STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455429	A. Building B. Wing	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rose Trail Nursing and Rehabilitation Center	930 S Baxter Tyler, TX 75701

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44637 Based on interview and record review, the facility failed to ensure residents receive treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for 1 of 7 (Resident #1) residents reviewed for quality of care. 1.The facility failed to provide wound care to Resident #1's right lower extremity stump (the remaining part of the right leg after amputation) as ordered resulting in infection and surgical debridement (the removal of damaged tissues from a wound) to rule out osteomyelitis (inflammation of the bone caused by infection). 2.The facility failed to report redness to Resident #1's abdomen to the Nurse Practitioner or Wound Care Physician resulting in hospitalization related to cellulitis (bacterial skin infection) and panniculitis (inflammation of the subcutaneous fat) requiring intravenous (IV) antibiotics. 3.The facility failed to document wound care assessments per facility policy. This failure resulted in an identification of an Immediate Jeopardy (IJ) at 2:35 p.m. on 4/2/24. While the IJ was removed on 4/3/24, the facility remained out of compliance with a scope identified as patterned and a severity of no actual harm with a potential for more than minimal harm due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. These failures could result in residents with venous stasis ulcer of not having their treatments performed as ordered, wounds becoming infected wounds, and decreased wound healing. Findings Included: 1. Record review of the face sheet dated 4/3/24 indicated Resident #1 was a [AGE] year-old male readmitted to the facility on [DATE] with diagnoses including panniculitis, morbid obesity, diabetes, acquired absence of right leg below the knee, localized edema (swelling), and congestive heart failure (chronic condition in which the heart does not pump blood as well as it should). (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
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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the physician orders dated 4/3/24 indicated Resident #1 had an order to cleanse right below the knee amputation with normal saline, pat dry, apply calcium alginate (highly absorptive, non-occlusive dressing made of soft, non-woven calcium alginate fibers), collagen (wound dressing derived from collagen used to absorb exudate (fluids excreted by a wound), and cover with a dry dressing daily and as needed starting on 2/5/24. The physician orders indicated Resident #1 had an order for lymphedema (swelling caused by a lymphatic system blockage) wound of left abdomen skin prep daily starting 4/2/24. Record review of the MDS dated [DATE] indicated Resident #1 understood others and was understood by others. The MDS indicated Resident #1 had a BIMS of 15 and was cognitively intact. The MDS indicated Resident #1 had a surgical wound and moisture associated skin damage. Record review of the care plan revised 4/3/24 indicated Resident #1 had actual impairment to skin integrity: unstageable [wound] to the right leg with interventions including cleanse wound, apply medications and dressings as ordered. The care plan indicated Resident #1 had an infection of the wound. The care plan indicated Resident #1 had panniculitis . The care plan indicated had potential impairment to skin integrity of the lower abdomen and skin folds related to morbid obesity/incontinence. Resident had wound to right leg with treatment continued. Record review of the TAR dated 2/1/24 through 2/29/24 indicated Resident #1's treatment to cleanse right below the knee amputation with normal saline, pat dry, apply calcium alginate, collagen and cover with a dry dressing daily and as needed was only performed on 2/7/24, 2/8/24, 2/10/24, 2/12/24, 2/13/24, 2/15/24, 2/16/24, 2/17/24, 2/22/24, 2/26/24, 2/27/24, 2/28/24, and 2/29/24. Record review of the TAR dated 3/1/24 through 3/31/24 indicated Resident #1's treatment to cleanse right below the knee amputation with normal saline, pat dry, apply calcium alginate, collagen and cover with a dry dressing daily and as needed was only performed on 3/1/24, 3/3/24, 3/10/24, 3/11/24, 3/30/24, and 3/31/24. Record review of the skin assessment dated [DATE] indicated Resident #1 had a right lower leg wound infection measuring 1.5cm x 0.3cm x 0.2cm. The skin assessment indicated Resident #1 had a wound to the right leg with treatment in place. Record review of the skin assessment dated [DATE] indicated Resident #1 had a right lower leg wound infection measuring 1.5cm x 0.3cm x 0.2cm. The skin assessment indicated Resident #1 had a wound to the right leg with treatment in place. The skin assessment indicated Resident #1 had redness to left lateral side of abdomen with barrier cream (a product applied to the skin to help maintain the skins physical barrier, providing protection from irritants and preventing the skin from drying out) applied and Resident #1 was instructed to change positions every 2 hours. Record review of the skin assessment dated [DATE] indicated Resident #1 had a wound to the right leg with treatment in place. The skin assessment indicated Resident #1 had redness to left lateral side of abdomen with barrier cream applied and Resident #1 was instructed to change positions every 2 hours. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the skin assessment dated [DATE] indicated Resident #1 had a wound to the right leg with treatment in place. The skin assessment indicated Resident #1 had redness to left lateral side of abdomen with barrier cream applied and Resident #1 was instructed to change positions every 2 hours. Record review of wound assessments indicated Resident #1 did not have a wound assessment performed by the facility from 2/1/24 through 3/13/24 when Resident #1 was transferred to the hospital. Record review of the Wound Care Physician's note dated 2/12/24 indicated Resident #1 had a right leg wound measuring 1cm x 0.3cm x 0.2cm. The Wound Care Physician's note indicated the right leg wound was healing as evidenced by 0% decrease in surface area within the wound bed. Record review of the Wound Care Physician's note dated 2/19/24 indicated Resident #1 had a right leg wound measuring 1cm x 0.3cm x 0.2cm. The Wound Care Physician's note indicated the right leg wound was at goal. Record review of the Wound Care Physician's note dated 2/26/24 indicated Resident #1 had a right leg wound measuring 2cm x 1.4cm x 0.2cm. The Wound Care Physician's note indicated the right leg wound had exacerbated due to more edema in the leg. Record review of the Wound Care Physician's note dated 3/4/24 indicated Resident #1 had a right leg wound measuring 2cm x 1.4cm x 0.2cm. The Wound Care Physician's note indicated the right leg wound was at goal. Record review of the Wound Care Physician's note dated 3/11/24 indicated Resident #1 had a right leg wound measuring 2cm x 1.4cm x 0.2cm. The Wound Care Physician's note indicated the right leg wound was at goal. Record review of the nursing progress note dated 3/11/24 indicated Resident #1 received an order for Doxycycline (antibiotic) 100mg twice a day for 7 days related to right stump wound. Record review of the nursing progress note dated 3/13/24 indicated Resident #1 noted with change in condition including not feeling well, body aches, chills, fever, and right leg pain and swelling. The nursing progress note indicated a new order was received to send Resident #1 to the emergency department for evaluation and treatment. Record review of the nursing progress note dated 3/27/24 indicated Resident #1 returned to the facility. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the hospital paperwork for hospital admitted d 3/13/24 through 3/27/24 indicated Resident #1 was admitted to the hospital with a primary diagnosis of acute panniculitis. The hospital paperwork indicated Resident #1 had discharge diagnoses including acute panniculitis, bacteremia (viable bacteria in the blood), and osteomyelitis of right tibia. The hospital paperwork indicated Resident #1 was admitted to the hospital with fever, chills and brought to emergency room for he was found to have an elevated white cell count of 17,200 (normal range 4,500 to 11,000) and large left-sided cellulitis involving his entire left abdominal wall pannus (excess skin and fat that hangs down from the abdomen). The hospital paperwork indicated Resident #1 was started on broad-spectrum IV antibiotics and based cellulitis spread from left flank to across his left midline. The hospital paperwork indicated Resident #1 had some evidence of wounds in his left abdominal wall. The hospital paperwork indicated Resident #1 had a right below-knee amputation stump ulcer with x-ray revealing osteomyelitis. The hospital paperwork indicated after right below the knee stump debridement on 03/21/2024 there was not any evidence of bone involvement. During an interview on 3/28/24 at 1:26 p.m. Resident #1 said there had been staffing issues with treatment nurses. Resident #1 said his wound care had not been done as scheduled. Resident #1 said he had just returned from the hospital due to infection to wound and cellulitis to abdomen. Resident #1 said he had surgery on his below the knee amputation while in the hospital to determine in the infection was in the bone. Resident #1 said the infection had not made it to the bone and