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	03/11/2026

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

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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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to immediately consult with the resident's physician when there was a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) for 1 of 8 residents (Resident #1) reviewed for resident rights. The facility failed to ensure the physician was notified from [DATE] through [DATE] when Resident #1 continued to have bloody urine draining from her indwelling urinary catheter. The physician was not notified until [DATE] that the resident was experiencing a change in condition, and the physician ordered for the resident to be sent to the hospital. At the hospital, the resident was diagnosed with severe sepsis with septic shock with a likely source of urinary tract infection.On [DATE] at 11:40 a.m. an IJ was identified. While the IJ was removed on [DATE] at 5:08 p.m., the facility remained out of compliance at a severity level of no actual harm with a potential for more than minimal harm, that was not immediate jeopardy at a scope of pattern, due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. This deficient practice could place residents at risk for pain, hospitalization, and death.Findings included:Record review of Resident #1's face sheet dated [DATE] reflected Resident #1 was an [AGE] year-old female who admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #1's Quarterly MDS, dated [DATE], reflected Resident #1 had the following diagnoses: Alzheimer's disease (progressive brain disorder that affects memory, thinking, and behavior), diabetes mellitus (disorder characterized by high blood sugar due to insulin resistance), chronic kidney disease (loss of kidney function), neurogenic bladder (lack of bladder control), anemia (low levels of red blood cells), and functional quadriplegia (state of complete immobility of all four limbs due to advanced frailty, illness, or cognitive decline). The MDS also revealed the Resident #1 had an indwelling urinary catheter, an ostomy (surgically created opening in the abdomen that allows stool to exit the body), had a feeding tube, and was dependent on staff for all ADLs. The MDS further reflected Resident #1 had a BIMS score of 7, indicating she had severe cognitive impairment. Record review of Resident #1's Care Plan, dated [DATE], reflected Resident #1 required assistance to perform all functional abilities due to multiple contractures, cognitive loss, use of catheter, use of colostomy, and depended on feeding tube for nutrition with interventions that resident was dependent on all ADLs. Resident #1's care plan also revealed she had anemia and was at risk for complications with interventions to monitor/document and report signs and symptoms of anemia which included fatigue, weakness, changes in cognition, and to monitor laboratory/diagnostic work as ordered, to report results to MD, and follow up as indicated. Resident #1's care plan further revealed that she had a catheter present and was at risk for UTIs with interventions to check tubing for kinks, encourage fluid intake, monitor for signs and symptoms of discomfort on urination, frequency and to, Monitor/record/report to MD for s/sx UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. The Care Plan also indicated that Resident #1 had (continued on next page)

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

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	frequent UTIs and was at risk for increased temperature, dehydration, and pain with interventions to, Encourage dietary\fluid intake within dietary limits. Give meds per order-monitor labs-report abnormals to M.D, Monitor to assure proper peri care is being done, Monitor urine for sediment, color, odor, amount, etc-report abnormals to M.D. Record review of Resident #1's progress note from LVN A on [DATE] at 3:27 p.m. reflected: Nursing Notes: Resident alert denies abnormal pain and discomfort, foley catheter draining blood-tinged urine to drainage bag, fluids encouraged; bp low x3; feeding tolerated, DR notified of urine and bp; I received n/o for ua and place an IV receive floods x2 liters. Notified oncoming nurse as well as weekend supervisor. Record review of Resident #1's progress note from LVN B on [DATE] at 4:15 p.m. reflected that Resident #1 refused the IV fluids. Record review of Resident #1's progress note from LVN B on [DATE] at 2:29 a.m. reflected, collected the urine specimen and was picked up by the lab personnel. Record review of Resident #1's progress note from NP C on [DATE] at 10:39 a.m. revealed Resident #1's indwelling catheter had dark orange/red urine.Assessment and plan. UA w c/s 2/15 with mixed microbial growth - recheck UA recollect 2/16 - labs reviewed 2/11 - pt refused IV fluids: Nursing reported hypotension [low blood pressure] 2/15: IV started and then pt pulled IV out as she noted she does not want IVF - monitor, improving: cmp [blood test] pending 2/17, cbc [blood test] orderd for 2/19. Record review of Resident #1's EHR revealed no documentation of urine color/characteristics or changes in condition from [DATE] - [DATE]. Further record review revealed Resident #1's last catheter change was completed on [DATE]. Record review of progress note on [DATE] at 2:38 a.m. reflected the following, Resident [Resident #1] was noted screaming and making unusual sound in her sleep, resident was lethargic and confused. VS: BP 83/53, P 82, T 97.1, SPO2 80, R 18. MD notified and ordered to transport resident to the hospital for evaluation. DON and family notified.Record review of Resident #1's physician orders revealed the following with a start date of [DATE]: Foley Catheter _18_ FR_30_cc bulb [size of catheter] to bedside drainage bag Diagnosis: obstructive uropathy as needed Change Foley Catheter PRN for s/s of infection, obstruction of if closed system