

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675832	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER Rising Star Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 411 S Miller Rising Star, TX 76471	
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to develop and implement a comprehensive person -centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a residents medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 3 of 8 residents (Residents #6, #25, #26,) reviewed for care plans. 1. The facility failed to ensure a care plan was developed for Resident #6's scalp wound.2. The facility failed to ensure a care plan was developed for Resident #25's psychosocial issues 3. The facility failed to ensure a care plan was developed for Resident #26's psychosocial issues. Findings include:Resident #6Review of Resident #6's admission Record, dated 9/18/25, revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including open wound of scalp, presence of other bone and tendon implants. Review of Resident #6's Quarterly MDS Assessment, dated 7/19/25, revealed the following:*Resident #6 scored 11 of 15 on his BIMS, indicating he was moderately cognitively impaired. *Resident #6 received Skin Treatments applications of ointments/medication other than to feet. Review of Resident #6's Order Summary Report, dated 9/18/25, revealed wound care orders for Right Scalp lesion, cleanse with wound cleanser. Pat Dry. Apply Protective Dressing order dated 4/9/25. Observation on 09/17/2025 at 3:18 PM, this surveyor observed wound care to Resident #6's skin graft on scalp. Review of Resident #6's Care Plan Report, initiated 4/11/25 and last revised on 5/13/25, revealed no care plan on Resident #6's scalp wound and related wound care. Resident #25Review of Resident #25's admission Record, dated 9/18/25, revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnosis including Arthritis. Review of Resident #25's Quarterly MDS Assessment, dated 7/28/25, revealed the following: *Resident #25 had moderate difficulty with hearing.*Resident #25 scored 13 of 15 on her BIMS, indicating she was cognitively intact.*Resident #25 reported no signs of depression and showed no behaviors.*Resident #25 required moderate assistance with most activities of daily living. Review of Resident #25's Order Summary Report, dated 9/18/25 revealed no psychotropic medication. Interview on 9/16/25 at 2:37 PM Resident #25 said she was mourning her family and loss of independence. Resident #25 stated she had no choices here. Resident #25 said she felt forgotten about. Resident #25 said she was [AGE] year-old and demanded if surveyor knew what that was like. Resident #25 said all she wanted to do was die because everyone she knew was gone. Resident #25 stated her children came to visit but they did not need her anymore. Review of Resident #25's Care Plan showed a care plan initiated 2/10/22 for Chronic Pain, and pain due to age. There was no care plan regarding Resident #25's acute unhappiness related to her desire to die because she was lonely for initial family, felt useless, and loss of independence. Resident #26Review of Resident #26's admission Record, dated 9/18/25, revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including arthritis, traumatic brain injury (can cause temporary or short-term memory problems and the person may exhibit signs such as frustration, irritability, problems with impulse control, and depression), and major depressive disorder (a disorder causes persistent feeling of sadness, loss of interest, outbursts of irritation, loss of interest in most normal (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	activities, sleep disturbances, lack of energy, agitation, fixating on past failures, trouble thinking or concentrating causing notable problems in day-to-day activities.) Review of Resident #26's Quarterly MDS Assessment revealed the following:*Resident #26 scored 15 of 15 on her BIMs, indicating she was cognitively intact.*Resident #26 did not report any indicators of depression. *Resident #26 exhibited delusions. *Resident #26 was on an anti-depressant and an anti-convulsant. Review of Resident #26's Care Plan revealed no care plan for the history of trauma, or PTSD. Review of Resident #26's Order Summary dated 9/18/25 revealed she received the following:*Citalopram 40 mg for neuropathic pain, dated 2/9/24 (an antidepressant also used to treat nerve pain)*Clonazepam 0.5 mg at bedtime for anxiety dated 7/16/25 (an antianxiety medication)*Venlafaxine 75 mg, 2 tablets by mouth twice a day for depressive disorder dated 9/16/25 (an antidepressant. Interview on 09/16/2025 11:16 AM Resident #26 stated how a CNA D did incontinent care triggered her history of trauma. Resident #26 stated she told the aide to stop and get out, but the CNA continued to do incontinent care. Resident #26 stated she rolled to punch the aide. Resident #26 stated it brought up unpleasant memories from her first marriage. Interview on 09/18/2025 at 11:17 AM, the ADON said Resident #26 was very happy when the ADON