| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676496 | A. Building<br>B. Wing | 01/30/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Advanced Rehabilitation & Healthcare of Burleson | 275 SE John Jones Drive<br>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) |
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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to implement a comprehensive care plan to meet the residents' highest practicable physical, mental, and psychosocial well-being of 1 (Resident #1) of 6 residents reviewed for care plans.The facility failed to update the comprehensive person-centered care plan for Resident #1's need for oral care and dentures.This failure could place residents at risk for not receiving appropriate care and treatment.Findings included:Record review of Resident #1's admission record dated 1/29/2026 reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnosis of Covid-19, acute kidney failure, low back pain, Hight blood pressure, Barretts esophagus ( a condition of the lining of the esophagus (throat) related to excessive acid exposure from the stomach resulting in food backing up into the throat and difficulty swallowing) and difficulty swallowing. Resident #1 was discharged to the hospital on [DATE] with pneumonia.Record review of Resident #1's admission MDS dated [DATE] reflected a BIMS score of 14 indicating Resident #1 was cognitively intact. The MDS reflected Resident #1 was set up assistance with eating and partial to moderate assistance with oral hygiene. Resident #1 had a loss of liquids/solids from mouth while eating or drinking and holding food in mouth/cheeks or residual food in mouth after meals. His weight on admission was 179 pounds. He was on a mechanically altered diet. Section L Oral/Dental Status was marked z none of the above were present indication Resident #1 did not have broken or loosely fitting full or partial dentures. Record review of Resident #1's care plan dated 12/20/2025 reflected Resident has an ADL self-care performance deficit and was at risk of not having their needs met in a timely manner. Interventions included therapy to screen, evaluate, and treat as needed. The Care plan review did not address needs for oral care or dentures.In an interview on 01/29/2026 at 1:45p.m. RN A stated she was Residents #1's bedside nurse at the hospital on Saturday 1/24/2026. She stated Resident #1 was admitted on [DATE] to the hospital without his dentures in his mouth. She stated he had impacted food in his gum line between his cheeks. She stated he had a large glob of pink denture glue lodged in the back of his throat that had to be suctioned out. She was concerned about the lack of oral care for Resident #1 while at the Nursing Facility.In an interview on 01/29/2026 at 1:52 p.m. Resident #1's Family Member stated he wore his dentures all the time prior to being ill but was having difficulty with them due to his recent weight loss. He stated he was having problems eating and the staff were aware, and they were supposed to be assisting him with feeding and cleaning his mouth. The Family Member stated they had not asked for assistance with dental services.In an interview on 1/29/2026 at 2:00 p.m. the Speech Therapist stated Resident #1 had dentures but did not wear them often due to poor fitness. He was admitted on a puree diet and was keeping [NAME] of food at the front of his mouth due to decreased strength of tongue to push food back. Speech therapy was treating him 4 times weekly.In an interview on 1/29/2026 at 2:24 p.m. CNA B stated Resident #1 did have difficulty eating. Staff had to encourage him and usually he would eat by<br><br>(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 |
|---|---|---|

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | himself. CNA B stated he did not remember if Resident #1 had dentures or teeth. He stated he would normally find out if a resident did or did not have dentures by asking the nurse in charge. CNA B stated there was not a place to see in writing that a resident required assistance with oral care or denture care. He stated that information would have been passed on orally in a report from another staff member. He stated if not passed on in report, then a resident may not receive the required services needed.In an interview on 1/29/2026 at 2:26 p.m. LVN C stated when Resident #1 first came in she did remember him with dentures. She stated a family member brought them in. The oral care for Resident #1 should had been completed daily it should be in care plan; it should be noted he had dentures and that he needed help with feeding his meals. She stated a by not having that information in the care plan it could lead to denture care or oral care not being performed.In an interview on 1/30/2026 at 2:00 p.m. The DON stated all nurse managers were responsible for updating and ensuring a care plan accurately reflected the residents' needs. She stated the DON was responsible for reviewing the care plan and monitoring to ensure it was completed. She stated the interventions