STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675681	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/11/2024
NAME OF PROVIDER OR SUPPLIER Bronte Health and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 900 S State St Bronte, TX 76933	

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 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** 44766 Based on observation, interview, record review, the facility failed to ensure each resident received adequate supervision to prevent accidents for 1 of 11 resident (Resident #1) reviewed for accidents. The facility failed to supervise Resident #1 to prevent falls. This failure could place residents who required supervision at risk for falls. The findings included: Review of Resident #1's annual MDS assessment, dated 9/20/23, reflected she was an [AGE] year-old female who admitted to the facility on [DATE]. Her cognitive status was a BIMs of 3. Her diagnoses included Neurocognitive disorder (is a general term that describes decreased mental function due to a medical disease other than a psychiatric illness), epilepsy, muscle wasting and atrophy, and lack of coordination. Review of Resident #1's Care Plan, dated 1/15/2024, reflected she was a fall risk. The Care Plan reflected: the resident was at high risk for falls due to impaired balance, bowel, and bladder incontinence, severe cognitive impairment and poor safety awareness, and use/side effects of psychotropic and pain medications. The resident had a history of multiple falls. Record review of facilities incidents by incident type dated 1/1/24 through 3/10/24 indicated Resident #1 has sustained 12 falls, 5 of which were witness, and 7 of which were unwitnessed falls. All falls indicated no injury or skin tear except for the fall sustained on 3/7/24. During a phone interview on 3/5/24 at 12:35 PM Family member indicated that they had concerns for Resident #1 due to the amount of falls she has sustained at the facility. She stated that the falls may be minor, but she had concerns that the falls may get worse if something is not done. (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: 675681	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/11/2024
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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 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #1's progress note dated 3/7/24 indicated by RN D: at approximately 5:45 AM, this nurse was notified by CNA that resident was laying on the floor in her room. Upon entering the room, resident was sitting on the floor with large amount of blood on the right side of her forehead and in her hair, along with a pool of blood on the floor. Firm pressure applied to the hematoma (bruise), measuring 3.5cm, with gauze to stop bleeding. Area cleansed and dressing applied. Resident c/o pain to area of injury then stated she was ok. No other injuries noted or voiced by resident. Neuro checks initiated and vital signs stable. Firm pressure applied to hematoma with gauze to stop the bleeding, then area cleansed, and dressing applied. Neuro checks initiated and vital signs stable. Physician A, DON, Hospice, and resident's Family member notified of unwitnessed fall. Record review of Resident #1's progress note dated 3/7/24 at 3:21 PM indicated: follow up to fall that occurred this am. Continues with 3.5 cm diameter hematoma to R side of forehead. Small abrasion noted over the hematoma. Drug applied to area due to small amount of bleeding noted. Neuro checks done as per protocol and hospice at the facility this afternoon and new order received formability 2mg q am. Family aware of fall and new order. During an interview on 3/11/24 at 1:15 PM CNA A stated on memory care there is only one aide. She stated that staffing was actually pretty good, but the issue is when residents need help, she calls the nurses station to get the floater into memory care to watch the residents while she helps another resident herself. She stated but there are a lot of times when the floater does not come to help her. During an interview on 3/11/24 at 1:45 PM the DON stated that Resident #1 has a bad knee and is a fall risk. She stated that Resident #1 has a lowered bed and a fall mat in the room. She stated that due to Resident #1's dementia and bad knee the resident forgets that she needs to ask for help or use her call light. She stated for resident #1 a scoot mat has been ordered. She stated that the only way as a CNA on memory care to be aware of any residents that are getting up is to be paranoid and listen for any creaking of beds, because the aids/nurses will know if a resident is moving. She stated that staffing is very good, and they keep an aide on memory care at all times, but they also have an aide that acts as a floater between memory care and SNF side. During an interview on 3/11/24 at 2:15 PM CNA B stated that on memory care there was only one aide. She stated that it's difficult to watch all the residents by herself. She stated a second aide back there would help a lot. She stated bed alarms would help a lot as well, but the facility does not have them, and she is not sure why. She stated there have been times where she has tried to reach out for another CNA to come back to the memory care unit to help her, but they never show up. She stated some of the other CNAs refuse to go to the memory care unit. She stated because of that, things are very difficult by herself. She stated that Resident #1 gets up around 5:30 am to 6:00 AM every day, but because she was helping the other residents out of bed, Resident #1 got out of bed on her own. She stated when she was doing her rounds to help residents out of bed, that is when she found Resident #1 on the floor. Review of the facility policy and procedure, Fall Risk Assessment, revised dated 3/2018, reflected: 1. The staff, with the input of all attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls.