STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455763	A. Building B. Wing	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Bend Rehabilitation and Healthcare Center	301 Huguley Blvd Burleson, TX 76028

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 - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 45507 Based on observation, interview and record review the facility failed to ensure that the resident environment remained as free of accident hazards as was possible for 1 of 5 residents (Resident #1) reviewed for accident hazards. 1. The facility failed to implement interventions for Resident #1 to ensure she did not consume hand sanitizer after empty bottles of hand sanitizer were found in her room. 2. The facility failed to ensure Resident #1 did not keep aspirin at her bedside. The noncompliance was identified at an Immediate Jeopardy (IJ) PNC (past nocompliance). The noncompliance began on 10/12/2024 and ended on 12/17/2024. The facility had corrected the noncompliance before the survey began. The Administrator was provided the IJ template on 02/27/25 at 5:32 PM. These failures could place residents at risk of harm, injury, or death. Findings include: Record review of Resident #1's admission record, dated 12/11/2024, revealed a [AGE] year-old female with an original admitted to the facility on [DATE] and readmitted [DATE]. Resident #1 had diagnoses which included unspecified dementia (brain disease that alters brain function and causes cognitive decline), chronic pain syndrome (pain that last for months or years), major depressive disorder (persistently low or depressed mood), and opioid dependence (development of tolerance or withdrawal to opioids). Record review of Resident #1's quarterly MDS assessment, dated 12/17/2024, revealed a BIMS score of 12, which indicated moderate cognitive impairment. Record review of Resident #1's, undated, care plan revealed Resident #1's psychosocial well-being was affected d/t Disease Process: Alcoholism/Addiction. Interventions included the following: - Allow the resident time to answer questions and to verbalize feelings, perceptions, and fears - Consult with: Pastoral care, Social Services, Psych services (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Encourage participation from resident who depends on others to make own decisions - Monitor surroundings for hazardous ingestible items. - Provide opportunities for the resident and family to participate in care - Refer to inpatient stay Record review of Resident #1's nursing note, dated 10/12/2024 at 1:07 PM, revealed a late entry: Housekeeping noted several bottles of squeezed empty store bought alcohol based hand sanitizer without pump inside and a bottle of 70% rubbing alcohol almost empty under residents bed. This nurse went to speak to resident regarding alcohol based products and facility guidelines/policies but resident sleeping in stable condition. DON [Name], RN made aware. Record review of Resident #'1 nursing note, dated 10/14/2024 at 1:49 PM, revealed Dr [Name] updated on hand sanitizer bottles and rubbing alcohol bottle found in [Resident #1's] room. New orders for CBC,CMP, Ethanol blood level. Record review of Resident #'1 nursing note, dated 11/15/2024, 8:48 AM, revealed Entered room to have pt sign consent for new order Trazodone. Noted a thermal cup with handle on the nightstand that appeared to have been run over and bent. Picked up the cup to question pt on how the cup got bent. When I brought cup up towards my face I could smell alcohol. Inside the mug was 2 plastic cups that facility utilizes to pass water with meds. Removed the plastic cups and at the bottom of the cup was a blue colored thicker then water liquid. There was also straw in the cup. Took cup to DON and notified Dr [Name]. Awaiting return call from Dr [Name]. Record review of Resident #'1 nursing note, dated 11/15/2024 11:00 AM, revealed Dr [Name] returned call and recommended in house treatment/ placement for ETOH addiction. Suggested starting with [Facility Name A]. DON notified. Record review of Resident #1's nursing note, dated 11/15/2024 at 11:54 AM, revealed Spoke with resident and son regarding continued drinking of hand sanitizer and physicians recommendation of in placement care. Both agreed this would be beneficial. Phoned [Facility Name A] and faxed requested info to transfer unit @ [Fax Number]. Awaiting response at this time. Record review of Resident #1's nursing note, dated 11/15/2024 at 2:14 PM, revealed Phoned [Facility Name A] for update no change in referral status. Reached out to [Facility Name B] Liaison, [Name] RN @ [Phone Number]. She is with both [Facility Name A] and [Facility Name B], requested to fax referral to [Facility Name B] and she would follow up for both via phone. Referral faxed to [fax number]. Awaiting response. MD and resident updated. Record review of Resident #1's nursing note, dated 11/15/2024 at 4:19 PM, revealed Recd call from [Facility Name B] that resident was accepted. MD, son and resident aware. Awaiting transport to take resident at this time. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's nursing note, dated 11/15/2024 at 5:16 PM, revealed Transferred to [Facility Name B] in [City Name] via wheelchair with necessary paperwork/spare clothing in facility van. All other personal belongings remain in room. Writer to notify dietary dept. and relay above to incoming charge nurse. Record review of Resident #1's nursing note, dated 12/02/2024 at 8:44 PM, revealed Resident has returned from [Facility Name B] around1800. Resident was transferred via transportation services, accompanied by no family members. Resident is alert and oriented to the current situation. Resident refused dinner meal. Resident has no skin issues. Resident is resting in her bedroom with call light within reach. Record review of Resident #1's nursing note, dated 12/09/2024 at 9:49 PM, revealed resident aa&ox4, during routine care noted rash to rt thigh pt denies pain, assessment done, area warm to touch, Dr [Name] notified, n/o Keflex 500mg I po tid x 5days DR states will come tomorrow to see patient, initial dose given from pyxis, no a/r noted, call light in reach, will cont. to monitor. Record review of Resident #1's nursing note, dated 12/10/2024 at 6:09 AM, revealed Resident is on Keflex for the right thigh rash. The area is warm to tach. She remains afebrile at 98.0 . No c/o pain/discomfort voiced. Call light within reach. Record review of Resident #1's nursing note, dated 12/10/2024 at 8:56 AM, revealed CNA reports to nurse that resident has bottle of aspirin in room. Nurse questioned resident who states 'Yes I have a bottle because I know what works for me'. Nurse then reinforced regulation that residents are not to have any meds in room, resident states 'I know that' and handed bottle to nurse. Reported to DON and administrator. Record review of Resident #1's nursing note, dated 12/10/2024 at 1:17 PM, revealed Per DON, amount of aspirin missing from bottle surrendered by resident exceeds safe dosage within time that resident has possessed bottle. Resident to be transferred to [Hospital Name] ER for eval. [EMS Name] called for transport, resident's son [Name] notified. Record review of Resident #1's nursing note, dated 12/13/2024 at 10:00 PM, revealed Resident came back from [Hospital Name] on a stretcher accompanied by ambulance personnel. Alert and oriented x4 with the ability to communicate needs in a clear speech. Vital signs are within normal limits. No concerns voiced at the moment. resting in bed with the call light within reach. Record review of Resident #1's nursing note, dated 12/17/2024 at 1:26 PM, revealed Resident readmitted to facility, adjusting well. clarification of ABT r/t cellulitis to leg, no AR noted- area with small amount of exudate. Alert able to voice needs appropriately. c/o pain medicated with PRN meds as needed, effective. Met with son and resident regarding plan for recent events. Resident agrees to not have any medications in room. Discussed pain and physicians hesitation with given history, resident promised to be open and honest with pysch and take any offers of resources from PASSR. Resident willing to have room checked periodically and give Admin key to her lock box. Will cont plan of care and have made MD aware. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of provider investigation report (PIR), dated 12/17/24, revealed Incident date:12/10/2024 Resident was noted to have a bottle of aspirin at bedside . Resident noted to have new rash to leg paired with nausea/vomiting while self medication . Provider investigation is unconfirmed. Per staff interviews, resident had stated that aspirin is the only thing that assists with pain and that she had only taken 'a few'. Upon count, DON noted 28 missing pills. When she questioned resident, resident stated she had opened the bottle 4 days ago and that she did not realize she had taken so many. Resident was then sent to ER for further evaluation and to rule out any negative outcomes related to self medication. Resident room was searched and any restricted items found were removed. Guardian Angels searched each room on their rounds and also removed restricted items found, if any. Resident was assessed by [Name], MD. and found to have right lower extremity cellulitis with no evidence of negative outcomes due to ingested aspirin noted. Resident also received a psych evaluation while in hospital and remains on psych services offered by [Company Name] at the facility. Provider concluded [family member] provided aspirin to resident. DON met with [family member] and resident to explain that he is not to bring any OTC's to [Resident#1] moving forward. A list of items not allowed in the facility were re-sent to all resident contacts via