

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2024
NAME OF PROVIDER OR SUPPLIER Bertram Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 540 E State Hwy 29 Bertram, TX 78605	
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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49410 Based on observation, interview and record review, the facility failed to ensure that residents were free from neglect. The facility failed to seek medical attention for Resident #1 who had fallen and complained of pain in her right shoulder. Findings include: Record review of Resident #1's face sheet dated April 18, 2024, revealed Resident #1 was a [AGE] year-old female admitted to the facility on [DATE]. Resident #1's diagnoses included primary degenerative joint disease, constipation, protein-calorie malnutrition, muscle weakness, schizophrenia, bipolar disorder, major depressive disorder, anxiety disorder, chronic pain syndrome, glaucoma, high blood pressure, congestive heart failure, chronic lung disease, gastro-esophageal reflux disease, age related osteoporosis without current pathological fracture, convulsions, pneumonia, insomnia, injury of muscle(s) and tendon(s) of the rotator cuff of right should initial encounter, presence of right artificial shoulder joint, femur (bone of upper thigh) fracture. Record review of Resident #1's quarterly MDS assessment dated [DATE] reflected Resident #1's BIMS Score was 14 , indicating cognition is intact. Record review of Resident #1's care plan dated 04/10/2024 revealed Resident #1 was at risk for falls related to history and decreased mobility. Resident #1's care plan revealed call light was to be within reach. The care plan also revealed Resident #1 had a surgical site to right shoulder. Staff were to observe for signs or symptoms of infection (increased redness, increased pain, drainage, etc. The care plan revealed Resident #1 had potential for uncontrolled pain related to joint disease arthritis and recent shoulder surgery. Resident #1 has disease that causes her bones to become brittle. Risk for spontaneous fracture. Monitor and document for Resident #1 risk of falls. Record Review conducted of facility sign in-services included: 04/10/2024 - Making sure Resident #1 was able to safely access her belongings. 04/10/2024 - Abuse and Neglect. 04/18/2024 - Preventative Strategies to Reduce Fall Risk. 04/18/2024 - Fall Post Surgery (Call MD, order x-ray for all for post-surgery to risk of any fractures. (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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F 0600 Level of Harm - Actual harm Residents Affected - Few	Observation conducted on 04/18/2024 at 10:45AM of Resident #1 participating in activities revealed Resident #1 was clean, well groomed, right shoulder slouched forward, and main control with left arm. Resident #1 was observed not using her right arm. Record review of the Provider Investigation Report dated 04/10/2024 revealed that Resident #1 had three falls on 04/06/2024 and denied pain. On 04/09/2024 Resident #1 complaining of knee and wrist pain, she received an x-ray that were negative. On 04/10/2024 Resident #1 complained of shoulder pain, received an x-ray that revealed her shoulder was separated. Record review of the facility's Fall Report Dated 04/16/2024 revealed that Resident #1 had 4 falls in the month of April. These falls took place on 04/04/2024, 04/06/2024 and two falls on 04/07/2024 which were reported . Fall Assessment completed by ADON and dated 04/04/2024 revealed that Resident #1 was alert and oriented, had no changes in blood pressure during changes of position, and Resident #1 was able to stand but had issues with balance. Fall Assessment completed by an LVN and dated 04/06/2024 revealed that Resident #1 was alert and oriented, no changes in blood pressure during changes of position, and Resident #1 was able to stand but had issues with balance. Fall Assessment completed by an LVN and dated 04/16/2024 revealed that Resident #1 was alert and oriented, had no changes in blood pressure during changes of position, and Resident #1 was able to stand with no issues. Pain assessment completed on 04/04/2024 revealed that Resident #1 did not complain of any pain and had no external injuries. Pain assessment completed on 04/06/2024 revealed that Resident #1 did not complain of any pain, had no external injuries, and was back to normal activities. Resident #1 had been prescribed Gabapentin Oral Tablet 800 mg 3 times a day. Resident #1 had received her daily pain medications as ordered on 04/04/2024, 04/06/2024, and 04/07/2024. Record review of Event Nurses' Notes-Fall, dated 04/04/2024 at 10:00 AM, revealed Resident #1 had a witnessed fall. No injuries. Nurse noted resident seating on the floor beside her bed stated that I was trying to seat (sic) and missed sat on the floor. No pain evident and Resident #1 did not complain of pain. Nurse assessment completed; Physician notified 04/04/2024 at 10:09 AM 04/06/2024 at 7:41 PM Resident #1 was noted to have had an unwitnessed fall, stated that her legs gave out. Discovered on the floor. No injuries. Heard resident and upon arriving found resident on floor laying on right side. Assisted X2 persons into the wheelchair. Upon assessment no obvious