was only in the soft tissue. Resident #1 said he had not been receiving proper wound care prior to being hospitalized . During an interview on 4/2/24 at 9:59 a.m. LVN A said she was familiar with Resident #1. LVN A said Resident #1's wound care was performed daily. LVN A said LVN F or LVN E were responsible for performing Resident #1's wound care. LVN A said the nurses were responsible for completing skin assessments. LVN A said she did not know if the increased redness to Resident #1's abdomen had been reported. LVN A said all wound treatments from the wound care physician were recommendations. LVN A said she would have to find out if the wound care physician recommendations were implemented or needed to be approved by the resident's primary care physician. LVN A said Resident #1 had a skin assessment dated [DATE] which indicated redness to left lateral abdomen. During an interview on 4/2/24 at 10:14 a.m. the Wound Care Physician said he was familiar with Resident #1. The Wound Care Physician said Resident #1 had lots of lymphedema (swelling, most often in an arm or leg, caused by lymphatic system blockage) in his right stump. The Wound Care Physician said the facility had not had a treatment nurse in months. The Wound Care Physician said it was not ideal for dressing changes that were ordered daily not to be performed. The Wound Care Physician said it was not out of the realm for a dressing change ordered daily and not being performed daily to lead to infection. The Wound Care Physician said he was not informed of redness or increased redness to Resident #1's abdomen but the facility may have informed his primary care physician. The Wound Care Physician said wound treatments in his notes were recommendations. The Wound Care Physician said he saw residents at the facility weekly. The Wound Care Physician said he could not say if lymphedema treatment recommendation not being performed would lead to worsening lymphedema or infection. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/2/24 at 10:21 a.m. the Nurse Practitioner said she was familiar with Resident #1. The Nurse Practitioner said she had not had any reports from the facility regarding Resident #1 having redness or increased redness to his abdomen. The Nurse Practitioner said most facilities notify them of changes in skin conditions or treatment orders, but this facility did not. The Nurse Practitioner said communication from this facility was lacking. The Nurse Practitioner said wound care treatments not performed as ordered could possibly lead to infection, but the surveyor would need to refer to the Wound Care Doctor. During an interview on 4/2/24 at 12:23 p.m. LVN B said charge nurses were responsible for wound care and skin assessments at this time. LVN B said the last training she had received at the facility regarding skin assessments, wound documentation, or wound care policies was a couple of months ago. LVN B said the TAR indicated whether wound care had been performed. LVN B said if it was not charted in the TAR wound care was performed you could look at the date on the dressing. LVN B said if it was further back than one day and was not charted in the TAR wound care was performed it could not be proved it was performed. LVN B said skin assessment should be completed weekly. Record review of the facility's Documentation of Wound Treatments policy dated 7/2022 indicated, The facility completes accurate documentation of the wound assessments and treatments, including response to treatments, change in condition, and changes in treatment. Wound assessments are documented upon admission, weekly, and as needed if the resident or wound condition deteriorates .Wound treatments are documented at the time of each treatment. If no treatment is due, an indication on the status of the dressing shall be documented each shift. Additional documentation shall include but is not limited to .e. Notification to physician and/or responsible party regarding wound or treatment changes. The Administrator was notified on 4/2/24 at 2:48 p.m. that an Immediate Jeopardy situation was identified due to the above failure. The Administrator was provided the Immediate Jeopardy template on 4/2/24 at 2:56 p.m. The facility's Plan of Removal was accepted on 4/3/24 at 9:40 a.m. and included: Plan of Removal 1. Immediate actions The Medical Director and Resident #1's Primary Care Physician were notified by the Assistant Director of Nursing on 04/02/2024. A full skin sweep was completed on all residents on 03/27-28/2024 by the Assistant Director of Nursing and the Director of Nursing. All residents admitted or readmitted from 03/27/2024 forward were reviewed to ensure for head-to-toe skin and wound assessments were completed appropriately. Any admitted or readmitted residents from 03/27/2024 forward that were identified to not have skin assessments were assessed immediately on 04/02/2024. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An omissions report was pulled from 03/27/2024 forward and all omissions were addressed by the Director of Nursing. This was completed on 04/02/2024 and all staff were trained on how to pull the omissions report and directed to check it daily prior to the end of their shift to ensure no treatments are missed going forward. The omissions report identified staff who had not completed their treatments as ordered. Resident #1 was immediately provided a head-to-toe skin assessment by the Director of Nursing and treatment was provided according to the Physician's orders for all areas on 04/02/2024. 2. Education (provided by DON, ADON or Designee) The Regional Director of Clinical Services in-serviced the Director of Nursing and Assistant Director of Nursing on all of the below in-services on 04/02/2024. All nurses were in-serviced by the Director of Nursing/Assistant Director of Nursing on appropriately completing skin assessments and notifying the Physician of all newly identified skin issues in a timely manner on 04/02/2024. Each nurse will be in-serviced prior to returning to shift. This will be completed by 04/03/2024 and nurses will not return to shift without the in-service. The Director of Nursing and Assistant Director of Nursing are responsible for ensuring each nurse completes their skin assessments. All nurses were in-serviced by the Director of Nursing/Assistant Director of Nursing on Policy and Procedure for Pressure Injury Prevention and Skin and Wound Care Management on 04/02/2024. This in-service will be completed by 04/03/2024 and nurses will not return to shift without the in-service. This in-service includes appropriately completing skin assessments, information on pressure and injury prevention, treatment for non-pressure injuries, the importance of wound care management and following the treatment orders. All nurses were in-serviced by the Director of Nursing/Assistant Director of Nursing on pulling an omission's report prior to the end of each shift and correcting any absence of documentation on 04/02/2024. The Omission report would show any order on the TAR that was not completed during the scheduled shift. This in-service will be completed by 04/03/2024 and nurses will not return to shift without the in-service. All nurses were in-serviced by the Director of Nursing/Assistant Director of Nursing on pulling and signing all MARs and TARs prior to the end of their shift on 04/02/2024. This in-service will be completed by 04/03/2024 and nurses will not return to shift without the in-service. If a nurse is unable to complete an assessment or wound care during their shift, they will notify the Director of Nurses and Assistant Director of nurses prior to leaving their shift. The oncoming shift will be notified during report that an assessment or treatment was not completed. 3. Medical Director - The Medical Director has been notified of the Immediate Jeopardy. 4. QAPI Committee Review - An interim QAPI committee meeting was completed on 04/02/2024. 5. Plan of removal date: 04/02/2024 (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 4/3/24 it was onfirmed the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy (IJ) by: Record review on 4/3/24 of 3 of 3 new admissions or re-admission from 3/27/24 through 4/3/24 indicated all admissions had skin assessments performed and wound assessments performed if applicable. Record review of a random sample of 16 of 66 residents on 4/3/24 indicated all sampled residents had skin assessments performed between 3/27/24 and 4/2/24. Record review of the QAPI sign-in sheet indicated the facility had an ad-hoc QAPI meeting on 4/2/24 regarding wound treatments, skin and wound assessments, physician notification, and omission report. The QAPI sign-in sheet indicated all appropriate members of the IDT team were present for the QAPI meeting. During interviews with staff (LVN C, LVN D, LVN E, LVN B, and the ADON) on 4/3/24 between 11:00 a.m. and 12:19 p.m. staff were able to explain importance of ensuring TARs and MARs were signed off, how to pull an omission audit to check to make sure all TARs and MARs had been signed off and treatments had been completed, how often skin and wound assessments should be performed, the importance of reporting changes in skin conditions to the PCP or wound care doctor, and interventions to prevent pressure ulcers including offloading, turning and repositioning every 2 hours, pressure relieving cushions in a resident's wheelchair, and bathing to aide in circulation. On 4/3/24 at 12:21 p.m., the Administrator was informed the IJ was removed; however, the facility