| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455429 | A. Building<br>B. Wing | 11/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Rose Trail Nursing and Rehabilitation Center | 930 S Baxter<br>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 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>(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 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | **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 baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the residents that meet professional standards of quality care within 48 hours of the residents' admission for 2 of 2 residents (Resident #1, Resident #2). The facility failed to ensure Resident #1, and Resident #2 had a baseline care plan.This failure could place residents at risk for not communicating appropriate treatment and services to meet their needs.Findings included: A Review of the physician's orders and face sheet dated [DATE] indicated Resident #1was a 58 -year-old female who admitted on [DATE] with diagnoses including acute respiratory failure, unspecified lack of coordination, scabies, urinary tract infection bacteremia muscle weakness, schizophrenia, borderline intellectual functioning, anemia, atrial fibrillation, mood disorder, pressure ulcer, rhabdomyolysis, acute kidney failure, Systemic inflammatory response syndrome, hyperkalemia, hyperlipidemia and hypertension. A review of Resident #1 quarterly MDS section C dated [DATE], revealed a BIM score of 05 (Brief Interview for Mental Status) score of 5 indicates severe cognitive impairment. Record review of Resident #1's care plans, there were none initiated since admission on [DATE] did not document, develop or implement any current diagnosis, care level, any measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs. During a phone interview on 10/14/2025 at 10:20 AM with a daughter of resident #1, she said she has not had a care plan meeting with the facility. During an observation and interview on 10/14/2025 at 11:00 AM, Resident #1 was resting in her bed. Sher was awake with some noticeable confusion, she was totally dependent on staff for ADL's, room was clean without any odors noted she said she was going to be going back to her hometown to another facility which was closer to her family. She said she knew that the social worker was contacting the other facility to help get her transferred. During an interview on 10/14/2025 at 12:18PM, the administrator and the Social Worker both said they were not aware of issues of residents #1 & #2's care plans, and the MDS nurses were responsible for these, and the DON should have overseen that the care plans were completed appropriately and timely. Both admitted the care plans were an issue due to transition of interim DON and new MDS Nurse who was out sick and only been with the facility for a couple of weeks. The administrator said they were addressing this issue in the daily morning meetings to be informed of changes to be care planned but did not know what happened. During an interview on 10/14/2025 at 2:00 PM, the ADON said the care plans were the responsibility of the MDS Nurse (RN) she was an LVN, and it is the responsibility of the RN. A Review of the physician's orders and face sheet dated [DATE] indicated Resident #2 was a 63 -year-old male who admitted on [DATE] and re-admitted on [DATE] with hypertension, Dementia, severity with other Behavioral Disturbance, lack of Coordination, abnormal posture difficulty in walking, not elsewhere classified, unsteadiness on feet, muscle weakness, cerebral infarction, type 2 diabetes with diabetic neuropathy, anxiety disorder, altered mental status, shortness of breath, constipation, hemiplegia and hemiparesis, skin changes, pressure ulcer of sacral region, stage 3, disorders of ear, bilateral, candidiasis, dry eye syndrome. A review of Resident #2 quarterly MDS section C revealed a BIM score of 10 (Brief Interview for Mental Status) score of indicates moderately cognitive impairment. Record review of Resident #2's care plans, there were none initiated since admission on [DATE] did not document, develop or implement any current diagnosis, care level any measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs. During an interview on 10/13/2025 at 12:30 PM resident #2 was observed up in his specialized wheelchair, with hydraulics up high in air, he did not response to verbal stimuli with first attempt, after much encouragement he responded and stated he had no current issues with the facility. During an interview on 10/14/2025 at 12:18PM, the administrator and the Social Worker both said they were not aware of issues of residents #1 & #2's care plans, and the MDS nurses were responsible for these, and the DON should have overseen that the care plans were completed appropriately and timely. Both admitted the care plans were an issue due to transition of interim DON and new MDS Nurse who was out sick and only been with the facility for a couple of weeks. The administrator said they were addressing this issue in the daily morning meetings to be informed of changes to be care planned but did not know what happened. During an interview on 10/14/2025 at 2:00 PM, the ADON said the care plans were the responsibility of the MDS Nurse (RN) she was an