injuries. Resident denies pain. ROM WNL. No swelling noted. Resident back to usual activities. Physician notified 04/06/2024 at 10:00 PM. 04/07/2024 at 7:17AM revealed an unwitnessed fall described as a trip/slip from low bed. No injuries. Resident was found on the floor by CNA lid (sic) to the floor from the bed nurse noted resident seating on the floor in front of bed. Resident #1 stated I slid out of the bed trying to get the trash can closer to the bed. Nursing assessment completed; Physician notified 04/07/2024 at 11:07 AM. Record review of NP Progress Note dated 04/05/2024 revealed an assessment was conducted by the facility NP. The chief complaint for the visit noted to be complaint of pain to left hand and right knee. Resident #1 stated the pain started a about a week ago after a fall. Stated pain medication have provided some relief. The NP notes that x-rays will be obtained of the left wrist and right knee. The admission history for Resident #1 is listed as right shoulder osteoarthritis with rotator cuff unresponsive to non-operative care. Resident #1 was seen by ortho and had a right reverse shoulder arthroplasty done on 02/29/24. The assessment and plan section revealed that the right shoulder osteoarthritis with rotator cuff tear is Stable. Surgical site is healed. (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #1's March TAR revealed on 03/13/2024 an order was added for nurses to monitor Resident #1's right shoulder two times a day and place a new band aide on the site. The TAR was initiated by nurses on the days of March that Resident #1 was in the facility. On 03/31/2024 the order was discontinued. Review of April MAR revealed on 04/01/2024 revealed Klonopin (used for seizures and/or anxiety) oral tablet 0.5 mg give one tablet by mouth two times a day for anxiety. Nursing initials on 04/01/24 indicated one dose given for pm dose. 4/3 it indicated an AM dose was given. All other dosage times indicate the drug was not available until 04/06/2024. On 04/06/2024 the am and pm dose were initiated as given. On 04/07/2024 the am dose was given. Continued review of the MAR revealed Resident #1 received scheduled pain medications. Baclofen (used to treat pain and muscle stiffness) 10 mg one time a day for Chronic Pain Syndrome and Gabapentin (used to treat nerve pain) 800 mg three times a day for Chronic Pain Syndrome. During an interview on 04/18/2024 at 11:18AM Resident #1 stated that before entering the facility she had right shoulder replacement surgery. Resident #1 stated that she has had multiple falls since living at the facility. She also stated that she did complain about pain in her shoulder because she landed on the right side when she fell . She stated that the facility did not send her to the hospital on 04/06/2024 when she had her fall. She stated the surgeon sent her from the clinic on 04/10/2024 when she went for a follow up appointment. Resident #1 stated during her falls, she had landed on her right shoulder where she had received surgery. Resident #1 stated that she had been prescribed anxiety medication which made her feel drunk when she took the medication. She stated the anxiety medication made her fall a lot. She stated she was no longer taking the medication. Resident #1 started crying and said the facility could have done something to help her. Resident #1 stated she was in better condition before she arrived at the facility. She stated before she was at the facility she was improving and was almost able to use her right arm. She stated now she could not use her arm. Resident #1 also stated that she reported being in pain to staff after the fall. She stated the facility did not ask if she wanted to go to the hospital, nor did she ask to go to the hospital. During an interview on 04/18/2024 at 1:05PM with CNA B revealed that she had worked at the facility for 9 years and was familiar with the residents. CNA B stated that she had received in-service on fall prevention in the month of March 2024. CNA B stated that the policy for when a resident has a fall was to notify the nurse and the nurse will evaluate the resident. CNA B stated the potential negative outcome of not sending Resident #1 to the hospital is that the facility could miss an injury internally or Resident #1 could have broken something. During an interview on 04/18/2024 at 1:31PM with CMA A revealed that she had worked at the facility for [AGE] years and was familiar with the residents. CMA A stated that she works on the hall of Resident #1 and was familiar with her care. CMA A stated that if a resident was found on the side of a recent surgery site, the facility should send that resident to the hospital. CMA A stated the potential negative outcome of not sending Resident #1 to the hospital was the resident could die. CMA A stated she had received training on Abuse and Neglect, as well as Fall Prevention Training. CMA A stated on 04/06/2024 that she witnessed Resident #1 being offered to go to the hospital but Resident #1 verbally denied wanting to go. (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 04/18/2024 at 01:36PM with CNA A revealed that she had worked at the facility for 3 years and was familiar with the residents. CNA A was asked if she knew why Resident #1 was not sent to the hospital on 04/06/2024 