

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/25/2025
NAME OF PROVIDER OR SUPPLIER Rose Trail Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44637</p> <p>Based on observations, interviews, and record review, the facility failed to develop and implement a comprehensive person-centered care plan to meet each resident's medical needs for 1 of 6 residents (Resident #3) reviewed for care plans.</p> <p>The facility failed to ensure Resident #3's care plan was updated when she completed her vitamin C, multivitamin with minerals, and zinc (supplements for wound care).</p> <p>This failure could place the residents at increased risk of not having their individual needs met and a decreased quality of life.</p> <p>Findings Included:</p> <p>1. Record review of the face sheet dated 3/25/25 indicated Resident #3 was admitted to the facility on [DATE] with diagnoses including pressure ulcer of the sacral region, dementia, and multiple sclerosis (a disease in which the immune system eats away at the protective covering of the nerves).</p> <p>Record review of the physician orders dated 3/25/25 indicated Resident #3 did not have an order for vitamin C, multivitamin with minerals, or zinc.</p> <p>Record review of the MDS dated [DATE] indicated Resident #3 understood others and was understood by others. The MDS indicated Resident #3 had a BIMS score of 11 and was moderately cognitively impaired. The MDS indicated Resident #3 had I unhealed stage 4 pressure ulcer that was present on admission/entry or reentry. The MDS indicated Resident #3 was receiving nutrition or hydration intervention to manage skin problems.</p> <p>Record review of the care plan last revised 10/28/24 indicted Resident #3 had actual impairment to skin integrity of stage 4 pressure injury to the coccyx (a small, triangular-shaped bone located at the bottom of the spine) with interventions including vitamin C 500mg twice a day, multivitamin with minerals, and zinc 50mg daily.</p> <p>Record review of the nurse progress note dated 3/15/25 indicated Resident #3 was sent to the ER due to a critical low hemoglobin (a protein found in red blood cells that carries oxygen throughout the body).</p> <p>(continued on next page)</p>

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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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview attempt on 3/21/25 at the hospital Resident #3 was unable to be observed or interviewed due to having the physician in the room examining her at the time of the state surveyor's visit.</p> <p>During an interview on 3/25/25 at 11:43 a.m. the DON said the facility did not have a policy specific to physician orders.</p> <p>During an interview on 3/25/25 at 2:01 p.m. the DON said the facility had a protocol for supplements such as vitamins and zinc for wound care. The DON said the facility's protocol was for a resident with a wound to be on supplements for 90 days and then the resident could be re-evaluated to determine if the supplements needed re-instated or not. The DON said the Treatment Nurse was responsible for updating care plans related to skin issues. The DON said once a supplement had been completed, she expected the care plan to be updated to reflect the resident was no longer on the supplement or for the supplement to be re-instated. The DON said the importance of updating care plans was for accuracy and to ensure the care plan matched each residents' needs.</p> <p>During an interview on 3/25/25 at 2:15 p.m. the Administrator said she expected care plans to be updated quarterly and as needed. The Administrator said the importance of updating care plans was to communicate a resident's needs and to ensure any changes in the residents' needs were documented for staff to know how to properly care for each resident.</p> <p>Record review of the facility's Comprehensive Care Plans policy dated 7/2022 indicated, 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 minimum the following: .f. Resident specific interventions that reflect the resident's needs and preferences and align with the resident's culture identity, as indicated .Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44637</p> <p>Based on interview and record review, the facility failed to ensure the necessary treatment and services, in accordance with comprehensive assessment and professional standards of practice, to prevent development of pressure injuries was provided for 1 of 4 (Resident #1) reviewed for pressure injuries.</p> <p>The facility failed to ensure Resident #1's dressing to her sacrum was changed/re-applied after becoming saturated or dislodged per physician orders.