STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675144	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burleson Nursing and Rehabilitation Center	600 Maple St 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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47772 Based on observations, interviews, and record review, the facility failed to ensure residents had the right to receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident for 4 of 62 residents (Resident #1, Resident #2, Resident #6, and Resident #10) reviewed for accommodation of needs. The facility failed to ensure the BCLB, in Resident #1, Resident #2, Resident #6, and Resident #10's was fully accessible for its intended use. This failure could have placed residents at risk of having their needs gone unmet. Findings Included: Resident #1 Record review of Resident #1's FS, downloaded from the Matrix on 10/4/2024, reflected a [AGE] year-old woman, born on 5/10/1951, who's admittance date to the facility was on 7/16/2024. She was diagnosed with Dementia (which was a disease that affected memory, thought, and interfered with daily life.) Record review of Resident #1's Admission MDS, dated [DATE], reflected the Resident #1 had a BIMS Score of 9. A BIMS Score of 9 indicated the resident had moderate cognitive impairment. Resident #1 had no impairment in either upper extremity (shoulder, elbow, wrist, and hand). Resident #1 had impairment on one side of their lower extremities (hip, knee, ankle, and foot). Resident #1 was occasionally incontinent of bladder. Resident #1 was always continent of bowel. Record review of Resident #1's CP reflected an area of Problem area for ADL Functions, started on 7/25/2024 evidenced by toileting, with the assist of 1 person. The Goal stated the resident would not develop skin breakdown related to incontinence. The Approach, started on 7/25/2024, delegated nursing home staff to assist to toilet as needed. Interview and observation on 10/1/2024 at 10:15 AM in the room of Resident #1 revealed her in her room, on the bed. The room was clean, free from clutter, no odors of bowel or urine. Resident alert; orientated to the day, date, and current president. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675144	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burleson Nursing and Rehabilitation Center	600 Maple St 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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations revealed the call light system in Resident #'1 bathroom consisted of a call light box, approximately 6 inches tall and 4 inches wide, attached to the wall. The bottom of the call light box was attached to the wall approximately 28 inches (at its bottom) to 34 inches (at its top) from the floor. The call light box had a thin white cord (BCLS,) about the size of a cooked piece of spaghetti, having extended from the bottom center of the call light box towards the direction of the floor. The top portion of the call light box, top 2 inches, had a reset button. On the bathroom wall, next to the toilet, was metal handrail, approximately 3 feet long, and as wide as a tube of toilet paper. The metal handrail was attached to the wall parallel to the floor at approximately 30 to 32 inches from the floor. The handrail was directly covering 2 inches, 30th inch to the 32nd inch, of the call light box. The BCLS was tied in a knot on the metal handrail, having resulted in a U-shaped loop. Resident #1 stated she had tied the BCLS in the knot around the metal bar because it was easier to push the U-shaped string configuration (the loop) downwards, with her hand and forearm, to call for assistance. From the seated position, and without the knot being tied (the loop), she had difficulty pinching the BCLS with two fingers and pushing the string downwards, because she had no leverage. She had not stated anything to staff. Having learned the BCLS was intended to be used if lying on the floor, she felt she would not have been able to reach it as it was tied in a knot. If she were to fall on the floor, and not have been able to reach the BCLS, she would have been uncomfortable, scared, and helpless. She then felt like she needed an accommodation to be able to use the call light system for both sitting on the toilet or lying on the floor. Interview on 10/1/2024 at 1:21 PM with the ADM revealed the facility had a system in place to identify and correct deficiencies in each resident's room. The practice in place was the use of a visual checklist used when having conducted daily [Angel Rounds.] Angel Round checklists directed staff to check specific items in each resident's room. The Angel Rounds checklists were kept on file if they contained information on needed repairs. The ADM stated it was the ADON's responsibility for the resident's room in question. Upon request, the ADM was unable to provide recent copies of the conducted Angel Rounds. Interview on 10/1/2024 at 1:29 PM with the ADON revealed she was the staff member who performed Angel Rounds for the resident's room in question. She stated she had utilized the Angel Rounds checklist. She stated she did not perform Angel Rounds today, 10/1/2024, yesterday, 9/30/2024. The ADON stated she utilized the Angel Rounds Checklist the last time she performed Angel Rounds, which was sometime last week. She put the Angel Round Checklist on the ADM's desk. Interview on 10/2/2024 at 10:45 AM with the SW revealed she had not previously been informed of a need for an accommodation for Resident #1's call light button. She stated she would speak to Resident #1 and address any accommodation she may have needed. Interview and observation on 10/3/2024 at 11:01 AM with the SW revealed Resident #1 had been moved to a new room. Observations in the bathroom in Resident #1's new room revealed the metal handrail, same as in the description on 10/1/2024 at 10:15 AM, had been raised on one end, and no longer blocked the call light box at the level of 30 to 32 inches from the floor. The metal handrail, having been raised on one end, uncovered a BCLB at the middle section of the call light box, 30 to 32 inches from the floor. The call light box had a button to press, from the seated position, and cord to pull, from lying on the floor. With the assistance of the SW, the BCLB and the BCLS were checked for function and the accommodation resulted with both having worked correctly. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675144	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burleson Nursing and Rehabilitation Center	600 Maple St 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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 10/3/2024 at 11:20 AM revealed the ADM and the MNTD having entered Resident #1's new room to have investigated the metal handrail having blocked the BCLB. The ADM stated he would gather a list of rooms in the building where the metal handrail blocked the BCLB of the call light box. Interview on 10/3/2024 at 12:57 PM with the ADM revealed the metal handrails interfered with resident's reaching the BCLB in an isolated number of rooms, which were 10. Record review of highlighted names on the facility's room roster, dated 10/3/2024, designated rooms C1, C3, C4, C5, C6, C7, C8, C9, C10, and E1 all had metal handrails that obstructed the call light system BCLB. He, and the MNTD, had been working to address the concern of inaccessibility. The facility's Call Light Policy was requested. Resident #10 Record review of Resident #10's FS, downloaded from the Matrix on 10/4/2024, reflected a [AGE] year-old woman, born on 9/09/1948, who's admittance date to the facility was on 4/14/2023. She was diagnosed with pain in the right arm and lack of coordination. Record review of Resident #10's Quarterly MDS, dated [DATE], reflected the resident had a BIMS Score of 11. A BIMS Score of 11 indicated the resident had moderate cognitive impairment. Resident #10 had no impairment in either upper extremity (shoulder, elbow, wrist, and hand). The resident had no impairment in either lower extremity (hip, knee, ankle, and foot). The resident utilized a walker for mobility. The resident was independent for toileting hygiene and toilet transfer, which meant the resident completed the activity. The resident was occasionally incontinent of bladder. The resident was occasionally incontinent of bowel. Record review of Resident #10's CP reflected an area of Problem area for falls, started on 9/24/2024, evidenced by weakness. The Goal stated the resident would have remained free from injury. The Approach, started on 9/4/2024, delegated nursing home staff to encourage call light use and always keep the call light within reach. Observation and interview on 10/4/2024 at 10:17 AM with Resident #10 revealed her lying in her bed under her covers. Room was free from odors and clutter. She ambulated with her walker to the restroom and used the toilet on her own. The metal handrail in the bathroom was covering the call light box and the BCLB. She stated the metal handrail posed difficulty having tried to press the BCLB; instead, she had to pinch and push the BCLS downward. Her toilet seat was raised and the angle to having pinched and pushed the BCLS from the sitting position, with her fingertips, was difficult. There was only a 1/2 to 3/4 inch gap between the metal handrail and the BCLB. It was not readily identifiable. To operate the BCLB on the toilet while seated, this investigator had to extend their hand straight out palm facing down, tilt the hand (thumb side down) 90 degrees, lower the hand by raising the elbow, insert the fingertips in the 1/2 to 3/4 inch gap, and feel for the button to press it. Resident #2 Record review of Resident #2's FS, downloaded from the Matrix on 10/4/2024, reflected a [AGE] year-old woman, born on 9/14/1949, who's admittance date to the facility was on 4/28/2024. She was diagnosed with Major Depression (which was a mental condition characterized by depressed mood, loss of pleasure, or interest in life.) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675144	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burleson Nursing and Rehabilitation Center	600 Maple St 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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's Quarterly MDS, dated [DATE], reflected the resident had a BIMS Score of 14. A BIMS Score of 14 indicated the resident had no cognitive impairment. The resident had no impairment in either upper extremity (shoulder, elbow, wrist, and hand). The resident had no impairment in either lower extremity (hip, knee, ankle, and foot). The resident utilized a walker for mobility. The resident required partial/moderate assistance with toileting and toilet transfer, which meant the helper provided less than half the effort while the resident completed the greater portion of the activity. The resident was occasionally incontinent of bladder. The resident was occasionally incontinent of bowel. Record review of Resident #2's CP reflected an area of Problem area for falls, started on 8/14/2024 evidenced by poor balance. The Goal stated the resident would remain free from injury. The Approach, started on 9/30/2024, delegated nursing home staff to always keep the call light in reach; and a Problem area for call lights, started on 10/2/2024 evidenced by non/compliant use. The Goal stated the resident would have begun to use the call light when she needed assistance. The Approach, started on 10/2/2024, delegated nursing home staff to educate risk versus benefit, make sure call light was in reach, and to respond promptly. Observation and interview on 10/4/2024 at 10:17 AM with Resident #2 revealed her lying in her bed under her covers. Room was free from odors and clutter. She ambulated with her walker to the restroom and used the toilet on her own. The metal handrail in the bathroom was covering the call light box and the BCLB. She stated the metal handrail, which covered the bathroom call button, made pressing BCLB difficult; instead, she had to pull the BCLS downward with her fingers. She stated the angle of having pulled the string from the sitting position was difficult. To operate the BCLB on the toilet while seated, this investigator had to extend their hand straight out palm facing down, tilt the hand (thumb side down) 90 degrees, lower the hand by raising the elbow, insert the fingertips in the 1/2 to 3/4 inch gap, and feel for the button to press it. Resident #6 Record review of Resident #6's FS, downloaded from the Matrix on 10/4/2024, reflected a [AGE] year-old man, born on 6/05/1967, who's admittance date to the facility was on 3/10/2021. He was diagnosed with acquired absence of left leg below knee (which was an amputation of his lower leg,) and lack of coordination. Record review of Resident #6's Quarterly MDS, dated [DATE], reflected the resident had a BIMS Score of 9. A BIMS Score of 9 indicated the resident had moderate cognitive impairment. The resident had no impairment in either upper extremity (shoulder, elbow, wrist, and hand). The resident had no impairment in either lower extremity (hip, knee, ankle, and foot). The resident utilized a wheelchair for mobility. The resident was independent with toileting and toilet transfer, which meant the resident completed the activity. The resident was always continent of bladder. The resident was always continent of bowel. Record review of Resident #6's CP reflected an area of Problem area for transfer self and falls, started on 7/24/2024 evidenced by below/knee amputation. The Goals stated the resident would have safely transferred self independently and remained free from injury. The Approaches, started on 7/4/2024, delegated nursing home staff to have encouraged resident to use the call light and to have kept the call light in reach. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675144	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burleson Nursing and Rehabilitation Center	600 Maple St 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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 10/04/2024 at 10:35 AM revealed Resident #6 in his room in his wheelchair. Room was free from odors and clutter. He stated he was able to ambulate with his wheelchair to the restroom and used the toilet on his own. The metal handrail was not blocking the call light box's BCLB. He realized at that time, that the support railing had been removed from his bathroom. There was fresh spackling compound, moist to the touch, in two spaces that were congruent with where the metal handrails were affixed to the wall in the other affected rooms. He stated he did not use the BCLS from inside his bathroom frequently, but remarked the BCLB was inaccessible because the bar was in the way. He stated he could pull the string with ease. Interview on 10/4/2024 at 1:13 PM with the MDSC revealed he was unaware the metal handrails could have impeded a resident's ability to call for help from in the bathroom. The MDSC, having then known about the positioning of the call light box and the metal handrail, stated the call light box was in a bad position on the wall. He stated the position of the metal handrail, which covered the BCLB, was in the most effective placement for the resident safety. The call light systems, in those isolated bathrooms, had not provided their intended function. Resident might not have been able to call from help. The MDSC stated there was a plan in place to address the remaining 8 resident rooms affected. Interview on 10/4/2024 at 1:30 PM with the ADM revealed the handrails, originally having blocked 10 resident BCLBs (corrected having left only 8) were already affixed to the wall when the new the call light system was replaced in 2022. Two had been corrected, that left 8 resident rooms. The old call lights were like a light switch on a wall and a split ring, like that on your car keys, led a string to the floor. The new call light system, with the BCLS and the BCLB, were installed by their local building safety company at the existing power source location on the bathroom wall, behind the metal handrail. The local building safety company did not bring the affected rooms to the attention of the facility administrator. He had never had a complaint from a resident, a health survey, or a LSC survey. The Angel Round checklist, created by the administrator, did not provide the staff instruction to check the resident's bathroom, but the checklist was meant for the staff to check the call button, which protruded from the wall on a long cord. The affected resident rooms, which were 10 then 8, were not viewed as a physical environment problem. The call light box was there and there was a BCLS. The Administrator thought the functionality of the call light system was adequate and the residents simply had the option to push the BCLB or pull the BCLS. Any reason to change the configuration would have been made as a case-by-case basis for the resident. There was no confirmation, from the ADM, of any resident assessment to have ascertained the unincumbered use of the BCLB or BCLS. Even though the ADM stated the change would have only been made on a case by case basis, the facility had already begun to fix the configuration so residents could use both the BCLB and the BCLS. Record review of the facility's Angel Round Checklist, undated, reflected a line item. The line item indicated to make sure the call light was within reach, untangled, with clip present. Record review of the facility's Call Light Policy, dated December 2009, reflected a resident who had disabilities that make use of the facility's communication system inaccessible, alternative auxiliary aids, or services are provided to meet the resident's needs as identified in the resident's assessment or the plan of care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675144	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burleson Nursing and Rehabilitation Center	600 Maple St 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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of U.S. Access Board, Guide to the ADA Accessibility Standards, Chapter 6: Toilet Rooms (access/board.gov), viewed on 10/5/2024, indicated side grab bars for toilet rooms must be 33 inches to 36 inches at the top of the gripping surface. Any projecting object must be located at least 12 inches above and at least 1.5 inches from the bottom, and ends, of grab bars, so that the reach and use of grab bars was not impeded. The 1.5-inch clearance between the grab bar and wall was not a minimum but an absolute dimension to prevent entrapment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675144	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burleson Nursing and Rehabilitation Center	600 Maple St 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47772 Based on observations, interviews, and record review, the facility failed to provide a safe, clean, comfortable, and homelike environment for the 1 of 15 residents (Resident #12) reviewed for a safe and comfortable environment. The facility failed to report maintenance issues to the MNTD and make repairs to a broken toilet seat in Resident #1's bathroom. This failure could have placed the residents at risk of falling from skin breakdown or falling from the toilet. Findings Included: Record review of Resident #1's FS, downloaded from the Matrix on 10/4/2024, reflected a [AGE] year/old woman, born on 5/10/1951, who's admittance date to the facility was on 7/16/2024. She was diagnosed with dementia (which was a disease that affected memory, thought, and interfered with daily life.) Record review of Resident #1's Admission MDS, dated [DATE], reflected the resident had a BIMS Score of 9. A BIMS Score of 9 indicated the resident had moderate