| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675046 | A. Building<br>B. Wing | 06/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Rosenberg Health & Rehabilitation Center | 1419 Mahlmann St.<br>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) |
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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort for 1 of 3 residents (Resident #1) reviewed for PASARR services. The facility failed to submit a complete and accurate request for nursing facility specialized services (NFSS) in the LTC Online Portal within 20 business days following Resident #1's Interdisciplinary Team meeting. This failure placed residents at risk for inadequate care, and losing access to specialized mental health or intellectual disability services.Findings included: Record review of Resident #1's facesheet revealed a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included: quadriplegia (the partial or total paralysis of all four limbs), neuromuscular dysfunction of bladder (brain, spinal cord, or nerve damage disrupts the signals between your nervous system and the urinary tract), major depressive disorder (a severe mood disorder causing persistent feelings of sadness, hopelessness, and a loss of interest in activities), anxiety disorder (mental health conditions characterized by excessive, persistent, and overwhelming worry or fear that interferes with daily activities), and spondylolisthesis (one of the vertebrae in your spine shifts forward over the bone directly beneath it). Record review of Resident #1's quarterly MDS dated [DATE] revealed a BIMS score of 15 out of 15 indicating his cognition was intact and used a wheelchair for a mobility device. Record review of Resident #1's Care Plan initiated on 11/3/2025 and last revised on 4/20/2026 revealed a focus area of PASRR Positive: The facility Interdisciplinary Team (IDT) has determined that resident has been deemed PASRR positive on the PASRR evaluation that was conducted by the designated LIDDA/LMHA which may place resident at risk for not having the ordered specialized services provided. PASRR positive status is related to a history of developmental disabilities. Resident receives habilitation coordination, CMWC and independent living skills. The interventions included: Appointed facility staff to schedule IDT meetings as required so that all necessary team members are in attendance. Designated staff member will invite the PASRR representative to quarterly care plan meetings and communicate any changes of condition as needed. Services are being used and will be included in all IDT approaches. Record review of Resident #1's PASRR Comprehensive Service Plan (PCSP) Form dated 3/16/2026 revealed LA - IDD had comments noting Individual and SPT agreed to following services Customized wheelchair, Habilitation Coordination and Independent living skills with LA-IDD signature dated 3/18/2026. Interview and observation on 6/9/2026 at 1:55pm, Resident #1 was in his room visiting with family. Resident #1 was up and in a motorized wheelchair. Resident stated he recently got the wheelchair after a lot of work to get it. Resident stated he was okay and had no complaints, he continued to visit with his visitor. Interview on 6/9/2026 at 3:15pm, PASSR Program Specialist stated that after the facility has an initial IDT meeting and services are agreed upon to request, the facility has 20 days from the date of the meeting to submit the request in the LTC portal for PASRR services. The PASSR Program Specialist stated the facility had not submitted the request within the 20 days of Resident #1's IDT meeting and an email was sent requesting the information be uploaded and still the<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 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | requests had not been uploaded which placed them in non-compliance. Interview on 6/9/2026 at 3:25pm, the Social Worker stated Resident #1 was already receiving PASRR services of Habilitation Coordination and Independent living skills, however, he was taken off of Hospice a few months ago which was a change in condition and another initial IDT meeting was required. The Social Worker stated at the new initial IDT meeting on 3/16/2026 it was agreed for Resident #1 to receive the same services of Habilitation Coordination and Independent living skills, as well as a motorized wheelchair. The Social Worker said she had not uploaded the IDT service requests to the portal and stated to her knowledge, usually the LIDDA coordinator would upload that information. The Social Worker stated she was not familiar with where the requests should be uploaded and said she had not done this before with their other PASSR residents. The Social Worker did recall getting an email from State Agency PASSR services regarding non-compliance with specialized services requests. The Social Worker said she forwarded the email to their LIDDA coordinator asking for assistance on what to do with the request and her response did not address what and where to submit requests. The Social Worker stated since Resident #1 was receiving the services and had gotten his motorized wheelchair, she figured the matter was taken care of. Record review of email dated 