STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675046	A. Building B. Wing	03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosenberg Health & Rehabilitation Center	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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45328 Based on observations, interviews, and record review the facility failed to ensure the resident received adequate supervision and assistance devices to prevent accidents as was possible for 1 (Resident #1) of 5 residents reviewed for accidents and supervision. -The facility failed to ensure a system was in place to adequately supervise Resident #1 when he left the faciity on [DATE] and did not return. The facility failed to notify law enforcement or conduct a thorough search for Resident #1. As of 03/21/25, the facility did not know Resident #1's whereabouts. An immediate Jeopardy (IJ) was identified on 03/21/25. The IJ Template was provided to the facility on [DATE] at 2:09 p.m. While the IJ was removed on 03/23/25, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal (POR). This failure placed residents at risk for harm, significant injury, or death. The findings included: Record review of Resident #1's Admission Record, dated 03/21/25, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnosis included candidiasis (fungal infection caused by overgrowth of a type of yeast), cellulitis (serious bacterial infection of the skin), depression (mood disorder that causes a persistent feeling of sadness and loss of interest), cognitive communication deficit (one or more cognitive processes involved in communication), and unsteadiness on feet. Record review of Resident #1's physician order's revealed he was taking the following medications: potassium chloride for on Lasix, furosemide for edema, metoprolol succinate for essential (primary) hypertension, melatonin for insomnia, aripiprazole for schizoaffective, atorvastatin calcium for high LDL, ergocalciferol for supplement, trazodone for insomnia, and sertraline HCL related to depression unspecified. Resident's medications were due. (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

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 03/25/2025
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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's MDS Assessment, dated 02/26/25, revealed a BIMS score of 13, indicating cognition was intact. Further review revealed the resident did not exhibit wandering behavior. The resident was independent (completes activity by himself with no assistance from a helper) with self-care, except shower/bathe self (required supervision or touching assistance) and mobility functional abilities. Record review of Resident #1's Care Plan Report, undated, revealed resident was in the facility for long-term care placement as a result of a continued need for the services of skilled nursing staff as evidenced by an inability to provide self-care and discharge planning is not needed. Resident was not care planned for leaving out on pass. Record review of Resident #1's Elopement/Wandering Risk Assessment, dated 03/15/25, reflected Category: Elopement Risk-Low, no plan of care needed .Score: 1.0. Record review of Resident #1's progress notes, entered by ADON B and dated 03/19/25 at 16:20 [4:20 p.m.], revealed Resident left facility out on pass. Record review of Resident #1's progress notes, entered by Nurse A and dated 03/20/25 at 6:42 [a.m.], revealed Resident did not return from off pass. Observation on 03/21/25 at 7:28 a.m. revealed the facility's Sign out Book was on the counter at the Nurse's Station. The Release of Responsibility for Leave of Absence form for Resident #1 was blank. During a telephone interview on 03/21/25 at 9:15 a.m., Nurse A said she was told by Nurse B that Resident #1 went out on pass on 03/19/25. She said she did not see him for her entire shift, 6:00 p.m. to 6:00 a.m., on the 19th. She said she documented in the resident's progress notes that he did not return. She said usually, residents sign out before they go out on pass, and were supposed to sign back in with the date and time. She said Nurse B did not give her any additional information. She said it could be the nurse's responsibility to make sure the resident signed out or any staff who the resident was under and said she was not sure but thinks the receptionist too. During an interview on 03/21/25 at 9:44 a.m., the DON said ADON A and B both reported to her that Resident #1 went out on pass on Wednesday, 3/19, in the afternoon around 4:00 p.m. She said to her knowledge, the resident did not tell anyone he was leaving or where he was going. She said the ADONs did not say when they expected Resident #1 to return. She said she did not know where Resident #1 was currently. She said the resident did not sign out. She said residents should sign out, but she did not believe they were required to say where they were going or who they were leaving with. She said she has been told the resident used a ride service himself to and from the facility in the past. She said the resident had a BIMS score of 13/14, was his own RP, and has family emergency contacts. She said she did not consider Resident #1 leaving the building an emergency at the time. She said residents were allowed to be on pass for 72 hours. She said the resident did not have a telephone. (continued on next page)