after complaining of pain, she said she was not working that day, but Resident #1 was sent to the hospital approximately 4 days later. CNA A stated she had received training on Abuse and Neglect as well as Fall Prevention Training. CNA A stated that the potential negative outcome of not sending Resident #1 to the hospital was that there could be an injury . An interview on 04/18/2024 at 01:45PM with LVN A revealed that she had worked at the facility for [AGE] years and was familiar with the residents. LVN A has received training for Abuse and Neglect, as well as Fall Prevention Training since working at the facility. LVN A had no knowledge of what happened during and after the fall for Resident #1 on 04/06/2024 but stated that Resident #1 has denied wanting to go back to the doctors in the past. During an interview on 04/18/2024 at 01:53PM with the DON revealed that she had been a DON for [AGE] years. The DON stated that the policy for when a fall occurs with a resident, is whoever found the resident needs to notify the nurse. The DON stated that if a resident falls on the side of surgery site, the policy is to find out what happened, evaluate the resident, and notify the doctor. The DON stated that staff assessed Resident #1 after her fall and determined there were no obvious injuries, no complaints, and no swelling to the surgery site. The DON stated that Resident #1 had fallen on 04/06/2024 and did not complain of any pain on her shoulder. She went to a follow up appointment with her doctor on 04/10/2024. The DON stated that Resident #1 complained of pain on her wrist and knee after a fall on 04/05/2024. The DON stated that the facility provided an x-ray to Resident #1 that revealed no injuries. The DON stated that if Resident #1 complained of pain, then the facility should have sent her to the hospital. The DON stated that Resident #1 was not sent to the hospital on 04/06/2024 after her fall because it was reported to her that Resident #1 did not complain of pain. The DON stated that Resident #1 usually had pain due to a possible infection in her right shoulder, which could be misidentified as reoccurring pain rather than a new pain. The DON stated that all training is provided by Relias or by corporation. The DON stated that she has completed Fall Prevention Training. The DON stated that they ensure residents are free from ANE by completing trainings and checking in with the residents. During an interview on 04/18/2024 at 02:14PM with ADON revealed that she had been a ADON for [AGE] years. The ADON stated that the policy when a resident has a fall and complains of pain is to complete an assessment, call the doctor and give them pain medication. The ADON stated that if a resident had fallen on the side of a surgery site, they would do x-rays and send them to the hospital. The ADON stated that she cannot tell what could happen if a resident had a fall and is not sent to the hospital after complaining about pain. The ADON stated that Resident #1 had refused to go to the hospital before and that could have been the reason Resident #1 did not go on 04/06/2024. During an interview on 04/18/2024 at 02:27PM with Administrator revealed that he had worked at the facility since 01/03/2024. The Administrator stated that the policy when a resident has an unwitnessed fall was to investigate, talk to the resident and assess the surroundings. The Administrator stated that an unwitnessed fall that results in major injury would be reported to the state. The Administrator stated that if Resident #1 had a fall on the side of surgery site, the facility will notify the doctor, the nurses do a general assessment, and follow up with an x-ray. The Administrator stated that he was not working on 04/06/2024 when Resident #1 had a fall but was reported that Resident #1 did not complain of any pain. The Administrator confirmed that Resident #1 did not go to the ER after her fall. (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 05/03/2024 at 10:50 AM with the facility NP revealed that if a resident falls the nursing staff call either him or the Physician. He stated they are good about notifying them. The NP stated Resident #1 seems to not be aware of safety skills. He stated Resident #1 constantly requires redirected to sit in her wheelchair and not be walking behind the wheelchair pushing it with her right arm/shoulder. Resident #1 is not supposed to be using her shoulder but does so despite the redirection. During an interview on 05/03/2024 at 11:20 AM with the facility Physician revealed he did not have concerns of not being notified of Resident #1's falls. The physician stated the nurse on duty at the time of the fall will notify him or the NP. He has not found a fall he was not notified about. The Physician stated Resident #1 was admitted with a history of falls and had received surgery on her shoulder. The nursing staff had been monitoring the area for infection for a period until the site healed. Resident #1 was found to have an infection in her shoulder, but it does not mean there was external evidence of an infection. Antibiotic therapy had been given as ordered by the hospital. If Resident #1 complained of pain after a fall the area she had indicated would be x-rayed at the time of the fall. Had provided x-rays