is compromised. Foley Catheter _18_ FR_30_cc bulb to bedside drainage bag Diagnosis: obstructive uropathy as needed Change foley drainage bag PRN. Foley Catheter _18_ FR_30_cc bulb to bedside drainage bag Diagnosis: obstructive uropathy as needed Foley Catheter care PRN.Record review of Resident #1's hospital records dated [DATE] at 4:36 a.m. reflected: Septic shock likely source UTI, indwelling foley's catheter draining purulent urine. The record review further revealed Resident #1 also had Acute Kidney Injury (a sudden decrease in kidney function), Acute Hypoxemic respiratory failure, (sudden condition when the body cannot get enough oxygen) , Atrial Fibrillation (irregular heartbeat), and required intubation (tube placed into airway to help breathe) on [DATE]. Record review of photograph taken on [DATE] at 11:05 a.m. by Hospital Nurse #2 of Resident #1's indwelling catheter from the facility revealed a black-appearing substance with lighter-colored specks present on the catheter balloon (inflatable piece filled with sterile water after insertion to keep the catheter secured in bladder), whiteish-yellow appearing substance in the tubing, the urine in the bag appeared black and opaque, and no visible date was present on the catheter bag. Record review of video footage provided by Family Member #1 for the following dates: [DATE] at 3:12 a.m., [DATE] at 4:29 a.m., [DATE] at 3:04 a.m., and [DATE] at 5:12 a.m. revealed CNAs draining the catheter bag with Resident #1 visible in the recordings. Review of the videos revealed the urine visible in the drainage bag and container was dark/black in color. The urine appeared opaque, and visibility through the container was obstructed by the darkness of the fluid. Observation on [DATE] at 11:40 a.m. of Resident #1 revealed she was in the ICU. Resident was observed to be unresponsive on ventilator support and was receiving CRRT (continuous dialysis treatment used when the kidneys were not working). Observation of hospital foley catheter revealed amber urine in catheter bag. During an interview on [DATE] at 11:50 a.m. with Hospital Nurse #3 revealed Resident #1 was unstable and had a poor prognosis. She stated Resident #1 was unable to be turned due to her condition and almost coding (when the heart or breathing stops and CPR must be performed). Hospital Nurse #3 stated when Resident #1's foley from the facility was removed, there (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	was mold present on the catheter balloon. She stated the urine was purulent, there was pus in the tubing, and the urine in the bag was very dark and appeared black. Hospital Nurse #3 stated Resident #1 was admitted to ICU due to septic shock from a UTI. During interview, Hospital Nurse #3 pulled up Resident #1 hospital records and stated the UA results did show the resident had a UTI. Hospital Nurse #3 stated black urine indicated blood, severe UTI, or kidney issues. She stated mold on the catheter indicated the catheter had been present for a long period of time. During an interview on [DATE] at 12:03 p.m. with Hospital Nurse #2 revealed she was present when removing the catheter that Resident #1 came with from the facility. She stated when the catheter was removed, there were strings of pus (thick yellow or white fluid that forms when the body fights an infection) and mold on the tip of the catheter that was in the bladder. Hospital Nurse #2 stated the urine was so dark that it looked black. She stated the smell of the catheter when removed was bad and caused the nurses to gag. She stated it appeared as though the foley had not been changed for a long time. During an interview on [DATE] at 2:03 p.m. with MA D revealed that she had worked at the facility since 08/25. She stated Resident #1's medications were given through her feeding tube, so she only went in to talk with her and assist when needed. MA D stated she had not looked at her catheter in the last few weeks, but it was typically yellow colored. She stated that on approximately [DATE], Resident #1 was complaining of stomach pain and moaning a lot that day. She stated that stomach pain was not normal for her, but LVN E was present in her room a few times to give her medications, so she did not notify anyone. LVN E stated she was not sure what medications were given. During an interview on [DATE] at 2:20 p.m. with LVN E revealed he had worked at the facility for 1.5 years. He stated Resident #1 was alert and usually in a good mood. LVN E stated she was on hospice, but her family took her off a few months ago. He stated Resident #1's urine had been dark colored for a couple of weeks and he thought antibiotics were started. LVN E stated Resident #1 refused the lab draws and staff encouraged her to drink fluids. LVN E stated Resident #1 did not have any other changes and he did not follow up or notify the MD on the dark urine color. He stated the dark urine was not normal for Resident #1 unless she had a UTI. LVN E stated a day the previous week (unable to recall specific date), Resident #1 was grabbing at her stomach. He stated Resident #1 was more confused that day. He stated he assessed her abdomen, and it was normal. LVN E stated Resident #1 received routine pain medication and her pain improved. He stated it was normal for Resident #1 to complain of generalized pain, but she had never previously complained about stomach pain. He stated he did not assess her catheter that shift. LVN E stated Resident #1's pain improved with the medication, so he did not notify the physician or anyone else. He stated the risk of not notifying the physician was the resident could not get treatment and it could cause health deterioration. During a telephone interview on [DATE] at 3:10 p.m. with CNA F revealed he has worked at the facility since 2019. He stated Resident #1 had a catheter and was talkative and pleasant. CNA F stated his last shift with Resident #1 was on [DATE] and she was moaning a lot and complaining of pain. He stated it was the