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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>675681 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                            | (X3) DATE SURVEY COMPLETED<br><br>04/01/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Bronte Health and Rehab Center |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>900 S State St<br>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.

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| <p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44766</b></p> <p>Based on interview, and record review the facility failed to have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial wellbeing for 5 (Residents #1, #2, #3, #4, and #5) of 10 residents reviewed for staffing concerns on the memory care unit.</p> <ol style="list-style-type: none"> <li>The facility failed to ensure there were sufficient staff to ensure Resident #1 did not sustain falls while on the memory care unit.</li> <li>The facility failed to ensure there were sufficient staff to ensure Residents #1-#5 had the proper assistance per the resident's required assistance.</li> </ol> <p>These failures placed residents at risk of not getting needed care and services, a decrease in quality of care and quality of life and/or injury.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet, dated 03/29/24, reflected an [AGE] year-old female with an admitted [DATE]. Resident #1 had diagnoses which included Neurocognitive disorder, collapse, bradycardia, and unsteadiness on feet.</p> <p>Record review of Resident #1's MDS dated [DATE] with a quarterly assessment dated [DATE] indicated BIMS score of 3, indicating severe cognitive impairment.</p> <p>Record review of Resident #1's Care Plan dated 3/29/24 for ADL's indicated Resident #1 is a 2 person assist for task such at transfers, locomotion, and toileting. Resident #1 is to be always in line of sight for fall risk.</p> <p>Record review of the facility's fall incident report dated 3/1/24 through 3/26/24 indicated Resident #1 sustained a witnessed fall on 3/15/24 with no injury and an unwitnessed fall on 3/23/24 sustaining laceration to left eyebrow.</p> <p>(continued on next page)</p> |

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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| <p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Record review of Resident #1's Care Plan dated 3/29/24 indicated interventions for Resident #1 per fall. Intervention for fall sustained on 3/15/24, increased supervision, education of staff, family, and caregivers. Intervention for fall sustained on 3/23/24, intervention/task, educate me/my family/caregivers about safety reminders and what to do if a fall occurs, ensure that I am wearing appropriate footwear (non-skit socks/shoes) when ambulating or mobilizing in wheelchair.</p> <p>Record review of Resident #2's face sheet, dated 03/29/24, reflected an [AGE] year-old male with an admitted [DATE]. Resident #2 had diagnoses which included Alzheimer's disease, Parkinson's disease, and muscle weakness.</p> <p>Record review of Resident #2's MDS dated [DATE] with a quarterly assessment dated [DATE] indicated BIMS score of 3, indicating severe cognitive impairment.</p> <p>Record review of Resident #2's Care Plan dated 3/29/24 for ADL's indicated Resident #2 is a 2 person assist for task such at transfers, locomotion, bed mobility, Dressing, and toileting.</p> <p>Record review of Resident #3's face sheet, dated 03/29/24, reflected a [AGE] year-old male with an admitted [DATE]. Resident #3 had diagnoses which included Depressive disorder, Dementia, psychotic disorder, and history of falling.</p> <p>Record review of Resident #3's MDS dated [DATE] with a quarterly assessment dated [DATE] indicated BIMS score of 3, indicating severe cognitive impairment.</p> <p>Record review of Resident #3's Care Plan dated 3/29/24 for ADL's indicated Resident #3 is a 2 person assist for task such at transfers (Hoyer lift), bed mobility, and toileting.</p> <p>Record review of Resident #4's face sheet, dated 03/29/24, reflected an [AGE] year-old male with an admitted [DATE]. Resident #4 had diagnoses which included Encephalopathy, dementia, type 2 diabetes, and lack of coordination.</p> <p>Record review of Resident #4's MDS dated [DATE] with a quarterly assessment dated [DATE] indicated BIMS score of 2, indicating severe cognitive impairment.</p> <p>Record review of Resident #4's Care Plan dated 3/29/24 for ADL's indicated Resident #4 is a 2 person assist for task such at mobility/locomotion, dressing, and toilet use. Resident #4 is to be always in line of sight for fall risk.</p> <p>Record review of the facility's fall incident report dated 1/1/24 through 3/27/24 indicated that Resident #4 had falls with injuries on 1/24/24 sustaining skin tear and bruising to hands, 2/13/24 sustaining skin tear R forearm with bruising.</p> <p>Record review of Resident #5's face sheet, dated 03/29/24, reflected a [AGE] year-old male with an admitted [DATE]. Resident #5 had diagnoses which included Respiratory failure, type 2 diabetes, dementia, and lack of coordination.</p> <p>Record review of Resident #5's MDS dated [DATE] with a quarterly assessment dated [DATE] indicated BIMS score of 6, indicating severe cognitive impairment.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Record review of Resident #5's Care Plan dated 3/29/24 for ADL's indicated Resident #5 required partial/moderate assistance with chair/bed-to-chair, toilet, and tub/shower transfers.</p> <p>Observation of Memory care unit on 3/26/24 at 11:30 am, only one CNA on unit.</p> <p>During an interview on 3/27/24 at 3:45 am, CNA A stated working memory care alone, even at night was very difficult sometimes. She stated there were 10 total residents on memory care. She stated that the issue was if she must assist any other resident on memory care while any of the residents that require supervision in the dining and the floater does not come to the memory care unit fast enough, she must leave the line-of-site residents alone. She stated that the normal schedule was one CNA on the memory care unit while one aide or CNA floats between the two units. She stated this system really doesn't work because there really should be two CNAs on the memory care unit, which would make it a lot safer for not only the residents but also the employees.</p> <p>Observation of Memory care unit on 3/27/24 at 4:05 am, only one CNA on unit. Around 4:15 am Resident #1 was laying in recliner in the dining area of memory care when CNA A got up to go assist another resident who was wondering and was gone for 30 sec to redirect the wondering resident, Resident #1 began to try and move her legs to the side of the recliner to begin sitting up. At this time CNA A came back to dining and assisted Resident #1 back down into the recliner.</p> <p>During an interview on 3/27/24 at 4:35 am, CNA B stated that she just finished her shift for the night shift on memory care and that the night staff on this shift was pretty good. She stated that the shift was from 6pm to 6am. She stated that the CNA's take 4 hour shifts instead of 1 CNA being on the memory care unit by themselves for 12 hours. She stated however, there were times in which you are alone, and the floater cannot make it to the memory care unit, this puts the residents at risk, primarily for falls. She stated that nights can be difficult because without a second CNA and another resident needs help with toileting, that puts all other residents at risk, especially the ones that were fall risk, Resident #1, and Resident #4. She stated that she does feel a few of the falls could have been prevented on memory care if there were always 2 CNAs on the unit instead of the one CNA and one floater system.</p> <p>Observation of Memory care unit on 3/27/24 at 3:55 am, only one CNA on unit. Resident #1 was lying in a recliner in the memory care unit. CNA B went to assist another resident from wandering into a sleeping residents' room. Resident #1 began to move in the recliner to set herself up and try to stand up out of the recliner. After about 45 seconds CNA B came back around the corner to assist Resident #1 back down into the recliner.</p> <p>During an interview on 3/27/24 at 5:40 am, CNA C stated they need help. She stated that she had done her night shift of memory care earlier that night and that the floater system does not work and honestly believes there should be always 2 employees on the memory care unit. She stated the acuity of the residents on memory care can not be covered with one CNA. She stated even their shift of the night staff was good and it was unsafe at times, not only for the residents but also for the employee's.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>During an interview on 4/1/24 at 12:15 pm, CNA D stated that on 3/23/24 Resident #1 was sitting in a recliner in the dining area, she requested for the floater to come over to help her. She stated the floater did come over within about 2min. She stated while her and the other CNA were in another resident's room changing them, they heard a bang and Resident #1 had fallen out of the recliner sustaining a cut above the eye. She stated the floater system does not work. She stated she does not feel safe working as one CNA on the unit. She stated it was very hard on the employees and not safe for the residents.</p> <p>During an interview on 3/28/24 at 11:20 am, RN E stated that it was very difficult and disheartening with memory care and protecting the residents. She stated she really does not feel there were enough employees on memory care. She stated they had enough employees in the building but there really needs to be always 2 CNAs on memory care. She stated she believes this would really decrease the falls, especially falls with injury.</p> <p>Observation of Memory care unit on 3/28/24 at 1:45 pm, only one CNA on unit.</p> <p>During an interview on 3/29/24 at 1:40 pm, CNA F stated that Resident #1 was very fast. She stated that she really tried to have most of the residents that were fall risk in the dining area while she was working so she can keep an eye on them. She stated that Resident #1 was a fall risk that she tries to always keep line of sight on. She stated that with Resident #1 she knows that if she was fidgety or trying to move around a lot, she must keep a closer eye on the resident. She stated if she does have another resident that needs help, she will call the floater over to the unit and wait until the floater makes it to the unit to watch the dining area while she assists the resident that needs it personally. She stated but she could use some help or another CNA back on the unit with her.