for complaints of pain to leg, hip, and pelvis. If the Resident does not complain of pain to an area, we do not know to have the area x-rayed. When Resident #1 did complain of shoulder pain, which was not after a fall. Resident #1 was sent to the orthopedic clinic, and they completed x-rays. Resident #1's dislocated shoulder was discovered by the x-ray. Surgery was the next day after the x-ray. Resident #1's infection was not apparent while she was here. Came to us after surgery in March, infection was not found until second surgery last month. Returned to us on intravenous antibiotics which we have been giving. During an interview on 05/03/2024 at 11:56 AM with the facility DON revealed nurses document falls on Event Nurses' Notes which contain Physician notification and descriptions of complaints of pain. Resident #1 did not have falls in March while at the facility. DON stated she believes the cluster of falls that occurred in April was due to a new medication, Klonopin, being prescribed due to Resident #1's complaints of anxiety. Resident #1 took the Klonopin on 04/06/2024 two times according to the order and one time on 04/07/2024. The DON stated she called the Physician on 04/07/2024 and asked for the Klonopin to be discontinued due to drowsiness, causing Resident #1 to fall. The Physician discontinued the Klonopin. DON stated Resident #1 did not complain of shoulder pain during the April falls. In addition, the DON stated Resident #1 has a high BIMs, is her own responsible party and can communicate needs/pain. Resident #1 is non-compliant with recommendations to not use the shoulder. Resident #1 frequently walks while pushing her wheelchair. All fall event notes are reviewed in the morning meetings to try and determine how we can intervene to prevent. The DON stated Resident #1's cause for falls was things like sliding out of her chair, not much they can do to intervene. Stopping the Klonopin had been an intervention. During an interview on 05/03/2024 at 1:20 PM with the DOR revealed Resident #1 was not receiving PT for ambulating because she was not to be ambulating. Resident #1 has poor posture, and it is hard for her to compensate without using her right arm. Resident #1 has been unable to use a walker, which she needs. DOR stated Resident #1 has been non-compliant with recommendations. She would see her walking around pushing the wheelchair. Resident #1 would be walking and using her right arm, frequently explained to her why she was not supposed to do that, she would do it anyway. Resident #1 was very mobile without ambulating, able to move the wheelchair. The DOR stated Resident #1 is scheduled to go to a PT class held daily but usually refuses to participate. OT does work with Resident #1 to increase her balancing ability. (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 05/03/2024 at 1:29PM with the MDS nurse revealed she also does the residents' care plans. She stated the falls Resident #1 was experiencing in April had been discussed during the morning meetings. If an intervention was decided she will add it to the care plan. MDS nurse stated that the new medication for Resident #1 was one of the things that was discussed, and the medication was discontinued. She stated interventions for things like a fall mat would have caused a tripping hazard for Resident #1. During an interview on 05/03/2024 at 12:40 PM with RN D revealed she had worked with Resident #1 and was on duty when she fell out of her wheelchair reaching for her purse. The fall was witnessed. RN D stated during her assessment after the fall the resident denied being in pain. About an hour later Resident #1 complained of pain. The Physician was notified, and x-rays ordered for the areas of pain. Resident #1 did not complain of pain to her shoulder. RN D stated she thinks part of the cause of the falls in April was due to the resident increasing the amount of time she walked behind the wheelchair starting towards the end of March. She stated Resident #1 received redirection to sit in the wheelchair but would either ignore the nurse or sit for a few minutes then get back up behind the wheelchair. On 04/18/2024 at 03:15PM the DON brought an in-service document into the conference room to the surveyors. The DON stated that she had thought about the resident being on the injury site during a fall and decided to complete an in-service with the staff working on that day 04/18/2024. The inservice was for Falls Post Surgery. With the DON completing this inservice, it showed that the DON was aware of the negative affects the fall had for Resident #1 and how the facility should react to future falls. Review of the hospital records for Resident #1 revealed that she had been admitted to the hospital for a dislocated infected right shoulder, s/p I and D, resection of shoulder arthroplasty on 04/11/2024. Wound vac placed, continue oral flagyl, IV Rocephin 1 gm daily and vancomycin daily until 05/10/2024 for weeks as per ID, weekly CBC, CMP. CRP while on antibiotics. Continue Aspirin daily for Deep Venous Thrombosis Prophylaxis. Midline can be removed after antibiotic treatment plan . Review of undated Leadership Policies and Procedures titled Abuse/Neglect reflected the following: Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress.		