day Resident #1 went to the hospital, but it was after his shift. He stated she did not have a lot of urine that day, but it had always been reddish colored. CNA F stated it looked like iced tea and had been like that for approximately a month. He stated when it first happened he notified the nurse. CNA F was unable to recall what nurse he reported the urine color to. He stated he assumed the reddish dark urine was normal since it remained that way. CNA F stated he did catheter care every time he cleaned her up. He stated he never observed any pus, but the urine did have a bad odor since it had turned into the iced tea color. CNA F stated he was not sure what the dark urine was from. He stated it was important to notify the nurse of changes so they could notify the MD.During an interview on [DATE] at 3:24 p.m. with the ADON revealed she had worked at the facility for two years. She stated Resident #1 was pleasant and had a feeding tube, colostomy, and foley catheter. The ADON stated she had no reports of any changes with Resident #1. The ADON stated a few weeks prior, Resident #1 refused IV fluids for hydration, and she had some UAs done. She stated she was not notified of any changes with her catheter. The ADON stated Resident #1's catheter was changed as needed according to the (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	persistent and worsening hematuria (bloody urine).The resident #1 no longer resides in the facility.Immediate action:1. A 100% audit was performed on [DATE], by the DON, ADON, Wound Care Nurse, RN, for eight residents with catheters, seven residents with Foley catheters, and one with a suprapubic catheter to ensure catheters placement and securement, Urine characteristics, signs/symptoms of UTI, EMAR documentation accuracy on resident catheter changed dates. 2. Any resident with noted abnormal findings in reference to their urinary catheter received an immediate catheter replacement by a licensed nurse. Immediate physician notification, new orders followed promptly, RP will be notified as well. Increased monitoring every shift for 72 hours. DON, ADON, and wound care nurse noted none with symptoms and abnormalities at this time. 3. On [DATE], the LVN who failed to document catheter change, and notify the physician for change of condition, urine appearance and consistency received a 1:1 in-service by the DON on the importance of ensuring all change of conditions are reported to the physician/NP, and RP, are documented in the EMAR. Further infractions will result in disciplinary action up to termination of employment.Facilities Plan to Ensure Compliance.4. On [DATE] the Don/Adon and designee initiated an in-service with all the licensed nurses regarding catheter care and maintenance, UTI prevention, change in condition notification of physician/NP and RP, including documentation requirements for each. Staff were not permitted to return to resident care until in-services were completed by [DATE].5. The DON/designee will review residents changes in condition via SBAR, documentation and initiated interventions during clinical meetings. Any issues identified will be addressed immediately and the physician/NP will be notified and reviewed with the License nurses and or the IDT. This process will be adopted by the IDT as standard review of residents with catheters.6. An impromptu QAPI meeting was conducted with the facility Medical Director, on [DATE] to notify of the potential for noncompliance and the action plan implemented for approval. He approved the plan on [DATE]. 7. The Administrator, DON/Designee will report the findings to the QI process and QA committee monthly. Any concerns or recommendations will be addressed immediately.The surveyor monitored the POR from 1:40 p.m. to 5:08 p.m. as followed: Record review of the facility's in-services dated [DATE] and [DATE] reflected the following: TOPIC: Change of Condition r/t Urinary CathetersAll staff must be diligent while caring for our residents to note changes in their condition. If any change is noticed they must inform the nurse immediately. Specifically, regarding urinary catheter devices. The following are some exampled of what should be reported to the nurse immediately: Dark colored urine, leaking catheter or collection bag, blood, mold or similar visible, foul/pungent odors, sediment. Upon notifying the nurse the nurse should: 1. When a resident has a COC (Change in condition) the nurse will completed a full assessment including vital signs. 2.After assessment, the nurse shall document findings (including the vital signs) in the SBAR. 3. The nurse will implement any new orders and notify the resident and resident's responsible party. There were 47 staff member signatures present on the in-service. There was a post-test/questionnaire completed that required staff to pass before working their shift. Record review of the facility's in-services dated [DATE]-[DATE] reflected the following: TOPIC: Catheter Changes and DocumentationCatheters (Foley and suprapubic could be changed for a multitude of reasons included but not limited to the following: 1. Urinalysis is being collected to ensure a clean catch 2. Upon a physician's order. 3. Catheter malfunctions. 