LVN, and it is the responsibility of the RN. Record review of an updated care planning policy dated March 2022 indicated the care planning/interdisciplinary team shall |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and records reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident to ensure the comprehensive care plan described the services and interventions to be used to attain and maintain the resident's practicable physical, mental, and psychosocial well-being for 4 of 4 residents reviewed for care plans (Resident #1, Resident #2 Resident #3, and Resident #4).The facility failed to ensure Residents 1, 2, 3, and 4 had documented a completed Comprehensive Care Plan. This failure could place residents at risk for not communicating appropriate treatment and services to meet their needs.Finding included: A Review of the physician's orders and face sheet dated [DATE] indicated Resident #1was a 58 -year-old female who admitted on [DATE] with diagnoses including acute respiratory failure, unspecified lack of coordination, scabies, urinary tract infection bacteremia muscle weakness, schizophrenia, borderline intellectual functioning, anemia, atrial fibrillation, mood disorder, pressure ulcer, rhabdomyolysis, acute kidney failure, Systemic inflammatory response syndrome, hyperkalemia, hyperlipidemia and hypertension. A review of Resident #1 quarterly MDS section C dated [DATE], revealed a BIM score of 05 (Brief Interview for Mental Status) score of 5 indicates severe cognitive impairment.Record review of Resident #1's care plans initiated since admission on [DATE] did not document, develop or implement any current diagnosis, care level any measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs. During a phone interview on 10/14/2025 at 10:20 AM with a daughter of resident #1, she said she has not had a care plan meeting with the facility. During an observation and interview on 10/14/2025 at 11:00 AM, Resident #1 was resting in her bed. She was awake with some noticeable confusion, she was totally dependent on staff for ADL's, room was clean without any odor noted she said she was going to be going back to her hometown to another facility which was closer to her family. She said she knew that the social worker was contacting the other facility to help get her transferred. During an interview on 10/14/2025 at 12:18PM, the administrator and the Social Worker both said they were not aware of issues of resident's care plans, and the MDS nurses were responsible for these, and the DON should have overseen that the care plans were completed appropriately and timely. Both admitted the care plans were an issue due to transition of interim DON and new MDS Nurse who was out sick and only been with the facility for a couple of weeks. The administrator said they were addressing this issue in the daily morning meetings to be informed of changes to be care planned but did not know what happened. During an interview on 10/14/2025 at 2:00 PM, ADON said the care plans were the responsibility of the MDS Nurse (RN) she was a LVN, and it is the responsibility of the RN. A Review of the physician's orders and face sheet dated [DATE] indicated Resident #2 was a 63 -year-old male who admitted on [DATE] and re-admitted on [DATE] with hypertension, Dementia, severity with other Behavioral Disturbance, lack of Coordination, abnormal posture difficulty in walking, not elsewhere classified, unsteadiness on feet, muscle weakness, cerebral infarction, type 2 diabetes with diabetic neuropathy, anxiety disorder, altered mental status, shortness of breath, constipation, hemiplegia and hemiparesis, skin changes, pressure ulcer of sacral region, stage 3, disorders of ear, bilateral, candidiasis, dry eye syndrome. A review of Resident #2 quarterly MDS section C revealed a BIM score of 10 (Brief Interview for Mental Status) score of indicates moderately cognitive impairment. Record review of Resident #2's care plans initiated since admission on [DATE] did not document, develop or implement any current diagnosis, care level any measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs. During an interview on 10/13/2025 at 12:30 PM with resident #2 was observed up in his specialized wheelchair, with hydraulics up high in air, he did not response to verbal stimuli with first attempt, after much encouragement he responded and stated he had no current issues with the facility During an interview on 10/14/2025 at 12:18PM, the administrator and the Social Worker both said they were not aware of issues of resident's care plans, and the MDS nurses were responsible for these, and the DON should have overseen that the care plans were completed appropriately and timely. Both admitted the care plans were an issue due to transition of interim DON and new MDS Nurse who was out sick and only been with the facility for a couple of weeks. The administrator said they were addressing this issue in the daily morning meetings to be informed of changes to be care planned but did not know what happened. During an interview on 10/14/2025 at 2:00 PM, ADON said the care plans were the responsibility of the MDS Nurse (RN) she was an LVN, and it is the responsibility of the RN. A review of Resident #3's face sheet and physician's orders both dated for [DATE], indicated Resident |