cliniconex. Safe surveys were positive. Record review of DON's statement included in the PIR, dated 12/10/2024, revealed in part: After [Resident #1] was sent to the Emergency Department a full room sweep was conducted [by Administrator Name and DON Name] and no further contraband was noted. Interview on 02/12/2025 at 9:37 AM, LVN A stated Resident #1 had aspirin at her bedside, and he did not remember who found it, but he took the bottle to the DON. He stated he could not remember if Resident #1 bought it or if a family member brought it in. He said he remembered looking at the count on it and it seemed Resident #1 took more than what should have been taken and wound up sending her out. LVN A stated residents were not supposed to have medications at the bedside because they could overdose on anything, mix meds that should not be, or another resident could take them. He stated there were no residents who self-administered medications in the facility. LVN A stated Resident #1 drank hand sanitizer and was sent to rehab for that but did not remember when. Interview on 02/12/2025 at 10:30 AM, the Unit Manager stated she was aware aspirin was found in Resident #1's room with so many missing. She stated she was in-serviced to look for medications and those types of things in resident rooms when doing angel rounds. Observation and interview on 02/12/2025 at 11:57 AM, revealed Resident #1 lying in bed in her room. No medications were observed near the resident or in the room. Resident #1 stated her legs hurt all her life, Tylenol did not work, and aspirin did. She stated she did not feel the pain was being addressed and when she went to[Store Name] during the facility's monthly trip, she bought aspirin one time and kept it in her drawer. She stated it was unopened and she had just opened it [when staff found it], and it was innocent on her part. She said she did not realize it was such a problem because she used to take them like candy when she was working. Resident #1 stated for some reason her drawer was open, she had a rash on her legs and when the nurse came in to look at her legs, the nurse saw the aspirin in the drawer. She said the nurse asked her about them, counted them and took them out of her room. She stated she was sent to the hospital with the rash, the hospital ran tests to see if any aspirin toxicity and there was nothing there. She said she had cellulitis in her legs. She stated staff explained she could not be buying things like aspirin at [Store Name] and she was on a blood thinner, and aspirin was also a blood thinner. Resident #1 stated the facility had since addressed her leg pain. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 02/12/2025 at 1:45 PM, the DON stated Resident #1 was sent to [Facility Name B] for drinking hand sanitizer, had been back about a week and then the aspirin was found in her room. She stated LVN A gave her the aspirin bottle and noticed the amount missing and talked with the doctor who said they needed to get labs. She said she asked Resident #1 when she opened the bottle, how many she took, and noticed she was lethargic. The DON stated since Resident #1 also had a rash and thought the 2 might be related. The DON said they sent Resident #1 out and the hospital ran all the labs when she was there and found she had not taken that many. The DON said the hospital treated her for cellulitis and psych, and when Resident #1 returned, she agreed to have random room searches and to talk with a counselor. When asked about Resident #1 drinking hand sanitizer, the DON stated the resident never admitted to how much she consumed, and the resident told her she came up to the front desk and took the bottles from the drawers. The DON stated the facility took residents to [Store Name] and the Driver and the Activity Director was in-serviced on providing Resident #1 her money or debit card at the register to monitor items she purchased. Interview on 02/12/2025 at approximately 2:40 PM, CNA B stated she was aware of incidents with Resident #1 and was in serviced that items like hand sanitizer and medications should not be near residents. CNA B stated if these items were near residents, they could overdose or have side effects. She said if she found these items, she would move them away and tell the nurse. CNA A stated if she noticed any changes like depression, crying, sadness, or something different she would report it to the nurse. Interview on 02/12/2025 at 2:56 PM, LVN C stated he was not working during any incidents with Resident #1 but was aware of Resident #1's alcoholism. He stated when he went to her room, he would check cognition to see if she was alert and oriented, and not acting out of her normal character. He said he would do a quick scan of the room to make sure nothing was there when it was not supposed to, like pills by the bedside, hand sanitizer or anything with alcohol. LVN