. Review of Resident #24 nursing progress notes dated 12/06/2022 revealed nursing progress note by LVN E dated 11/26/2022 at 9:39 AM CNA alerted this nurse that resident had a fall and was lying on the floor. Upon entering room noted resident lying on her left side between her bed and bedside table, gash noted on resident's left forehead above eyebrow, copious amount of blood noted coming from gash, resident unable to tell this nurse if she was in pain, resident noted holding head with hand . Review of Resident #24 nursing progress notes dated 12/06/2022 revealed nursing progress note by LVN E dated 11/26/2022 at 9:43 AM revealed CNA A stated I was waiting for a co-worker to come assist me with the ETAC [NAME] and get the resident up on the side of the bed and turned around to get the wheelchair when she fell over onto the floor. Review of Resident #24 nursing progress notes dated 12/06/2022 revealed nursing progress note by LVN E dated 11/26/2022 at 1:24 PM revealed Resident returned from ER with 8 stitches to left forehead. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	In an observation on 12/06/2022 at 1:45 PM, Resident #24 was sitting in her wheelchair in the common area and had bruising and a scar to her forehead. In an interview on 12/07/2022 at 3:34 PM CNA A stated she was present when Resident #24 fell . CNA A said she dressed Resident #24 then sat her on the side of Resident #24's bed. She said she was new to the facility and was not sure how Resident #24 was transferred. She said the other CNA B told her Resident #24 required an ETAC [NAME] and went to get the ETAC. She said she sat Resident #24 up on the side of the bed and then stepped away from Resident #24 to get Resident #24 ready for transfer. She stated as she turned away Resident #24 fell and hit her head on the nightstand. She said the wheelchair was on the other side of the nightstand and she was not more than 12-18 inches away from Resident #24. She did not know Resident #24 well and did not realize Resident #24 was not steady enough to sit on the side of bed. She stated she received training on the ETAC transfers and resident safety. She said she found out how residents were transferred or other needs by their care plan or asking other staff members. In an interview on 12/07/2022 at 3:45 PM, the DON stated the fall for Resident #24 was accidental because Resident #24 was stable to sit on the side of her bed. She stated Resident #24 had good core strength and did not require assistance when sitting on the side of the bed. In an interview on 12/08/2022 at 9:05 AM CNA C stated he frequently assisted Resident #24 with transfers to and from her wheelchair to her bed. He stated Resident #24 was not stable enough to sit on the side of her bed without assistance. He stated he would not leave her even briefly just sitting on the side of the bed. He stated Resident #24 was transferred with the ETAC [NAME] with two people without a problem. He stated new staff would know how to transfer and know a resident's ability by their care plan or asking other staff members. In an interview on 12/08/2022 at 9:09 AM, LVN D stated Resident #24 had good core strength and safely sat in a wheelchair, but she would not leave her sitting on side of the bed unattended even for a second because Resident #24 would fall. She stated new staff or unfamiliar staff would know by shift reports from staff or the resident's care plan what and how much assistance a resident required. In an interview on 12/08/2022 at 10:19 AM, the RP for Resident #24 said he was notified of the fall suffered by Resident #24 but not the details of the fall. He said he would not think Resident #24 could sit up on the side of the bed without assistance due to her weakened condition at 96-years-old. He said he would think someone would have to remain by Resident #24 at all times until laying down or in her wheelchair. In a follow-up interview on 12/08/2022 12:32 PM, the DON stated Resident #24 had good trunk control and can sit up on her own. She stated she would not leave Resident #24 alone on side of bed and Resident #24 was not left alone. She stated the aide turned to get the wheelchair and Resident #24 slipped down off the bed and hit her head on the nightstand. She said it was identified as an unwitnessed fall because CNA A did not actually watch Resident #24 slide down off the bed. She stated Resident #24 had no long lasting effects from the fall. When asked if the fall could have been prevented, she said no because normally Resident #24 could sit on the side of the bed. When asked why staff would say Resident #24 was not stable enough to sit on the side of the bed, she said she did not know.