4. Possible exposure (tubing being pulled on the floor) The nurse must document these catheter changes in the resident electronic medical record. There is a standing PRN order that should be checked off on the MAR. Also, prudent nurse should include in the notes section of the MAR explaining why the catheter was changed. If it wasn't documented, it appears it wasn't done. Please take time to document the care you provide to our residents. There were 12 nurse signatures present on the in-service. Record review of 1:1 in-service, dated [DATE], reflected the following: Topic: COC/SBAR - Notifying Physician1. When a resident has a COC (Change in condition) the nurse will complete a full assessment including vital signs.2. After assessment, the nurse shall document findings (including vital signs) in the SBAR3. The nurse will implement any new orders and notify the resident and the resident's (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	responsible party.Discussed other options nurse could have taken regarding the change in appearance of urine color and expectations moving forward. There were 2 nurse signatures that had completed the 1:1 in-service. During interviews on [DATE] from 1:40 p.m. - 5:00 p.m. revealed that the following staff from all shifts: CMA D, Wound care Nurse, CNA F, LVN H, LVN I, OT N, SLP O, LVN Q, LVN R, CMA S, CNA T, CNA U, CMA V, LVN W, LVN X, CMA Y, CNA Z had been in-serviced before their shifts on catheter care, assessing catheters, and notifying of any changes. The CNAs stated they were responsible for input/output, cleaning the catheter during cares, and notifying the nurse of anything abnormal such as blood in urine/color changes, cloudiness, and sediment. Therapy stated they were to conduct observations when working with the residents and to notify the nurse of any changes. CNAs and Therapy stated if the issue was not resolved, they were responsible for notifying management, such as the ADON or DON. The nurses stated it was their responsibility to set eyes on residents' catheters every shift, monitor urine characteristics, change catheters as needed, and contact the MD immediately with any changes or abnormalities. The nurses stated they were also responsible to follow up to ensure interventions were effective and to notify the physician if not. The above staff members stated they completed the post-test/questionnaire and passed prior to working their shift. Record review of QAPI minutes completed on [DATE] revealed that there was a QAPI meeting that discussed the deficient practice of notification of physician.Record review of progress notes revealed that an audit was completed by the DON on the 8 residents with catheters. Progress notes revealed no concerns with catheters, documentation, catheter changes, or any signs/symptoms of UTIs. Observations completed on [DATE] from 1:26 p.m.-1:45 o,n, of Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, Resident #7, Resident #8, and Resident #9 revealed they all had catheters. No catheter concerns were identified during observations. The Administrator was informed the IJ was removed on [DATE] at 5:08 p.m. The facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm and a scope of pattern, due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections for 1 (Resident #1) of 8 residents reviewed for catheter care.The facility failed to assess, intervene, and change Resident #1's indwelling urinary catheter when Resident #1's catheter was draining blood from [DATE] through [DATE]. On [DATE], Resident #1 was sent to the hospital for a change of condition and was diagnosed with severe sepsis with septic shock with a likely source of urinary tract infection. On [DATE] at 6:45 p.m. an IJ was identified. While the IJ was removed on [DATE] at 5:08 PM, the facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm and a scope of pattern due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal.This failure could place residents at risk for hospitalization, infection, and death. Findings included: Record review of Resident #1's face sheet, dated [DATE], reflected Resident #1 was an [AGE] year-old female admitted [DATE] and readmitted on [DATE]. Record review of Resident #1's Quarterly MDS, dated [DATE], reflected Resident #1 had the following diagnoses: Alzheimer's disease (progressive brain disorder that affects memory, thinking, and behavior), diabetes mellitus (disorder characterized by high blood sugar due to insulin resistance), chronic kidney disease (loss of kidney function), neurogenic bladder (lack of bladder control), anemia (low levels of red blood cells), and functional quadriplegia (state of complete immobility of all four limbs due to advanced frailty, illness, or cognitive decline). The MDS also revealed the Resident #1 had an indwelling catheter, an ostomy (surgically created opening in the abdomen that allows stool to exit the body), a feeding tube, and was dependent on staff for all ADLs. The MDS further reflected Resident #1 had a BIMS of 7, indicating she had severe cognitive impairment.Record review of Resident #1's Care Plan, dated [DATE], revealed she required assistance to perform all functional abilities due to multiple contractures, cognitive loss, use of catheter, use of colostomy, and depended on feeding tube for nutrition with interventions that resident was dependent on all ADLs. Resident #1's care plan also revealed she had anemia with interventions to monitor/document and report signs and symptoms of anemia which included fatigue, weakness, changes in cognition, and to monitor laboratory/diagnostic work as ordered, to report results to MD, and follow up as indicated. Resident #1's care plan further revealed she had a catheter and was at risk for UTIs with interventions to check tubing for kinks, encourage fluid intake, monitor for signs and symptoms of discomfort on urination, frequency and to, Monitor/record/report to MD for s/sx of UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. The Care Plan also indicated Resident #1 had frequent UTIs and was at risk for increased temperature, dehydration, and pain with interventions to, Encourage dietary\fluid intake within dietary limits. Give meds per order-monitor labs-report abnormals to M.D, monitor to assure proper peri care is being done, monitor urine for sediment, color, odor, amount, etc-report abnormals to M.D. Record review of Resident #1's progress note, from LVN A dated [DATE] at 3:27 p.m., reflected: Nursing Notes: Resident alert denies abnormal pain and discomfort, catheter draining blood-tinged urine to drainage bag, fluids encouraged; bp low x3; feeding tolerated, DR notified of urine and bp; I [LVN A] received n/o for UA and place an IV receive floods x2 liters. Notified oncoming nurse as well as