C stated if any of those items were found he would take them from the room and assess the resident, notify the DON, Doctor, and family if needed. He stated CNA's were trained to look for these things in the room and not to leave hand sanitizer in rooms. Interview on 02/12/2025 at 3:21 PM, the Activity Director stated Resident #1 participated in activities, and she liked to read, go to [Store Name], bingo, and social events. She said she was aware medications were found at Resident #1's bedside and when going to the resident rooms she looked for meds, eye drops, and hand sanitizer. She said these items were not allowed by the bedside because anybody could get a hold of it and take it, they could be allergic, and a lot of things could happen and go wrong. The AD stated nursing had instructed her and the van driver to assist Resident #1 and to make sure she did not purchase any alcoholic substances at [Store Name]. She stated she was told to lock up extra hand sanitizer bottles kept in her office. Interview on 02/12/2025 at 3:42 PM, the SW stated Resident #1 attempted to drink hand sanitizer, went to a psych hospital, the family was aware, and Resident #1 was being seen by psych services at the facility. She stated interventions included educating staff, educating family, knowing the history of the resident so they had a bigger picture, and where the resident was in acceptance or denial, and refer to psych services. She said staff were on the lookout for those things in her room and encouraged to carry hand sanitizer for their use in pockets or carts. She stated Resident #1 was encouraged to participate in activities. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 02/12/2025 at 4:44 PM, Resident #1 stated she consumed hand sanitizer in November. She stated she was an alcoholic and read on the side of the bottle ethyl alcohol and decided to try it. She stated a staff member saw the remains in her cup, confronted her and took her to the DON's office. She said she got 18 oz bottles at the front and reception desk and the facility removed it. Resident #1 stated she drank 3-4 oz only that one time and did not get sick and was sent to rehab for 16 days afterwards. Interview on 02/12/2025 at 5:04 PM, the DON stated the risk was possible harm form ingesting substances. She stated her expectations for staff were if they saw something out in the open that was not supposed to be there to remove it and report it. Interview on 02/12/2025 at 5:19 PM, the Administrator stated keeping medications or things like hand sanitizer at resident bedside could cause harm when ingested. She stated she expected staff to look for substances kept in Resident #1's room that could be ingested. She stated unless Resident #1 was acting unusual then that would warrant a deeper search, she still has the right to some privacy. Record review of Angel room rounds/grand room rounds included in the PIR, dated 12/12/24, revealed in part no medications at bedside including cough drops, neb treatments, eye drops and ointments were found in rooms. Record review of Inservice, dated 12/12/24, on the topic of Abuse/Neglect and Resident Rights revealed staff signatures and Abuse/Neglect policy and Resident Rights policy. Record review of Inservice dated 12/18/24 on the topic of Restricted Resident Items and what to do if you see them revealed staff signatures and List of Things NOT Allowed o Prescription and over-the-counter medications are not allowed in resident rooms . o Anything that can create a life safety hazard must be removed from resident rooms o Any liquid item that says, Keep out of reach of children. Record review of the facility policy, titled Incidents and Accidents revised on 08/2023, revealed in part: It is the policy of this facility for staff to utilize risk management tool from [EHR] and complete an incident report. The Administrator and DON will report and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident . The purpose of incident reporting can include: o Assuring that appropriate and immediate interventions are implemented and corrective actions are taken to prevent recurrences and improve the management of resident care. o Conducting root cause analysis to ascertain causative/contributing factors as part of the Quality Assurance Performance Improvement (QAPI) to avoid further occurrences. o Alert risk management and/or administration of occurrences that could result in claims or further reporting requirements. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	o Meeting regulatory requirements for analysis and reporting of incidents and accidents The noncompliance was identified at an Immediate Jeopardy (IJ) PNC (past nocompliance). The noncompliance began on 10/12/2024 and ended on 12/17/2024. The facility had corrected the noncompliance before the survey began. The Administrator was provided the IJ template on 02/27/25 at 5:32 PM.