within the care plan were assigned to employees and denture care/oral care would be assigned to the nurse aides. She stated once that assignment was made the oral care needs would flow over onto the task bar to be completed by the CNA. She stated not care planning oral care needs could impair a resident's ability to chew, leading to weight loss.Record review of facility policy titled Comprehensive Care Plans dated 2/10/2021 and revised 9/4/2024 reflected: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. The comprehensive care plan will describe, at a minimum, the following:The services that are to be furnished are to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrated that this was not possible or resident preferences indicated otherwise for 1 (Resident #1) of 6 residents reviewed for nutrition status maintenance.The facility failed to Accurately and consistently assess a resident's weight status on admission and weekly for 4 weeks for Resident #1.These failures could place residents at risk of further weight loss, malnutrition, and a decreased quality of life. Findings include:Record review of Resident #1's admission record dated 1/29/2026 reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnosis of Covid-19, acute kidney failure, low back pain, High blood pressure, Barretts esophagus ( a condition of the lining of the esophagus (throat) related to excessive acid exposure from the stomach resulting in food backing up into the throat and difficulty swallowing) and difficulty swallowing. Resident #1 was discharged to the hospital on [DATE] with pneumonia.Record review of Resident #1's admission MDS dated [DATE] reflected a BIMS score of 14 indicating Resident #1 was cognitively intact. The MDS reflected Resident #1 was set up assistance with eating and partial to moderate assistance with oral hygiene. Resident #1 had a loss of liquids/solids from mouth while eating or drinking and holding food in mouth/cheeks or residual food in mouth after meals. His weight on admission was 179 pounds. He was on a mechanically altered diet. Section L Oral/Dental Status was marked z none of the above were present indication Resident #1 did not have broken or loosely fitting full or partial dentures.Record review of Resident #1's care plan dated 12/20/2025 reflected The resident has, unplanned/unexpected weight loss related to poor po intake Date Initiated: 01/21/2026 Interventions included: Give supplements as ordered. Med Plus (a meal replacement drink) Mirtazapine (a medication) 7.5 mg for appetite stimulant. Monitor and evaluate any weight loss. Determine percentage lost and follow facility protocol for weight loss. Provide and serve diet as ordered.Record review of Resident #1's speech therapy evaluation dated 12/21/2025 reflected A bedside swallowing evaluation (BSE) was completed during this evaluation. Patients trialed thin liquids and medications. Oral phase impairments with thin liquids were characterized by anterior spillage, while pharyngeal phase impairments were noted as reflexive throat clearing x2. During medication administration, oral phase deficits included anterior spillage, oral residue, and decreased activity tolerance, with pharyngeal impairments characterized by reflexive throat clearing xl. Patient was admitted to the facility on a pureed diet and declined all solid trials during the (evaluation, including pureed and mechanical soft textures. Due to limited assessment of solid consistencies at this time, it is recommended that patient remain on a pureed diet. Patient was educated regarding findings and the plan to trial solid textures during future skilled sessions and verbalized' understanding and agreement with the recommendations. signed by speech therapist.Record review of speech therapy treatment notes dated 1/16/2026 reflected Clinician provided extensive information regarding modified barium swallow study referral, reason for further assessment and instrumentation to gain improved insight into patient's concerns regarding food feeling stuck on mechanical soft PO trials to determine risk for silent aspiration or related oral-pharyngeal dysphagia concerns to provide further treatment to most appropriately support patient's increased by mouth intake and swallowing function on LRD. Clinician contacted scheduling company and provided information to patient's family members regarding MBSS referral and need for signature/ consent/ approval signed by speech therapist.Record review of Nutritional assessment dated [DATE] reflected Resident #1 did not like pureed foods. He usually wears dentures, but they were too big right now because he has lost weight. Resident #1<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | reported he drank 1-2 ensure drinks daily. Dietician intervention recommendations were to continue current diet order, start Ensure health drinks two times daily at breakfast and lunch, and start med plus 120ml two times a day. Signed by Registered DieticianRecord review of weight change communication form dated 1/21/2026 reflected Resident #1 had a significant weight loss of 16 pounds or 9% with a most recent weight of 162 pounds. Pertinent history included Barretts Esophagus with Dysplasia, heart failure, and dysphagia. Resident #1 was currently taking diuretics. He was currently on a mechanically altered diet, the family and physician were notified, and new orders were received for Mirtazapine 7.5mg at bedtime to stimulate appetite. Will continue weights.Record review of Orders Recap Report dated 1/30/26 reflected a diet with No Restrictions diet Pureed (liquid) texture, thin liquidsconsistency, ensure (a nutritional supplement drink) with breakfast and lunch dated 12/20/2025. Furosemide (a diuretic) 20mg daily for heart failure, Med Plus 2.0 120ml by mouth two times a day dated 01/08/26. Mirtazapine Oral Tablet 7.5 MG (Mirtazapine) Give 1 tablet by mouth at bedtime for appetite stimulant dated 1/21/2026.Record review of Resident #1's weight summary reflected the following:*12/29/26 -an admission weight of 170 pounds*01/06/2026-162 pounds*1/23/2026 a weight of 155 pounds at discharge.In an interview on 01/29/2026 at 1:45p.m. RN A stated she was Residents #1's bedside nurse at the hospital on Saturday 1/24/2026. She stated Resident #1 was admitted on [DATE] to the hospital without his dentures in his mouth. She stated he had impacted food in his gum line between his cheeks. She stated he had a large glob of pink denture glue lodged in the back of his throat that had to be suctioned out. She was concerned about the lack of oral care for Resident #1 while at the Nursing Facility.In an interview on 01/29/2026 at 1:52 p.m. Resident #1's Family Member stated he wore his dentures all the time prior to being ill but was having difficulty with them due to his recent weight loss. He stated he was having problems eating and the staff were aware, and they were supposed to be assisting him with feeding and cleaning his mouth. The Family Member stated they had not asked for assistance with dental services.In an interview on 1/29/2026 at 2:00 p.m. the Speech Therapist stated Resident #1 had dentures but did not wear them often due to poor fitness. He was admitted on a puree diet and was keeping bolus of food at the front of his mouth due to decreased strength of his tongue to push food back. Speech therapy was treating him 4 times weekly. She stated one of the therapists usually assisted Resident #1 with at least 1 meal daily with the therapy treatment.In an interview on 1/29/2026 at 2:24 p.m. CNA B stated Resident #1 did have difficulty eating. Staff had to encourage him and usually he would eat by himself. He stated he did occasionally have to feed Resident #1. CNA B stated he did not remember if Resident #1 had dentures or teeth. He stated he would normally find out if a resident did or did not have dentures by asking the nurse in charge. CNA B stated there was not a place to see in writing that a resident required assistance with oral care or denture care. He stated that information would have been passed on orally in a report from another staff member. He stated if not passed on in report, then a resident may not receive the required services needed.In an interview on 1/29/2026 at 2:24 p.m. LVN C stated Resident #1 had a weight loss, he refused to eat. She stated that he did have difficulty swallowing and pocketed food in his mouth. She stated Resident #1 did have some dementia and would often be resistant to help. LVN C stated resident #1 would occasionally require assistance with eating. She stated the staff would give him supplements if he refused his meals. She stated weights were usually obtained weekly by the transportation nurse aide and if there were to be some significant difference she would notify the charge nurse. She was not sure why the weekly weight was not obtained.In an interview on 1/30/2026 at 2:00 p.m. The DON stated she had worked at the facility for 3 days and the Restorative Aid was responsible for obtaining any residents' weights who had triggered weight loss, newly admitted resident, and<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | readmissions weekly for four weeks. She stated ADON was responsible for reviewing the weights and monitoring to ensure it was completed. She stated weights were talked about daily in the morning meeting and at that time recommendations were made care plans were updated and interventions were put in place to implement and attempt to mitigate the weight loss. She stated not weighing resident's weekly could lead to a delay in interventions leading to malnutrition and increased weakness.Record review of facility policy titled Comprehensive Care Plans dated 1/2005 reflected: The facility management/clinical team will know the weight status of their residents, including the number of residents who have had significant and insidious weight loss. Resident weights will be recorded in each resident's medical record monthly, unless specifically ordered otherwise. Residents will maintain an acceptable weight unless clinically unavoidable, it is a planned weight change, or it is against the residents' wishes. |