weekend supervisor. Record review of Resident #1's progress note from LVN B, dated [DATE] at 4:15 p.m., reflected Resident #1 refused the IV fluids. Record review of Resident #1's progress note, from LVN B on [DATE] at 2:29 a.m., reflected, collected the urine specimen and was picked up by the lab personnel. Record review of Resident #1's progress note, from NP C on [DATE] at 10:39 AM, revealed Resident #1's had dark orange/red (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	urine.Assessment and plan. UA w c/s [DATE] with mixed microbial growth - recheck UA recollect [DATE] - labs reviewed [DATE] - pt refused IV fluids: Nursing reported hypotension [low blood pressure] 2/15: IV started and then pt pulled IV out as she noted she does not want IVF - monitor, improving: cmp [blood test] pending 2/17, cbc [blood test] ordered for 2/19. Record review of Resident #1's UA results collected [DATE] and reported on [DATE] revealed the presence of blood, protein, mucus, and white blood cell clumps. The amount of blood and protein in the UA was in red, indicating critical results. Record review of EHR revealed no follow-up orders or interventions after the results were reported. Record review of Resident #1's EHR reflected Resident #1's indwelling catheter was last changed on [DATE]. There was no documentation in the resident's clinical record after [DATE] through [DATE] reflecting that Resident #1's catheter had been changed. Also, there was no documentation describing the color or characteristics of Resident #1's urine nor any documentation regarding Resident #1 experiencing a change of condition from [DATE]-[DATE].Record review of progress note from LVN AA, dated [DATE] at 2:38 a.m., reflected the following, Resident [Resident #1] was noted screaming and making unusual sound in her sleep, resident was lethargic and confused. VS: BP 83/53, P 82, T 97.1, SPO2 80, R 18. MD notified and ordered to transport resident to the hospital for evaluation. DON and family notified. Record review of Resident #1's physician orders dated of [DATE] reflected the following: Foley Catheter _18_ FR_30_cc bulb [size of catheter] to bedside drainage bag. as needed Change Foley Catheter PRN for s/s of infection, obstruction or if closed system is compromised. Foley Catheter _18_ FR_30_cc bulb to bedside drainage bag. as needed Change foley drainage bag PRN. Foley Catheter _18_ FR_30_cc bulb to bedside drainage bag.as needed Foley Catheter care PRN.Record review of Resident #1's hospital records, dated [DATE] at 4:36 a.m., reflected the following: Septic shock likely source UTI, indwelling foley's catheter draining purulent urine. The record review further revealed Resident #1 also had acute kidney injury (a sudden decrease in kidney function), acute hypoxemic respiratory failure, (sudden condition when the body cannot get enough oxygen), atrial fibrillation (irregular heartbeat), and required intubation (tube placed into airway to help breathe) on [DATE]. Record review of a photograph taken on [DATE] at 11:05 a.m. by Hospital Nurse #2 of Resident #1's catheter from the facility revealed a black-appearing substance with lighter-colored specks present on the catheter balloon (inflatable piece filled with sterile water after insertion to keep the catheter secured in bladder), whiteish-yellow appearing substance in the tubing, the urine in the bag appeared black and opaque, and no visible date was present on the catheter bag. Record review of video footage provided by Responsible Party #1 for the following dates: [DATE] at 3:12 a.m., [DATE] at 4:29 a.m., [DATE] at 3:04 a.m., and [DATE] at 5:12 a.m. revealed CNAs draining the catheter bag with Resident #1 visible in the recordings. Review of the videos revealed the urine visible in the drainage bag and container was dark/black in color. The urine appeared opaque, and visibility through the container was obstructed by the darkness of the fluid. During an observation on [DATE] at 11:40 a.m., Resident #1 was in the hospital ICU, and she was unresponsive on ventilator support. She was also receiving CRRT (continuous dialysis treatment used when the kidneys were not working). Observation of the resident's indwelling catheter revealed amber urine in catheter bag. During an interview on [DATE] at 11:50 a.m., Hospital Nurse #3 stated Resident #1 was unstable and had a poor prognosis. She stated Resident #1 was unable to be turned due to her condition and almost coding (when the heart or breathing stops and CPR must be performed) with any reposition. Hospital Nurse #3 stated when Resident #1's foley from the facility was removed, there was mold present on the catheter balloon. She stated the urine was purulent, there was pus in the tubing, and the urine in the bag was very dark and appeared black. Hospital Nurse #3 stated Resident #1 was admitted to ICU due to septic shock from a UTI. During interview, Hospital Nurse #3 pulled up Resident #1's hospital records and stated the UA results showed the resident had a UTI. Hospital Nurse #3 stated black urine indicated blood, severe UTI, or kidney issues. She stated mold on the catheter indicated the catheter was present for a long period of time. During an interview on [DATE] at 12:03 p.m., Hospital Nurse #2 stated she was (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	present when removing the catheter that Resident #1 arrived with from the facility. She stated when the catheter was removed, there were strings of pus (thick yellow or white fluid that forms when the body fights an infection) and mold on the tip of the catheter that was in the bladder. Hospital Nurse #2 stated the urine was so dark that it looked black. She stated the smell of the catheter when removed was foul. She stated it appeared as though the foley had not been changed for a long time. During an interview on [DATE] at 2:03 p.m., MA D stated she had worked at the facility since [DATE]. She stated Resident #1's medications were given through her feeding tube, so she only went in to talk with the resident and assist when needed. MA D stated she had not looked at Resident #1's catheter in the last few weeks, but it was typically yellow colored. She stated that on approximately [DATE], Resident #1 was complaining of stomach pain and moaning a lot that day. She stated that stomach pain was not normal for Resident #1, but LVN E was present in her room a few times to give her medications. She stated she was not sure what medications were given. During an interview on [DATE] at 2:20 p.m., LVN E stated he had worked at the facility for 1.5 years. He stated Resident #1 was alert and usually in a good mood. LVN E stated Resident #1 was on hospice services, but her family took her off a few months ago. He stated Resident #1's urine was dark colored for a couple of weeks and he thought antibiotics were started. LVN E stated Resident #1 refused the lab draws and staff encouraged her to drink fluids. LVN E stated Resident #1 did not have any other changes and he did not follow up on the dark urine color. He stated the dark urine was not normal for Resident #1 unless she had a UTI. He stated he thought Resident #1's foley had been changed but was unable to recall for sure. He stated if it was changed, it would be documented in Resident #1's EHR. LVN E stated catheters should be cleaned every shift. He stated the CNAs were cleaning Resident #1's catheter, but he never checked the catheter site. LVN E stated he trusted the CNAs to perform the care and report any concerns. LVN E stated a day the previous week (unable to recall specific date), Resident #1 was grabbing at her stomach. He stated Resident #1 was also more confused that day. He stated he assessed her abdomen, and it was normal. LVN E stated Resident #1 received routine pain medication and her pain improved. He stated it was normal for Resident #1 to complain of generalized pain, but she never previously complained about stomach pain. He stated he did not assess her catheter that shift. LVN E stated Resident #1's pain improved with the medication, so he did not notify the physician or anyone else. He stated dark urine could be an infection or blood. He stated the risk of not changing out the catheter or assessing the urine every shift was the infection could get worse and lead to sepsis. During an interview and observation on [DATE] at 2:58 p.m., the Wound Care Nurse stated she was familiar with Resident #1. She stated she was not her normal nurse but did check on her to ensure the catheter was patent (open and unobstructed). The Wound Care Nurse stated it was normal for Resident #1 to have sediment in the catheter, but that she had never seen her urine dark. The Wound Care Nurse stated she observed the catheter on [DATE] and did not recall the dark urine. She stated she was unsure why she did not document the urine color in her note that day. During interview, video footage provided by Responsible Party #1 of the urine was shown and the Wound Care Nurse stated that it was not normal for Resident #1 to have dark urine. She stated she had seen the resident's urine blood tinged previously, but never that dark. The Wound Care Nurse stated she would have notified the doctor if she saw that. She stated the dark color could be due to blood because Resident #1 had a UTI. She stated catheters should be changed monthly and if the catheters were not changed timely, it was an infection risk. During a telephone interview on [DATE] at 3:10 p.m., CNA F stated he had worked at the facility since 2019. He stated Resident #1 had a catheter and was talkative and pleasant. CNA F stated his last shift with Resident #1 was on [DATE] and she was moaning a lot and complaining of pain. He stated it was the day Resident #1 went to the hospital, but her transfer was after his shift. He stated she did not have a lot of urine that day, but it had always been reddish colored. CNA F stated it looked like iced tea and had looked like that for approximately a month. He stated when it first happened he notified the nurse. CNA F was unable to recall what nurse he reported the urine color to. He stated he assumed the reddish dark urine was (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	catheter could hit the urethra and cause some blood. She stated if the urine got worse, did not resolve, or anything else was abnormal, she would have wanted to be notified again. NP C stated dark brown/blackish urine was not normal for Resident #1 and she would want to be notified. She stated when she observed the orange urine, she ordered fluids and a CBC, but Resident #1 refused. NP C stated she told the facility staff to discuss hospice with the family and the family agreed once they moved her to a new facility. She stated the family moved and wanted Resident #1 to be closer to them. NP C stated she spoke to the facility staff after they notified her of Resident #1 refusing the labs and IV fluids on approximately [DATE]. NP C stated no facility staff informed her of the urine worsening/darkening in color or any other changes. NP C stated she would have ordered more labs and reevaluated the resident. NP C stated dark urine could be from blood and meant Resident #1 needed to drink more fluids. She stated Resident #1's kidney function was normal on [DATE], so maybe the foley catheter was pulled on and caused bleeding. NP C stated whenever a UA was ordered, staff were supposed to change the catheter out. She stated it could contaminate the UA or cause an infection risk if the catheter was not switched out properly. During an interview on [DATE] at 7:00 p.m., CNA G stated Resident #1's urine was brown/blackish colored and smelled awful. CNA G stated the urine had been that way for a while but was unable to specify the timeframe. CNA G stated the nurse was already aware because she reported it previously to LVN H. She stated since the urine remained that color, she thought it was normal for Resident #1. CNA G stated Resident #1 was acting normal to her, but she worked