STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676496	A. Building B. Wing	06/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Rehabilitation & Healthcare of Burleson	275 SE John Jones Drive 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure that allegations involving abuse, neglect, and misappropriation of resident property were reported immediately, but no later than 2 hours after the allegation is made to the State Survey Agency for 1 of 6 residents (Resident #1) reviewed for injury unknown origin.The facility failed to report within 2 hours to the State Survey Agency (HHSC - Health and Human Services Commission) an injury of unknown origin when CNA A reported to LVN B that Resident #1 had complained of pain while trying to get out of bed on 05/29/2026 and was sent out to the hospital for further evaluation. Upon evaluation the hospital notified the facility that x-rays showed Resident # 1 had a distal femur fracture when the hospital reported to the facility on [DATE].This failure could place residents at risk for abuse, pain, and a diminished quality of life. Findings included: A record review of Resident #1's face sheet dated 06/29/2026 reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1's diagnoses were age related osteoporosis (bone breakdown outpaces bone renewal, resulting in brittle, fragile bones), dementia in other diseases classified elsewhere unspecified (development of dementia as a direct symptom or complication of another diagnosed medical condition), essential primary hypertension (high blood pressure that does not have a single, clearly identifiable medical cause, and chronic obstructive pulmonary disease unspecified (progressive, irreversible lung condition that restricts airflow, making it difficult to breathe. A record review of Resident #1's Quarterly MDS assessment, dated 06/09/2026, reflected Resident # 1 had a BIMS score of 13, which indicated cognitive intact. Resident # 1 used a motorized wheelchair and was dependent on helper for bed to motorized wheelchair transfer. A record review of Resident #1's care plan, dated 06/02/2026 reflected Resident # 1 had osteoporosis (bone breakdown outpaces bone renewal, resulting in brittle, fragile bones) with interventions to administer medications as ordered and monitor side effects and effectiveness. A record review of Resident #1's facility investigation report dated 05/29/2026 reflected the cause of the femur fracture was not determined and was not able to prove the actual cause of injury. A record review of Resident #1's facility investigation report dated 05/29/2026, reflected it was determined at the hospital visit Resident # 1 had a distal femur fracture. A record review of the facility's investigation report dated 05/29/2026 reflected that the facility did not report the alleged injury of unknown origin within 2 hours to the State Survey Agency (HHSC). (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
	676496	A. Building B. Wing	06/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Rehabilitation & Healthcare of Burleson	275 SE John Jones Drive 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the facility's incident report dated 05/29/2026 reflected CNA A told LVN B Resident #1 complained of left knee pain while trying to get her out of bed. LVN B tried to assess Resident #1, and she would not allow LVN B to assess her. So Resident # 1 was sent out to the ER for further evaluation. A record review of progress note written by LVN B on 05/29/2026 at 2:46 PM reflected Resident #1 had the following change in condition: fracture/severe pain and since the change symptoms were worse and the condition, symptom, or sign had occurred before. A record review of Resident #1's hospital record dated 05/29/2026 Resident #1 reflected nursing facility staff was trying to adjust her wheelchair, and she slid out the wheelchair and fell. X-ray showed acute supracondylar fracture of the femur (break in the thigh bone just above the knee joint) with mild anterior displacement (a bone, joint, or anatomical structure had shifted slightly forward). A record review of TULIP(Texas Unified Licensure Information Portal) on 06/29/2026 did not reveal the facility made a report of injury of unknown origin. A record review of staff In-service with 14 nursing staff was conducted by the DON started on 05/29/2026 over abuse, neglect, falls, and transfers. Review reflected the sign-in sheet of the completed staff in-service. A record review of safe surveys with 10 residents was conducted by the DON started on 05/29/2026, and no residents had any issues with abuse or neglect. During an interview with Resident #1 on 06/29/2026 at 12:00 PM, Resident #1 was not able to recall an incident until she was asked had she had an issue with a CNA. Resident #1 stated she was safe, but had an incident where she was sitting in her wheelchair, she could not recall the date and time, when an unnamed CNA, who she was not able to describe, came into her room from behind her electronic wheelchair, while she was seated, and started messing with the electronic wheelchair joystick. Resident # 1 stated the chair lifted forward and she slipped out the chair. Resident #1 stated the unnamed CNA did not call for help, took her cell phone, left her in the floor, and did not send her to the hospital because the unnamed CNA thought she did not like black people. During an interview with Resident #1's RP on 06/29/2026 at 12:41 PM, she stated Resident #1 was safe, and she heard several different stories. Resident # 1 RP stated Resident # 1 stated she had slid out the electronic chair while being adjusted in the wheelchair and slid down and fell on knee. Resident #1's RP stated Resident #1 could not recall when the incident happened or who was helping her. Resident # 1's RP stated she then was told CNA A was attempting to get Resident #1 out of bed on 06/29/2026 when Resident #1 was experiencing pain and was sent out to the hospital. Resident #1's RP stated the facility made contact to let her know when Resident #1 was sent out to the hospital. Resident #1's RP stated that Resident #1 legs didn't bend, and the fracture may have happened anytime she was getting in and out of bed. Resident #1's RP stated it was not determined Resident # 1 had a fracture until she was sent out to the hospital. During an interview with CMA C on 06/29/2026 at 2:35 PM, she stated she was passing medications on 05/29/2026 between 9:30 AM and 10 AM when she heard Resident # 1 scream out as if she was in pain. CMA C stated she went to check back on Resident # 1 because she had just given her medications to her. CMA C stated she had entered, Resident #1's room and asked CNA A did she need help getting Resident # 1 out of the bed and she stated she did not want to get out the bed right then. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676496	A. Building B. Wing	06/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Rehabilitation & Healthcare of Burleson	275 SE John Jones Drive 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CMA C stated she had observed Resident # 1 laying in bed and the bed was at the lowest position to the floor. CMA C stated CNA A then went to notify LVN B, and she left Resident #1's room tright after LVN B came in to access Resident #1. Attempted interview with CNA A on 06/29/2026 at 2:55 PM, 3:12 PM, and 4:57 PM was unsuccessful. Left voice messages, but no returned call was received by exit. Attempted interview with LVN B on 06/29/2026 at 3:36 PM, 5:09 PM, and 5:42 PM was unsuccessful. Left voice messages, but no returned call was received by exit. The DON stated that LVN was on vacation, out of the country and may not have phone access. During an interview with the DON on 06/29/2026 at 4:29 PM, she stated the ADM would have been responsible for reporting the injury of unknown origin on 05/29/2026 . The DON stated that the facility was without an ADM on 05/29/2026, and she was responsible for reporting within 24 hours to the state, once the hospital had discovered the fracture. The DON stated that the ADM did not start at the facility until 6-2-2026. The DON stated she was getting conflicting information from LVN B. The DON stated LVN B had documented the injury of unknown record as a unwitnessed fall. The DON was not aware of the allegations of the electronic scooter. The DON stated that CNA A stated that Resident # 1 had started screaming when she was attempting to transfer the resident from the bed to electronic wheelchair . The DON stated CNA A never transferred Resident # 1, and she never came out the bed. The DON stated the CMA C had heard Resident #1 screaming and she had went to see if CNA A needed assistance and she verified Resident # 1 was in bed. The DON stated she had started her investigation on 05/29/2026 and in-serviced staff over abuse, neglect, and conducted safe surveys with Residents. The DON stated she was not able to determine the cause of the injury due to conflicting stories. The ADM stated she was told by corporate that she did not have to make a state report because the facility investigation was started when the hospital called on 05/29/2026 to report Resident # 1 had a fracture. The ADM stated that she followed corporate directives even though she knew she had to make the report on injury of unknown origin. The DON stated it was very important to have notified the state within 24 hours on 05/29/2026 to ensure a thorough investigation to make sure staff were educated and following policies and procedures. During an interview with the ADM on 06/29/2026 at 4:58 PM, she stated that she was not working with the facility on 05/29/2026 when Resident # 1 was sent out to the hospital for further evaluation for pain when it was determined she had a femur fracture. The ADM stated the ADM would be the one who would have made the report to the state on 05/29/2026 when the femur fracture was discovered. The ADM stated the report to the state of the injury unknown origin should have been made to HHSC on 05/29/2026 when the hospital had notified the facility. The ADM stated he was responsible for reporting the incident to the state timely. The ADM stated it was expected to report alleged abuse to HHSC within 24 hours to prevent further abuse. A record review of the facility's policy named Policy And Procedures Abuse, Neglect, Exploitation implemented 10/24/2022 and revised 09/16/2024 reflected It is the policy of this facility to provided protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property.