cognitive impairment. The resident had no impairment in either upper extremity (shoulder, elbow, wrist, and hand). The resident had impairment on one side of their lower extremities (hip, knee, ankle, and foot). The resident was occasionally incontinent of bladder. The resident was always continent of bowel. Record review of Resident #1's CP reflected an area of Problem area for ADL Functions, started on 7/25/2024 evidenced by toileting, with the assist of 1 person. The Goal stated the resident would not develop skin breakdown related to incontinence. The Approach, started on 7/25/2024, delegated nursing home staff to assist to toilet as needed. Interview and observation on 10/1/2024 at 10:15 AM in the room of Resident #1 revealed her in her room, on the bed. The room was clean, free from clutter, no odors of bowel or urine. Resident alert; orientated to the day and date; current president. Resident #1 complained about the toilet lid, and that it had broken in August, and it took about a week to fix. It was fixed up until a week ago, 9/22/2024, when it became loose; it came off for good 2 days ago, 9/29/2024. The toilet seat was observed removed and resting up against the wall under the bathroom sink. The back of Resident #1's toilet, where the seat was supposed to have been attached, had two grey protruding plastic attachments (male connectors), which were about 1/2 inch high and the diameter of a quarter. The loose toilet seat had two connections on its underside (female connectors) underneath the spot where a sitting resident's upper buttock would have been. Having used to toilet in its current state of repair, use caused discomfort on her upper left and right buttock area. She stated she told her nurse about the broken seat. The nurse stated she would put in a work order. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675144	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burleson Nursing and Rehabilitation Center	600 Maple St 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/1/2024 at 11:25 AM with LVN C revealed staff were able to submit work orders for broken items through the maintenance QR code submittal process. Staff simply scanned a QR code (a small picture on a piece of paper made up of dots and dashed, shaped like a square, that directed the user to a centralized computer program) at the nurse's station and wrote a description of the broken item. The MNTD received the alerts . Interview and observation on 10/1/2024 at 1:04 PM with the MNTD revealed there was a QR code system, with TELS (an internet based technology for building maintenance records) to report maintenance issues. The staff scanned a QR code, located at the nurse's station, and described the error by having written a brief description. The MNTD read the workorder on the computer and fixed the issue; safety repairs took priority. Observation at the nurse's station revealed an 8 inch by 10 inch piece of paper with a maintenance request QR code. The MNTD printed out the work orders that were made, or in progress. Record review of list did not reveal a work order had been entered for the broken toilet seat in Resident #1's bathroom. The MNTD stated management, and department heads, conducted daily rounds of the facility and rooms, to identify maintenance needs. The process was called Angel Rounds (management room visits to check their condition.) Interview on 10/1/2024 at 1:21 PM with the ADM revealed each Angel Round covered a specific area of the facility. Angel Round checklists were kept on file if they contained information on needed repairs. The ADM stated the ADON was assigned the specific area. Upon request, the ADM was not able to produce a completed Angel Round checklists. Interview and observations on 10/1/2024 at 1:29 PM with the ADON revealed she was a staff member who performed Angel Rounds at the facility. Observations revealed the ADON walking with this state investigator and pointing out the rooms she checked. The ADON pointed at Resident #1's Room. She did not perform Angel Rounds today, 10/1/2024, yesterday, 9/30/2024, and did not recall further. The ADON stated she utilized the Angel Rounds Checklist the last time she performed Angel Rounds, which was sometime last week. She put the Angel Round Checklist on the ADM's desk . Observations on 10/1/2024 at 1:53 PM revealed Resident #1's toilet lid still broken off. Interview and observation on 10/1/2024 at 8:00 PM with Resident #1 revealed she told staff earlier in the day, 10/1/2024, about the toilet seat and it was fixed. Observations revealed the toilet seat was connected to the toilet. She was happy and stated the plastic pieces that stuck up from the toilet were not pressing up against her skin like before. Interview on 10/4/21024 with the ADM at 2:20 PM revealed the facility used a QR code to report maintenance issues to the MNTD. He expected his staff to report the work, per policy, so the MNTD could make the repair. A system in place to catch maintenance issues was Anger Rounds, which specifically talked about the toilet functioning correctly. He was not aware that the resident had experienced discomfort while having utilized the toilet, due to the 1/2 inch raised; quarter in diameter raised plastic attachments pressing into her skin. The failure to identify the broken toilet seat fell upon the ADM for not following up and having ensured the Angel Rounds were performed correctly . Record review of the facility's Maintenance Service Policy, dated November 2021, reflected the MNTD was responsible for having maintained the building, the grounds, and equipment in a safe and operable manner at all times. Functions of maintenance personnel included having maintained plumbing fixtures. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675144	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burleson Nursing and Rehabilitation Center	600 Maple St 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Direct Supply's TELS work order list, dated 10/1/2024 and signed by the MNTD, reflected open and in-progress work orders. Review of the work order list did not reveal a work order for Resident #1's toilet seat repair. Record review of the facility's Angel Round's Checklist, undated, indicated staff were supposed to check for sink and toilets to have been in good repair.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675144	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burleson Nursing and Rehabilitation Center	600 Maple St Burleson, TX 76028