went to see her and the ADON was not aware of any complaints. The ADON stated she did Resident 26's care plan meetings and tried to keep Resident #26 very involved. The ADON said Resident #26 saw a therapist in a neighboring town for treatment of PTSD. The ADON stated Resident #26 said there was a history of PTSD from history, and she wanted to get started with therapy. The ADON stated she was not aware of the history of trauma when she was a nurse on floor. The ADON stated Resident #25 talked to the ADON about previous relationships. The ADON stated she did not believe there was a care plan for Resident #26's PTSD and Resident #26 disclosed the history probably end of May 2025. Interview on 09/18/2025 11:37 AM the ADON stated the previous ADON trained her to add skin issues, falls, code status, plans for discharge, Activities of Daily Living, medications and diagnoses, malnutrition or weight changes. The ADON said she looked at the resident, saw what they needed and added it to the care plan. The ADON said the needs of residents were communicated between staff members or she (the ADON) would talk to staff about how much help the residents needed. ADON said she did add care plans if something came up in-between care plan meetings. Interview on 09/18/2025 12:18 PM, the ADON stated she did not find care plans for Resident #6's wound care, #25's extreme unhappiness or #26's reported history of trauma and trigger management. Review of the facility's Policy on Comprehensive Care Plans, undated, revealed: the facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that include measurable objectives and timeframes to meet a resident' medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan will describe the followingThe services that are to be furnished to attain the resident's highest practicable physical, mental, and psychosocial well-being.		

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide the necessary behavioral health care to maintain their highest level of practicable physical, mental and psychosocial well-being for 2 of 6 residents (Resident #25 and #26) reviewed for psychosocial adjustment.1. The facility failed to ensure Resident #25's had the services to cope with psychosocial issues related to statements of age-related wanting to die and feeling useless.2. The facility failed to ensure Resident #26's psychosocial triggers were addressed, the COTA failed to communicate a history of psychosocial distress that needed to be addressed. These failures could affect residents by placing them at risk of not receiving individualized care and services to meet their psychosocial needs. The findings included: Resident #25 Review of Resident #25's admission Record, dated [DATE], revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnosis including Arthritis. Review of Resident #25's Quarterly MDS Assessment, dated [DATE], revealed the following: *Resident #25 had moderate difficulty with hearing. *Resident #25 scored 13 of 15 on her BIMS, indicating she was cognitively intact. *Resident #25 reported no signs of depression and showed no behaviors. *Resident #25 required moderate assistance with most activities of daily living. Review of Resident #25's Order Summary Report, dated [DATE] revealed no psychotropic medication. Review of Resident #25's Care Plan showed a care plan initiated [DATE] for Chronic Pain, and pain due to age. There was no care plan regarding Resident #25's acute unhappiness related to her desire to die because she was lonely for initial family, felt useless, and loss of independence. Review of the Social Service assessment dated [DATE]: In reference to outliving all of her siblings she stated, That's my punishment here on earth. Family History She was married to her ex-husband for 50 years. She stated that 50 is the Year of the [NAME], and I decided it was a good time to get out. Resident #25 told the social worker that the ex-husband suffered from bipolar disorder which escalated after his mother's death. Resident #25 told the social worker, It is very hard to deal with, for the person and the family. Review of the Social Services quarterly assessment dated [DATE] revealed Resident #25 fluctuated between asking God why he keeps leaving her here and being socially engaged and attending competitive activities. The social worker documented Resident #25 celebrated her 103rd birthday. The social worker documented Resident #25 had a history of episodes of acute anxiety requiring medication intervention. Interview on [DATE] at 2:37 PM 6 B Resident #25 said she was sad because she was not the favorite of her mother and a loss of independence. Resident #25 said she had no choices in the facility and felt forgotten about. Resident #25 said she was 103 and all she wants to do is die because everyone she knew is gone. Interview on [DATE] 9:56 AM the ADON stated Resident #25 was pretty antisocial for the last couple of years. The ADON said Resident #25 was beginning to come out for activities. The ADON stated wanting not to be on earth at 103 was pretty normal and the