

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 02/27/2025
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48863</p> <p>Based on observation, interview, and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 5 residents (Resident #27) reviewed for pharmacy services.</p> <p>The facility failed to acquire and administer Resident #27's scheduled dose of Clonazepam for several days.</p> <p>This failure could place residents at risk of decreased therapeutic efficiency and a poor quality of life.</p> <p>The Findings were:</p> <p>Record review of Resident #27's face sheet, dated 02/27/25, revealed [AGE] year-old male resident who was admitted to the facility on [DATE] with diagnoses including Respiratory failure, Cerebral infarction (blood flow to brain is interrupted causing the brain tissue to die), depression, and Schizophrenia (Mental disorder that affects a person's ability to think, feel, or behave clearly).</p> <p>Record review of Resident # 27's annual MDS dated [DATE], revealed Resident #27 had a BIMS summary score of an 8, indicating moderate cognitive impairment. His behavior symptoms include Hallucinations and delusions that are directed towards self and others.</p> <p>Record review of Resident #27's comprehensive care plan revealed the resident has a behavior problem as evidence by increased audio and visual hallucinations which caused increase confused thought process. His interventions included to administer medication as ordered, approach resident in a calm manner, call by name, speak slowly, and maintain eye contact, talk to resident while providing cares, allow time for a response, and do not rush. Resident #27 was also care planned for cognitive impairment. He has a history of schizophrenia which causes him to have a cognitive deficit. His interventions included Administer medications per physician's orders and monitor for unusual/adverse reactions and effectiveness. Report abnormal findings to the physician and Provide instructions using a clear voice and simple sentences and repeat as needed.</p> <p>Record review of Resident #27's physician orders for February 2025 revealed Clonazepam oral tablet 0.5 MG. Give 0.5 mg by mouth three times a day for anxiety.</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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #27's February 2025 MAR revealed Clonazepam oral tablet 0.5 MG. was not administered as ordered on 02/12/25, 02/13/25, and 02/14/25 due to the medication being on hold.</p> <p>Record review of behavior monitoring from 02/10-02/25/25 revealed no increased episodes of inappropriate behaviors or interventions required while on psychoactive medication.</p> <p>Record review of nurse's progress note on 02/13/25 at 7:42 PM revealed that the MA notified LVN N of the Clonazepam script for Resident # 27. She said the MA informed her of the need to notify the pharmacy. A call was placed to MD office, and she spoke with the receptionist regarding the resident's Clonazepam order. He then stated that he would let the MD know about it.</p> <p>Record review of nurse's progress notes dated 02/15/25, 02/16, 02/18, 02/19, and 02/21/25 with nursing staff (MA and LVN) noting resident's refusal of medications with education provided.</p> <p>Observation on 02/26/25 at approximately 2:00 PM. Resident #27 was sitting in his wheelchair in the front lobby. He was observed staring at the ceiling and talking to himself. He was non-verbal when asked questions. Resident stared at surveyor during the attempted interview.</p> <p>Observation on 02/27/25 at 11:28 AM in the 3rd hall. The resident was in his wheelchair. Resident #27 was without signs of aggressive behavior or staring at the ceiling. He was still non-verbal when the surveyor spoke to the resident.</p> <p>Interview on 02/27/25 at 12:31 PM with CNA D who had worked at the facility for 2 years. She said that she was familiar with Resident #27. She the resident's behaviors had constantly changing with good and bad days since she had worked at the facility, including cursing and staring at the ceiling; however, he was easily redirected. She said the resident was combative only with staff and refused services such as showers. She denied witnessing him being a threat to himself or others.</p> <p>Interview on 02/27/25 at 1:55 PM with MA B, who had been working at the facility for 6 months. She said she was trained on what to do with missing/unavailable medications during onboarding. She said Resident #27 medications were on hold because he did not have a prescription. She said she informed LVN N that the medication was unavailable, and she contacted the doctor and sent a message to the pharmacy. She said she could not get the medications from the e-kit, and only the nurses could pull medications from the e-kit. She said LVN N could not get Resident #27 medication from the e-kit because there was no triplicate. She said the resident would refuse medications frequently, he was educated on his refusal, but he was his own responsible party. She said the risk of the resident not getting his medication as ordered was his condition could worsen.