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 03/25/2025
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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 03/21/25 at 9:58 a.m., ADON A, said Resident #1 went out on pass on Wednesday, 3/19/25, and she believed ADON B told her. She said she did not know where the resident went. She said she did not know where the resident was now. She said she would have to check to see if the resident signed out. She said if residents go out on pass, they can stay out for 72 hours, residents let them know where they were going, when they plan to return, and sign back in when they return. She said Resident #1's medications did not go with him as far as she was aware. She said the resident had a high BIMS score, she believed it was a 13 or 14 and was cognitively intact. During an interview on 03/21/25 at 10:11 a.m., ADON B said the Staffing Coordinator/CNA reported to him, the DON, and ADON A that Resident #1 went out on pass. He said she did not say where he was going. He said he did not ask any additional questions. He said he did not know if he signed out. He said he did not know where Resident #1 was currently. He said he did not know if he had any of his medications with him. He said he did not know when Resident #1 was expected to return. He said residents can stay out on pass for up to 72 hours. During an interview on 03/21/25 at 10:51 a.m., the Receptionist said she worked Wednesday the 19th and saw Resident #1 leave the facility. She said the resident asked her if he could go outside and she said she thought he meant to sit outside. She said she asked the Staffing Coordinator/CNA if he was allowed to go outside and she said yes, he was okay and so she let him go outside. She said after she let Resident #1 go outside, she received a telephone call and walked to the hall and told the nurse she had a call. She said when she returned, she sat down, and the Staffing Coordinator/CNA asked her where the resident was, and she said he should be sitting outside. She said the Staffing Coordinator/CNA said he was not out there and asked if he signed the book, and she said no he did not. She said the Staffing Coordinator/CNA told her everyone needed to sign out. She said the Staffing Coordinator/CNA told ADON B and he went to go find the resident on foot, and that was when ADON B was told by another resident that he saw Resident #1 get into a car. She said Resident #1 did not tell her he was going to leave the facility. During an interview on 03/21/25 at 11:01 a.m., the Staffing Coordinator/CNA said she saw Resident #1 go outside and went on the porch and sat in a rocking chair. She said when she went back by, she saw him down the walkway and he got into a white vehicle. She said she notified the ADONs and the DON. She said they said he was out on pass. She said early that morning, 3/19/25, before 7:00 a.m., Resident #1 mentioned wanting to go to another facility and she told him to talk to the social worker. She said she did not know where the resident was now. During an interview on 03/21/25 at 11:11 a.m., the Administrator said he was out on PTO on the 19th and the 20th. He said he was notified that Resident #1 got into a white vehicle and forgot to sign out by the ADONs at approximately 4-5 o'clock, could not recall the day, but wanted to say it was Wednesday, 3/19/25. He said no one knew where he was. He said initially when Resident #1 first left, they tried to find the white SUV to get him to sign out, but they were unsuccessful. He said he would have to review what their Therapeutic Leave policy stated. He said there had not been any other attempts to find him because they knew he left out on pass. He said even if residents leave and forget to sign out, they try to call them or try to see in what general direction they went and try to redirect them to go back and sign out. He said ultimately, Resident #1 had a high enough BIMS score, and the facility did not want to infringe upon his rights. (continued on next page)

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 03/25/2025
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)

F 0689

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

During an interview on 03/21/25 at 12:44 p.m., the DON said she just called the phone number listed for Resident #1 on his face sheet and a family member answered. She said the family member told her she was happy they called her because she had some concerns about a group home he was at previously. She said the resident's sister believed the Owner/Manager of the group home sent someone to pick him up. She said the family member told her the resident made his own decisions.

During an interview on 03/21/25 at 1:01 p.m., the Administrator and DON said they just got off the phone with the Owner/Manager of the group home and was told Resident #1 was with her. They said the Owner/Manager told them the resident called her Tuesday, 3/18/25, night and said he wanted to go back and so she sent an Uber to pick him up. They said they asked to speak with the resident but was told she was driving and would have him call them when she got to where she was going.

During an interview on 03/25/25 at 10:54 a.m., the Owner/Manager of the group home said Resident #1 was no longer at her personal care home and believed he went to another home.

Record review of the facility's Therapeutic Leave policy, revised 07/14/2023, read in part .Compliance Guidelines .13. The resident or resident representative will sign a release form indicating the date and time the resident is leaving, location, (including address if going to a specific residence) of where resident is going, a telephone number where resident can be reached .17. If the resident has not returned from therapeutic leave as expected, the facility will attempt to contact the resident and resident representative and document attempts in the medical record .

Record review of the facility's Missing Resident Policy, revised 08/15/23, read in part .Definitions .Elopement occurs when a resident leaves the premises or a safe area without authorization (an order for discharge or leave of absence) and/or any necessary supervision to do so .

The Administrator was notified on 03/21/25 at 2:09 p.m. that an IJ was identified due to the above failures and the IJ template was provided.

The following Plan of Removal (POR) was accepted on 03/22/25 at 2:55 p.m.:

Plan of Removal

Tag Cited: F-689

Issue Cited: Free of Accidents/Hazards/Supervision

Failure to ensure residents receive adequate supervision to prevent elopement

1.Immediate Action Taken

On 3/21/25 @ 4:35pm DON/designee located and visited Resident #1 at the Personal Care Home in a nearby city.

