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	09/12/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 49640 Based on observations, interviews and record reviews, the facility failed to provide a safe, clean, comfortable and homelike environment. The facility failed to ensure the front door was monitored from 5:00pm-7:00pm once the receptionist left for the day. Leaving the door unlocked and unattended allowed anyone to enter without knowledge. This failure could place residents at risk for living in an unsafe, unhomelike environment which could cause a decline in resident psychosocial well-being. The findings included: A confidential group meeting on 09/11/24 at 10:43 am, revealed residents were concerned about security. It was revealed that the receptionist leaves at 5:00pm but the front door locks at 7:00pm. It was stated that an unknown person, who claimed to be from Maintenance, entered the room of a resident, approximately six months ago. It was stated that the unknown person looked at the resident's TV, stated he would hang it and left but never returned. It was revealed after checking with Maintenance that no one from Maintenance was scheduled to provide service to the resident's TV. It was stated that the unknown person was a homeless individual. An interview with the Receptionist on 09/11/24 at 12:26 pm, revealed she worked 8:00am-5:00pm, Monday-Friday. She stated there was a receptionist on weekends who worked 9:00am-6:00pm, Saturday and Sunday. She stated the front door was locked at 6:55pm and unlocked at 6:55am daily. She stated no other employee worked at the front desk outside of her working hours as well as the weekend receptionist's working hours. An interview and observation with the Administrator on 09/12/24 at 11:39 am, revealed she has never considered security an issue. The Administrator stated she has worked at places where the front door remained unlocked for 24 hours. The Administrator stated it may have been a Maintenance worker that went into the resident's room regarding the TV. The Administrator stated it may have been a vendor. The Administrator stated vendors come into the facility all the time. The Administrator was observed viewing her computer. The Administrator stated she did not show any invoices regarding vendors for TVs specifically, but vendors may have worked on wiring in the resident's room. (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

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 09/12/2024

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An email received from the Administrator on 09/12/24 at 12:08 pm, revealed, Artcomm was here on 3/8/24 and Direct TV was here on 3/18/24 but I have no proof of whose room(s) they were in during their visit. An interview with LVN C on 09/12/24 at 02:13 pm, revealed when she worked double shifts, she did not feel comfortable due to the location of the building. She said there were lots of homeless people in the area. An interview with Med Aide D on 09/12/24 at 2:20 pm, revealed she worked 2:00pm-10:00pm. She stated she felt safe although she has thought about safety in the facility, but she hasn't been scared. An interview with a Housekeeper on 09/12/24 at 2:30 pm, revealed she worked 8:30am-9:00pm today. She stated she has felt unsafe when working because there was not anyone working up front. She stated there was an open field on the east part of the facility near the dumpsters. She said she has seen clothes and people talking in the field area. She said there were homeless people that hang out at the Quick Trip store nearby. Record review of Resident Council Minutes Secretary's Worksheet dated 07/31/2024 revealed: Any additional business or Comments: Sitting in front of the building unsafe.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42971 Based on observations, interviews, and record review the facility failed to provide the necessary services for residents who were unable to carry out activities of daily living to maintain good grooming and personal hygiene for 2 (Resident #138, Resident #19) of 8 residents reviewed for ADLs. The facility failed to ensure: 1- Resident #138 had his fingernails cleaned and trimmed. 2- Resident #19 had her fingernails cleaned and trimmed. This failure could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections, and a decreased quality of life. Findings included: 1- A record review of Resident #138's Comprehensive MDS assessment dated [DATE] reflected Resident #138 was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses included diabetes mellitus, above knee amputation of both legs, and anxiety. Resident #138 had a BIMS score of 11 which indicated Resident #138's cognition was moderately impaired. He required partial assistance with self-care. A record review of Resident #138's Comprehensive Care Plan, revised 08/01/24, reflected the following: Focus: [Resident#138] requires assistance to perform functional abilities in self-care .Interventions: Provide the following self-care assistance: . Personal hygiene - moderate assist. An