STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675681	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bronte Health and Rehab Center	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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to update the care plan after quarterly assessment was completed for 1 of 3 residents (Resident #1) reviewed for care plans.The facility failed to update the care plan as there were no interventions to prevent falls added to the care plan for Resident #1's fall sustained on 2.6.26.This failure could place residents at risk of not receiving the necessary care or services and having personalized plans developed to address their needs.Findings included: Record review of Resident #1's detailed summary report/face sheet, dated 2.26.26, indicated she was [AGE] year old female admitted to facility on 12.15.25 with diagnoses of dementia (a progressive, irreversible syndrome characterized by a decline in memory, language, and cognitive function severe enough to disrupt daily life), diverticulosis of intestine (is the formation of small, bulging pouches (diverticula) in the lining of the intestine, most commonly the colon, often due to high pressure from low-fiber diets), and heart failure. Record review of Resident #1's MDS, dated 2.26.26, indicated the BIMS score of 14 indicating the resident was cognitively intact. Resident was independent in all ADLs. Record review of Resident #1's care plan, dated 2.9.26, indicated she was a fall risk but there was no incident under falls dated 2.6.26. There were no fall interventions put in place, due to no previous falls. Record review of Resident #1's Risk management note, dated 2/6/2026, 19:08 indicated, During shift change report, CAN (CNA A) informed nurse that resident had fallen. Writer immediately responded and discovered resident sitting on the floor by her bed. Assessed for signs of possible injuries. Noted redness to the right side of the waist. Skin is intact and area is not raised. No bruising noted at this time. Resident denies hitting head. Stated, She was trying to get something from her bedside table and lost her balance and fell. Complaint of pain/discomfort to the right side of the waist. Administered PRN tramadol as ordered. No lumps or bumps to head. Pupils equal and reactive to light. Denies headache. Denies dizziness or lightheadedness. No nausea/vomiting. Grips are equal and strong. Active rom maintained. Residents was wearing proper footwear and floor is free of clutters. Call light was within easy reach but was not utilized. Resident is currently in the dining hall with her peer playing dominoes. No signs of distress noted. No further complaint of pain. No changes in loc noted. Called and notified resident's daughter and physician A of the incident. Reminded resident to use the call light for assistance. Resident verbalized understanding. Record review of the facility investigation report, 2/6/26, interview with resident fall timeline: On 02/06/2026 at approx. 1800 hrs., resident was found on floor, stated she was trying to get something from her bedside table and lost her balance and fell. She was assessed for injuries, and although she reported having some soreness/discomfort to her right side of waist, she denied headache, dizziness or nausea, active range of motion maintained, and showed no signs of distress. A short time later, she went to the Dining Room to play dominoes.On 02/07/2026 at approx. 0145 hrs., resident complained of continued discomfort to abdomen, physician (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notified, ordered x-rays in a.m.On 02/07/2026 at approx. 0715 hrs., physician ordered resident sent by EMS to ER in for eval/treatmentOn 02/07/2026 at approx. 0815 hrs., EMS departed facility with residentOn 02/07/2026 at approx. 1540 hrs., family notified staff the resident reportedly had a fractured rib and was admitted to the hospital.On 02/08/2026, resident's roommate was interviewed by the Administrator and the Director of Nursing, and the roommate stated she did not see the resident fall, but when she heard the noise, she turned around and saw the resident lying on the floor with her head near the night stand, and her feet towards the resident's wheelchair and the wheelchair sitting a short distance away.On 02/09/2026, documentation obtained from, confirmed right posterior 11th rib fracture. The resident returned to the facility 02/09/2026. During an interview on 2.26.26 at 12:55 pm CNA A stated that he was walking down the hall when he heard Resident #1's roommate say, oh honey are you alright?. He stated he went to her room, and her roommate Resident #1 was on the ground. He stated she was sitting on her butt up against her bed holding her lower right side. He stated as she fell his guess was that she hit the corner of her nightstand. He stated he yelled down the hall to the nurse letting them know she had fallen. He stated the nurse came down and did an assessment on the resident and the resident was put back into bed. He stated he never touched the resident, since he was not allowed to. He stated this all happened toward the end of day/shift change he stated the resident was resting in bed by the time he left for the day. He stated he only found out a couple days later that the resident sustained a broken rib. On 02/10/2026, the resident was interviewed by the Administrator, and when asked to describe what happened, the resident stated, Truthfully, I don't remember. I don't know now I fell or anything. During an interview on 2.26.26 at 12:30 p.m., the DON stated that she went into the electronic system and into Resident #1's care plan and does not see the fall with injury in the care plan. She stated this fall should have been updated in the care plan the day the resident returned from the hospital. She stated the importance of the care plan was a snapshot of the individual resident's needs and medical diagnosis. She stated this was needed so the resident file was up to date and could be monitored accordingly. During an interview on 2.26.26 at 12:45 p.m., Resident #1 stated she was at the facility for a little while. She stated she fell a couple weeks ago. She stated she fell and broke one of her right ribs. She stated she had never fallen before. She stated it was an accident. She stated she had no issues walking, getting up on her own, etc. During an observation on 2.26.26 at 12:45 pm, Resident #1 was in her bed. The resident was dressed and groomed. The room was clean and organized with no clutter and nothing at all on the floor, no trip hazards in the room. No smells or odors in the room. The resident had one pair of shoes sitting next to the bed that were slip on's that she could put on and off by herself. Record review of facility policy titled, Care Plans, Comprehensive Person-Centered, not dated, indicated a comprehensive, person-centered care plan that includes measurable objectives and timetable to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.