</p> <p>Observation of Memory care unit on 3/29/24 at 1:45 am, only one CNA on unit.</p> <p>During an interview on 4/1/24 at 3:25 pm, the DON stated that corporate came in around December of 23 and stated that per the census there was too much staff for the facility. She stated that there was a reduction in aides and a transition from 8 hour shifts to 12-hour shifts. She stated before December the memory care unit did always have 2 aides on the unit. She stated when the staffing change was made the facility switched to having one aide on memory care and started to use a floating CNA that went back and forth between long term care and memory care. She stated that she does believe that there has been an increase of falls on memory care since this change has been made.</p> <p>During an interview on 4/1/24 at 3:15 pm, the ADMIN stated that based on census the facility was staffed correctly. He stated but he could see how on the memory care unit per the acuity of the residents more staff on memory unit could be necessary.</p> <p>Observation of Memory care unit on 4/1/24 at 3:35 pm, only one CNA on unit.</p> <p>Record review of the facility's Staffing requirements for Long-term care facilities dated 10/30/2011 did not indicate any specific requirements for memory care units.</p> |   |  |

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| <p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44766</b></p> <p>Based on observation, interview and record review, the facility failed to ensure residents on psychotropic drugs had the correct diagnosis in place for 1 of 4 residents (Resident #1).</p> <p>The facility failed to ensure that Resident #1 should not have received antipsychotic (ABH gel), without the proper diagnosis in place.</p> <p>This failure could affect residents who received medications in the facility and put them at risk for adverse consequences such as impairment or decline in an individual's mental or physical condition or functional or psychosocial status.</p> <p>The findings included:</p> <p>Record review of Resident #1's face sheet, dated 03/29/24, reflected an [AGE] year-old female with an admitted [DATE]. Resident #1 had diagnoses which included Neurocognitive disorder, collapse, bradycardia, and unsteadiness on feet.</p> <p>Record review of Resident #1's MDS dated [DATE] with a quarterly assessment dated [DATE] indicated BIMS score of 3, indicating sever cognitive impairment.</p> <p>Record review of Resident #1's Care Plan dated 3/29/24 did not indicate any anti-psychotic medications or needs for such medications.</p> <p>Record review of Resident #1's MAR dated 2/22/24 through 3/27/24 revealed ABH (Ativan 1mg, Benadryl 25mg, Haldol 1mg; 1mL gel) apply to skin topically every 12 hours as needed for agitation, was administered 11 times to Resident #1. Dates ABH administered to Resident #1, 2/23/24, 2/28/24, 3/2/24, 3/4/24, 3/10/24, 3/11/24, 3/13/24, 3/14/24, 3/17/24, 3/19/24, and 3/21/24.</p> <p>During an interview on 3/28/24 at 12:45 pm RN G stated that Resident #1 is currently on hospice and that she was a hospice nurse and was not exactly sure of the process for the facility to get Resident #1 on this medication per the diagnosis. She stated she relays the findings to the hospice physician and the physician fills the order. She stated sometimes the hospice nurse will administer the medication or the facility staff will administer the medication.</p> <p>During a phone interview on 4/1/24 at 3:50 pm, GA stated her understanding would be that once a hospice nurse puts in an order it was on the facility to review all medications ordered before being administered and make sure that the diagnosis matches the medication being ordered in the resident file. She stated she just got off the phone with the facility requesting documentation to make a change in diagnosis to support the medication Resident #1 was on.</p> <p>Attempted to contact hospice physician on 4/1/24 at 3:55 pm. No answer left voicemail.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 4/1/24 at 3:25 pm, the DON stated that even though Resident #1 was under hospice care, it was still the facility's responsibility to review all medications being ordered by hospice. She stated ABH gel being an antipsychotic medication but Resident #1 did not have a diagnosis should have been caught by her or her staff and it was not. She stated that a diagnosis request should have been put in to have the diagnosis change for Resident #1 so Resident #1 could get the ABH gel. She stated this did not occur. She stated that medications must match the resident's diagnosis, or it could harm the resident. She stated but, Resident #1 never reacted to the ABH gel.</p> <p>The facility did not have a policy related to Unnecessary Drugs-Without Adequate Indication by the time of exit on 4/1/24, requested from administrator on 4/1/24 at 11:45 am.</p> |