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	08/15/2024

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28637 Based on interviews and record review, the facility failed to ensure each resident had the right to make choices about aspects of his or her life in the facility that were significant to the resident for 1 of 8 residents (Resident #18) reviewed for self-determination. The facility failed to ensure Resident #18 received a bed bath as scheduled and upon request and failed to assist her out of bed when she requested to attend a Resident Council meeting. This failure could place residents at risk for being denied the opportunity to exercise his or her autonomy regarding things that are import in their life and decrease their quality of life. Findings included: Record review of Resident #18's Face Sheet dated 8/14/24 revealed she was a [AGE] year-old female readmitted to the facility on [DATE]. Record review of Resident #18's Quarterly MDS assessment dated [DATE] revealed she had a BIMS score of 15 indicating she was cognitively intact. She was completely dependent on staff for bed to chair transfers and required maximal assistance for bathing. Her diagnoses included hypertension (high blood pressure), diabetes, anxiety and depression. Record review of Resident #18's Care Plan revealed an entry dated 7/8/24 that reflected: she required extensive assistance with 2 people for transfers, and extensive assistance by 1 person for personal hygiene. Goal: Will maintain a sense of dignity by being clean, dry, odor free and well-groomed over next 90 days. Approaches included, .2) Staff will give -shower, shave, oral, hair, nail care per schedule and prn . 3) Assist with dress according to climate, monitor appearance .5) Assist with transfer as needed . (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: 675144	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2024

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Burleson Nursing and Rehabilitation Center	600 Maple St 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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 8/13/24 (Tuesday) at 12:35 PM, Resident #18 was observed sitting up in her bed eating lunch. Resident #18 stated she sometimes felt like staff did not want to do their jobs. She stated, This last Saturday (08/10/24) I asked for a bed bath 4 times. The first time she said, 'Oh ok, let me finish with this other person and I'll be right back' and she never came. I called again, she said, 'Oh ok, I'll be right back'. It happened 4 times then she left. The last call was around 10:00 PM. The night aide came and said, 'we don't do baths at night' and left. Resident #18 stated she had an outing planned with her family the next day and really wanted to be bathed before she left. She stated it took a while on Sunday, but they finally bathed her before she left. She stated her bath days were Tuesday, Thursday, and Saturday in the evening. She was unable to recall the name of the Aide. Resident #18 stated, This past Tuesday, they came around and informed me there was a Resident meeting at l1:00 AM. I told the Aide at 10:00 AM I wanted to go. I missed the last meeting because I couldn't get help. I waited and called; they never got me up. I just watched the clock, 11:00, 11:15, 11:30-nothing. I want to tell them not to even tell me they are happening if I can't go. What's the point in telling me if you won't help me get up and go? It made me feel like I'm not worth it, like I'm not worth their time. Why even tell me if you won't get me up? Resident #18 stated she required a mechanical lift for transfers to her chair as she was unable to use her legs. Resident #18 stated she had complained to facility management about the incidents and thought she had told the DON. She did not know whether they had addressed her issue. In an interview on 8/14/24 at 1:07 PM, CNA A stated she had worked the 6:00 AM to 2:00 PM shift and had worked at the facility for two months. She stated she regularly worked with Resident #18 and had worked the previous week. CNA A stated she did not recall Resident #18 asking to get up for the Resident Council meeting or being asked to get her up. She stated Resident #18 usually wanted to get up after lunch for therapy. In an interview on 8/15/24 at 7:45 AM, Resident #18 stated she had not heard anymore from facility management and had also missed her scheduled bath on 8/13/24. She stated she had not received a bath since Sunday, 8/11/24. She stated she asked the Aide twice on 8/13/24 for her bath and was told she did not have enough help and was working two halls that day. She could not recall the name of the aide. She stated she was not offered a bath on 8/14/24 either. Resident #18 stated she prefers evening baths because she gets up daily for rehab after lunch and that takes a while. She stated, I guess we'll see if I get one tonight. She stated she has had so many problems and just wanted them addressed. In an interview on 8/15/24 at 8:03 AM, CNA B stated she cared for Resident #18 and had been assigned to her hall on 8/13/24. She stated she knew Resident #18 got up after lunch for rehab and was due for a bath that evening. When asked about her scheduled bath for Tuesday 8/13/24, CNA B stated she did not know why she did not do it. She stated they were down an aide that evening, but she should have done it. She stated they usually had enough staff to care for the residents and even had shower aides most of the time. She stated the risk for not getting bathed was you don't feel very good if you're not clean. CNA B did not recall whether she worked with Resident #18 the day of the last Resident Council meeting but stated residents had a right to get up whenever they wanted. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675144	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2024
NAME OF PROVIDER OR SUPPLIER Burleson Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 600 Maple St 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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/15/24 at 8:42 AM, the Activity Director stated she had worked at the facility for 3 years but had just taken over as the Activity Director on 8/1/24. She stated there was a Resident Council meeting on 8/9/24. She stated she lets all the residents know on the day before and the day of Resident Council meetings by going room to room and handing out a paper letting them know the date and time of the meeting. She stated, if a resident was dependent and said they wanted to go, she would check with them and let the nursing staff know they would need assistance. She stated she would verbally alert the staff and offer to assist with resident transfers because she was a CNA and could help. She stated she also placed a paper with a list of dependent residents who expressed interest in attending the Resident Council meetings in a binder at the nurse's station that contained the staff schedule. The Activity Director stated she recalled telling Resident #18 about the meeting on 8/9/24 and recalled her saying she wanted to get up and go. The Activity Director stated she recalled making an aide aware but could not recall the name of the aide. She stated she did not assist with transfers that day because the meeting was in the morning and there was little time. She stated she noticed Resident #18 was not at the meeting but did not know what had happened. She stated residents often changed their minds about attending at the time of the meeting. She stated she thought she recalled Resident #18 complaining about missing the meeting and believed she had reported it to the Administrator but was not certain. She stated Resident #18 was the only one unable to attend that day. She stated the risk of failing to assist residents to meetings or other activities was emotional distress. She stated, If no one will get them up when they want to, can make them feel like, 'is it me, is it the staff?', if you don't communicate, they can think anything. The Activity Director stated she usually kept a copy of the lists provided and would look for the list used for the last Resident Council meeting. No list was located prior to the exit conference. In an interview on 8/15/24 at 9:30 AM, the ADON stated she had worked on 8/11/24 and recalled Resident #18 complaining that she had missed her bath on 8/10/24. She stated Resident #18 was upset because she had family coming and wanted her bath. She stated the aide was CNA C who told her Resident #18 had refused her bath 8/10/24. The ADON stated she did not follow up with Resident #18 to ask if she had, in fact, refused her bath because she was upset and they took care of her bath for her. She stated she had completed a grievance form on the matter. The ADON stated CNA C had resigned and no longer worked for the facility. She was not aware Resident #18 also missed her bath on 8/13/24 or the previous Resident Council meeting. The ADON stated risks for residents missing baths and activities included social and skin breakdowns, mental health decline and a spectrum of breakdowns. During an interview on 8/15/24 at 10:26 AM, the DON stated they had received complaints about missed baths and showers over a month ago and had added a shower aide to the schedule to assist with completions. She stated the shower aides provided a list at the end of the day of completed showers they were using to track. She stated the shower aides did not provide bed baths, but the assigned CNAs completed them . The DON stated she had heard from the ADON that Resident #18 had missed a bath over the weekend and the ADON had taken care of it. She stated Resident #18 had her and the Administrator's personal phone numbers to call if she had any concerns. She stated she was unaware Resident #18 had missed her bath again on 8/13/24. The DON stated they did have a shower aide that day but had to suspend her and send her home when they received a complaint about her which may have contributed to the situation. She checked her phone and stated she had not received any complaints. The DON stated she did not know about Resident #18 missing the Resident Council meeting the previous week. She stated Resident #18 had a history of not wanting to get out of bed and they had had a meeting with her about it, so she was disappointed to hear they did not get her up when she wanted to. She stated the risk of not getting residents bathed or out of bed as desired was it could diminish their dignity. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Burleson Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 600 Maple St 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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/15/24 at 12:14 PM, LVN D stated she worked the 6:00 AM to 2:00 PM shift and regularly cared for Resident #18. She stated she recalled the resident complaining to her after she missed the last Resident Council meeting. She stated she had complained after the fact. LVN D stated she was aware of the list provided by the Activity Director of residents who needed assistance to go to an activity and checked it daily. She could not recall whether she had noted Resident #18's name on the list for that day. LVN D stated she would typically assist with transferring residents out of bed when needed. She stated she attempted to find the aide to determine why she had not gotten her out of bed but did not recall who the aide was or what she was told on that day. LVN D stated Resident #18 had complained to her previously about missing baths but could not recall when it was but stated it had not been the current week. She stated Resident #18 received her baths on the evening shift. She stated the nurses were responsible for ensuring the baths were completed and were told in report when they were completed. She stated she had not heard anything about her missing any baths that week. She stated the risk to residents when not receiving baths or transfers as requested included pressure ulcers, poor hygiene, not having their voices heard, and depression. On 8/15/24 at 3:24 PM, an attempt to reach CNA C via telephone was unsuccessful. A voicemail message was left. No return call was received prior to facility exit. In an interview on 8/15/24 at 3:42 PM, LVN E stated she worked the 2:00 PM to 10:00 PM shift and regularly cared for Resident #18. She stated Resident #18 usually received bed baths on her shift and the aides reported to her when the baths were given. She stated her last bath should have been this week and she was not aware Resident #18 had missed her scheduled bath on 8/13/24. She stated Resident #18 did not complain to her about it. She denied asking her or the aide whether her bath had been done. LVN E stated the risk of missing baths was loss of dignity. LVN E stated she, herself, would not want to be around anyone if she missed a shower. She stated this was the resident's home and they deserved good treatment. During an interview on 8/15/24 at 3:48 PM, the Administrator stated he was very familiar with Resident #18, and she had his cellphone number to call or text with any complaints. He checked his phone and stated the last call he received had been in July and was related to staff taking too long to answer her call light. He stated he was away from the facility at that time but sent a staff member to check on her and had re-educated the staff about customer service after the incident. He stated she had made him aware of missing the Resident Council meeting. He stated he had been assisting another facility that day and came back and made evening rounds which was when she told him. He stated he told her he would personally ensure it did not happen again and would transfer her himself if needed. The Administrator stated he was not aware that had been the second time it had happened. He stated he did not know about the missed baths that had occurred on Saturday or Tuesday. The Administrator stated the risks to residents in these instances included decreased emotional status and pressure sores. He stated they generally followed up on resident complaints during QA meetings. He stated, with Resident #18, they were focused on ensuring she had been getting up for therapy, which had improved. Record review of the facility's policy titled, Resident Self Determination and Participation dated, Revised February 2021 reflected: Policy Statement: Our facility respects and promotes the right of each resident to exercise his or her autonomy regarding what the resident considers to be important facets of his or her life. Policy Interpretation and Implementation: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Burleson Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 600 Maple St 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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Each resident is allowed to choose activities, and schedule health care and healthcare providers, that are consistent with his or her interests, values, assessments and plans of care, including: a. daily routine, such as sleeping and waking, eating, exercise and bathing schedules. b. personal care needs, such as bathing methods, grooming styles and dress; . e. activities, hobbies, and interests . 2. In order to facilitate resident choices, the administration and staff: . b. gather information about the residents' personal preferences on initial assessment and periodically thereafter, and document these preferences in the medical record; c. include information gathered about the resident's preferences in the care planning process; and d. document and communicate any medical conditions or limitations that may inhibit or interfere with participation in preferred activities. 3. Residents are encouraged to make choices about aspects of their lives in the facility, including: . b. organizing and participating in resident groups; . 4. Residents are provided assistance as needed to engage in their preferred activities on a routine basis .

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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** 28637 Based on observation, interview, and record review the facility failed to ensure residents unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal hygiene for 1 of 8 residents (Resident #18) reviewed for ADLs. The facility failed to ensure Resident #18 received a bed bath as scheduled and upon request and failed to assist her out of bed when she requested to attend a Resident Council meeting. This failure could place residents at risk for being denied the opportunity to exercise his or her autonomy regarding things that are import in their life and decrease their quality of life. Findings included: Record review of Resident #18's Face Sheet dated 8/14/24 revealed she was a [AGE] year-old female readmitted to the facility on [DATE]. Record review of Resident #18's Quarterly MDS assessment dated [DATE] revealed she had a BIMS score of 15 indicating she was cognitively intact. She was completely dependent on staff for bed to chair transfers and required maximal assistance for bathing. Her diagnoses included hypertension (high blood pressure), diabetes, anxiety and depression. Record review of Resident #18's Care Plan revealed an entry dated 7/8/24 that reflected: she required extensive assistance with 2 people for transfers, and extensive assistance by 1 person for personal hygiene. Goal: Will maintain a sense of dignity by being clean, dry, odor free and well-groomed over next 90 days. Approaches included, .2) Staff will give -shower, shave, oral, hair, nail care per schedule and prn . 3) Assist with dress according to climate, monitor appearance .5) Assist with transfer as needed . (continued on next page)

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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	During an observation and interview on 8/13/24 (Tuesday) at 12:35 PM, Resident #18 was observed sitting up in her bed eating lunch. Resident #18 stated she sometimes felt like staff did not want to do their jobs. She stated, This last Saturday (08/10/24) I asked for a bed bath 4 times. The first time she said, 'Oh ok, let me finish with this other person and I'll be right back' and she never came. I called again, she said, 'Oh ok, I'll be right back'. It happened 4 times then she left. The last call was around 10:00 PM. The night aide came and said, 'we don't do baths at night' and left. Resident #18 stated she had an outing planned with her family the next day and really wanted to be bathed before she left. She stated it took a while on Sunday, but they finally bathed her before she left. She stated her bath days were Tuesday, Thursday, and Saturday in the evening. She was unable to recall the name of the Aide. Resident #18 stated, This past Tuesday, they came around and informed me there was a Resident meeting at l1:00 AM. I told the Aide at 10:00 AM I wanted to go. I missed the last meeting because I couldn't get help. I waited and called; they never got me up. I just watched the clock, 11:00, 11:15, 11:30-nothing. I want to tell them not to even tell me they are happening if I can't go. What's the point in telling me if you won't help me get up and go? It made me feel like I'm not worth it, like I'm not worth their time. Why even tell me if you won't get me up? Resident #18 stated she required a mechanical lift for transfers to her chair as she was unable to use her legs. Resident #18 stated she had complained to facility management about the incidents and thought she had told the DON. She did not know whether they had addressed her issue. In an interview on 8/14/24 at 1:07 PM, CNA A stated she had worked the 6:00 AM to 2:00 PM shift and had worked at the facility for two months. She stated she regularly worked with Resident #18 and had worked the previous week. CNA A stated she did not recall Resident #18 asking to get up for the Resident Council meeting or being asked to get her up. She stated Resident #18 usually wanted to get up after lunch for therapy. In an interview on 8/15/24 at 7:45 AM, Resident #18 stated she had not heard anymore from facility management and had also missed her scheduled bath on 8/13/24. She stated she had not received a bath since Sunday, 8/11/24. She stated she asked the Aide twice on 8/13/24 for her bath and was told she did not have enough help and was working two halls that day. She could not recall the name of the aide. She stated she was not offered a bath on 8/14/24 either. Resident #18 stated she prefers evening baths because she gets up daily for rehab after lunch and that takes a while. She stated, I guess we'll see if I get one tonight. She stated she has had so many problems and just wanted them addressed. In an interview on 8/15/24 at 8:03 AM, CNA B stated she cared for Resident #18 and had been assigned to her hall on 8/13/24. She stated she knew Resident #18 got up after lunch for rehab and was due for a bath that evening. When asked about her scheduled bath for Tuesday 8/13/24, CNA B stated she did not know why she did not do it. She stated they were down an aide that evening, but she should have done it. She stated they usually had enough staff to care for the residents and even had shower aides most of the time. She stated the risk for not getting bathed was you don't feel very good if you're not clean. CNA B did not recall whether she worked with Resident #18 the day of the last Resident Council meeting but stated residents had a right to get up whenever they wanted. (continued on next page)

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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	During an interview on 8/15/24 at 8:42 AM, the Activity Director stated she had worked at the facility for 3 years but had just taken over as the Activity Director on 8/1/24. She stated there was a Resident Council meeting on 8/9/24. She stated she lets all the residents know on the day before and the day of Resident Council meetings by going room to room and handing out a paper letting them know the date and time of the meeting. She stated, if a resident was dependent and said they wanted to go, she would check with them and let the nursing staff know they would need assistance. She stated she would verbally alert the staff and offer to assist with resident transfers because she was a CNA and could help. She stated she also placed a paper with a list of dependent residents who expressed interest in attending the Resident Council meetings in a binder at the nurse's station that contained the staff schedule. The Activity Director stated she recalled telling Resident #18 about the meeting on 8/9/24 and recalled her saying she wanted to get up and go. The Activity Director stated she recalled making an aide aware but could not recall the name of the aide. She stated she did not assist with transfers that day because the meeting was in the morning and there was little time. She stated she noticed Resident #18 was not at the meeting but did not know what had happened. She stated residents often changed their minds about attending at the time of the meeting. She stated she thought she recalled Resident #18 complaining about missing the meeting and believed she had reported it to the Administrator but was not certain. She stated Resident #18 was the only one unable to attend that day. She stated the risk of failing to assist residents to meetings or other activities was emotional distress. She stated, If no one will get them up when they want to, can make them feel like, 'is it me, is it the staff?', if you don't communicate, they can think anything. The Activity Director stated she usually kept a copy of the lists provided and would look for the list used for the last Resident Council meeting. No list was located prior to the exit conference. In an interview on 8/15/24 at 9:30 AM, the ADON stated she had worked on 8/11/24 and recalled Resident #18 complaining that she had missed her bath on 8/10/24. She stated Resident #18 was upset because she had family coming and wanted her bath. She stated the aide was CNA C who told her Resident #18 had refused her bath 8/10/24. The ADON stated she did not follow up with Resident #18 to ask if she had, in fact, refused her bath because she was upset and they took care of her bath for her. She stated she had completed a grievance form on the matter. The ADON stated CNA C had resigned and no longer worked for the facility. She was not aware Resident #18 also missed her bath on 8/13/24 or the previous Resident Council meeting. The ADON stated risks for residents missing baths and activities included social and skin breakdowns, mental health decline and a spectrum of breakdowns. During an interview on 8/15/24 at 10:26 AM, the DON stated they had received complaints about missed baths and showers over a month ago and had added a shower aide to the schedule to assist with completions. She stated the shower aides provided a list at the end of the day of completed showers they were using to track. She stated the shower aides did not provide bed baths, but the assigned CNAs completed them . The DON stated she had heard from the ADON that Resident #18 had missed a bath over the weekend and the ADON had taken care of it. She stated Resident #18 had her and the Administrator's personal phone numbers to call if she had any concerns. She stated she was unaware Resident #18 had missed her bath again on 8/13/24. The DON stated they did have a shower aide that day but had to suspend her and send her home when they received a complaint about her which may have contributed to the situation. She checked her phone and stated she had not received any complaints. The DON stated she did not know about Resident #18 missing the Resident Council meeting the previous week. She stated Resident #18 had a history of not wanting to get out of bed and they had had a meeting with her about it, so she was disappointed to hear they did not get her up when she wanted to. She stated the risk of not getting residents bathed or out of bed as desired was it could diminish their dignity. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/15/24 at 12:14 PM, LVN D stated she worked the 6:00 AM to 2:00 PM shift and regularly cared for Resident #18. She stated she recalled the resident complaining to her after she missed the last Resident Council meeting. She stated she had complained after the fact. LVN D stated she was aware of the list provided by the Activity Director of residents who needed assistance to go to an activity and checked it daily. She could not recall whether she had noted Resident #18's name on the list for that day. LVN D stated she would typically assist with transferring residents out of bed when needed. She stated she attempted to find the aide to determine why she had not gotten her out of bed but did not recall who the aide was or what she was told on that day. LVN D stated Resident #18 had complained to her previously about missing baths but could not recall when it was but stated it had not been the current week. She stated Resident #18 received her baths on the evening shift. She stated the nurses were responsible for ensuring the baths were completed and were told in report when they were completed. She stated she had not heard anything about her missing any baths that week. She stated the risk to residents when not receiving baths or transfers as requested included pressure ulcers, poor hygiene, not having their voices heard, and depression. On 8/15/24 at 3:24 PM, an attempt to reach CNA C via telephone was unsuccessful. A voicemail message was left. No return call was received prior to facility exit. In an interview on 8/15/24 at 3:42 PM, LVN E stated she worked the 2:00 PM to 10:00 PM shift and regularly cared for Resident #18. She stated Resident #18 usually received bed baths on her shift and the aides reported to her when the baths were given. She stated her last bath should have been this week and she was not aware Resident #18 had missed her scheduled bath on 8/13/24. She stated Resident #18 did not complain to her about it. She denied asking her or the aide whether her bath had been done. LVN E stated the risk of missing baths was loss of dignity. LVN E stated she, herself, would not want to be around anyone if she missed a shower. She stated this was the resident's home and they deserved good treatment. During an interview on 8/15/24 at 3:48 PM, the Administrator stated he was very familiar with Resident #18, and she had his cellphone number to call or text with any complaints. He checked his phone and stated the last call he received had been in July and was related to staff taking too long to answer her call light. He stated he was away from the facility at that time but sent a staff member to check on her and had re-educated the staff about customer service after the incident. He stated she had made him aware of missing the Resident Council meeting. He stated he had been assisting another facility that day and came back and made evening rounds which was when she told him. He stated he told her he would personally ensure it did not happen again and would transfer her himself if needed. The Administrator stated he was not aware that had been the second time it had happened. He stated he did not know about the missed baths that had occurred on Saturday or Tuesday. The Administrator stated the risks to residents in these instances included decreased emotional status and pressure sores. He stated they generally followed up on resident complaints during QA meetings. He stated, with Resident #18, they were focused on ensuring she had been getting up for therapy, which had improved. Record review of the facility's policy titled, Resident Self Determination and Participation dated, Revised February 2021 reflected: Policy Statement: Our facility respects and promotes the right of each resident to exercise his or her autonomy regarding what the resident considers to be important facets of his or her life. Policy Interpretation and Implementation: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675144	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2024
NAME OF PROVIDER OR SUPPLIER: Burleson Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 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.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Each resident is allowed to choose activities, and schedule health care and healthcare providers, that are consistent with his or her interests, values, assessments and plans of care, including: a. daily routine, such as sleeping and waking, eating, exercise and bathing schedules. b. personal care needs, such as bathing methods, grooming styles and dress; . e. activities, hobbies, and interests . 2. In order to facilitate resident choices, the administration and staff: . b. gather information about the residents' personal preferences on initial assessment and periodically thereafter, and document these preferences in the medical record; c. include information gathered about the resident's preferences in the care planning process; and d. document and communicate any medical conditions or limitations that may inhibit or interfere with participation in preferred activities. 3. Residents are encouraged to make choices about aspects of their lives in the facility, including: . b. organizing and participating in resident groups; . 4. Residents are provided assistance as needed to engage in their preferred activities on a routine basis .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45053 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed, in that: The facility failed to ensure that the cucumbers in the facility's refrigerator, were placed in a sealed container according to guidelines. The facility failed to ensure that the dented cans were removed and separated from the other canned food. The facility failed to ensure that the dust on the air filters and air vents in the kitchen were cleaned. These deficient practices could affect residents who received meals and/or snacks from the main kitchen and place them at risk for cross contamination and other air-borne illnesses. Findings Included: Observation of the kitchen on 08/13/2024 at 9:05 AM, revealed that inside the large refrigerator were 6 cucumbers in a box on a shelf. They were not in a sealed container and were not dated. In the dry storage area, there were 2 dented cans of Vegan Salad Sliced Beets on the shelf with the other canned goods. There were 7 air vents in the kitchen that were dusty including 2 air vents above the food preparation area. There was 1 air vent above the dishwashing area that had a considerable amount of dust on the exposed air filter. In an interview with [NAME] F on 08/14/2024 at 1:30 PM, she stated that she was responsible for storing the canned goods in the dry pantry area. She stated that she did not observe the 2 dented cans of Vegan Salad Sliced Beets on the shelf when she was restocking the canned goods. She stated that the dented cans are to be placed in a separate area for the dented cans. She stated that a resident possibly ingesting foods from a dented can could cause the resident to become sick and ill. In an interview with [NAME] G on 08/14/2024 at 1:37 PM, she stated that she had been told by someone that it was okay to keep the vegetables in the box in the refrigerator. She could not recall who told her the information but stated that she would correct the error and place the 6 cucumbers in a sealed container and label and date the container. She stated that the risk of the 6 cucumbers being in the refrigerator in an open box on the shelf could be cross-contamination and could lead to air-borne illnesses for the residents. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview with the Maintenance Director on 08/15/2024 at 1:42 PM, he stated that the general cleaning of the kitchen would be the responsibility of the staff in the kitchen including the cleaning of the air filters and air vents. He stated that he did not have a cleaning log that recorded the cleaning and sanitization of the air filters and air vents in the kitchen. He stated that the risk of the dust being on the air filters and air vents in the kitchen above the food preparation and dishwashing areas could be that the dust from the air filters and vents could land on the food that the residents eat and can make them sick. In an interview with the Dietary Manager on 08/15/2024 at 1:55 PM in the presence of the Maintenance Director, she stated that the Maintenance Director was responsible for the cleaning of the air vents in the kitchen. She stated that it was her responsibility to ensure that the air vents and air filters in the kitchen remained free of any dust. She stated that her staff can also notify her if the air filters and air vents needed to be cleaned and then she would notify the Maintenance Director to request for the air filters and air vents in the kitchen to be cleaned and sanitized. She stated that the kitchen did not have a log or schedule for cleaning the air vents in the kitchen. She stated that it is the responsibility of everyone in the kitchen to ensure that there are not any dented cans in the dry storage area with the other canned goods. She stated that she has a routine of checking the dry storage area to ensure that everything is labeled, dated and that there were not any dented cans on the shelf with the other canned goods. She stated that she was absent from work the day before and had not checked the dry storage area upon her return. She stated that the 6 cucumbers in the open box in the refrigerator should be placed in a sealed container and labeled and dated. She stated that the risks for there being dust on air filters and vents, the 6 cucumbers in the open box in the refrigerator, and the dented cans being stored with the other canned goods could be cross-contamination, dust getting in the food that is prepared for the residents and has the potential for air-borne illnesses for the residents who eat food that is prepared in the kitchen by staff. Interview with the Maintenance Director on 08/15/2024 at 2:06 PM, he stated that the cleaning of the air vents in the kitchen are his responsibility. He stated that if the air vents needed to be painted, they would be his responsibility as well. He stated that the air vent above the dishwashing area does not have a vent cover and is designed to have an exposed air filter. He reported that the changing of the air filter is his responsibility and the air vents and air filters should be cleaned at least twice a month. In an interview with the Administrator on 08/15/2024 at 4:55 PM, he stated that the Dietary Manager is responsible for overseeing the staff in the kitchen. He stated that the cleaning of the air vents is the responsibility of the Maintenance Director, but it is the responsibility of the staff in the kitchen to notify the Maintenance Director to clean the air vents in the kitchen. He stated that the dented cans should be separated from the other cans in the kitchen to prevent the risk of sickness and illness of the residents in the facility. The Administrator stated that the vegetables in the kitchen should be stored in a sealed container and labeled and dated to prevent the risk of sickness and illness of the residents or anyone that eats food that comes from the kitchen. Record review of the facility's undated policy, Kitchen Sanitization and Cleaning Schedules, revealed All surfaces, including floors, walls, storage shelves, prep tables, trash cans, and all food contact surfaces must be routinely cleaned and sanitized. Ceilings, vents, light fixtures, pipes, and any other potentially contaminated surface will be cleaned as needed. All equipment must be thoroughly washed and sanitized between uses, in different food preparation tasks and anytime contamination occurs or is suspected. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Food and Storage Sanitation .Dented or otherwise damaged cans will not be used. Once identified, dented cans should be stored in a separate area of the storeroom to be returned to vendor or discarded. Record review of the facility's August 2024 Weekly Cleaning Schedule revealed that there were not any cleaning schedule entries that included the cleaning the air vents in the kitchen. Record review of the facility's August 2024 Weekly Cleaning Schedule revealed that in the Item column there was a handwritten entry All Vents. In the Responsible Party column, there was a handwritten entry, All Staff. The Week 1 and Week 2 columns were empty and Week 3 column, there was a handwritten entry with 2 staff members initials, [Cook F and [NAME] G] Review of the U.S. Food and Drug Administration (FDA) Code (2022) revealed, PACKAGED FOOD shall be labeled as specified in LAW, including 21 CFR 101 FOOD Labeling, 9 CFR 317 Labeling, Marking Devices, and Containers, and 9 CFR 381 Subpart N Labeling and Containers, and as specified under S 3-202.18. FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306.