observation and Interview on 09/10/24 at 9:32 AM revealed Resident #138 was laying in his bed. The nails on both hands were long and dirty. The fingernails on both hands were approximately 0.5 inches long and had dirt underneath the nails. Observation of the right hand reflected a greenish matter on the nail beds. In an interview with Resident#138 he stated he would like the fingernails to be trimmed and cleaned. He stated usually the nails were trimmed and cleaned by a nurse, but the nails have not been cut for long time. 2- A record review of Resident #19's Quarterly MDS assessment dated [DATE] reflected Resident #19 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included contracture of left hand, Alzheimer's disease, and diabetes mellitus. Resident #19 had a BIMS score of 14 which indicated Resident #19's cognition was intact. She required extensive assistance of two-person physical assistance with personal hygiene. A record review of Resident #19's Comprehensive Care Plan, revised 08/09/24, reflected the following: Focus: [Resident #19] has an ADL self-care performance deficit. Interventions: . Personal hygiene: Extensive assist x 1 staff. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation and interview on 09/10/24 at 09:56 AM revealed Resident #19 was laying in her bed. The nails on the right hand were approximately 0.4 centimeter in length extending from the tip of his fingers. The nails were discolored tan and the underside had dark brown colored residue. The nails on the left, contracted, hand were approximately 0.5 centimeter in length extending from the tip of her fingers. Resident #19 stated she did not like her fingernails that long and she stated she did not tell the nurse. She stated she did not remember when the last time somebody trimmed her fingernails. In an interview with CNA D on 09/10/24 at 12:39 PM, she stated CNAs and LVNs were responsible for nail care. She stated if a resident has diabetes, only nurses were allowed to provide nailcare. She stated the risk for not performing nailcare was an increased risk of infection. She stated Resident #138 and #19 both were diabetic; she would notify the nurse. In an interview with LVN E on 09/10/24 at 12:47 PM, she stated she did not notice both residents' nails this morning, and nobody notified her about the nailcare needed for both residents. Since both residents had a diagnosis of diabetes, nurses should provide nailcare. She stated that nailcare should be provided as needed. She stated the risk of not providing adequate nail care was increased infections. In an interview with the DON on 09/11/24 at 2:16 PM revealed her expectation was that nail care should be provided as needed, especially during shower time. She stated that CNAs were responsible for doing nail care unless the resident had a diagnosis of diabetes. She also stated that as the DON, either herself or her designee were responsible to do routine rounds for monitoring. The DON stated that residents having long, and dirty fingernails could be an infection control issue and skin breakdown. Record Review of the facility policy titled Activities of Daily Living revised 2, 2023 reflected, Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming, and oral care . A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48560 Based on observations, interviews, and record review the facility failed to ensure a resident who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan and the residents' goals and preferences for 1 of 3 Residents (Resident #36) reviewed for respiratory care. The facility failed to ensure Resident #36's nasal cannula tubing was labeled or dated. This failure could place residents at risk of respiratory infections. The findings were: Record review of Resident #36's Quarterly MDS assessment, dated 05/27/2024, reflected Resident #36 was a [AGE] year-old male who had a readmitted [DATE]. Resident #36's relevant diagnoses included chronic obstructive pulmonary disease (lung disease that block airflow and make it difficult to breathe), Stroke (disruption of blood flow to the brain), hypertension (high blood pressure), dysphagia (difficulty swallowing) and cognitive communication deficit (a difficulty with communication caused by disruption in mental cognition). Resident#36 had BIMS of 11, which indicated moderate cognitive impairment. Record review of Resident #36's comprehensive care plan dated 8/12/2024, reflected, Focus: Behavior [Resident #36] has a history of disruptive behaviors of yelling out .not using call light, refusing lab draws, and refusing to get out of bed at times. Refuses to wear oxygen at times, even when oxygen saturation are low. Goal: [Resident#36] will have less than daily episodes of behavior by review date. Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. Record review of Resident #36's Physician order, dated 09/08/24, reflected Oxygen at 2 L/min via Nasal Cannula PRN for Shortness of breath, Low oxygen saturation as needed for Cyanosis (blue discoloration of skin, lips due to low oxygen in blood), Respiratory distress, Labored breathing, Tachypnea (rapid and shallow breathing). Record review of Resident #36's Physician order dated 09/08/24, reflected Oxygen at 2 L/min via Nasal Cannula PRN for Shortness of breath, Low oxygen saturation as needed for every night shift every Sunday for Oxygen Change and label water humidification and nasal cannula tubing weekly every Sunday night shift. Date bottle and tubing. Keep nasal cannula bagged when not in use. In an observation on 09/10/24 at 11:09 AM revealed Resident #36 was sleeping in his room, was on oxygen therapy, and the nasal cannula tubing was not labeled or dated. Attempted interview with Resident #36 on 9/10/24 at 11:10 AM, was not able to interview Resident#36 since he was too sleepy to arouse for the interview. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation and interview on 09/10/24 at 11:11 AM with LVN C stated that she started working in the facility since July 2024. She stated that nurses on the night shift every Sunday were responsible for changing, labeling, and dating oxygen equipment. LVN C stated that she did not observe a date on the nasal cannula tubing during the interview. She stated that the nasal cannula would have been switched out, but the nursing staff may have forgotten to date and label it. She stated that the risk to the resident for not dating and labeling oxygen equipment was lapses in infection control since it was unknown how long the resident was on the same oxygen tubing. She also stated that she would change out the nasal cannula tubing after the interview was completed. In an interview on 09/11/2024 at 3:01 PM the DON stated that her expectation was that nurses were responsible for changing and dating the nasal cannula oxygen tubing weekly, every Sunday on 10-6 shift, or as needed. She also stated that as the DON of the facility, she had checked on quality-of-care needs for all residents in the facility on Monday, 09/09/24, and was certain Resident #36 had new nasal cannula tubing with date and label on it. She stated that one of the nursing staff may have changed the nasal cannula tubing and possibly forgotten to date it. She stated that as the DON of the facility, department heads of the facility, including herself, conducted daily rounds to check on residents. She stated that the potential risk of not dating the residents' oxygen equipment was the nasal cannula tubing could crack, malfunction, delivery of amount of oxygen and quality of oxygen could be hampered as well as the tubing could be dirty, if not changed or dated. She stated that there was no facility policy for changing and dating the nasal cannula tubing, however it was her expectation that they follow standard nursing protocols and physician orders for oxygen equipment. Record review of facility's policy titled Oxygen administration dated 10/2023 reflected, Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42971 Based on observations, interviews, and record review the facility failed to label drugs and biologicals used in the facility in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable for 1 (600 hall nurses' medication cart) of 3 medication carts reviewed for pharmacy services. The facility failed to ensure the 600 Hall medication cart had 1 insulin pen for Resident #74 with no opened date. This failure could affect residents resulting in diminished effectiveness, and not receiving the therapeutic benefits of the medications. The findings included: Record review of Resident #74's Quarterly MDS, dated [DATE], revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus, elevated blood pressure, and hyperlipidemia (too many lipids and fats in the blood). He had a BIMS score of 15 indicating his cognition was intact. Record review of Resident #74's physician's orders dated [DATE] revealed an order for Insulin lispro subcutaneous solution pen-injector 100 unit/ml; inject per sliding scale: if 151 - 200 =2; 201 - 250 =4; 251 - 300 =6; 301 - 350 =8; 351 - 400 =10. Over 405 call doctor. Observation on [DATE] at 12:15 PM revealed the 600-hall nurse's medication cart had a pen of Insulin lispro U-100 insulin 100 unit/ml, for Resident #74, had no opened date. The label revealed discard after 28 days. Interview on [DATE] at 12:20 PM, LVN D stated the insulin pen that belonged to Resident #74 had no open date. LVN D stated she did not use the insulin pen in the morning. She stated she did not check the pen for an expiration date because she did not use it. LVN D stated the purpose of open dates were for expiration purposes because the insulin was only good for 28 days. She stated expired insulin would be ineffective. Interview on [DATE] at 2:16 PM, the DON stated the insulin flex pens, once opened, needed to be dated because each insulin pen had a 28 or 30 days shelf life and if the insulin used after the shelf life time, it could lose its effectiveness. The DON stated the Assisted DON and the DON were supposed to do random checks of the medication carts for monitoring. Record review of the facility's policy titled Medication Storage, dated [DATE], revealed in part .8. All medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. Thes medications are destroyed .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47690 Based on observations, interviews, and record review, the facility failed to maintain an Infection Prevention and Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one (Residents #52) of 9 residents observed for infection control. CNA A and CNA B failed to perform hand hygiene during incontinence care for Resident #52. This failure could place residents at risk for the development and/or worsening of urinary tract infections, cross contamination, and skin breakdown. Findings included: Review of Resident #52's quarterly MDS assessment dated [DATE] reflected she was a [AGE] year-old-female originally admitted to the facility on [DATE], and readmitted [DATE], no BIMS score recorded. Her active diagnoses included stroke (a brain damaged due to a lack of blood flow due to blocked or ruptured blood vessel, CVA), diabetes mellitus, hemiplegia of right side (paralysis of one side of the body), and aphasia (a language disorder that affects a person's ability to communicate). Review of Resident #52's Care Plan dated 07/16/2024 reflected the following: .Focus: She had impaired cognitive function, and impaired thought processing The resident has an ADL self-care performance deficit r/t CVA with Hemi Goal: The resident will be clean, dry, and well-groomed through review date. Interventions and task: . Resident requires extensive assist of 1 staff with personal hygiene Observation on 09/11/24 at 9:20 a.m. revealed CNA A entered Resident #52's room, washed her hands with soap and water, put on double pair of clean gloves. CNA B entered Resident #52's room, donned gloves without any form of hand hygiene and went to the right side of Resident #52's bed. CNA B uncovered Resident #52, both CNAs unfastened Resident #52's brief. CNA A cleaned Resident #52's front area using one wipe per stroke, front to back. Both CNAs helped Resident #52 turn to her left side. CNA A cleaned Resident #52's buttocks area, removed the brief, and disposed of it in the trash can. CNA A removed one pair of gloves, placed clean brief under Resident #52's buttocks, and applied zinc oxide to the resident's buttocks. Both CNAs turned the resident on her back side and fastened the brief. Both CNAs removed their gloves and donned clean gloves without any form of hand hygiene. Both CNAs helped Resident #52 redress and transfer from the bed to the wheelchair. Both CNAs removed gloves, and washed hands before exiting the resident's room. In an interview with CNA A on 09/11/24 at 09:38 a.m. revealed she knew she was supposed to perform hand hygiene between glove changes. She stated she forgot, and there were no hands sanitizers in rooms in this place. She stated she had an in-service on hand hygiene and did a skill check off with the ADON. She stated the risk to residents were development of infection, and contamination. In an interview with CNA B on 09/11/24 at 10:38 a.m. revealed she knew she was supposed to perform hand hygiene between glove changes. She stated she thought she had done it correctly and did not realize she had missed some of the steps. She stated the risk to the resident was they could get infection and if there was anyone around, they would transfer it to them. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the ADON on 09/11/24 at 1:09 p.m. revealed, she stated staff were supposed to do hand hygiene when going into resident rooms, any time their hands were visibly soiled, when coming out residents room, and after removing gloves. She stated the risk to the residents was it could give them an infection. The ADON further stated it was the responsibility of the department head, herself, to make sure residents' direct care staff follow the proper procedure for hand hygiene. She stated in-service on hands hygiene, and infection control done monthly and as needed. Interview with the DON on 09/12/24 at 11:26 a.m. revealed staff were to sanitize their hands before care, when going from clean to dirty and after care, and each time they changed their gloves. The DON stated staff were responsible to make sure to follow the training, and the ADON did audits monthly on hand hygiene. She stated the training and skills check off were done annually, monthly, and upon hire. She stated the risk to the residents if hands hygiene protocol was not followed could be possible cross contamination, and infection. Record review reflected both CNAs A&B had an in-service titled hands Hygiene Competency Validation on 08/05/24. Review of the facility's policy titled Infection Prevention and Control Program dated May 2023, reflected, .1. Standard Precaution b. Hand hygiene shall be performed in accordance with our facility's established hands hygiene procedure . Review of the facility's' policy titled Hand Hygiene dated February 2023, reflected Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to .Before applying and after removing personal protective equipment (PPE), including gloves.