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	03/18/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and records review, the facility failed to ensure that medical records were accurately documented for three (3) of nine (9) residents (Resident #2, Resident #8 and Resident #9) reviewed for accurate clinical records. The facility failed to ensure Resident #2, Resident #8 and Resident #9 EMRs contained orders upon admission to the secured unit with corresponding clinical criteria to admit them to the secured unit. This failure could result in errors in care and treatment and violate resident rights.Findings included: Resident #2 Review of Resident #2's face sheet dated 3/18/2026, reflected an [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included: Dementia, (decline in cognitive function), muscle wasting, delusional disorders, heart failure, abnormalities of gait and mobility and lack of coordination. Review of Resident #2's quarterly MDS dated [DATE], reflected a BIMS core of 4, suggestion severe cognitive impairment. Further review of the behavior section of the MDs reflected no presence of wandering behaviors. Review of Resident #2's census reflected Resident was moved to the secured unit on 3/5/2026. Review of Resident #2's physician orders dated 3/18/2026 reflected no orders for secured unit placement prior to 3/18/2026. Review of Resident #2's care plan dated 3/18/2026 reflected a problem with a revision date of 3/1/2026: Resident exhibits impaired safety awareness and elopement risk related to cognitive impairment with a goal Resident will remain safe and free from injury related to wandering and impaired safety awareness through the next 90 days and an intervention Resident to reside in locked/secured unit with monitored entry/exit doors to reduce elopement risk. Resident #8 Review of Resident #8's face sheet dated 3/18/2026, reflected a [AGE] year-old male admitted to the facility to the secured unit on 12/23/2025 with diagnoses that included: Dementia, (decline in cognitive function), anxiety disorder, insomnia (lack of sleep), hypertension (high blood pressure), abnormalities of gait and mobility and difficulty in walking. Review of Resident #8's admission MDS assessment dated [DATE], reflected a BIMS score of 1, suggesting severe cognitive impairment. Further review of the behaviors section of the MDS reflected that the resident had no wandering behaviors exhibited in the last 7 days. Review of Resident #8's physician orders dated 3/18/2026 reflected no orders for secured unit placement. Review of Resident #8's care plan dated 3/18/2026 reflected the focus initiated on 1/13/2026: Resident has progressive cognitive impairment related to dementia/Alzheimer's disease, resulting in memory loss,disorientation, impaired judgment, and risk for injury or elopement, with a goal of Resident will remain free from injury and elopement during the care plan period. Resident #9 Review of Resident #9's face sheet dated 3/18/2026, reflected an [AGE] year-old female admitted to the facility on [DATE] to the secured unit with diagnoses that included: Dementia (decline in cognitive function), cognitive communication deficit, lack of coordination and muscle weakness. Review of Resident #9's admission MDS assessment dated [DATE], reflected a BIMS score of 3, suggesting severe cognitive impairment. Further review of the behaviors section of the MDS reflected resident had wandering that occurred for 1 - 3 days and placed the resident at significant risk of getting to a potentially dangerous place Review of Resident #9's physicians' orders dated 3/18/2026, reflected no orders for secured unit placement. Review of (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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(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	Resident #9's care plan dated 3/18/2026, reflected the following problem initiated 2/26/2026: Resident exhibits impaired safety awareness and elopement risk related to cognitive impairment, resulting inwandering behavior and need for secured environment, with the goal of Resident will remain safe and free from injury related to wandering and impaired safety awareness in the secured unit through the next 90 days. During an interview on 3/18/2026 at 3:30 pm the Corporate DON stated she was not aware that residents on the secured unit did not have physician's orders in place. She stated that she found out when she arrived at the facility today that the orders were missing. The DON stated her expectation was that residents on the secured unit would have a physician's order and that the order would be entered into the EMR. She stated by placing residents on the secured unit without a physician's ' order we could be secluding them or violating their rights. She stated the facility would be correcting this today. During an interview on 3/18/2026 at 4:29 pm, the MD stated residents were evaluated for secure unit placement based on cognition levels, medical diagnoses, previous history of any elopement or wandering attempts, agitation or expression of verbal intent. The MD stated he was aware of the residents currently on the secured unit and the placement for these residents was appropriate. He stated he was not aware a physician's order was needed per the facility policy, but he would ensure this would be fixed for all residents on the unit. He stated he did not have any concerns about the residents currently placed on the unit, even though there was a documentation issue; but he did not want to put people there without an order because we don't want them to appear secluded. Review of Facility Policy Secured Unit Placement dated 9/1/2023 reflected:The facility will ensure that residents are placed in a secured unit only when clinically indicated, based on a comprehensive assessment, and in accordance with physician orders, interdisciplinary team (IDT) recommendation, and resident rights. Placement will reflect the least restrictive environment necessary to maintain resident safety and well-being.8.Documentation Requirementsa. The following must be documented:* Physician order