5/20/2026 at 3:45pm from State Agency PASSR services revealed the facility was not in compliance with submitting specialized service request to the LTC portal within 20 days of the IDT meeting. The email requested the information be uploaded within 3 -5 days upon receiving the email. Further review of the email chain showed the Social Worker forwarded the email to the LIDDA Coordinator on 5/21/2026 at 8:36am asking, Are you able to assist me with this? Is Resident #1 receiving specialized services?. The email chain showed a response from LIDDA Coordinator on 5/22/2026 at 9:07am apologizing for delayed response and noted, When he was taken off of hospice care (change of condition), we held a new initial PASSR meeting on 3/16/2026. He is currently receiving the following specialized services: Habilitation Coordination, Independent Living Skills and Customized Wheelchair (which he had already received). Phone interview attempted on 6/9/2026 at 3:46pm with LIDDA Coordinator but there was no answer and a voicemail requesting a return phone call was left. Interview on 6/10/2026 at 11:00am, the Administrator stated after some investigation it appeared Resident #1 got his motorized wheelchair through his insurance which the resident arranged on his own. The administrator stated Resident #1 was originally denied getting the wheelchair through PASSR services back at his first initial IDT meeting and his insurance also denied him the wheelchair because he was on hospice. The Administrator said Resident #1 took himself off hospice so he could get the wheelchair through his insurance. The Administrator stated given that the Resident was already receiving services and the facility saw he had received the motorized wheelchair, this caused some confusion on whether the service requests needed to be submitted in the portal after change in condition IDT meeting. Record review of the facility Preadmission and Screening Resident Review (PASSR) Rules Guidelines last revised on 7/2023 revealed in part, .Facility initiates Specialized Services by submitting request to Agency within 20 days of PCSP meeting. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents with pressure ulcers receive necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 1 of 7 residents (Resident #2) reviewed for pressure ulcers. The facility failed to complete wound assessments for Resident #2's left heel wound that developed in the facility for approximately 5 weeks. This failure placed the resident at risk for infection, impaired healing, further skin breakdown, and delayed identification of changes in wound status.Findings included: Record review of Resident#2's facesheet revealed a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included Type 2 diabetes, heart failure, Chronic Obstructive Pulmonary Disease, and morbid obesity. Record review of Resident #2's admission MDS dated [DATE] revealed BIMS score of 11 out of 15 indicating moderate cognitive impairment. Further review of the MDS revealed he was not at risk for pressure ulcers, he did not have one or more unhealed pressure ulcers, and he had no venous(an open sore, typically located near the ankle, caused by poor blood circulation and high pressure in the leg veins). or arterial ulcers (wounds caused by poor blood circulation to the lower legs and feet) Record review of Resident #2's Care Plan initiated on 5/10/2026 revealed a care area for a stage 2 pressure ulcer (a partial-thickness skin loss involving the outer layer and the middle layer)to the left heel. The interventions included:Administer analgesics as needed for discomfort or pain. If necessary provide pain management prior to dressing changes and repositioning.Monitor and document for signs and symptoms of infection such as foul-smelling drainage, redness, swelling, tenderness, fever, and red lines or streaking originating at the wound. Notify the physician when detected.Monitor dressing to ensure it is intact and adhering. Report loose or soiled dressings to treatment or charge nurse.Provide wound care per physician's order. Keep dressing clean, dry, and intact.Replace the dressing as needed for soiling.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 Resident #2's SBAR dated 4/30/2026 at 4:07pm revealed he had a change in condition of dark discoloration noted to left heel that had not occurred before. The SBAR noted an observation of, skin intact, wound care nurse to follow-up with treatment plan. Heels offloaded. Monitoring ongoing. Additional information noted, Patient noted with dark discoloration to left heel with Skin intact, NP notified. Attempted to update POA but Unsuccessful. Wound care nurse to follow up with treatment plan. Heels offloaded and floated. Monitoring ongoing. Record review of Resident #2's physician note dated 5/3/2026 at 11:43am, revealed the skin examination noted, small open area to left lateral heel, dry flaky skin bottom of bilateral feet. Appropriate wound care orders already in place. Record review of Resident #2's physician orders dated 5/3/2026 revealed an order for Left lateral heel stage 3 pressure ulcer (a deep, crater-like wound that features full-thickness skin loss)- clean with wound cleanser, apply calcium alginate, secure with island dressing one time a day for