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	08/25/2024

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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35340 Based on interview and record review the facility failed to provide or obtain laboratory services to meet the needs of residents for 1 of 5 residents (Resident #1) reviewed for laboratory services. The facility did not obtain UA labs as ordered by the physician for Resident #1. This failure could place residents at risk of not receiving treatment and services to meet their needs. Findings included: Record review of Resident #1's face sheet, printed on [DATE], reflected he was a [AGE] year-old male who originally admitted to facility on [DATE], readmitted to facility on [DATE] and expired in the facility on [DATE] with diagnoses which included Type 2 diabetes mellitus diabetic neuropathy (A chronic condition that affects the way the body processes blood sugar (glucose);With type 2 diabetes, the body either doesn't produce enough insulin, or it resists insulin) Diabetic neuropathy, which affects people with diabetes, causes pain or numbness in the hands, feet or limbs because the nerves are damaged.); Peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs); Lack of coordination (a neurological sign that causes a lack of voluntary muscle coordination. It can affect any part of the body, but people often have difficulty with balance and walking, speaking, swallowing, writing, and eating.); and Muscle weakness (occurs when your muscles don't contract properly, making them weaker than usual.) Record review of Resident #1's quarterly MDS date [DATE] reflected he had a BIMS of 13 and was cognitively intact. Resident #1 was able to make himself understood and had no issues understanding others. Also, revealed Resident #1 required moderate to substantial assistance with most ADLs. Record review of Resident #1's progress notes reflected the following: -On [DATE] at 11:56pm - Urine amber color [Physician] called at that time n.o lab order Urinalysis collected and ready to be picked up. Completed by: LVN B. -On [DATE] at 2:32am - n.o lab waiting to be collected at this time. Completed by: LVN B. Record review Resident #1's physician order dated [DATE] indicated LVN B created the order on [DATE] for UA with C/S. Directions: one time only to rule out UTI. (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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's electronic health records from [DATE] to [DATE] indicated there was no documentation of the UA results. During an attempted telephone interview on [DATE] at 2:35 p.m., LVN B was called but an unknown female answered, and denied knowing LVN B and ended the phone call. During an interview on [DATE] at 6:38 pm at 7:18 p.m., with LVN C who said she reviewed Resident #1's electronic chart and said LVN B ordered Resident #1 UA lab but did not see documentation of the UA results in Resident #1's chart. LVN C said she was not working on [DATE] and did not know if Resident #1's UA was picked up by the lab company who they were using at the time. LVN C said during the period of Resident #1's UA lab they were in the process of using a new lab company so it was possible something could have got missed. LVN C contacted the previous lab company who the facility used at the time Resident #1's UA lab was ordered, and the previous lab company told LVN C they did not have any information or UA labs regarding Resident #1 for the [DATE] period and was not aware of what she was talking about. LVN C said it was possible Resident #1's UA was never picked up by the previous lab company. During an interview on [DATE] at 7:30 p.m., VP of Clinical Operations said the previous DON no longer worked at the facility and said she had been working as the Interim DON until facility can find a new DON. The VP of Clinical Operations said reviewed Resident #1's electronic chart and said she did see an UA order for Resident #1, but she did not see the UA lab results on the chart. She said ultimately it was the DON's responsibility to ensure all labs were being done. The VP of Clinical operations said the following morning during morning meetings was when DON should have followed up and verified Resident #1's UA labs were done, said she was not sure if the previous DON did that. She said LVN C just informed her the previous lab company told her on the phone they did not have UA labs for Resident #1 and for [DATE] period. VP of Clinical Records explained the previous lab company who they were using at the time of the incident used a binder they kept at the nurse stations with Labs to pick up. VP of Clinical Operations said she tried looking for the previous Lab's company binder and she said she could not locate it and could not confirm if Resident #1's UA labs had been done. Record review of facility's laboratory services and reporting policy dated ,d+[DATE] revealed the following: The facility must provide or obtain laboratory services when ordered by a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with state law. Policy Explanation and Compliance Guidelines: 1. The facility must provide or obtain laboratory services to meet the needs of its residents. 2. The facility is responsible for the timeliness of the services. 3. Should the facility provide its own laboratory services, the services must meet the applicable requirement for laboratories. 6. All laboratory reports will be dated and contain the name and address of the testing laboratory and will be filed in the resident's clinical record. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside the clinical reference range.