STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676117	A. Building B. Wing	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bertram Nursing and Rehabilitation	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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, interviews, and record review the facility failed to ensure, in accordance with accepted professional standards and practices, medical records were maintained on each resident that were complete, accurately documented, readily accessible, and systematically organized for 1 of 5 residents (Resident #1) reviewed for resident records. The facility failed to ensure physician orders for Resident #1's X-ray were entered on the porta on 01-16-2026. This failure could place residents at risk for incorrect treatment decisions, evaluation, and treatment plans compromising patient safety due to insufficient information records.Findings Included:Record review of Resident #1's admission record, dated 01-28-2026, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included Dementia (Condition which involves memory loss, affecting thinking, and social abilities which interfere with their daily lives) and, Repeated Falls and Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).Record review of Resident #1's quarterly MDS assessment, dated 12-17-2025, reflected Resident #1 had a BIMS of 03, which indicated the resident had severe problems with thinking and memory. The document reflected that she used a walker for mobility, and she was independent regarding eating and toileting.Record review of Resident #1 care plan, dated 12-23-2025, reflected the resident had a behavior problem related to dementia. Her behavior was to hoard napkins, food and spoons. Interventions included anticipating and meeting the residents' needs. Interventions which included the activity director would encourage and remind Resident # 1 of current activities.Record review of Resident # 1's Progress Notes dated 01/16/2026 at 8:15 PM reflected. LVN A documented a note as late entry, NP orders received for lidocaine 4% pain patch to back and X-ray left rib area times 3 views. Record review of Resident #1's order summary on 01-28-2026 reflected Chest X-ray order was entered into PCC on 01/18/2026 at 7:30 a.m.During an interview with LVN A on 01/28/2026 at 10:01 a.m., LVN A stated, after I assessed [Resident # 1], I called the doctor to report [Resident # 1's] condition and I received verbal orders from PA that included a chest X-ray and 4% lidocaine patch. She stated she put the orders in PCC under the Doctors' orders tab. LVN A stated it was her responsibility to enter the orders for the X-ray into the portal immediately upon receiving the orders. LVN A stated she forgot to put the orders into the portal and that caused the resident to not get the chest Xray stat. During an interview on 01/28/2026 at 12:02 p.m., reflected, ADON B worked on Sunday, 01/25/2026 at 6:00 a.m. and she reviewed the facility's 24-hour report. She stated on the 24-hour report there was a record of the incident with Resident # 1, and the record included orders for an X-ray of the residents' ribs. ADON B checked the portal and Resident # 1's name was not on the portal for an X-ray order. ADON B then, I ordered the X-ray Stat. ADON B ordered the X-ray before 12:00 p.m. on 01/18/2026 with the expectation that the mobile X-ray service would arrive at the facility within 4-6 hours. ADON B stated, she returned to work on Monday 01/19/2026 at 6:00 a.m. and I found the X-ray team was (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	just performing the ordered X-ray for Resident # 1. ADON B stated the X-ray technician told her they arrived at the facility on 01/18/2026, but the machine was not working so they could not do the rib X-ray at that time, and the X-Ray was performed on 01/29/2026. ADON stated the X-ray report results were received on 01/19/2026 at 1:28 p.m. indicated a hairline fracture to the left 5th rib. The ADON notified the Doctor who ordered Tylenol, Extra Strength, 500mg 1 time per 8 hours. ADON was asked why the staff did not use an alternative service or send Resident # 1 to the hospital immediately when the X-rays were done on 01/18/2026. ADON B stated the residents' pain was being managed by the lidocaine patch and Tylenol. ADON B stated rib fracture diagnosis was addressed through pain management and no other therapies would have been available for this type of injury.Interview on 01/28/2026 at 3:25 p.m., revealed the RN C was the Infection Control Nurse for the facility and among her other duties she was responsible for entering lab and X-ray results into the patient charts. The RN stated, when X-rays were ordered stat, the expectation was that it would be done within 4 hours. The RN stated, if the x-ray could not be done stat, the staff would assess the residents pain level to determine if there was a need to call the doctor for orders to send the resident to the hospital.Interview on 01/28/2026 at 3:06 p.m., revealed the NP visited the facility 1 time per week. The NP stated she was familiar with Resident # 1, and she recalled receiving a call from LVN A on 01/16/2026 with a report that Resident # 1 had pain in her ribs. The NP stated, I ordered the X-ray stat, because it was Friday and there are less X-ray Technicians working on the weekends. The NP stated ‘stat' meant it should be done between 6-12 hours from when it was ordered. The NP stated, he was not notified that the X-ray was not done on Friday (01/16/2026). The NP stated, I she would only get a report if something was wrong such as a fracture and didn't get a call about this. The NP visited the facility on 01/22/2026 and she observed the resident was up and walking around in the dining room and back to her room. The NP stated her observations made her have no concerns for Resident # 1. The NP stated, with a rib fracture there was no treatment other than pain management. If the X-ray report had come in sooner, there would not have been any other treatments available. The NP stated if the resident was in greater pain she would have recommended, she go to the hospital but, that was not warranted for Resident # 1.During an interview on 01/28/2026 at 11:00 a.m., it was revealed the DON was notified by the ADON on 1/18/2026 the X-ray for Resident # 1 had not been ordered using the online portal and the order would be put into the portal immediately. DON stated it was her expectation that staff would immediately submit orders for X-Rays onto the portal. DON stated there were no treatments other than pain management that could have been implemented for the diagnosis of a fractured rib. DON stated, Resident #1 was being treated medically for pain since prior to the diagnosis. Record review of the facility's policy titled, Medication Orders revised 2014, reflected .2. A current list of orders must be maintained in the clinical record of each resident. 3. Orders must be written and maintained in chronological order .6. Treatment orders - When recording treatment orders, specify the treatment, frequency, and duration of the treatment .