Resident #1 had a safe discharged to the Personal Care Home on 3/21/25 with the assistance of the Personal Care Home manager and the Administrator delivered all medications. DON evaluated resident #1 at the Personal Care Home to ensure his safety and well-being.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675046	A. Building B. Wing	03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosenberg Health & Rehabilitation Center	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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Administrator was responsible for the facility's decision not to call the resident/RP/police. Administrator and DON were in-service by Regional Nurse Consultant on 3/21/25 by 6:00pm on the Missing Resident Policy, which was reviewed on 3/21/25 at 11:41am with no changes made, along with notifying the police/RP/physician and the state agency when resident is not located in the facility or on facility grounds. The nearby hospital should not be contacted. Don/designee will have the 1:1 training with the receptionist on Therapeutic Leave policy and to notify charge nurse of residents that have not returned from leave that day when the receptionist shift is over and the Missing Resident Policy by 3/22/25 at 10 am. Residents therapeutic leave sign out book will be located at receptionist desk on 3/21/25 by 7:30pm, for her/him to know who is leaving. The Charge nurses will be responsible for tracking of the residents leaving after 5:30pm. Don/designee will educate charge nurses on 3/21/25 by 8pm on giving a follow-up call to resident/RP that did not return from therapeutic leave for the day and document in progress notes. Any charge nurse not present will not be allowed to work their next shift until receiving the education. 2. Identification of Residents Affected or Likely to be Affected: A. On 3/21/25 by 11 pm DON/designee will have 100% of resident's Elopement Risk Assessment completed to identify all elopement risk residents. No new resident identified. B. On 3/21/25 by 11pm DON/designee will identify all the residents with the physical ability to have therapeutic leave. 59 residents were identified. 3. Actions to Prevent Occurrence/Recurrence: A. DON/designee will In-service all staff on the Missing Person Policy on 3/21/25 by 7pm. Any staff not present will not be allowed to work their next shift until they have the training. B. DON/designee will In-service all staff on the Therapeutic Leave Policy on 3/21/25 by 7pm. Any staff not present will not be allowed to work their next shift until they have the training. On 3/21/25 at 8:08am the Regional Nurse Consultant emailed the Therapeutic Policy after reviewing, no changes were made. C. Missing Person Drill will be completed and documented with all staff on 3/21/25 by 7pm. Any staff not present will not be allowed to work their next shift until they have (continued on next page)

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 03/25/2025
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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the drill. D. The Elopement binder will be updated with any newly identified residents on 3/21/25 by 7pm. E. All the residents identified as Elopement Risk will have their care plans updated by DON/designee on 3/21/25 by 11 pm. F. All residents identified with physical ability for Therapeutic Leave will have their care plan updated by DON/designee on 3/21/25 by 11 pm. G. DON/designee will educate and be completed by 3/22/25 by 4pm, residents/responsible party on the Therapeutic Leave Policy for those residents identified with the physical ability for therapeutic leave. H. Administrator will have an ad hoc meeting with the Medical Director on IJ findings and actions taken will be completed on 3/21/25 by 7:45pm. Date Facility Asserts Likelihood for Serious Harm No Longer Exists: ________________. On 03/22/25-03/23/25, the state surveyor monitoring confirmed the facility implemented their plan or removal (POR) to sufficiently remove the IJ by: Observation on 03/23/25 at 7:15 a.m. revealed the sign out book was located at the nurse's station. Record review on 03/23/25 revealed, the Regional Nurse Consultant in-serviced the Administrator and the DON on the Missing Person policy on 03/21/25. Record review on 03/23/25 revealed, the Receptionist received 1:1 training on 03/22/25 on the Therapeutic Leave policy and when to notify the charge nurse of residents who have not returned from leave that day when the shift was over. Record review on 03/23/25 of in-service sign in sheet revealed charge nurses were educated on 03/21/25 on follow-up calling the resident/RP who have not returned from Therapeutic Leave and documenting it in the progress notes. Record review on 03/23/25 revealed an Elopement Risk assessment was completed for 100% of the residents on 03/21/25 and no new residents were identified. Record review on 03/23/25 revealed residents with the physical ability to have therapeutic leave was completed on 03/21/25 and 59 residents were identified. (continued on next page)

Printed: 06/26/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675046	A. Building B. Wing	03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosenberg Health & Rehabilitation Center	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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of in-service trainings dated 03/21/25 and 03/24/25 revealed 44 staff were in-serviced on the Missing Person and Therapeutic policy. Record review on 03/23/25 of the facility's Elopement binder revealed it was updated. Record review on 03/23/25 of resident Care Plans revealed those who were identified with physical ability for Therapeutic Leave was updated. Record review on 03/23/25 of Therapeutic Leave documentation revealed contact/attempted contact was made with residents/responsible party for those identified with the physical ability for Therapeutic Leave was completed. Record review of Ad hoc sign in sheet on 03/23/23 revealed meeting was completed with the Medical Director on the IJ findings on 03/21/25. Interviews were conducted from 03/22/25 to 03/23/25 with staff from all shifts and all interviewees verbalized an understanding on the Therapeutic Leave and Missing Person policies. Interviewed staff included the Administrator, ADON A, ADON B, Receptionist A, Receptionist B, Nurse C, Nurse D, Nurse E, CNA A, CNA B, CNA C, and CNA D. The Administrator was notified the Immediate Jeopardy was removed on 03/23/2025 at 2:16 p.m. The facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm that was not immediate jeopardy and a scope of pattern due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.