

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675046	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2024
NAME OF PROVIDER OR SUPPLIER Rosenberg Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1419 Mahlman St Rosenberg, TX 77471	

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46561</p> <p>Based on interviews and record reviews the facility failed to ensure that the resident environment remained as free of accident hazards as was possible and that each resident received adequate supervision and assistance devices to prevent accidents for one (Resident #1) of five residents reviewed for accidents hazards and supervision, in that:</p> <p>The facility failed to ensure Resident #1's noodles were served at the appropriate temperature, which resulted in a burn to the palm of her hand.</p> <p>The failure could place residents at risk of experiencing accidents, injuries, and/or death.</p> <p>Findings Included :</p> <p>Resident #1</p> <p>Record review of the face sheet for Resident #1 revealed a [AGE] year old female who was admitted to the facility on [DATE]. Her admitting diagnoses was epilepsy (neurological condition that causes unprovoked, recurrent seizures), unsteadiness on feet, seizures, unspecified convulsions, and dementia (memory loss).</p> <p>Record review of Resident #1's MDS assessment completed 05/31/24 revealed a cognitive score of a 10 (moderately impaired) out of 15. Cognitive functioning in relation to eating revealed that supervision and set up was required during meals.</p> <p>Record review of Resident #1's care plan revised 06/10/19 displayed that she had a diagnosis of seizures and took anticonvulsant medications which placed the resident at risk for falls and Injury. Focus initiated on 8/19/24 revealed that she was at risk for injury related to preparing and transporting hot liquids without staff assistance. Interventions were for staff to assist Resident #1 with preparation and delivery of hot liquids and to educate nursing and dietary staff on the proper temperature for meal requests.</p> <p>Record review of the accident report dated 08/19/24 stated that Resident #1 had red discoloration on her hand due to transporting a cup of noodles to her room after lunch. Inservice's were started on 08/19/24 and the dietary staff was educated on safe hot beverage handling. Education had begun for nurses and CNA's on the microwave and hot beverage policy and abuse and neglect.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 08/21/24 at 12:00 p.m., DA B stated that on 08/19/24, Resident #1 came to the kitchen and requested that she warmed up her cup of ramen noodles in the microwave. She stated that the kitchen staff was instructed not to warm up outside food in the kitchen, but DM A gave her permission to do so this time. She explained that she warmed the cup of noodles in the microwave for exactly one minute and 30 seconds. She stated that other residents were also at the kitchen door so she did not give Resident #1 the cup of noodles immediately out of the microwave, but she was cautious when doing so. She explained that Resident #1 was an independent eater, but she did shake on her hands and arm. When she handed her the cup, she gave it to her in her hand. DA B stated that she was not a cook and only the cooks would check the temperatures on food. Her role in the kitchen was to wrap napkins and she tended to trays .</p> <p>In an interview on 08/21/24 at 1:04 p.m., Resident #1 stated that on the day she burned her hand, she stated that she went to the kitchen with her cup of instant noodles. She stated that when the dietary aid gave her the noodles, she shoved it into her hand. This made the water spill out and burn the palm of her hand. She explained that she shook and when they normally warmed up her noodles, they gave it to her with a tray. She stated that her hand felt better today, but it was hurt badly a few days prior.</p> <p>In an observation on 08/21/24 at 1:05 p.m., the instant cup of noodles from Resident #1 was reviewed. Packaging directions read to fill the cup with boiling hot water and let them stand for 3 minutes with the lid on the cup. Warning label instructed to be cautious, hot; handle with care especially when serving children.</p> <p>In an interview on 08/21/24 at 2:22 p.m., DM A stated that in regard to Resident #1, DA B should have given the noodles to her on a tray because she would shake. DM A stated that after the incident, she asked DA B that if she knew Resident #1 shook, why she did not give her the noodles on a tray. DA B responded that she was not thinking. DM A stated she would have never given her the noodles without a tray and she instructed her to give out a tray in the future, however the protocol had changed and they were no longer allowed to warm up resident food inside of the kitchen.</p> <p>In an interview on 08/21/24 at 3:57 p.m., the Admin stated that the incident with Resident #1 happened on 08/19/24. When he saw her, she was walking down the hallway near the nurses station after lunch. She looked shaky and agitated and when he observed her hand, he could see that her right hand was a lot more red than her left. When asked what happened, Resident #1 stated that she burned her hand on a cup of noodles. She stated that when the dietary aid handed her the noodles, she handed it to her more than gently so the noodles slushed out of the cup and burned her hand. There were also noodles hanging off the side of the cup. Resident #1 told him that she normally received a tray during this handoff. Admin stated that a new policy was implemented where only nurses were allowed to heat up things in the microwave. All staff had not completed the in-service, but they were in the process of updating everyone of the new procedures. He also followed up with wound care and the burn did not result in a wound, only redness.