Wound Care. Record review of Resident #2's May 2026 and June 2026 MAR revealed order for Left lateral heel stage 3 pressure ulcer- clean with wound cleanser, apply calcium alginate, secure with island dressing one time a day for Wound Care ordered on 5/3/2026 was marked completed from 5/5/2026 - 6/9/2026. Record review of Resident #2's Skin check dated 5/5/2026 at 7:55am by Wound Care Nurse revealed no new skin issue's identified but noted skin issue #001 to the right inner forearm. Further review of the skin check assessment revealed no mention of Resident #2's left lateral heel wound. Record review of Resident #2's Skin issue assessment dated [DATE] at 9:28am by Wound Care Nurse revealed Skin Issue #001 to right inner forearm was resolved/healed. Further review of the skin issue assessment revealed no mention of Resident #2's left lateral heel wound. Record review of Resident #2's physician note dated 5/9/2026 at 3:38pm revealed in part, .wound nurse present performing dressing change to left heel. SKIN: Denies rash and pruritus (irritating skin sensation that creates an<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | urge to scratch). Soreness to left heel. SKIN: dry, intact, normal color. Wound to left lateral heel, dressing changed today. Record review of Resident #2's Skin issue assessment dated [DATE] at 7:13am by the Wound Care Nurse revealed no mention of left lateral heel ulcer. Record review of Resident #2's Physician note dated 5/17/2026 at 2:08pm revealed in part, .SKIN: Denies rash and pruritus. Soreness to left heel. SKIN: dry, intact, normal color. Wound to left lateral heel. Record review of Resident #2's Skin Check assessment dated [DATE] at 8:35am by Wound Care Nurse revealed, No skin issues identified. Foot Evaluation completed. No new skin issues identified. Record review of Resident #2's Skin Check assessment dated [DATE] at 2:22pm by Wound Care Nurse revealed, No skin issues identified. Foot Evaluation completed. No new skin issues identified. Record review of Resident #2's Physician note dated 5/30/2026 at 8:08pm revealed in part, .SKIN: Denies rash and pruritus. Soreness to left heel. SKIN: dry, intact, normal color. Wound to left lateral heel. Record review of Resident #2's Skin Check assessment dated [DATE] at 7:21pm by RN A revealed, No skin issues identified. No new skin issues identified. Record review of Resident #2's clinical record from 4/30/2026 - 6/8/2026 revealed no documented assessments of Resident #2's left lateral heel wound. Further review of clinical records revealed only mention of Resident #2's left lateral heel wound was within the physician treatment order from 5/3/2026 indicating it was a stage 3 pressure ulcer, care plan started on 5/10/2026 indicating stage 2 left heel wound, and physician notes documenting a wound to the left heel on 5/3/2026, 5/9/2026, 5/17/2026, and 5/30/2026. Review further revealed no initial assessment of Resident #2 left heel wound to determine size and appearance of wound upon its discovery to determine progression. Interview on 6/9/2026 at 11:00am, the Wound Care Nurse said the protocols are to do weekly skin checks where it is checked if there are any new skin issues. If there is a skin issue, staff will notify her by entering an SBAR and slipping a paper under her door noting the new skin issue. She will then go and evaluate the skin issue and complete an assessment. She notifies the doctor about the skin issue and her assessment and they may go ahead and give treatment orders over the phone and they will be added to be seen by the wound care doctor depending on the severity of the wound. The Wound Care Nurse said if there is a skin issue she enters weekly skin issues assessments until it is resolved. The Wound Care Nurse stated within the skin issue assessment it allows her to enter in the assessment of the wound, including staging, measurements, drainage, etc. The Wound Care Nurse said the Wound Care Doctor comes weekly and she follows along with him to treat and assess the residents he sees. She stated Resident #2 does have a wound on his left lateral heel but he does not see the wound care doctor because the wound was minor. The Wound Care nurse explained that if the wound was small and minor she will do the treatment and assessments and Resident #2's heel wound qualified for this. The Wound Care Nurse recalled the wound started as a popped blister that turned into a small wound. She stated she does his wound treatment every day for left lateral heel wound and though it is minor it something she keeps an eye on due to issues with lower extremity swelling and reopening the wound. She also stated resident would try to propel himself in the wheelchair by pulling himself with his heel causing further breakdown or reopening. The Wound Care Nurse said she had completed assessments of Resident #2's wound in the skin issue assessments but after reviewing his records she stated she did not know why they were not showing. The Wound Care Nurse stated his Skin Assessment was due today, but she just had not entered it yet. She said she will enter the assessment for today on her end and see if it shows up in the record. Record review of Resident #2's Skin Issues assessment dated [DATE] at 11:09am by Wound Care