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47772 Based on observations, interviews, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible for the facility's only kitchen reviewed for accidents and hazards. The facility failed to take temperatures of soup during meal service, which resulted with soup being served at 180 degrees. This failure could have placed residents at risk of being burned. Findings included: Record review of Resident #11's FS, downloaded from the Matrix on 10/4/2024, reflected a [AGE] year-old man, born on 09/23/1970, who's admittance date to the facility was on 05/31/2023. He was diagnosed with quadriplegia (which meant paralyzed from the neck down). Record review of Resident #11's Significant Event (Discharge) MDS, dated [DATE], reflected the resident had a BIMS Score of 14. A BIMS Score of 14 indicated the resident had no cognitive impairment. The resident was dependent for eating, which meant the helper provided all the effort of the activity. Interview on 10/1/2024 at 3:55 PM with Resident #11 revealed the food, served from the facility's only kitchen, had a chemical taste. He was worried other residents at the facility tasted it too but were not willing to say anything. Observation and interview on 10/2/2024 at 11:38 AM reflected the facility served Cream of Mushroom soup, as part of a state surveyor requested lunch test tray. The state surveyor was provided with a test tray at 11:38 AM from the facility's only kitchen. Some residents were observed having had soup on their trays, but soup was not provided on the state surveyor requested lunch test tray. A soup was requested from the kitchen, which was poured in a thermal bowl, immediately and directly from the kitchen's steamtable. The thermal bowl was an insulated serving dish meant to keep food warm longer and prevent fast cooling. The steamtable was a metal food serving apparatus designed to use water, and steam, to warm food from underneath to keep food at the minimum temperature of 135 degrees. Having received the Cream of Mushroom Soup, after the meal service and plating had already begun, it was evaluated for temperature. The temperature of the Cream of Mushroom soup was taken at 11:38 AM, with the use of a state issued thermometer, model TP301. The internal temperature of the Cream of Mushroom soup was 180 degrees. The Cream of Mushroom Soup was tasted for patentability, which resulted extreme heat and having burned this state investigators mouth and lips. The facility's SPT had been standing in proximity of the state surveyor having evaluated the lunch tray for temperature. The SPT observed the thermometer's results of 180 degrees and stated 180-degree soup could have burned a resident's tongue, roof of mouth, or cheeks. Interview with the KM, ADM, and the MDSC revealed the soup was 180 degrees. The further delivery of the soup stopped at that moment. The ADM and the MDSC were observed immediately having searched the dining room for effected residents in the facility. The KM stated she checked the temperature of the soup, on the steam table, prior to food service, and the temperature was 172 degrees. Of the foods tasted on the state surveyor test tray, none of the food had a chemical taste. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675144	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burleson Nursing and Rehabilitation Center	600 Maple St Burleson, TX 76028

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations and interview on 10/2/2024 from 11:43 AM reflected the originally served Cream of Mushroom Soup was 160 degrees, interview with the SPT stated 160 degrees could have still caused burns to the mouth; 11:52 AM revealed the soup was 146 degrees; 11:54 AM revealed the soup was 145 degrees; 11:59 AM revealed the soup was 130 degrees. Observation on 10/2/2024 at 12:05 PM observed Resident #9 having requested soup, towards the end of the meal service; observed soup being served. Overheard the resident state the soup was not too hot. Interview on 10/2/2024 at 12:30 PM with KM revealed she, and her staff, immediately stopped serving the soup at 11:38 AM. She stated she added heavy whipping cream, and it had a temperature of 160 degrees at 11:43, but still had not served any more. She stated she continued to add heavy whipping cream until the soup had lowered to a temperature at 140 degrees. Interview and record review on 10/2/2024 at 12:45 PM with the KM revealed the facility had utilized the dial thermometers, which were not instant result thermometers; furthermore, the KM stated she did not wait the entire time to see the true temperature of the soup. She stated she removed the thermometer from the Cream of Mushroom soup, when the dial on the dial thermometer started to slow down, having suggested the soup may have been hotter than 172 degrees. The facility's food temperature chart, for the date of 10/2/2024, indicated the soup temperature was 172 degrees. Interview and record review on 10/2/2024 at 3:00 PM with the ADM revealed he performed a resident safety survey of the census of residents, which was 62 residents. The safe surveys, dated 10/2/2024, reflected the questions: 1. Was the soup at lunch today too hot for you? 2. Did you spill the soup from lunch on you today? * If either question was answered [yes,] resident would have been assessed by a nurse. Review of the safe surveys resulted in 20 residents having received soup on their lunch tray. Of the 20 safe surveys, no resident responded with a [yes] response. Only one resident, Resident #9, responded with a response other than [no.]: Question: Was the soup at lunch today too hot for you? Response: [No. It was warm, real warm but not too hot. It was good.] Question: Did you spill the soup from lunch on you today? Response: [No. I did not.] Observation and interview on 10/2/2024 at 4:55 PM with the KM manager revealed potato soup, sandwiches, and goulash (mixture of beef and macaroni) were being served for dinner. The KM sated the potato soup was cooked on the stove to an internal temperature of 170 degrees. The soup was poured into small sized individual thermal bowls, and she was instructed to monitor and not to serve any soup until it had an internal temperature of 140 degrees. Temperature observations taken, with the facility's own thermometer, of the sandwiches and goulash on the steam table were 145 degrees and 155 degrees, respectively. The steam table had three sections, each controlled by its own low, medium, and elevated temperature dial. A temperature was taken, with the state issued thermometer (sanitized) on an unused [NAME] on the steam table, set at the highest level. The temperature of the water, which produced steam, was 183 degrees. A soup was requested for evaluation at the beginning of meal service. The soup had the temperature taken at 5:05 PM, which resulted in 138 degrees. The soup was tasted for palatability, which resulted with an easily consumable temperature. Interview on 10/4/2024 at 3:26 with the ADON revealed there were parameters for the temperature for safe consumption of foods and beverages. 180-degree liquids consumed would result in burns to the mouth, tongue, and cheeks. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675144	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burleson Nursing and Rehabilitation Center	600 Maple St Burleson, TX 76028

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and record review on 10/4/2024 at 3:58 PM with the KM revealed the kitchen made sure the steam tables were set to an appropriate temperature and hot foods were not served too hot. She stated they took the temperatures about 10 minutes before meal service started and only checked the temperature the one time. If a resident would have asked for a food item after meal service began, it would have been served but the temperature would not have been taken again. If a resident consumed soup at 180 degrees, it could have scalded the mouth, lips, and tongue. The KM stated the kitchen staff should have checked the food's temperatures more than once during meal service, and thought the steam table, set on high, may have contributed to the 180-degree soup. Record review of the facility's food temperature chart reflected a spot for two annotations of the meals' temperatures. Interview and record review on 10/4/2024 at 4:25 PM with the ADM revealed the facility did not have a policy that indicated food's maximum levels of temperature. The facility's food temperature chart indicated optimum temperatures for entrees was 160-175 degrees. The facility's Food Holding and Service Policy, dated 2018, indicated food should be served at least 135 degrees or greater; adjust the temperature to account for the time the food would have been held prior to the service on the steam table and on the tray carts; take and record temperatures of all hot foods at the beginning, middle, and end of tray service. The ADM expected his dietary manager to follow policy and check the temperatures at the beginning, middle, and the end. A safeguard in place to prevent food from being served too hot was the policy and checks that were supposed to have occurred prior to food having been served. The failure of the facility's only kitchen to prevent service of food out of temperature range, was the kitchen having not checked a state surveyor test tray item like they would have for a resident. Record review of the facility's Hot Beverage Policy, undated, reflected hot beverages should have been served at appropriate temperatures to maintain palatability and reduce the risk of burns. The serving temperature of hot coffee was supposed to be 140 degrees or less. Coffee temperatures were supposed to be monitored to promote resident safety. Record review of the facility's Safety of Hot Liquids Policy, dated October 2021, reflected the potential from burns from hot liquids was considered an ongoing concern among residents with weakened motor skills, balance issues, impaired cognition, and nerve or musculoskeletal conditions. Residents with these, or other conditions, may have suffered from accidental burns and related complications stemming from thinner, more fragile skin, which may burn quickly and severely, and take longer to heal. Record review of the facility's incident and accident list, dated 8/1/2024 to 10/2/2024, did not result in the discovery of residents having been injured due to burns from hot coffee or hot food.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675144	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burleson Nursing and Rehabilitation Center	600 Maple St 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47772 Based on observations, interviews, and record review the facility failed to store, prepare, and distribute food in accordance with professional standards for food service safely for 3 of 11 residents (Resident #2, Resident #4, and Resident #5) reviewed for dietary services. The facility failed to ensure staff cleaned, or sanitized, their hands prior to meal service delivery. This failure could have placed residents at risk of the spread of infection. Findings included: Resident #2 Record review of Resident #2's FS, downloaded from the Matrix on 10/4/2024, reflected a [AGE] year-old woman, born on 9/14/1949, who's admittance date to the facility was on 4/28/2024. She was diagnosed with major depression (which was a mental condition characterized by depressed mood, loss of pleasure, or interest in life.) Record review of Resident #2's Quarterly MDS, dated [DATE], reflected the resident had a BIMS Score of 14. A BIMS Score of 14 indicated the resident had no cognitive impairment. The resident was independent with eating, which meant the resident completed the activity by herself. Record review of Resident #2's order summary report, downloaded from the Matrix on 10/4/2024, reflected an order, on 7/26/2024, for a regular diet. Record review of Resident #2's CP reflected an area of Problem area for weight loss, started on 8/14/2024, evidenced by refusal of breakfast. The Goal stated the resident would not have significant weight loss. The Approach, started on 8/14/2024, delegated nursing home staff to provide the resident a regular diet. Resident #4 Record review of Resident #4's FS, downloaded from the Matrix on 10/4/2024, reflected a [AGE] year-old woman, born on 3/08/1957, who's admittance date to the facility was on 05/11/2024. She was diagnosed with major depression (which was a mental condition characterized by depressed mood, loss of pleasure, or interest in life.) Record review of Resident #4's Quarterly MDS, dated [DATE] reflected the resident had a BIMS Score of 12. A BIMS Score of 12 indicated the resident had moderate cognitive impairment. The resident was independent with eating, which meant the resident completed the activity by herself. Record review of Resident #4's order summary report, downloaded from the Matrix on 10/4/2024, reflected an order, on 7/11/2024, for a low sodium/regular diet. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675144	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burleson Nursing and Rehabilitation Center	600 Maple St 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #4's CP reflected an area of Problem area for weight loss, started on 8/27/2024, evidenced by her ordered diet. The Goal stated the resident would not have significant weight loss. The Approach, started on 8/27/2024, delegated nursing home staff to provide the resident diet as ordered. Resident #5 Record review of Resident #5's FS, downloaded from the Matrix on 10/4/2024, reflected a [AGE] year-old man, born on 1/05/1963, who's admittance date to the facility was on 2/10/2024. He was diagnosed with Schizophrenia (which was a severe mental disorder having caused hallucination, delusions, and disorganized speech.) Record review of Resident #5's Quarterly MDS, dated [DATE], reflected the resident had a BIMS Score of 10. A BIMS Score of 10 indicated the resident had moderate cognitive impairment. The resident was independent with eating, which meant the resident completed the activity by himself. Record review of Resident #5's order summary report, downloaded from the Matrix on 10/4/2024, reflected an order, on 3/20/2024, for a regular diet. Record review of Resident #5's CP reflected an area of Problem area for failure to thrive, started on 9/20/2024, evidenced by medical diagnosis. The Goal stated the resident would not have exhibit signs of malnutrition. The Approach, started on 9/20/2024, delegated nursing home staff to provide the resident diet as ordered and provide selective menu. Observation on 10/4/2024 at 11:10 AM revealed CNA A having delivered food service tray to Resident #2. She was observed having taken a food tray from the service cart and having entered Resident #2's room without having sanitized her hands. She was observed exiting the resident's room without the lunch tray and did not sanitize her hands. Observation on 10/4/2024 at 11:15 AM revealed CNA A having delivered food service tray to Resident #4. She was observed having taken a food tray from the service cart and having entered Resident #4's room without having sanitized her hands. She was observed exiting the resident's room without the lunch tray and did not sanitize her hands. Observation on 10/4/2024 at 11:18 AM revealed CNA A having delivered food service tray to Resident #5. She was observed having taken a food tray from the service cart and having entered Resident #5's room without having sanitized her hands. She was observed exiting the resident's room without the lunch tray and did not sanitize her hands. Observation and interview on 10/4/2024 at 11:19 AM revealed the MDSC having approached CNA A and having held his face close to her ear. Interview with CNA A revealed the MNDSC reminded her to sanitize her hands before she served a lunch tray. She stated she had not sanitized her hands before she served the three residents listed above. She stated she was trained to sanitize her hands before each meal tray service but did not sanitize her hands until reminded by the MDSC . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675144	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burleson Nursing and Rehabilitation Center	600 Maple St 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 10/4/2024 at 3:05 PM with the ADON revealed staff were supposed to sanitize their hands prior to delivering the resident food to reduce the spread of infection. Hand sanitizing was part of the facility policy. Staff were trained to know how to sanitize their hands. They used the hand washing skill check trainable item on the CNA competency check off sheet. A negative result of a resident ingesting germs could be an illness, having to unnecessarily take medications, or go to the hospital. A safeguard in place to make sure staff were sanitizing their hands in between each meal tray delivery was continued education and on-the-spot corrections. The failure for staff to sanitize their hands prior to serving meals trays falls on management. Interview on 10/4/2024 at 4:19 PM with the ADM revealed staff were trained, per facility policy, to sanitize hands prior to delivering residents their meal trays. Sanitizer dispensers were attached to the walls throughout the facility. The failure to meet the standard of infection control fell upon human error and honest mistakes. Upon request, the ADM was unable to present a policy that addressed hand sanitizing prior to each meal tray delivery . Record review of the facility's Handwashing/Hand Hygiene Policy, undated, reflected all personnel were supposed to follow hand washing and hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Staff were supposed to apply generous amounts of alcohol-based hand sanitizers to the palm of hand and rub together cover all surfaces of hands and fingers until hands were dry. Record review of the 2022 Food Code, Section 2-301; Hands and Arms. Food employees were supposed to keep their hands clean. Employees were supposed to clean their hands immediately before engaging in food preparation, including working with exposed food, clean equipment and utensils, and unwrapped single service and single use articles.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675144	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burleson Nursing and Rehabilitation Center	600 Maple St 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 - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47772 Based on observations, interviews, and record review, the facility failed to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections 1 of 1 facility reviewed for infection control. 1. The facility failed to keep stored linens covered. 2. The facility failed to follow EBP (Enhanced Barrier Precaution was an infection control intervention designed to reduce transmission of MDRO that employed targeted gown and glove use during high contact resident care activity) while having provided direct care for Resident #12. This failure could place resident at risk of infection transmission. Findings included: Linens Observation on 10/1/2024 at 6:57 PM revealed a small laundry cart in a facility hallway. The cart had two shelf levels and was made of plastic pipe. The laundry cart had blue meshing that covered the rear, the top, the left, and the right side. The piece of the blue meshing, designed to cover the front of the cart, was folded backwards over the top of the laundry cart. The front opening of the laundry cart was not covered, having exposed the stored linens, towels, and a box of open rubber gloves (size large) to dust, or other soiling agents. Facing the cart, exposed items were brown and blue towels on the lower left, white towels on the lower right, white towels, and white sheets on the upper left, and white linens and a box of open rubber gloves on the upper right. Resident #12 Record review of Resident #12's FS, downloaded from the Matrix on 10/4/2024, reflected an [AGE] year-old man, born on 6/20/1941, who's admittance date to the facility was on 2/10/2024. He was diagnosed with peripheral vascular disease (which was a disease that cause problems with the circulatory function in the extremities) and a bacterial infection. Record review of Resident #12's Quarterly MDS, dated [DATE] reflected the resident had a BIMS Score of 9. A BIMS Score of 9 indicated the resident had moderate cognitive impairment. Record review of Resident #12's order summary report, downloaded from the Matrix on 10/4/2024, reflected an order, on 7/23/2024, for EBP. The resident was ordered Cefepime Reconstitution Solution (antibiotic,) intravenous (inserted into a vein,) starting on 9/17/2024 till 10/4/2024. The resident was ordered Daptomycin (antibiotic,) intravenous starting on 9/13/2024 till 10/3/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675144	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burleson Nursing and Rehabilitation Center	600 Maple St 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 - Some	Record review of Resident #12's CP reflected an area of Problem area for [General], started on 8/20/2024, evidenced by precautions for MDRO acquisition from wound. The Goal stated the resident would not exhibit signs of MDRO. The Approach, started on 8/20/2024, delegated nursing home post a sign on door referring to see a nurse before entering; Staff will wear PPE during high contact activities such as dressing, bathing/showing, transferring, providing hygiene, changing lines, incontinent care, wound care, and device care or use (central line.) Interview and observation on 10/1/2024 at 7:47 PM with Resident #12 revealed an EBP sign on his door. An EBP sign warned staff, and visitors, that the resident required targeted gown and glove use during high contact resident care activity. Resident #12 was in his bed resting comfortably, his head, at the 12 o'clock position, the bed was at a 60-degree angle. The resident had intravenous drugs through a connect line on his right arm, at the 9 o'clock position. During interview, he stated he was hungry and called the nurse's station for a snack. LVN A came to his room, where she was asked for a snack. She was observed leaving to retrieve Resident #12 a snack. Upon her return, she conversed with the resident about how he was doing. She was not wearing gloves; she was observed opening his snack and touching his tray top table. He voiced difficulty with having had enough slack on his call light button cord fully extend to reach his left hand, to the 3 o'clock position. LVN A was observed standing at his right side, at the 10 o'clock position, and was observed, with her bare hands, taking the resident's call light button cord from his left hand. She pulled the resident's covers down from his right midsection to his waist. With both hands, she was observed having attempted to untangle the call light button cord from being looped around the resident' right side support rail. In doing so, LVN A touched the resident's right arm, to get him to raise it. She had to untangle the residents call light button cord from his intravenous antibiotic line. She had to move the intravenous line with her bare hands, reverse loop the call light button cord for its entanglement, and then return the call light button cord to the residents left hand. Once completed the touched the resident's right arm to let him know he could lower it. She moved the resident's covers back to his right-side mid-section. LVN A was observed touching her face after the resident care was provided. Gloves and Protective gear were located outside of the resident's door. Interview on 10/2/2024 at 10:05 AM with LVN B revealed Resident #12 required EBP while having provided resident care in his room. He required EBP because he had an intravenous antibiotics and received wound care on his feet. Having described the observations from 10/1/2024 at 7:47 to LVN B, she stated LNN A staff should have used gloves and PPE to provide the described care. EBP was an intervention used to prevent infections, and keep any present infections at bay or, from worsening. Interview on 10/04/2024 at 3:26 PM with the ADON revealed the facility had a policy in place to address the requirements for residents with EBP and how to safely store linens. Residents on EBP had a sign on the door, to signify the resident had an order for EBP. The facility staff practiced EBP because those residents, who required EBP, were more susceptible to infections and their health could become compromised. In addition to the sign on their door, gowns, gloves, and face shields were available on the floor. As far as linens, the linen carts were supposed to be covered to protect them from dirt and germs. The failure for staff to follow EBP procedures and keep linens protected from dirt and germs fell upon staff oversight and the need for continued education . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675144	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burleson Nursing and Rehabilitation Center	600 Maple St 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 - Some	Interview on 10/4/2024 at 4:19 PM with the ADM revealed staff were trained per facility policy for EBP and safe storage of linens. Residents who required EBP had a sign on the door to say what level of PPE to use for what type of care and contact provided. The intent of the EBP was to stop the spread of infection and the intent of the policy for linens was to make sure they stayed clean. The failure to meet the standard of infection control fell upon human error and honest mistakes. Record review of a Center for Disease Control and Prevention certificate, dated 11/20/2023, indicated the ADM successfully completed the Nursing Home Infection Preventionist Training Course. Record review of the facility's Enhanced Barrier Precautions Policy, undated, indicated an order for EBP would have been obtained for residents with wounds and indwelling medical devices, such as central lines. Enhanced Barrier Precaution was an infection control intervention designed to reduce transmission of MDRO that employed targeted gown and glove use during high contact resident care activity. High-contact resident care activities included device care, or use of central lines. Record review of the facility's Soiled and Bedding Policy, dated April 2020, reflected clean linens were supposed to be protected from dust and soiling during storage to ensure cleanliness.