nights so Resident #1 slept most of the shift. CNA G stated she was not sure what would cause the urine to be that dark, but that it did not seem normal. During an interview on [DATE] at 7:11 p.m., LVN H stated she had worked at the facility for 5 months. She stated Resident #1's urine was dark brown colored and had been that way for a few weeks. LVN H stated she was not sure why it was never documented in the EHR. She stated she had not changed Resident #1's catheter, but that typically they were changed every 30 days. LVN H stated she was not sure when Resident #1's catheter had last been changed. LVN H stated she did notify the NP in person one day a while back but was unable to specify the date. LVN H stated blood in the urine could be a sign of an infection or irritation. She stated not changing the catheter timely was an infection risk. During an interview on [DATE] at 7:31 p.m., LVN A stated she notified the physician on [DATE] because she noticed blood in Resident #1's urine. She stated it was an orange colored at that time which usually happened when Resident #1 had a UTI. LVN A stated Resident #1 had a UA completed but came back negative for a UTI. LVN A stated she worked at the facility one time a week and was unable to recall what Resident #1's urine looked like after [DATE]. LVN A stated if the urine was dark brown/black, the physician should have been notified again because that was worse than when she saw it. LVN A stated she expected the CNAs to notify her if the urine was worse and that she had not been notified. LVN A stated she did not assessed Resident #1's urine or catheter every shift. LVN A stated dark colored urine was from blood and it could be caused by a UTI and kidney failure.During an interview on [DATE] at 11:48 a.m., LVN I revealed she worked with Resident #1 twice a week. She stated she never had any issues with Resident #1's catheter, but she did not always look at the urine. She stated one day a couple of weeks ago, she received orders from the previous shift for IV fluids. LVN I stated she went to connect the IV fluids and Resident #1 ripped the IV out. She stated she reported the fluid refusal to the physician and RP. LVN I stated that day she recalled Resident #1's urine appearing normal yellow colored. She stated she does not recall seeing it dark. During interview, LVN I watched video recordings of the catheter bag being emptied, she stated that was not Resident #1's normal urine color. LVN I stated she did not assess Resident #1's catheter every shift. She stated urine being that dark would mean Resident #1 had an infection, UTI, dehydration, or possibly kidney issues. LVN I stated she did not recall the last time the catheter was changed, she stated she had not changed it this year. LVN I reviewed the hospital image of catheter and stated it did appear to be the facility's catheter. She stated it looked like mold on the catheter which meant it was in there a long time, probably months or that Resident #1 had an infection. LVN I stated if she saw urine that (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	dark, or any changes, it should have been reported immediately to the physician. She stated not notifying the physician could cause residents to not get the treatment they need. Record review of the facility's policy titled, Indwelling Catheter Use and Removal, revised [DATE], reflected: 1.If an indwelling catheter is in use, the facility will provide appropriate care for the catheter following current professional standards of practice and resident care policies and procedures that include but are not limited to.Timely and appropriate assessments related to the indication for use of an indwelling catheter.Insertion, ongoing care, and catheter removal protocols that adhere to professional standards of practice and infection prevention and control procedures. Response of the resident during the use of the catheter; and Ongoing monitoring for changes in condition related to potential catheter-associated urinary tract infections, recognizing, reporting, and addressing such changes.7. Additional care practices include:a. Recognition and assessment for complications and their causes and maintaining a record of any catheter-related problems.Catheters and drainage bags should be changed based on clinical indications such as infection, obstruction, or when the closed system is compromised. Routine, fixed intervals are not recommended. This was determined to be an IJ on [DATE] at 6:45 p.m. The Administrator and DON were notified. The Administrator was provided the IJ Template on [DATE] at 6:45 p.m. The following Plan of Removal was approved on [DATE] at 10:24 a.m. The Plan of Removal reflected the following: Plan of RemovalName of facility: [Facility Name]Date: [DATE]F- 690The facility failed to ensure a resident with an indwelling catheter received appropriate treatment and services to prevent urinary tract infections (UTIs).The Resident #1 no longer resides in the facility.Immediate action:1. A 100% audit was performed on [DATE], by the DON, ADON, Wound Care Nurse for eight residents with catheters, seven residents with Foley catheters, and one with a suprapubic catheter to ensure catheters placement and securement, Urine characteristics, Signs/symptoms of UTI, EMR Documentation accuracy on resident catheter changed dates. 