remained out of compliance the facility remained out of compliance with a scope identified as patterned and a severity of no actual harm with a potential for more than minimal harm due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44637 Based on observation, interview, and record review the facility failed to ensure a resident who had a urinary catheter received appropriate treatment and services to prevent urinary tract infections and pain for 1 of 7 (Resident #2) residents reviewed for urinary catheters. The facility did not ensure Resident #2's urinary catheter (a tube inserted into the bladder to drain urine) bag was not lying in the floor . This failure could place residents at risk for urinary catheter bags busting by being stepped on or wheeled over by a wheelchair allowing bacteria into the catheter tubing, pain, and infection. Findings included: 1. Record review of the face sheet dated 4/3/24 indicated Resident #2 was a [AGE] year-old female readmitted to the facility on [DATE] with diagnoses including muscle weakness, dementia, overactive bladder, chronic kidney disease, hypertension (elevated blood pressure), and lack of coordination. Record review of the MDS dated [DATE] indicated Resident #2 was understood others and was usually understood by others. The MDS indicated Resident #2 had a BIMS of 15 and was cognitively intact. The MDS indicated Resident #2 had an indwelling catheter (urinary catheter that is left in place) and was always incontinent of urine. Record review of the care plan revised on 2/7/24 indicated Resident #2 had impaired cognitive function/dementia or impaired thought processes related to dementia. During an observation on 4/2/24 at 1:36 p.m. Resident #2's urinary catheter bag was lying on floor. During an observation and interview on 4/3/24 at 9:34 a.m. Resident #2's urinary catheter drain bag was lying in the floor. Resident #2 said she did not put the catheter drain bag in the floor. Resident #2 said she could not reach the catheter drain bag to hang it on the bed where she liked it. Resident #2 said a staff member stepped on her catheter drain bag yesterday when it was in the floor and busted it. Resident #2 said staff replace the busted catheter drain bag and mopped the urine out of the floor. During an interview on 4/3/24 at 12:33 p.m. the ADON said a foley catheter drain bag should be positioned below the abdomen unless otherwise requested by the resident. The ADON said a foley catheter drain bag should not ever be in the floor. The ADON said the importance of ensuring a foley catheter drain bag was not in the floor was for infection control. The ADON said there were approximately 3 residents in the facility she thought would put their foley catheter drain bag in the floor. The ADON said one of those residents was Resident #2. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/3/24 at 1:00 p.m. CNA G said she usually worked the 200 hall. CNA G said urinary catheter drain bags should be below the waist of the resident with the tubing straight without kinks. CNA G said urinary catheter drain bags should not be in the floor. CNA G said the importance of catheter drain bags not being in the floor was for sanitary purposes and to ensure they do not get busted by being stepped on or rolled over with a wheelchair. CNA G said she was not aware of any residents who would place their foley catheter drain bag in the floor. During an interview on 4/3/24 at 1:31 p.m. the DON said she expected a urinary catheter drain bag to be positioned below the level of the bladder. The DON said a urinary catheter drain bag should not be in the floor. The DON said the importance of a foley catheter drain bag not being in the floor was infection control. During an interview on 4/3/24 at 1:33 p.m. the Administrator said she expected a foley catheter drain bag to be covered, anchored, and not in the floor. The Administrator said the importance of a foley catheter drain bag not being in the floor was infection control. Record review of the facility's Indwelling Catheter Use and Removal policy dated 7/2020 indicated, It is the policy of this facility to ensure that indwelling urinary catheters that are inserted or remain in place are justified or removed according to regulations and current standards of practice .Additional care practices include .c. Keeping the catheter anchored to prevent excessive tension on the catheter, which can lead to urethral tears or dislodgement of the catheter; and d. Securement of the catheter facilitate flow of urine, prevention of kinks in the tubing and positioning below the level of the bladder . Record review of the facility's Infection Prevention and Control Program policy dated 3/2022 indicated, This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections