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	10/02/2025

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 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. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that all alleged violations involving abuse, or mistreatment were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 1 of 4 residents (Resident #7 and Resident #6) reviewed for abuse and neglect. The facility failed to report to Health and Human Services Commission an alleged incident of verbal abuse by Resident #6 towards Resident #7 on or about 07/2025. This failure could place residents at risk for abuse, humiliation, intimidation, fear, shame, agitation, and a decreased quality of life.Findings include:Resident #7Record review of a face sheet dated 10/01/25 indicated Resident #7 was a [AGE] year-old female initially admitted to the facility on [DATE] with diagnoses which included anxiety (intense, excessive and persistent worry and fear about everyday situations), mood disorder (disturbance in a person's mood), bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs). Record review of the Comprehensive MDS assessment dated [DATE] indicated, Resident #7 was able to make herself understood and understood by others. The MDS assessment indicated Resident #7 had a BIMS score of 4 which indicated Resident #7 severely cognitively impaired. The MDS assessment indicated Resident 7 was dependent on staff for all ADLs except partial assistance for eating and oral care. Record review of Resident #7's care plan with a target date of 12/24/2026 indicated she had a psychosocial well-being problem related to anxiety, dependent behavior, family discord, inability to solve problems with a goal to adjust and maintain ability to seek social contact and stimulation. Record review of Resident 7's Order Summary Report dated 10/01/25 indicated: Olanzapine Oral Tablet 15 MG (Olanzapine) Give 1tablet by mouth at bedtime related to bipolar disorder, current episode depressed, severe, with psychotic features. Record review of Resident #7's nursing progress note dated 07/11/25 indicated day 1/3 room change. Resident #7 was tolerating well. Record review of Resident #7's electronic data record indicated no further documentation of room change or why it was needed. Resident #6Record review of a face sheet dated 10/01/25 indicated Resident #6 was a [AGE] year-old female initially admitted to the facility on [DATE] with diagnoses which included systemic lupus erythematosus(an illness that occurs when the immune system attacks healthy tissues and organs), bipolar ((a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), depression, anxiety (intense, excessive and persistent worry and fear about everyday situations), mild cognitive impairment, and insomnia (inability to sleep),. Record review of the Comprehensive MDS assessment dated [DATE] indicated Resident #6 was able to make herself understood and was understood by others. The MDS assessment indicated Resident #6 had a BIMS score of 15 which indicated Resident #6 was cognitively intact. The MDS assessment indicated Resident #6 was independent with eating and oral hygiene, required set up personal hygiene, supervision of dressing, and dependent for toileting hygiene. Record review of Resident #6's care plan with a target date of 12/24/2025 indicated she was at risk for complications due to refusing care with a goal of no complications related to refusing care through next review. Record review of Resident 6's Order Summary Report dated 10/01/25 : Oxcarbazepine Oral Tablet 300 MG (Oxcarbazepine) Give 1 tablet by mouth two times a day related to bipolar disorder. During an interview on 09/27/25 at 06:30 PM, Resident #6 stated the facility removed Resident #7 from her room on or about 7/2025 and she was not told why. Resident #6 stated Resident #7 was her family member and wanted Resident #7 placed back into the same room. [During an interview on 10/01/25 at 1:15 PM, the Administrator stated a couple of months ago, Human Resources and the Maintenance Supervisor reported Resident #6 threatened to push Resident #7 out of a window like she did her first husband. The Administrator stated she immediately called Ombudsman M and reported the incident. The Administrator stated Ombudsman M advised her to separate Resident #6 and Resident #7. The Administrator stated she separated the residents but did not write a report or report it to HHSC. The Administrator stated she was the abuse coordinator. The Administrator stated allegations of abuse should have been reported to HHSC. The Administrator said it was important to ensure allegations of abuse were reported to HHSC to ensure a thorough investigation was completed and to protect the residents from further abuse. During an interview on 10/01/25 at 3:16 PM, the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm 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. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 8 residents (Resident #4) reviewed for care plans. The facility failed to ensure a care plan was developed and implemented for Resident #4's use of a Foley catheter and leg band strap stabilizer. These failures could place residents at risk of not having individual needs met and a decreased quality of life.The findings include: Record review of a face sheet dated 09/29/25 indicated Resident #4 was a [AGE] year-old male initially admitted to the facility on [DATE] with diagnoses which included acute kidney failure and neuromuscular dysfunction of the bladder (problem due to disease or injury of the central nervous system or nerves involved in the control of urination),. Record review of the Quarterly MDS assessment dated [DATE] indicated, Resident #4 was rarely able to make himself understood and was rarely understood by others. The MDS assessment indicated Resident #4 did not have BIMS score, which indicated Resident #4 was unable to complete the assessment. The MDS assessment indicated Resident #4 was dependent on staff for all ADLs. The MDS assessment indicated Resident #4 had an indwelling catheter. Record review of Resident #4's care plan did not indicate he had an indwelling catheter Resident #1's care plan did not address securing his Foley catheter. Record review of Resident #4's Order Summary Report dated 09/29/25 indicated: Foley catheter care every shift and as needed and may use leg strap to secure Foley tubing with a start date of 07/26/25. During an observation on 09/27/25 at 06:45 PM , Resident #4 was lying in the bed with the head of his bed elevated. Resident #4's Foley catheter was not secured to his leg. There was no securement device observed. During an observation on 09/28/25 at 12:00 PM Resident #4 was lying in the bed with the head of his bed elevated. Resident #4's Foley catheter was not secured to his leg. There was no securement device observed. During an observation on 09/29/25 at 11:13 AM, Resident #4 was lying in the bed with the head of his bed elevated. Resident #4's Foley catheter was not secured to his leg. There was no securement device observed. During an observation on 10/02/25 at 11:13 AM, Resident #4 was lying in bed with the head of his bed elevated. Resident #4's Foley catheter was not secured to his leg. There was no securement device observed. During an interview on 10/01/25 at 12:15 PM, the Administrator stated she expected the clinical nursing staff which included DON, ADON, and the MDS Coordinators to update and implement the residents' care plans quarterly and yearly. The Administrator said Resident 4's care plan should have included that he had a Foley catheter and reflected the care that was needed. The Administrator stated it was important for the care plans to be accurate to ensure all residents were provided with continuity of care. During an interview on 10/02/25 at 3:32 PM, the MDS Coordinator started working at the facility approximately 1 week ago. The MDS Coordinator stated the comprehensive care plan should be updated with every MDS assessment, any change in condition, any new or worsening behaviors, or any changes to the care or services received. The MDS Coordinator stated a Foley catheter should have been included in the care plan. She was unsure why Resident #4's Foley catheter was not care-planned. The MDS Coordinator stated she noticed comprehensive care plans were not being completed and developed a QAPI to fix it. The MDS Coordinator stated it was noticed today [10/02/25]. The MDS Coordinator stated it was important to ensure comprehensive care plans were implemented within appropriate timeframes to ensure residents received the care and services they needed. During an interview on 10/02/25 at 04:35 PM, ADON K said clinical nursing and the MDS Coordinator were responsible for updating the care plans. ADON K stated the corporate MDS nurse had been assisting the facility because the MDS Coordinator was new to the position. ADON K stated the care plans should be person-centered so that staff were aware how to take care of the residents. ADON K stated Resident #4's care plan should have reflected the foley catheter was in place and needed to have a security band to keep the Foley tube from being pulled and potentially causing damage to a resident. During an interview on 10/20/25 at 4:45 PM, the interim DON said the ADON, DON and MDS Coordinator were responsible for ensuring the care plans actively related to the resident to show the necessary care needed to allow the residents to meet their goals. The interim DON stated the care plans were a pathway to provide proper and appropriate care for each resident specifically. Record review of the Care Plan , Comprehensive Person policy, revised on March of 2022, stated, This identification and implementation of a plan of care will

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	455429	A. Building B. Wing	10/02/2025

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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. (continued on next page)

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	455429	A. Building B. Wing	10/02/2025

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for 2 of 8 residents (Resident #1 and Resident #4) reviewed for treatment and services related to indwelling catheters. 1. The facility failed to ensure Resident #1's foley catheter was secured on 09/11/2025. 2. The facility failed to ensure Resident #4 foley catheter was secured on 09/27/25, 09/28/25, 09/29/25, and 10/02/25. These failures could place residents at risk for urinary tract infections, dislodgment, potential complications and a decreased quality of life.Findings included:1. Record review of a face sheet dated 09/29/25 indicated Resident #1 was a [AGE] year-old male initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included neuromuscular dysfunction of the bladder (problem due to disease or injury of the central nervous system or nerves involved in the control of urination). Record review of the Comprehensive MDS assessment dated [DATE] indicated Resident #1 was rarely able to make himself understood and was rarely understood by others. The MDS assessment indicated Resident #1 did not have BIMS score, which indicated Resident #1 was unable to complete the assessment. The MDS assessment indicated Resident #1 was dependent on staff for all ADLs. The MDS assessment indicated Resident #1 had an indwelling catheter. Record review of Resident #1's care plan dated 05/27/25 with a target date of 10/21/25 indicated he had an indwelling catheter with a goal of he would be free from catheter related trauma through the review date. Resident #1's care plan did not address securing his Foley catheter. Record review of Resident #1's Order Summary Report dated 09/25/25 indicated: Foley catheter care every shift and as needed and may use leg strap to secure foley tubing with a start date of 06/23/24. Record review of Resident #1's Treatment Administration Record indicated Resident #1's Foley catheter tubing securement device placement had been checked daily. During an observation on 09/29/25 at 2:19 PM of a video, date stamped at 09/11/25 at 4:04 PM, showed Resident #1 was lying in the bed with the head of his bed elevated. Resident #1's Foley catheter was not secured to his leg. There was no securement device observed. 2. Record review of a face sheet dated 09/29/25 indicated Resident #4 was a [AGE] year-old male initially admitted to the facility on [DATE] with diagnoses which included acute kidney failure, and neuromuscular dysfunction of the bladder (problem due to disease or injury of the central nervous system or nerves involved in the control of urination). Record review of the Quarterly MDS assessment dated [DATE] indicated, Resident #4 was rarely able to make himself understood and was rarely understood by others. The MDS assessment indicated Resident #4 did not have BIMS score, which indicated Resident #4 was unable to complete the assessment. The MDS assessment indicated Resident #4 was dependent on staff for all ADLs. The MDS assessment indicated Resident #4 had an indwelling catheter. Record review of Resident #4's care plan did not indicate he had an indwelling catheter Resident #1's care plan did not address securing his Foley catheter. Record review of Resident #4's Order Summary Report dated 09/29/25 indicated: Foley catheter care every shift and as needed with a start date of 07/26/25. check Foley catheter tubing secure device placement every shift. May use leg strap to secure Foley in place with a start date of care every shift and as needed with a start date of 07/26/25. Record review of Resident's # 4's electronic Treatment Administration Record dated 09/2025 indicated the Foley catheter tubing secure device placement had been verified every shift for 09/01/25 - 09/28/25. During an observation on 09/27/25 at 06:45 PM , Resident #4 was lying in the bed with the head of his bed elevated. Resident #4's Foley catheter was not secured to his leg. There was no securement device observed. During an observation on 09/28/25 at 12:00 PM Resident #4 was lying in the bed with the head of his bed elevated. Resident #4's Foley catheter was not secured to his leg. There was no securement device observed. During an observation on 09/29/25 at 11:13 AM, Resident #4 was lying in the bed with the head of his bed elevated. Resident #4's Foley catheter was not secured to his leg. There was no securement device observed. During an observation on 10/02/25 at 11:13 AM, Resident #4 was lying in bed with the head of his bed elevated. Resident #4's Foley catheter was not secured to his leg. There was no securement device observed. During an interview on 10/01/25 at 01:15 PM, the Administrator stated she was not clinical, and she expected the ADONs and the DON to have oversight of the nursing staff to ensure the safety and well-being of the resident's health care needs and to ensure the physician orders were followed appropriately During an interview on 10/02/25 3:46 PM, RN B stated nurses were responsible for ensuring Foley catheters were secured. RN B stated it should have been checked every shift. RN B stated

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	455429	A. Building B. Wing	10/02/2025

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. (continued on next page)

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	455429	A. Building B. Wing	10/02/2025

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide respiratory care, including tracheostomy care and tracheal suctioning consistent with professional standards of practice, the resident's care plan, and the resident's preferences, for 2 of 3 residents (Resident #1 and Resident #2) reviewed for respiratory care. The facility failed to ensure LVN C assessed Resident #1 when he exhibited abdominal retractions (a sign of respiratory distress) while breathing on 09/24/25. The facility failed to ensure LVN A, LVN C, LVN D, and the Interim DON used sterile technique while performing tracheotomy suctioning on Resident #1. The facility failed to ensure RN B used sterile technique while performing tracheotomy care on Resident #2 on 09/29/25. The facility failed to follow the tracheotomy care and suctioning policy and procedure. The facility failed to provide competency check offs for LVN A, LVN C and LVN D on tracheotomy care and suctioning. Immediate jeopardy (IJ) was identified on 09/30/25 at 04:00 PM. The IJ template was provided to the facility on [DATE] at 04:38 PM. While the IJ was removed on 10/02/25 at 05:13 PM, the facility remained out of compliance at a scope of a patterned and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy because all staff had not been provided education on the policy and procedure for sterile tracheotomy care and suctioning. These failures could place residents at risk of respiratory complications, infections and death.Findings included: 1. Record review of a face sheet dated 09/29/25 indicated Resident #1 was a [AGE] year-old male initially admitted to the facility on [DATE] and re-admitted on [DATE] with a diagnosis of tracheostomy status. Record review of the Comprehensive MDS assessment dated [DATE] indicated, Resident #1 was rarely able to make himself understood and was rarely understood by others. The MDS assessment indicated Resident #1 did not have BIMS score, which indicated Resident #1 was unable to complete the assessment. The MDS assessment indicated Resident #1 was dependent on staff for all ADLs. The MDS assessment indicated Resident #1 had a tracheotomy. Record review of Resident #1's care plan dated 04/16/25 with a target date of 10/21/25 indicated he had a tracheotomy with a goal indicating he would be relieved of secretions and congestion within five minutes of suctioning and no occurrence of infection. Record review of Resident #1's Order Summary Report dated 09/29/25 indicated: Change tracheotomy dressing with tracheotomy care every day and PM with a start date of 06/27/25. Record review of Complaint/Grievance dated 08/12/25 indicated Resident #1's family member complained the staff was not providing tracheotomy care and suctioning using sterile technique. Resident #1's family member provided videos of staff providing tracheotomy care without using sterile technique. The grievance indicated the resolution was all nurses on North Hall were in serviced on tracheotomy care and suctioning using sterile technique. Record review of Resident #1's electronic medical record did not indicate a re-assessment was performed by LVN C after 09/24/25 at 09:29 AM when Resident's #1 was showing signs and symptoms of respiratory distress . Record review of a nursing progress note dated 09/25/25 at 01:42 PM written by LVN C indicated [family member] called stated the hospital called and informed her that patient needed to go back to the hospital. I attempted to call the hospital and get more information but no luck. Doctor making rounds per his advice to send resident out to the hospital for further treatments since he was positive gram. Called [family member] informed of the situation of him going back to the hospital. Called EMS no estimated time of arrival on pick up time. ADON, DON aware of situation. Record review of a nursing progress note dated 09/25/25 at 05:20 PM indicated family at facility inquiring why resident was not yet transferred to hospital, this nurse explained that transportation had been set up but facility was waiting on non emergent EMS. Call placed to EMS for updated ETA. EMS stated that they had not received a call for transport. This nurse relayed that resident was needing to be transported to [name] Hospital. EMS stated that they would be on they way to transport. Record review of the admission hospital records dated 09/25/25 indicated Resident #1 was admitted with chronic respiratory failure with tracheostomy in place. Laboratory results indicated Resident #1 had bacteremia (bacteria is present in the bloodstream), staph hominis (gram positive bacteria in the bloodstream), and pseudomonas (gram positive bacteria found in lungs, skin, ears) During an observation on 09/29/25 at 2:19 PM of a video, date stamped 09/16/25 at 05:09 AM, LVN A entered Resident #1's room wearing gloves and carrying a pitcher of water. LVN A flushed Resident #1's PEG tube (a feeding tube inserted into the abdomen into the stomach) and then provided incontinent care. LVN A did not change gloves or perform hand hygiene. LVN A proceeded to grab the suction catheter from the bedside table and suctioned Resident #1. LVN A did not change her

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	455429	A. Building B. Wing	10/02/2025

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to establish and 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 5 of 5 residents (Resident's #1, # 2, #3) reviewed for infection control practices. The facility failed to ensure LVN A, LVN C, LVN D, and the Interim DON used sterile technique while performing tracheotomy suctioning on Resident #1. The facility failed to ensure RN B used sterile technique while performing tracheotomy care on Resident #2 on 09/29/25. The facility failed to follow the tracheotomy care and suctioning policy and procedure. The facility failed to ensure LVN A, LVN C, LVN D, the interim ADON, LVN G and CNA H wore enhanced barrier precautions while performing care on Resident #1, who had a feeding tube, tracheostomy tube, wound, and Foley catheter. The facility failed to ensure CNA E and CNA F wore enhanced barrier precautions while providing care to Resident #3 who had a Foley Catheter. The facility failed to ensure the nursing staff knew how to access PPE and sterile supplies for enhanced barrier precautions. Immediate jeopardy (IJ) was identified on 09/30/25 at 04:00 PM. The IJ template was provided to the facility on [DATE] at 04:38 PM. While the IJ was removed on 10/02/25 at 05:13 PM, the facility remained out of compliance at a scope of a patterned and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy because all staff had not been provided education on providing sterile tracheotomy care and suctioning and enhanced barrier precautions. These failures could place residents and staff at risk for cross contamination and serious injury, harm, impairment, and death from the spread of an infectious disease.Findings included: 1. Record review of a face sheet dated 09/29/25 indicated Resident #1 was a [AGE] year-old male initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included autistic disorder (difficulties in social communication and interaction, strong preference for routine, sensory processing differences, focused interest and repetitive behaviors), schizoaffective disorders (symptoms of delusional, hallucinations, depressed episodes followed by manic periods of high energy), anemias, and neuromuscular dysfunction of the bladder (problem due to disease or injury of the central nervous system or nerves involved in the control of urination), tracheostomy status, encounter for attention to gastrostomy (feeding tube). Record review of the Comprehensive MDS assessment dated [DATE] indicated, Resident #1 was rarely able to make himself understood and was rarely understood by others. The MDS assessment indicated Resident #1 did not have BIMS score, which indicated Resident #1 was unable to complete the assessment. The MDS assessment indicated Resident #1 was dependent on staff for all ADLs. The MDS assessment indicated Resident #1 had a tracheotomy. Record review of Resident #1's care plan with a target date of 10/21/25 indicated he had a tracheotomy with a goal of he would be relieved of secretions and congestion within five minutes of suctioning and no occurrence of infection. Record review of Resident #1's Order Summary Report dated 09/29/25 indicated: Change tracheotomy dressing with tracheotomy care every day and PM with a start date of 06/27/25. Record review of Complaint/Grievance dated 08/12/25 indicated Resident #1's family member complained the staff was not providing tracheotomy care and suctioning using sterile technique. The grievance indicated the resolution was all nurses on North Hall were in serviced on tracheotomy care and suctioning using sterile technique. Record review of the admission hospital records dated 09/25/25 indicated Resident #1 was admitted with chronic respiratory failure with tracheostomy in place. Laboratory results indicated Resident #1 had bacteremia (bacteria is present in the bloodstream), staph hominis (gram positive bacteria in the bloodstream), and pseudomonas (gram positive bacteria found in lungs, skin, ears) 2. Record review of a face sheet dated 09/30/25 indicated Resident #2 was a [AGE] year-old male initially admitted to the facility on [DATE] with diagnoses which included anoxic (lack of oxygen) brain damage, flaccid neuropathic bladder (central nervous system or nerves involved in the control of urination) , anemia, epilepsy (seizures), mild protein-calorie malnutrition, cerebral infarction due to embolism (stroke), acute respiratory failure, tracheostomy (surgical procedure that creates an opening in the front of the neck (trachea) and inserts a tube to help a person breath). Record review of the Quarterly MDS assessment dated [DATE] indicated, Resident #2 was rarely able to make himself understood and was rarely understood by others. The MDS assessment indicated Resident #4 did not have BIMS score, which indicated Resident #4 was unable to complete the assessment. The MDS assessment indicated Resident #4 was dependent on staff for all ADLs. The MDS assessment indicated