</p> <p>This failure could place residents at risk for new development or worsening of existing pressure injuries, pain, and decreased quality of life.</p> <p>Findings included:</p> <p>1. Record review of the face sheet dated 3/25/25 indicated Resident #1 was a [AGE] year-old female readmitted to the facility on [DATE] with diagnoses including pressure ulcer of the sacral region (the lower portion of the spine, located at the base of the vertebral column), muscle weakness, heart failure, and hypertension (elevated blood pressure).</p> <p>Record review of the physician orders dated 3/25/25 indicated Resident #1 had an order for wound care: stage 4 pressure wound (involves full-thickness skin and tissue loss, potentially exposing muscle, tendon, or bone and carries a high risk for infection) to the sacrum: cleanse with normal saline or wound cleanser, apply collagen powder (a specialized product derived from collagen that is applied directly to wound to promote healing and tissue regeneration) and pack with kerlix (gauze bandage rolls) dampened with Dakin's (a dilute solution of sodium hypochlorite, and antiseptic agent used to treat and prevent infections in wounds), and cover with foam dressing daily and PRN for saturation/dislodgement starting 3/17/25.</p> <p>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 score of 01 and was severely cognitively impaired. The MDS indicated Resident #1 had 1 stage 4 unhealed pressure ulcer that was present on admission/entry or reentry.</p> <p>Record review of the care plan last updated 1/16/25 indicated Resident #1 had actual impairment to skin integrity with a stage 4 pressure ulcer to the sacrum with interventions including clean, apply medications, and dressings as ordered by the physician.</p> <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 3/25/25 at 8:56 a.m. the Treatment Nurse performed wound care on Resident #1. The Treatment Nurse said Resident #1 had a stage IV pressure wound to her sacrum. The Treatment Nurse said Resident #1 had been sent to a behavior hospital (dates unknown) and from the behavior hospital was transferred to a medical hospital. The Treatment Nurse said when Resident #1 returned to the facility she had a large stage IV pressure covering the majority of her bottom. The Treatment Nurse said most of the wound had healed and scar tissue was present. Resident #1 was observed without a dressing in place to her sacral wound. The Treatment Nurse said Resident #1 would urinate heavy and often saturate her dressing. The Treatment Nurse said the dressing to Resident #1's sacral wound should be changed/reapplied if it became wet.</p> <p>During an interview on 3/25/25 at 9:00 a.m. Resident #1 said the night shift (did not provide names) changed her and her dressing was wet, so they removed the dressing, and did apply a new dressing.</p> <p>During an interview on 3/25/25 at 12:36 p.m. the Wound Care Doctor said he was familiar with Resident #1 and felt her wound was trending in the right direction. The Wound Care Doctor said if a wound dressing became soiled or wet, he expected the nurses to reapply a dressing to the wound per his orders. The Wound Care Doctor said the importance of keeping a dressing on a wound was to prevent bacteria and soilage from entering the wound.</p> <p>During an interview on 3/25/25 at 11:43 a.m. the DON said the facility did not have a policy specific to physician orders.</p> <p>During an interview on 3/25/25 at 2:01 p.m. the DON said if a wound dressing became saturated or dislodged, she expected CNAs to report the dressing to the nurses and the nurses to change/reapply the dressing as soon as possible. The DON said the importance of changing/reapplying a dressing to a wound was so the wound was not left open and the wound was kept clean.</p> <p>Record review of the facility's Comprehensive Care Plans policy dated 7/2022 indicated, 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 minimum the following: .f. Resident specific interventions that reflect the resident's needs and preferences and align with the resident's culture identity, as indicated . Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>44637</p> <p>Based on observations, interviews, and record review, the facility failed to maintain 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 for 2 of 3 residents (Resident #1 and #2) and 1 of 4 staff (Treatment Nurse) observed for infection control.</p> <p>The facility failed to ensure the Treatment Nurse changed gloves and performed hand hygiene while performing wound care and incontinent care on Resident #1 and Resident #2.</p> <p>This failure could place residents and staff at risk for cross-contamination, spread of infection, and could potentially affect all others in the building.</p> <p>Findings Included:</p> <p>1. During an observation on 3/25/25 at 8:56 a.m. the Treatment Nurse performed wound care and incontinent care on Resident #1 with assistance from CNA A. The Treatment Nurse and CNA A performed hand hygiene and donned PPE (gown and gloves) prior to providing care to Resident #1. CNA A assisted with Resident #1's positioning during the care. The Treatment Nurse opened Resident #1's wet brief and used a disposable wipe to wipe under Resident #1's abdominal fold. The Treatment Nurse changed gloves and did not perform hand hygiene. The Treatment Nurse cleaned Resident #1's vaginal area with disposable wipes utilizing one wipe per swipe. The Treatment Nurse changed gloves and did not perform hand hygiene. Resident #1 rolled to her right side with assistance from CNA A. The Treatment Nurse wiped Resident #1's bottom removed her gloves, performed hand hygiene, and donned clean gloves. The Treatment Nurse cleansed Resident #1's wound with normal saline, changed gloves, and did not perform hand hygiene. The Treatment Nurse applied collagen powder (a specialized product derived from collagen that is applied directly to wound to promote healing and tissue regeneration) to Resident #1's wound bed, packed the wound with Dakin's (a dilute solution of sodium hypochlorite, and antiseptic agent used to treat and prevent infections in wounds) soaked gauze, and applied a clean dressing. The Treatment Nurse did not change her gloves and began to apply barrier cream to Resident #1's bottom. The Treatment Nurse cleansed fresh urine from between Resident #1's legs, did not change gloves and continued applying barrier cream. The Treatment Nurse changed gloves and did not perform hand hygiene. CNA A assisted Resident #1 back on her back. The Treatment Nurse cleansed fresh urine from Resident #1's vaginal area, did not change gloves, and finished changing Resident #1's bed linens. The Treatment Nurse changed her gloves and did not perform hand hygiene. The Treatment Nurse applied barrier cream to Resident #1's vaginal area.</p> <p>2. During an observation on 3/25/25 at 9:41 a.m. the Treatment Nurse performed wound care on Resident #2. The Treatment Nurse prepared her supplies, performed hand hygiene, removed the dressings from Resident #2's heels, and removed her gloves. The Treatment Nurse performed hand hygiene with alcohol prep pads and donned clean gloves. The Treatment Nurse cleansed the wound to the right heel and changed her gloves without performing hand hygiene. The Treatment Nurse applied a collagen pad (pads derived from collagen that can play a crucial role in the wound healing process) and a dressing to the right heel. The Treatment Nurse changed her gloves and did not perform hand hygiene. The Treatment Nurse cleansed the wound to Resident #2's left heel, changed her gloves, and did not perform hand hygiene. The Treatment Nurse applied a collagen pad and dressing to the left heel.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/25/25 at 10:07 a.m. the Treatment Nurse said hand hygiene should be performed before and after providing care for a resident. The Treatment Nurse said she used alcohol wipes to perform hand hygiene between glove changes and washed her hands with soap and water if they were visibly dirty. The Treatment Nurse said gloves provided 100% protection against contamination. The Treatment Nurse said the importance of performing appropriate hand hygiene was to prevent the spread of bacteria and for infection control.</p> <p>During an interview on 3/25/25 at 2:01 p.m. the DON said she expected staff to perform hand hygiene in between care, when staff changed gloves, and when hands were visibly soiled. The DON said hand hygiene should be performed between glove changes to ensure there was not any transfer of germs or bacteria to the resident. The DON said the importance of appropriate hand hygiene was not to transfer microbes to a resident that could get them sick.</p> <p>During an interview on 3/25/25 at 2:15 p.m. the Administrator said she expected staff to perform hand hygiene before, during, and after providing resident care. The Administrator said the importance of proper hand hygiene was to keep infection down.</p> <p>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 .All staff are responsible for following all policies and procedures related to the program .Standard Precautions: a. All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services.</p> <p>b. Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures .</p>		