Nurse revealed, Skin Issue: #001: New skin Issue. Location: Right heel. Issue type: Skin tear. Progress: Stable: previously deteriorating wound characteristics plateaued. Wound was present on admission. Signs and symptoms of infection: None. Painful: No. Staged by: In-house nursing. Length (cm): 1 Width (cm): 0.5 Depth (cm): 0 Area (cm2): 1.5 Undermining (occurs when tissue destruction extends beneath the intact skin at the wound margins, creating a hidden pocket or cave-like space beneath the surface): No. Tunneling (an open injury that extends as a narrow passageway or channel beneath the skin into deeper tissues, muscles, or organs): No. (continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Exudate (wound drainage or fluid) amount: Light. Exudate type: Serous (a clear, watery, or slightly yellow plasma-like discharge): clear watery fluid, which is separated from solid elements. Odor after cleansing: None. Surrounding tissue: Intact. Induration: None present. Edema (swelling caused by excess fluid trapped in your body's tissues): No swelling or edema. Dressing appearance: Intact. Dressing saturation: Minimal < 25%. Cleansing solution: Normal saline. Primary dressing: Calcium alginate. Secondary dressing: Foam. frequency of treatment: daily Skin issue education: Treatment of skin issue. Skin issue education: Signs and symptoms of infection. Skin issue education: Dressing change. Interview on 6/9/2026 at 12:06pm, the Wound Care Nurse said she entered Resident #2's wound assessment in his record for today but she could not produce others like it for previous dates or the initial assessment of the wound to determine how the wound started and had progressed since development. Wound Care Nurse said she completed previous assessments but could not explain why they were now missing or not showing in the record. She stated the wound had improved from when it initially began and had resolved but would occasionally reopen depending on if the resident was having increased swelling in his lower extremities. The Wound Care Nurse added she might have accidentally entered the wound was on his right heel instead of his left and stated she would go back and fix the note. Interview on 6/9/2026 at 1:25pm, the NP stated she was aware of a small wound to Resident #2's left heel and stated from her memory the wound was a reoccurring wound. The wound started as a blister and the Wound Care Nurse provided treatment. The wound closes but sometimes reopens from the swelling in his lower extremities. NP denied having recent visualization of the left heel wound. The NP could not speak on the missing assessments of Resident #2's wounds but stated they should be completed because they are used to determine treatment of the wound. The NP stated if there was a new wound, the Wound Care Nurse would call her and report the assessment of the wound, and she would provide a treatment order for the wound until the resident is picked up by the Wound Care Doctor if needed. The NP added the wound assessments are looked at and used by providers during their chart reviews and assessments when deciding if new orders are needed. Interview on 6/9/2026 at 2:05pm, Resident #2 said about three weeks after he was admitted to the facility, he had a blister form on his heel from wearing his shoes. Resident #2 said apparently the back of the shoe was rubbing his heel and caused the blister to form. Resident #2 said there was a lady staff member who accidentally ripped the top skin off the blister, and it caused the wound to open. Resident #2 said he could not see the wound himself, but he could feel it there. Resident #2 said since the blister had opened causing the open wound it had not completely resolved to his knowledge because it continued to hurt when the area was touched and he received wound treatment on it every day. Observation and interview on 6/10/2026 at 12:50pm, Wound Care Nurse removed dressing dated 6/10/2026 from Resident #2's left lateral heel revealing a dime sized opening on his left lateral heel. No visible drainage, redness, or swelling to the area. Wound had a white center and skin looked moistened around the edges of opening due to recent wound treatment performed, inside the wound was dry. Resident #2 voiced that he thought the wound was getting better but stated he could still feel pain in the wound when it is touched. He voiced no pain at the time of the observation. Record review of the facility Skin Management policy last reviewed on 2/10/2020 revealed in part, .3. A daily skin evaluation is completed by the licensed nurse or wound nurse for those patients with pressure ulcers. Documentation that the skin evaluation was completed and is entered in the Treatment Administration Record. 4. The wound nurse or licensed nurse re assess/ reevaluates pressure ulcers weekly and as clinically indicated. The weekly evaluation/assessment of the pressure ulcer is documented on the pressure ulcer form. 5. A pressure ulcer is classified weekly by using the deepest identified stage and the term healing. 2. Pressure ulcer healing is documented using descriptive characteristics of the wound (i.e., depth, width, presence of granulation tissue, exudate) and by using a PUSH tool a validated pressure ulcer healing tool. |