

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 12/11/2025
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)		
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observations, interviews, and record reviews the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for two (Resident #57 and Resident #68) of five residents, reviewed for incontinence. 1. The facility failed to ensure Resident #57 and Resident #68 did not have their Foley Catheter bags lying on the ground. This failure placed residents at risk for healthcare associated cross contamination and urinary tract infections. Findings included: 1. Review of Resident #57's Quarterly MDS Assessment, dated 10/28/25, reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. His cognitive skills for daily decision making were severely impaired. His BIMS score was 06. The resident had a Foley Catheter (catheter inserted into the bladder to drain urine). His diagnoses included obstructive uropathy (blockage in the urinary tract). Review of Resident #57's Care Plans reflected: 1. Revised 12/10/25 - Resident #57 had increased risk for infection due to collection bag placement and residents need for independence re: using bed controls and collection bag placement. Facility interventions - Date Initiated: 12/09/25 (this intervention was added after the State Surveyor observed the resident's catheter bag on the floor.) Position catheter bag and tubing below the level of the bladder and in a privacy bag. An observation on 12/09/25 at 11:18 AM of Resident #57 revealed he was lying in bed. He said he did not want to be interviewed. His Foley Catheter bag was lying on the floor. He said he did not know why it was on the floor. An interview on 12/09/25 at 2:25 pm with CNA B revealed she saw Resident #57's Foley Catheter bag on the floor the morning of 12/09/25. She said she did not know why it was on the floor. She said when she saw it (unknown time), she picked it up and put it back on the bed frame. CNA B said the resident had a remote control on the bed and it made it easy for the Foley Catheter bag to fall to the floor. CNA B said the resident was at risk for infection if the Foley Catheter bag was on the floor. 2. Review of Resident #68's Quarterly MDS Assessment, dated 11/25/25, reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. His cognitive skills for daily decision making were intact. His BIMS score was 15. The resident had a Suprapubic Catheter (catheter inserted directly into the bladder to drain urine). His diagnoses included neurogenic bladder (nerve damage that disrupts bladder control). Review of Resident #68's Care Plans reflected: Revised 12/10/25 - Resident #68 had a suprapubic catheter and was at risk for complications. Facility interventions - Date Initiated: 12/09/25 (this intervention was added after the State Surveyor observed the resident's catheter bag on the floor.) Educate resident on proper placement of bag as he tends to grab and move it. An observation and interview on 12/09/25 at 10:45 AM with Resident #68 revealed the resident was sitting upright in bed. He was awake, alert, and oriented. The resident's Foley Catheter bag was lying on the floor. The resident said he did not know why it was on the floor. The resident grabbed the Foley Catheter tubing and pulled the bag to himself and off the floor. The resident then hung the bag on his trash can. An interview on 12/09/25 at 2:25 pm with CNA B revealed she did not see Resident #68's Foley Catheter bag on the floor. CNA B said she did not know why it was on the floor. CNA B said Resident #68 would reposition himself frequently and hang the bag on the trash can. CNA B said (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
--	-------	-----------

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 12/11/2025
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)		
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	having the Foley Catheter bag on the floor or hanging on the trash could cause infection. An interview with the Infection Preventionist on 12/10/25 at 12:40 PM revealed staff were supposed to ensure that residents with a Foley Catheter bag placed it on the rail of the bed and not on the floor. She said having a Foley Catheter bag on the floor could result in infection. An interview on 12/11/25 at 1:10 PM with the DON revealed she said Resident #68 liked to mess with his Foley Catheter bag. She said she was going to ask maintenance to place hooks on the bed to hang it from. She said Resident #57 was very active but would deny touching the Foley Catheter bag. She said she did not see their bags on the floor very frequently. She said having the Foley Catheter bags on the floor could lead to infection. Record review of the facility policy, Catheter Care, dated March 2023, reflected: .Ensure drainage bag is located below the level of the bladder to discourage backflow of urine. There was not a policy that addressed Foley Catheter bags on the floor.		

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 12/11/2025
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)		
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** Based on observations, interviews, and record reviews the facility failed to establish and 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 (Resident #24) of five residents, reviewed for infection control. 1. The facility failed to ensure CNA A performed hand hygiene after performing catheter care and a brief change for Resident #24. This failure placed residents at risk for healthcare associated cross contamination and infections. Based on observations, interviews, and record reviews the facility failed to establish and 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 (Resident #24) of five residents, reviewed for infection control. 1. The facility failed to ensure CNA A performed hand hygiene after performing catheter care for Resident #24. This failure placed residents at risk for healthcare associated cross contamination and infections. Findings included: 1. Review of Resident #24's Quarterly MDS Assessment, dated 10/16/25, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her cognitive skills for daily decision making were moderately impaired. Her BIMS score was 11. The resident had a Foley Catheter (catheter inserted into the bladder to drain urine). Her diagnoses included stroke, heart failure, obstructive uropathy (blockage in the urinary tract), and diabetes. The resident required maximal assistance by staff for rolling her to the side, to her back, and back to her side again. Review of Resident #24's Care Plans reflected: 1. Revised 05/22/25 - Catheter: Resident #24 had a Foley Catheter present and was at risk for urinary tract infection and complications due to catheter use related to her diagnosis of obstructive uropathy. Facility interventions: Position catheter bag and tubing below the level of the bladder and in privacy bag. 2. 05/14/25 - Functional abilities: Resident #24 required assistance to perform functional abilities in self-care. Facility interventions: Toilet Hygiene: Moderate assistance. An observation on 12/11/25 at 10:45 AM of Foley Catheter care and a brief change for Resident #24 revealed the resident was lying in bed. CNA A washed her hands and put on gloves. She folded down the resident's brief and performed catheter care. CNA A removed her gloves but did not perform hand hygiene. CNA A put on new gloves and cleaned the resident's buttocks. CNA changed gloves but did not perform hand hygiene. CNA A placed a new brief on the resident. An interview on 12/11/25 at 10:52 AM with CNA A revealed she had been trained to perform hand hygiene between glove changes but did not need to unless the resident had bowel movement on them. CNA A said failure to perform hand hygiene could lead to the spread of infection. An interview on 12/11/25 at 12:05 PM with the Infection Preventionist revealed staff were supposed to perform hand hygiene after removing their gloves. The Infection Preventionist said failure to do so could result in a negative outcome for the resident including infection. The Infection Preventionist said she was responsible for monitoring staff and in-servicing staff to perform hand hygiene. An interview on 12/11/25 at 1:15 PM with the DON revealed staff were supposed to perform hand hygiene after removing their gloves and had been trained to do so. The DON said failure to do so could cause a negative outcome such as infection for the resident. The DON said the facility did monthly checks and random staff check-offs to monitor and ensure staff performed hand hygiene. Record review of the facility policy, Hand hygiene, revised February 2023, reflected: .6. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves.		