2. Any resident with noted abnormal findings in reference to their urinary catheter received an immediate catheter replacement by a licensed nurse. Immediate physician notification, new orders followed promptly, Increased monitoring every shift for 72 hours. DON, ADON, and wound care nurse noted none with symptoms and abnormalities at time. 3. On [DATE], the LVN who failed to document catheter change, received a 1:1 in-service by the DON on the importance of ensuring all care provided including the change of catheters is appropriately documented. Further infractions will result in disciplinary action up to termination of employment.Facilities Plan to Ensure Compliance.4. On [DATE] the DON/ADON and designee initiated an in-service with all the licensed nurses and CNAs on: Catheter care and maintenance, UTI prevention, change in condition notification, documentation requirements, when to notify the physician. Staff were not permitted to return to resident care until in-services were completed by [DATE].5. The DON/designee will review residents changes in condition via SBAR, documentation and initiated interventions during clinical meetings. Any issues identified will be addressed immediately and reviewed with the License nurse and or the IDT, the resident and the resident responsible party, and physician as necessary. This process will be adopted by the IDT as standard review of residents with catheters.6. The DON/designee will verify catheter orders, documentation of catheter care, assessments, this process will be adopted by the IDT as standard review of residents with catheters. The DON/designee will conduct weekly visual checks to ensure catheter care is maintained and without any abnormalities until [DATE] or deemed no longer necessary by 100% compliance. The DON and or designee will communicate any potential issues to the IDT, the resident/resident responsible party and the physician. 7. [DATE] The DON/designee began a questionnaire to validate effectiveness of the facility urinary catheter care process. The questionnaire is conducted with Licensed nurses, CNAs, and nurse managers. Immediate re-education will be completed by the DON/designee if any staff are unable to answer appropriately to the questions on the questionnaire Education will be completed by [DATE]. 8. The DON/Designee will run the physician orders report from the prior day, any new catheter orders received will be checked and verified for accuracy. Issues identified will be immediately corrected. This process will be adopted by (continued on next page)

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	03/11/2026

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 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	the IDT as standard review of residents with catheters.9. When, if incomplete, incorrect, conflicting documentation catheter orders are noted, it will be clarified and corrected by DON/Designee immediately. This process will be adopted by the IDT as standard review of residents with catheters.10. An impromptu QAPI meeting was conducted with the facility Medical Director, on [DATE] to notify of the potential for noncompliance and the action plan implemented for approval. He approved the plan on [DATE]. 11. The Administrator, DON/Designee will report the findings to the QI process and QA committee monthly. Any concerns or recommendations will be addressed immediately.The surveyor monitored the POR from 10:25 a.m. to 5:08 p.m. as follows: Record review of the facility's in-services dated [DATE] and [DATE] reflected the following: TOPIC: Change of Condition r/t Urinary CathetersAll staff must be diligent while caring for our residents to note changes in their condition. If any change is noticed they must inform the nurse immediately. Specifically, regarding urinary catheter devices. The following are some examples of what should be reported to the nurse immediately: Dark colored urine, leaking catheter or collection bag, blood, mold or similar visible, foul/pungent odors, sediment. Upon notifying the nurse the nurse should: 1. When a resident has a COC (Change in condition) the nurse will completed a full assessment including vital signs. 2.After assessment, the nurse shall document findings (including the vital signs) in the SBAR. 3. The nurse will implement any new orders and notify the resident and resident's responsible party. A total of 47 staff, from all shifts, signed off on the in-service attendance record. There was a post-test/questionnaire completed that required staff to pass before working their shift. Record review of the facility's in-services dated [DATE] reflected the following: TOPIC: Catheter Changes and DocumentationCatheters (Foley and suprapubic could be changed for a multitude of reasons included but not limited to the following: 1. Urinalysis is being collected to ensure a clean catch 2. Upon a physician's order. 3. Catheter malfunctions. 4. Possible exposure (tubing being pulled on the floor) The nurse must document these catheter changes in the resident electronic medical record. There is a standing PRN order that should be checked off on the MAR. Also, prudent nurse should include in the notes section of the MAR explaining why the catheter was changed. If it wasn't documented, it appears it wasn't done. Please take time to document the care you provide to our residents. There were 12 nurse signatures present on the in-service. Record review also revealed that a 1:1 in-service was completed on the same topics as above. No concerns were identified about in-services. During interviews on [DATE] from 11:48 a.m.-5:00 p.m. revealed that the following staff from all shifts: MA D, Wound care Nurse, CNA F, LVN H, LVN I, CNA J, CNA K COTA L, COTA M, OT N, SLP O, CNA P, LVN Q, LVN R, MA S, CNA T, CNA U, MA V, LVN W, LVN X, MA Y, CNA Z were in-serviced before their shifts on catheter care, assessing catheters, and notifying of any changes. The CNAs stated they were responsible for cleaning the catheter during care and notifying the nurse of anything abnormal such as blood in urine/color changes, cloudiness, and sediment. Therapy stated they were to conduct observations when working with the residents and to notify the nurse of any changes. Both CNAs and Therapy stated, if the issue did not resolve, they were responsible for notifying management, such as the ADON or DON. The nurses stated it was their responsibility to set eyes on residents' catheters every shift, monitor urine characteristics, change catheters as needed, and contact the MD immediately with any changes or abnormalities. The nurses stated they were also responsible to follo