</p> <p>In an interview on 08/21/24 at 4:15 p.m., the WCN stated that she was called to assess Resident #1's hand on 08/19/24. She explained that the palm of her hand was reddened but it didn't blister. Resident #1 stated her hand hurt and the wound was treated with an order of Silvadene cream and was wrapped up. She monitored the wound daily and told Resident #1 to let the charge nurse know if she was in pain. The wound care doctor was in the facility earlier the morning of 08/21/24 and said that the burn had resolved, and he discharged the order for the cream because the redness was gone.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 08/21/24 at 4:24 p.m., RN A stated that when she saw Resident #1 on 08/19/24, she was in the hallway talking to the Admin and she said she had burned her hand with the cup of noodles. RN A assessed her hand, and it was red. She offered her Tylenol for pain and when she checked on Resident #1 15 minutes later, she denied anymore pain. She described the injury on her right hand as red in discoloration but there were no tears. RNA Stated that she worked on 08/19/24 and 08/20/24, and when she checked on her on 08/20/24, she denied pain and pain medication. She stated the wound care doctor reviewed her hand and stated that everything was good.</p> <p>Record review of the facility's Food and Safety sanitation policy reviewed 07/22/21 revealed:</p> <p>a. Proper reheating- foods reheated in the microwave over must be reheated in a uniform manner so that all parts are heated to 165 degrees F. The food will be rotated or stirred, covered, and the allowed to sit for 2 minutes.</p> <p>b. Personal Hygiene Practices- thorough hand washing is required (but not limited to) the following situations: after coughing, sneezing, or touching hair or face.</p> <p>Food handling: Food service employees will minimize bare hand contact with food that is ready to eat. Except when washing fruits and vegetables, food service employees may not contact exposed, ready to eat food with their bare hands, Instead, suitable utensils such as deli tissue, tongs, single use gloves, or dispensing equipment must be utilized.</p>

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46561</p> <p>Based on interview and record review, the facility failed to ensure that each resident receives, and the facility provides food that accommodates resident allergies, intolerances, and preferences for 1 (Resident #2) of 5 residents reviewed, in that:</p> <p>[NAME] A denied Resident #2, the 2 cheese flour tortillas requested on his breakfast meal ticket every morning.</p> <p>This failure could place residents at risk for decreased quality of life and weight loss.</p> <p>Findings included:</p> <p>Record review of Resident #2's face sheet revealed a sixty-year-old man who was admitted to the facility on [DATE]. His admitting diagnoses was Parkinson's Disease (disorder that affects the nervous system and the parts of the body controlled by the nerves), kidney failure, reduced mobility, and obesity.</p> <p>Record review of Resident #1's MDS assessment completed 07/03/24 revealed a cognitive score of a 15 (cognitively intact) out of 15. Cognitive functioning in relation to eating revealed that supervision and set up was required during meals.</p> <p>Record review of Resident #2's care plan revised 01/14/20 that he was a regular diet, regular texture, and was to receive large portions. Interventions were to provide and serve diet as orders.</p> <p>In an interview on 08/21/24 at 12:26 p.m., Resident #2 stated he had a problem with his meal ticket. He explained that every morning he was supposed to receive two flour tortillas with cheese but he never got them. Instead, he said he would be given two slices of toast. On the ticket, he explained that this order is always highlighted at the bottom and he informed DM A and the Admin about this occurrence. He could not detail how long his food preference had been denied, but he stated that it had been a long time. He felt that this was being done on purpose and it made him mad.</p> <p>In an interview on 08/21/24 at 12:31 p.m., DM A was asked to go through the breakfast meal tickets to view what is requested by Resident #2. At the bottom of the meal ticket, it stated that he was to receive two flour tortillas with cheese and it was highlighted in green. She stated that he told her on 08/20/24 that he had not been receiving his tortillas and she had an in-service with [NAME] A. The in-service instructed her to follow exactly what was on the ticket. [NAME] A was sent home on 08/20/24 due to insubordination. DM A stated that the dietary staff have to give the residents what they have requested.</p> <p>(continued on next page)</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 08/21/24 at 1:30 p.m., [NAME] A stated it was her fault that Resident #2 had not gotten his flour tortillas and she recognized that. She then stated that she did not know that he had cheese tortillas on his ticket because another dietary staff would read it out to her while she plated. She stated that on the morning on 08/21/24, the order for the tortillas was on the ticket but it was not read out to her. When asked when he liked those tortillas, she stated that he wanted them Monday-Sunday. She explained that some days he would want multiple tortillas but when they would bring his plate back, they would still be on his plate uneaten. She stated that going forward, she is going to start giving him the requested cheese tortillas.