</p> <p>Interview on 02/27/25 at 2:01 PM LVN N, who had been working at the facility for 2 months. She said she was familiar with Resident #27. She said she contacted the pharmacy and the physician's office regarding his medication. She said she left a message with the receptionist, who said she would let the physician know he needed a script to administer the Clonazepam. She said MA B notified her twice that the medication was not received. She said she contacted the physician's office again without a response. She said the 3rd time, she contacted the on-call physician group who gave the pharmacy the information needed to fill the prescription. She said she could not pull the ordered medication from the e-kit without 1st having a triplicate from the doctor. She said the resident was currently receiving the medication as ordered. She was not able to provide a risk for him not receiving his medication.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 02/27/25 at 2:18 PM with ADON A, who said that the nurses can get medication out of the e-kit. He said Clonazepam was one of the medications available in the e-kits . He said the process was that if a medication were unavailable due to the pharmacy, the MA would inform the nurse, who could obtain the medication for the e-kit and follow-up with the physician. He said some nurse pulled the Clonazepam from the e-kit, but other nurses did not. He said he was responsible for pulling the report of medication availability in the e-kit. ADON A said LVN W was one of the nurses who obtained Resident #27's Clonazepam from the e-kit and administered his medication per the inventory report.</p> <p>Telephone interview on 02/27/25 at 2:25 PM with the consulting pharmacy. Pharmacist B said he received an initial order for Clonazepam 0.5 mg. on 02/17/25 in electronic medical record. He said he needed a script before he was able to dispense the medication, and the MD needed to sign-off on the medication before approving the Clonazepam. The medication was not filled until 02/24/25; however, the Clonazepam was available in the e-kit for administration.</p> <p>Attempted telephone interview on 02/27/25 at 3:43 PM with Dr A. The surveyor left a voicemail message with contact information.</p> <p>Attempted telephone interview on 02/27/25 at 3:45 PM with Dr. D. The surveyor left a voicemail message with contact information.</p> <p>Attempted telephone interview X's 2 on 02/27/25 at 3:51 PM with LVN W. The surveyor left a voicemail message with contact information.</p> <p>Interview on 02/27/25 at 4:36 PM with the interim DON, who started at the facility on 02/12/25. She said the resident had a recent inpatient stay at a psychiatric facility, and the hospital discontinued all his medications and restarted him on new meds to include Clonazepam. She said she was unsure of his behaviors and thought his baseline consisted of auditory and visual hallucinations. She said the Clonazepam was ordered 3 x' s a day for anxiety. She said he started receiving the Clonazepam as ordered on 02/24/25. She said her expectation was that the staff follows the physician orders and call to notify the pharmacy and physician if a medication was not received. She said some medications are in the e-kit, and the nurses can pull meds from the e-kit until the pharmacy delivers the meds. She said the risk of not receiving his antianxiety meds was an increased risk for inappropriate behaviors. She said she conducted an in-service today regarding the unavailable medications and the e-kit.</p> <p>Interview on 02/27/25 at 4:48 PM with the administrator, who said his expectation was to contact the pharmacy for medication that was ordered but unavailable. He said there should be a collaborative effort between the inpatient psych facility and psych physicians. He said the risk of not administering the Clonazepam could manifest in an was an episodic break.</p> <p>Interview on 02/27/25 at 4:51 PM with the regional nurse, who said the staff was trained on medication administration during on-boarding to include a competency check-off, and staff are periodically in-serviced by the pharmacy consultant. She said the risk of not administering the medication as ordered could have an adverse effect. She said the medication was in the e-kit and the staff should have followed-up with the pharmacy and notified the physician.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 02/27/25 at 5:25 PM with Dr. D's assistant, who said he was seen on 02/13/25 when Resident #27 was discharged from the inpatient facility. She said the Clonazepam started while in the inpatient facility. She said the resident had a history of refusing meds, and the MD was aware on his 02/13/25. She said the staff kept in contact with the MD regularly to discuss any changes in behaviors.</p> <p>Interview on 02/28/25 at 10:47 AM with Dr. D, he said Resident #27 was non-compliant with his medication and had been on several different medication regimens. He said the medication was not ordered by him but by the inpatient facility when he was discharged from the facility. He said the resident was on Abilify, but the clonazepam would have helped with his anxiety and should have been administered as ordered. Dr D. said the risk of not getting his medication was increased behaviors. He said the resident was not a harm to others, and a long-term care facility was an appropriate setting.</p> <p>Record review of the Facility's Medication -Treatment Administration and Documentation Guidelines, revision date 2/2/2014, read in part . Process 4. Administer the medication according to the physician order .</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>47709</p> <p>Based on observations, interviews, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 Kitchen.</p> <p>-Thirteen 8 oz glasses of juice were not labeled and not dated in the facility refrigerator.</p> <p>-Nine 4 oz glasses of apple sauce were not labeled and not dated in the facility kitchen.</p> <p>This deficient practice could place residents who received meals from the main kitchen at risk for food borne illness.</p> <p>Findings included:</p> <p>Observation in the facility kitchen on 2/25/25 at 06:30 am revealed thirteen 8 oz glasses of juice and nine 4 oz glasses of apple sauce were not labeled (attach a label to something) or dated.</p> <p>Interview with the Dietary Manager on 2/26/25 at 4:01 pm, she said she starts her workday by making sure everything is correctly labeled and dated . She said she make sure the date and use by date are on each food item. She said if the item used is not labeled or dated the residents can get sick or have an allergic reaction.</p> <p>Interview with the [NAME] on 2/27/25 at 1:39 pm, she said all food items should be labeled and dated. She said if the items are not labeled and dated, she had no idea how long the item had been sitting there. She said if she was to use the item and it's not dated or labeled it can make the residents sick.</p> <p>Interview with the Tray-aide on 2/27/25 at 1:45 pm, he said all the food items should be labeled and dated always. He said if the items are not labeled and dated, and the food is used it can put the residents at risk of getting sick.</p> <p>Record review of the Facility's Nutrition Policies and Procedures dated December 5, 2017, read in part . proper labeling with an expiration or use by date .</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Dispose of garbage and refuse properly.</p> <p>47709</p> <p>Based on observation, interview and record review, the facility failed to dispose of garbage and refuse properly for 2 of 2 garbage dumpsters (dumpsters #1 and #2) reviewed for disposal of garbage.</p> <p>The facility failed to ensure 2 of 2 dumpster lids were secured.</p> <p>This failure could place residents at risk of infection for exposure to germs and diseases carried by rodents from improperly disposed garbage.</p> <p>Finding included:</p> <p>Observation on 2/25/25 at 7:15 am revealed Dumpster #1 and Dumpster #2 had their lids completely open with the garbage exposed. The cook said they were not the only ones using the dumpsters in the facility.</p> <p>Interview with the Nutrition Director on 2/26/25 at 4:01 pm, she said she had worked at the facility for seven years. The Nutrition Director said the dietary staff were responsible for the dumpster lids remaining closed. She said if the dumpster lid was open the residents are at risk for potential rodents that could come into the building and make the residents sick.</p> <p>Interview with the [NAME] on 2/27/25 at 1:39 pm, she said she had worked at the facility for eight months. She said the kitchen staff responsible for making sure the dumpster lids closed. She said when the lid of the dumpster did not close it can cause the rodents, flies, and gnats to enter the facility which can cause the residents to become sick.</p> <p>Interview with the Tray-Aide on 2/27/25 at 1:45pm, he said he had worked for the facility for one year. He said the kitchen responsible for the dumpster lids remaining closed. He said if the dumpster lids remain open it can put the residents at risk. He said the resident can be put at risk once rodents surround the dumpster. He said the residents can get rabies and become sick.</p> <p>Record review of the Facility's Nutrition Policies and Procedures dated December 2017 read in part . dumpsters must be covered with lids . dumpster doors and lids must be kept closed when not in use .</p> <p>Record review of the Facility's Food-Related Garbage and Rubbish Disposal policy, revised April 2006 revealed . 2. All garbage and rubbish containers shall be provided with tight-fitting lids or covers and must be covered when stored or not in continuous use. 5. Garbage and rubbish containing food wastes will be stored in a manner that is inaccessible to vermin. 7. Outside dumpsters provided by garbage pick-up services will be kept closed and free of surrounding litter.</p>