

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455763	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2025
NAME OF PROVIDER OR SUPPLIER Park Bend Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791</p> <p>Based on interviews and record reviews the facility failed to ensure residents were free from neglect for 1 of 4 residents (Resident #1) reviewed for neglect.</p> <p>1. The facility failed to ensure Resident #1 was protected from neglectful treatment by failing to respond to family members performing medical procedures on her.</p> <p>2. The facility delayed sending Resident #1 to the hospital after discovering family had started an IV on the resident.</p> <p>An IJ was identified on 05/22/25. The IJ template was provided to the facility on [DATE] at 5:10 PM. While the IJ was removed on 05/23/25, the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal.</p> <p>This failure could place residents at risk of harm or death from medical procedures being performed on them.</p> <p>Findings included:</p> <p>Record review of Resident #1's undated Admission Record reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included Seizures, stroke, legal blindness, and malnutrition.</p> <p>Record review of Resident #1's discharge MDS, dated [DATE], reflected her BIMS score was not calculated. Her Functional Status reflected she was dependent on staff for her ADLs.</p> <p>Record review of Resident #1's care plan, dated 02/03/25, indicated she had impaired communication, loss of vision, and dehydration related to fluid hydration maintenance.</p> <p>Record review of the facility's investigation report revealed on 05/01/25 the resident's Family Member A (her RP as well) was discovered to have brought in the supplies and equipment to initiate IV fluid therapy, and had inserted an IV into the right neck of Resident #1. Staff visualized IV fluid hanging from an IV pole, but never observed IV fluids being administered to the resident. Family Member A was trespassed from the facility by the Administrator and the police department.</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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Record review of Resident #1's nursing progress notes reflected the following entries:</p> <p>04/28/25 written by the Unit Manager - Received a fax with orders for Seroquel 25 mg QHS PRN insomnia, agitation , or hallucinations and Remeron 15 mg at bedtime for insomnia. Called and spoke with .RN with . Hospice who stated that [Family Member B], gave the orders. [Family Member B] notified concerning the orders for Seroquel and Remeron. [Family Member B] stated she was the medical director of XXX hospice and wanted the Seroquel to be PRN for hallucinations. Educated [Family Member B] that pt is already on Depakote and the dose could be increased if needed. Remeron, which was written for insomnia, educated the [Family Member B] that Remeron is an antidepressant that in lower dosage is appetite stimulant not a hypnotic. Pt is currently on Melatonin which could be increased. Educated [Family Member B] that orders could not be taken from her just because she is a Dr in the community. This is when [Family Member B] stated I am the medical director of hospice and several different nursing homes, I have hospital privilege's. Give one extra tab of Depakote if hallucinations are present and [Family Member A] is concerned about her not eating so give the Mirtazapine 7.5 mg at bedtime. Called .hospice to ask who Medical director is and it is Dr. XX MD. Questioned if [Family Member B] was one of [hospice agency] hospice physicians and the answer was no. Notified DON and Admin.</p> <p>05/01/25 at 1:39 PM written by the Unit Manager - [Family Member A], in house, trying to start an IV on resident. Spoke with [Family Member A] educating him that on Hospice and if wanting IV therapy then resident should be sent to the hosp. [Family Member A] stated no, I still want her on hospice.'. Questioned [Family Member A] why the IV and he responded because we can, it will either help or it won't. Notified DON at this time.</p> <p>05/01/25 at 2:03 PM written by LVN A - Resident's [Family Members] in room at this time, inserting iv line into resident's right neck for infusion of lactated ringers solution. [Family Member A] is physician, no orders from resident's primary doctor or from hospice regarding iv therapy, DON and unit mgr aware of [Family Member A's] actions</p> <p>05/01/25 at 7:45 PM written by LVN B - [EMS] here to transport resident to [hospital] ER for further evaluation and treatment r/t to IV placement by family. Resident AAO to self only. No s/s of discomfort noted at this time. No grimacing or c/o pain. [Family Member A] called and notified of transfer. All necessary paperwork completed and sent with resident.