STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675132	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bremond Nursing and Rehabilitation Center	211 N Main Bremond, TX 76629

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675132	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bremond Nursing and Rehabilitation Center	211 N Main Bremond, TX 76629

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 0842 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 interviews and record reviews, the facility failed to maintain clinical records on each resident, in accordance with accepted professional health information management standards and practices that are complete, accurately documented, readily accessible, systematically organized and protected from unauthorized release for 3 (Resident #1, Resident #2, and Resident #3) of 4 residents reviewed for maintenance of clinical records. 1. The facility failed to ensure staff documented accurately after Resident #1 was found on the floor and sent out for evaluation on 10/12/25 and returned to the facility on [DATE].2. The facility failed to ensure staff updated the care plan for Resident #2 after she reported she had a fall on 09/15/25.3. The facility failed to ensure staff accurately documented a progress note after Resident #3 had an apparent unwitnessed fall on 10/13/25. These deficient practices could place residents at risk of injuries related to falls or not receiving necessary treatment.Findings included:1. Review of Resident #1's admission record, printed 10/15/25, reflected a [AGE] year-old male originally admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included unspecified intellectual disabilities, unsteadiness on feet, unspecified lack of coordination, dementia with agitation, and Alzheimer's disease with late onset. Review of Resident #1's MDS assessment dated [DATE] reflected he was rarely/never understood so a BIMS assessment was not completed. The MDS assessment reflected he needed set up assistance for transfers and ambulation and had no falls since the prior MDS assessment. Review of Resident #1's comprehensive care plan initiated 08/07/25, reflected in part, Focus: I am at risk for falls related to unsteady gait, history of falls, muscle weakness, cognitive impairment. Goal: I will remain free from injury due to falls. Interventions/Tasks: I will be given non-skid socks or footwear to help me move safely. I will be assisted with walking, transfers, or toileting as needed, based on my current ability. Review of the incident log from 09/01/25 through 10/14/25, reflected Resident #1 had an unwitnessed fall on 10/12/25 at 8:30 PM. Review of Resident #1's progress note dated 10/13/25 at 5:48 AM., and written by LVN A, reflected EMS was notified and Resident #1 was sent to the acute hospital after being found on the floor. Review of Resident #1's progress notes from 09/14/25 to 10/15/25 reflected there were no notes to address: The date and time the resident was found on the floor and sent out to the hospital or the date and time the resident had returned to the facility. During an interview on 10/14/25 at 2:25 PM., LVN B stated Resident #1 had gone out to the hospital sometime on the night shift on 10/12/14. She stated when she was coming in for her shift on the morning of 10/13/25, Resident #1 was just returning to the facility. LVN B stated if there was an unwitnessed fall, they were expected to get vital signs, complete a head-to-toe assessment, write a progress note and incident report, and notify the NP/MD, RP, and DON. She stated thorough documentation was important to ensure the residents received the proper care. During an interview on 10/15/25 at 10:57 AM, the VPCO stated the DON had told her Resident #1 had been sent out to the hospital on [DATE] because of a fall. She stated with any fall; she expected the event to be reported. That report triggered the required assessments. She expected the DON to complete an assessment and to reassess the resident before closing out the event at 72 hours as some bruises took time to develop. She stated if the documentation was missing or not accurate, there was no way to assess the outcome, and the facility may have missed something. During an interview on 10/15/25 at 11:42 AM, the DON stated she expected documentation to be accurate and timely. She expected after a fall the nurse completed a fall assessment, a progress note, an incident report, notification of the NP/MD, RP, and DON. She stated she and the ADON were responsible for monitoring the documentation and train/in-service staff, but since the ADON was out, she was responsible. The DON stated the ADON was also the MDS nurse who was responsible for care plans. She stated while the ADON was out, she was responsible for ensuring care plans were updated. During an interview on 10/15/25 at 12:18 PM, the ADM stated it was important that documentation was thorough and timely. She expected staff to take care of the resident first then complete the documentation. She stated it was her expectation that the documentation painted a picture of the resident's status so anyone would know what happened. She expected all documentation was completed before the staff left at the end of their shift. The ADM stated the new ADON was responsible for monitoring documentation, but she was out on leave, so the monitoring was done by the DON. During an observation and attempted interview on 10/15/25 at 1:28 PM, Resident #1 was sitting in a wheelchair in the dayroom. His posture was relaxed, no indicators of pain or distress observed. He made eye contact and smiled. He responded to questions with a giggle but did not respond verbally. A telephone