</p> <p>In an interview on 08/21/24 at 2:22 p.m., DM A stated that on 08/20/24, she asked [NAME] A to make a requested item for a different resident and she stated she was not going to do it. She did not know what was wrong with [NAME] A, but she was sent home for insubordination. On the morning of 08/21/24, she asked [NAME] A if Resident #2 had his two cheese flour tortillas. She said no and [NAME] A was written up. DM A stated that every day, extra requests are highlighted on the ticket and she knew it be a fact that the dietary aid read the ticket out to her in full. She did not know why she did not make the tortillas for Resident #2. When told that [NAME] A denied knowing that Resident #2 requested the tortillas but later stated that he would not eat them, DM A stated Exactly. If he she didn't know he wanted them, then how does she know that he does not eat them?.</p> <p>In an interview on 08/21/24 at 3:57 p.m., the Admin stated that Resident #2 told him on Friday that he had not been receiving his tortillas from his meal ticket. He told me to look at his meal ticket and it said that he was to receive two flour tortillas. He stated that he went to dietary and the DM said she would handle it, but apparently he did not receive flour tortillas on 08/21/24 or 08/20/24.</p> <p>Record review of the Employment Action/Disciplinary Notice Form dated 08/21/24 revealed that [NAME] A was written up because Resident #2 had not received his 2 flour tortillas as it was written his tray ticket. The summary stated that her behavior was not acceptable and it would not be tolerated.</p> <p>Record review of the Culinary Specialist Job responsibilities (not dated) displayed that they were to prepare quality food and baked goods according to the planned menu.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>46561</p> <p>Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 (DA A) kitchen staff reviewed for dietary services .</p> <p>During lunch, DA A failed to wear gloves and properly clean his hands during service while he touched his face mask, key chain, and rubbed his eyes.</p> <p>This failure could place residents at risk for injury and food borne illness during food preparation and services.</p> <p>Findings included :</p> <p>In an observation and interview on 08/21/24 at 12:13 p.m., DA A was tasked with taking the finished plates off the hot line and putting them on the trays inside of the food cart. DA A was the only kitchen staff observed without gloves. During service, DA A touched his face mask covering his mouth. When he spoke, DA A used his bare hand to pull the mask down and speak with other kitchen staff. He bent over and grabbed the bottom of his shirt and pulled it up to his eye, which exposed his bare back and boxers. He used the shirt to wipe his eyes then dropped the bottom of his shirt and continued to grab trays off the line and place them on the cart. DA A stated that he had been working in the kitchen for 8 months and expressed that if he was supposed to be wearing gloves, he had not worn any since his initial employment and no one had enforced it. He explained that the reason he kept touching his face mask was because his glasses pushed it down and he was aware that there was Covid inside of the facility. During the interview, with his bare hands, DA A touched his pants, arm, jewelry, key chain, and scratched his hair underneath his hair net. As he waited for the next line of plates, he was asked if he was supposed to touch different items outside of the plates and cart during services, which he responded I guess not while dropping the key chain. When asked if touching the different items could lead to cross contamination, he responded I guess so. The interview was ended</p> <p>In an interview on 08/21/24 at 12:22 p.m., DM A was made aware that DA A was not wearing gloves or washing his hands and touched multiple unclean services while preparing lunch, she stated that she would let him know. She walked over and instructed him to wash his hands and told him to put gloves on. He walked to the sink to wash his hands and grabbed a new pair of gloves after. She stated that he knew he should have worn gloves during service.</p> <p>In an interview on 08/21/24 at 2:22 p.m., DM A stated that she would talk to DA A about not being sanitary during service and he would be in-serviced. She explained that the harm in having poor sanitary practices in the kitchen would be cross contamination. If DA A was sick and did not wash his hands, he could have passed it to someone else, especially with Covid in the building. She also felt that he needed to review the training given during the food handlers training.</p> <p>Record review of the facility's Food and Safety sanitation policy reviewed 07/22/21 revealed:</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>a. Proper reheating- foods reheated in the microwave over must be reheated in a uniform manner so that all parts are heated to 165 degrees F. The food will be rotated or stirred, covered, and the allowed to sit for 2 minutes.</p> <p>b. Personal Hygiene Practices- thorough hand washing is required (but not limited to) the following situations: after coughing, sneezing, or touching hair or face.</p> <p>c. Food handling: Food service employees will minimize bare hand contact with food that is ready to eat. Except when washing fruits and vegetables, food service employees may not contact exposed, ready to eat food with their bare hands, Instead, suitable utensils such as deli tissue, tongs, single use gloves, or dispensing equipment must be utilized.</p>