</p> <p>Record review of EMS report indicated 911 was called at 7:19 PM on 05/01/25. The crew was dispatched at 7:19 PM, and arrived at the facility at 7:32 PM. The EMS report reflected: Upon arrival, pt was lying supine in a bed unresponsive. Staff reports this is the pt's normal baseline. Staff reports the [Family Member A] started an IV on the pt's neck and giving her something unknown. Staff reports wanting to send the pt out due to not knowing what the family gave the pt. Staff relays pt's is also on hospice. Upon talking with [Family Member A], stated he is a plastic surgeon who started an EJ on the pt using a sonogram and gave 3L of fluid. [Family Member A] relays pt' s temperature has been all over the place recently and pt was tachycardic so that is why he gave the fluids. [Family Memebr A] also reports having done this 2 other times. [Family Member A] agreed with transport. Vitals were monitored and a head to toe was done. Pt was transferred onto the stretcher. PD arrived on scene. Pt was placed on oxygen via NC for low oxygen saturation. There was no change in pt condition while en route to the hospital. Verbal report was given and pt care was transferred.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Record review of the Unit Manager's written statement, dated 05/02/25, reflected she was contacted by the hospice nurse that the resident's son might be on the way to start and IV on the resident. The Unit Manager checked on the resident and saw Family Member A with two 1-liter bags of IV fluid. She advised Family Member A that if the resident needed IV fluid she needed to go to the hospital. After she left the room, Family Member A apparently started the IV anyway.</p> <p>Record review of LVN A's written statement, dated 05/02/25, reflected he stated when he entered the resident's room he noted the resident had an IV in her right neck. The family member stated they put it in the resident's neck there because it was the only place they could get an IV.</p> <p>In an interview on 05/22/25 at 12:50 PM, the Unit Manager stated she was called by the hospice nurse and told they had been made aware the (Family Member A) might try to start an IV on the resident. When she arrived at work the (Family Member A) was stating he was going to start an IV because it might help the resident. When she told him the resident needed to go to the hospital if she needed IV fluid therapy, he did not want the resident go to the hospital and come off hospice. She notified the DON right away and left it for the DON to handle.</p> <p>In an interview on 05/22/25 at 1:45 PM, the DON stated the Unit Manager's note was incorrect and that at 1:39 PM Family Member A was wanting an IV placed and the Unit Manager was contacting hospice about doing so. The Unit Manager thought they were waiting to hear back from Hospice but apparently Family Member A started the IV in the Right EJ at some point. LVN-A did not notify the DON or the Unit Manager as he stated in his note at 2:03 PM. The Unit Manager contacted the DON at 5:53 PM about the IV being placed. In the intervening time the family was keeping staff out of the room. After being notified the DON contacted the Administrator, the Administrator was making phone calls to the doctor, hospice, and corporate about how to proceed. Hospice notified them that they had fired the resident from their services. When Family Member A was notified the police were coming, he removed all the evidence from the room and took it out to his car. The DON displayed the Unit Manager's text message on 5/22/25 at 5:53 PM.</p> <p>In an interview on 5/22/25 at 2:24 PM, LVN A stated charting was not totally accurate. He stated he was approached by the hospice aide who was looking for an IV pole. He asked why and she stated they were trying to start an IV, he assumed hospice was starting an IV. When he went into the room around 1:50 PM he noticed a pink IV catheter in the resident's right neck, with a bad of Lactated Ringers hanging from the IV pole, but not infusing into the resident. He asked why it was in the neck and Family Member C stated it was where they could get one. He realized at that point the family had put the IV in, not hospice. He notified the Unit Manager via text right away and he left as his shift was over.</p> <p>In an interview on 05/22/25 at 4:10 PM, the Administrator stated she was made aware of the situation around 6:00 PM by the DON via phone. She then called her boss for guidance as she had not encountered this type of situation before. She was advised to call the police to have Family Member A trespass from the facility. She was also calling hospice to consult to see if they had authorized IV fluids, etc. She did not know why the Unit Manager had delayed contacting the DON.</p> <p>In a follow up interview on 05/22/25 at 4:15 PM, the Unit Manager stated she was contacted by LVN-A via text around 2:00 PM while she was in a meeting. She called the nurse on duty to verify if there was an IV in the resident. She heard him ask the family member standing at the desk and she confirmed there was an IV in the resident's neck. She stated she contacted the DON right away.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Immediate action:</p> <ol style="list-style-type: none"> 5/1/25 The facility administrator completed a self-report incident to HHSC due to (Family Member A) placing an IV in resident's right jugular. 5/22/25 The facility/DON/Administrator educated staff regarding immediately reporting any family member performing a procedure on their family. 5/22/25 The facility/DON/Administrator educated all families via [electronic notification application] regarding the prohibited action of performing any procedure on their family member and that they will be reported to the facility administrator immediately if seen doing so. <p>Interventions:</p> <ol style="list-style-type: none"> On 5/22/25 the DON/Designee initiated an in-service with the facility staff that any individual not employed or contracted by facility performing any procedures, i.e. starting an IV on a resident must be immediately reported to the abuse coordinator. On 5/22/25 the DON/Designee initiated an in-service with the families via [electronic notification application] regarding the prohibition of any non-employed or non-contracted performing any procedure on any resident and that if anyone is seen doing so, they will be reported immediately to the abuse coordinator. Completed 5/22/25 On 5/22/25 the Regional Corporate nurse/Designee initiated an in-service with the Administrator and DON regarding the prohibition of any individual not employed or contracted with [Facility] performing a procedure on any resident. Completed 5/22/25 On 5/22/25 DON and Administrator placed a sign at the entrance to the facility where visitors sign in stating that they are not allowed to bring outside medications or perform any medical procedure on any resident. <p>Ongoing Projected completion 5/24/25</p> <p>Any staff member not present or in service, will not be allowed to assume their duties until in-serviced. Ongoing In-service will be completed by Administrator/DON/ADON/WC NURSE/or weekend nurse supervisor, until all staff, weekend, prn, and agency staff is completed.</p> <p>If it is determined family or non-staff are attempting to provide medical services and/or medication prescription after the Abuse Coordinator is notified the Abuse Coordinator will alert the police and the perpetrator will be removed from the building.</p> <p>If staff observe non-staff providing or attempting to provide medical services, staff will intervene and ensure the resident is safe and that the procedure is halted to protect the resident.</p> <p>If the facility determines there might be issues with family or non-staff interfering with resident care, the facility will immediately alert the physician, Medical Director and provide education to said family or non-staff regarding the prohibition of interfering with resident care.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Monitoring</p> <p>8. On 5/22/25 The DON/designee began a questionnaire to validate the effectiveness of the training. The questionnaire is conducted with facility staff. Immediate re-education will be completed by the DNS/designee if any staff is unable to answer appropriately to the questions on the questionnaire. Staff will not be allowed to work until after completion of the questionnaire. Projected completion 5/24/25</p> <p>9. An impromptu QAPI meeting was conducted with the facility's Medical Director, Dr. XX on 5/22/25 to notify of the potential for non-compliance and the action plan implemented for approval. Plan approved on 5/22/25</p> <p>Monitoring of the IJ continued, reflecting:</p> <p>Signage posted at front desk stating family are not allowed to bring outside medications or perform any medical procedure on any resident</p> <p>The Administrator and DON were in-serviced on reporting any family member performing a procedure on their family member by the Regional Nurse Consultant on 05/22/25 at 6:01 PM.</p> <p>The Administrator in-serviced resident Responsible Parties via their electronic notification application on 05/22/25 at 6:58 PM to advise family is not to bring any medications, including OTC medications, to their family member, and they are not to perform any medical procedures on their family member, including starting an IV on the resident.</p> <p>The DON initiated in-services for all staff that any individual not employed or contracted by facility performing any procedures, i.e. starting an IV on a resident must be immediately reported to the abuse coordinator. The in-service was followed up with a written test.</p> <p>Interviews were conducted with staff regarding the in-service they received and the written test completed afterwards. Staff were able to verbalize what interventions they were expected to do if they observed a family member administering a medication to a resident or performing a medical procedure on a resident. The staff interviewed included: Director of Rehab, MDS Coordinator, Business Office Manager, ADON, Unit Manger, Maintenance Supervisor, Dietary [NAME] C , CNA D, Dietary Director, Dietary Aide, Restorative Aide, Dietary [NAME] E, LVN F, LVN G, OTA, OT, LVN H, Housekeeper I, LVN J, Housekeeper K, CNA L, CNA M, CNA N, MA O, OT P, CNA Q, CNA R, CNA S, CNA T, MA U, Activity Director, Social Worker, and LVN-V</p> <p>The Administrator and DON were informed the Immediate Jeopardy was removed on 05/23/25 at 12:20 PM. The facility remained out of compliance at a scope of isolated with no actual harm with a potential for more than minimal harm, due to the facility's continuation of in-servicing and monitoring the plan of removal.</p>		