

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 11/20/2025
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)
<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</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 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure, a resident received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, based on the comprehensive assessment for 1 of 5 residents (CR #1) reviewed for quality of care in that: CR #1 had a palm protector medical device on his contracted left hand for approximately 7 days, resulting in admission to an acute care hospital on [DATE] with left hand pain, cellulitis, and deep, open pressure wound that involved the thenar web space (the space between the index finger and thumb) that appeared chronic with a foul odor. The noncompliance was identified as past noncompliance (PNC). The Immediate Jeopardy (IJ) began on 11/11/25 and ended on 11/18/25. The facility corrected the noncompliance before the survey began. This deficient practice placed residents at risk of developing avoidable pressure injuries, severe pain, and decreased quality of life. Findings include: Record review of CR #1's admission record generated on 11/19/25 revealed he was admitted to the facility on [DATE] and had diagnoses of hypertensive heart disease without heart failure (heart problems caused by long-term high-blood pressure), metabolic encephalopathy (a brain dysfunction caused by a chemical imbalance from a systemic illness, organ failure or exposure to toxins), cerebral infarction (occurs when a blockage in a brain artery cuts off blood flow, leading to brain tissue death), abnormalities of gait and mobility, contracture of muscle (the permanent tightening of muscles, tendons, and other tissues which causes a joint to shorten and become stiff, limiting movement), dementia (a decline in mental ability, such as memory loss and impaired thinking, that affects daily life) and hemiplegia (paralysis that affects one side of the body). He was [AGE] years old. Record review of CR #1's quarterly MDS assessment dated [DATE] revealed he had a BIMS of 0, indicating he had severe cognitive impairment. He was dependent on staff for eating, hygiene, dressing, and transfers. He was always incontinent of bowel and bladder. He had one stage 4 pressure ulcer /injury (a severe, full-thickness wound that involves damage to underlying bone, muscle or tendon) and was at risk of developing pressure ulcers/injuries. Record review of CR #1's care plan revised on 7/8/25 revealed he had the potential for skin breakdown due to decreased mobility and incontinence. Interventions included reposition frequently, check for wetness and soiling every two hours and provide incontinence care as needed, bathe per schedule, weekly skin checks to monitor for redness, circulatory problems, pressure sores, open areas, and other changes in skin integrity, report new conditions to the physician. Record review of CR #1's care plan revised on 7/16/25 revealed he had an activity of daily living self-care performance deficit related to impaired mobility, contracture of muscles and hemiplegia following a cerebrovascular accident (occurs when blood supply to the brain is blocked or a blood vessel ruptures, leading to brain damage). Interventions included total assistance of two staff for bed mobility and dependent on two staff for personal hygiene and dressing. Record review of CR #1's physician's orders dated November 2025 revealed there were no orders for a palm guard or other medical device (a palm guard is a device used for moderate to severe contractures to help prevent skin breakdown in the palm). Record review of CR #1's Progress Note documenting skin issues dated 11/4/25 revealed Treatment Nurse B indicated CR #1 did not have an external device, and there were no documented skin issues on his left hand. Record review of CR #1's Nurse Progress Note dated 11/6/25 revealed CR #1 was sent to an acute care hospital for g-tube replacement. Record review of CR #1's After Visit Summary from an acute care hospital dated 11/10/25 revealed he had his feeding tube replaced. The summary included instruction for CR #1 to start taking Ceftin (an antibiotic medication), 1 tablet in the morning and 1 tablet in the evening administered by feeding tube for 5 days. Record review of CR #1's nurse progress note dated 11/14/25 revealed NP A visited CR #1 for a readmission evaluation day #3. (CR #1) was sent to (acute care hospital) on 11/6/2025 due to dislodgement of his PEG tube. At the time of hospitalization he was treated with IV antibiotic for elevated WBC count and suspected pneumonia. After stabilization and PEG tube replacement patient is send (sic) back to the facility on [DATE]. Record review of CR #1's Treatment Administration Record dated 11/1/25 to 11/30/25 revealed Treatment Nurse A documented a head-to-toe skin assessment daily between 11/11/25 and 11/14/25 and on 11/17/25. Treatment Nurse A indicated that there were no changes to CR #1's skin integrity. Record review of Resident #1's Progress Note documenting skin issues dated 11/17/25 completed by Treatment Nurse A indicated CR #1 did not have an external device, and there were no documented skin issues on his left hand. Record review of CR #1's nurse progress note dated 11/17/25 at 9:00am completed</p>		