facility talked to doctor about the wish several times. The ADON said they had Resident #25 on a mood stabilizers. The ADON said the facility did not know if Resident #25 had little melt downs or didn't want to live this and long didn't anticipate living this long The ADON said Resident #25 focused on everyone she knew was gone. The ADON said they talked to Resident #25 about antidepressant will have to go through notes and though it could make a difference. Interview on [DATE] at 11:12 AM, the ADON talked to the DON who said the facility had increased involvement and the Doctor had talked to Resident #25 constantly about it there. The ADON agreed there were no notes about it. Interview on [DATE] at 2:20 p.m. the DON stated Resident #25 attributed all her issues to her ex-husband or children. The DON said Resident #25 had an acute episode of anxiety and had to go to hospital. The DON Resident #25's distress may be from seizure-like activity. The DON stated Resident #25 needed everything to be very routine and absolute. Resident #26 Review of Resident #26's admission Record, dated [DATE], revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses (continued on next page)		

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	including arthritis, traumatic brain injury (can cause temporary or short-term memory problems and the person may exhibit signs such as frustration, irritability, problems with impulse control, and depression), and major depressive disorder (a disorder causes persistent feeling of sadness, loss of interest, outbursts of irritation, loss of interest in most normal activities, sleep disturbances, lack of energy, agitation, fixating on past failures, trouble thinking or concentrating causing notable problems in day-to-day activities.) Review of Resident #26's Quarterly MDS Assessment revealed the following:*Resident #26 scored 15 of 15 on her BIMS, indicating she was cognitively intact.*Resident #26 did not report any indicators of depression. *Resident #26 exhibited delusions. *Resident #26 was on an anti-depressant and an anti-convulsant. Review of Resident #26's Care Plan reviewed [DATE], revealed no care plan for the history of trauma. Review of Resident #26's Order Summary dated [DATE] revealed she had orders forCitalopram 40 mg for neuropathic pain, dated [DATE] (an antidepressant also used to treat nerve pain)Clonazepam 0.5 mg at bedtime for anxiety dated [DATE] (an antianxiety medication)Venlafaxine 75 mg, 2 tablets by mouth twice a day for depressive disorder dated [DATE] (an antidepressant. Interview on [DATE] 11:16 AM Resident #26 stated how a CNA D did incontinent care triggered her history of trauma. Resident #26 stated she told the aide to stop and get out, but the CNA continued to do incontinent care. Resident #26 stated she rolled to punch the aide. Resident #26 stated it brought up unpleasant memories from her first marriage and caused panic attacks. Resident #26 said she had to go back to therapy to get things (trauma) tidied up and put away again. Resident #26 stated she would make herself breathe slowly and it would sometimes help with the panic but it comes and goes. Resident #26 stated she requested help with setting up therapy, but it was too slow, so she did it herself. Interview on [DATE] 11:48 AM, the COTA described Resident #26 as a talker. The COTA said Resident #26 shared she experience a history of abuse prior to incident and then the incident really triggered Resident #26. The COTA stated Resident #26 indicated there was history of physical, emotional, and sexual abuse. The COTA said she did not report it because it was historical it had nothing to do with her. The COTA continued when the residents came to therapy, the residents told her things in confidence. The COTA said when Resident #26 made a current allegation she reported it to the DON immediately. Interview on [DATE] at 11:17 AM, the ADON said Resident #26 was very happy when the ADON went to see her and the ADON was not aware of any complaints. The ADON stated she did Resident 26's care plan meetings and tried to keep Resident #26 very involved. The ADON said Resident #26 saw a therapist in a neighboring town for treatment of PTSD. The ADON stated Resident #26 said there was a history of PTSD from history, and she wanted to get started with therapy. The ADON stated she was not aware of the history of trauma when she was a nurse on floor. The ADON stated Resident #25 talked to the ADON about previous relationships. The ADON stated she did not believe there was a care plan for Resident #26's PTSD and Resident #26 disclosed the history probably end of [DATE]. Interview on [DATE] at 2:20 PM, the DON said she assessed for trauma-informed care. The DON stated Resident #26 did not reveal her history to the DON until she reported the event. The DON stated Resident #26 did not historically discuss details about her trauma. Interview on [DATE] at 2:20 PM, the DON said she assessed for trauma-informed care: based on earmarks and signs and symptoms, and from the resident's triggers are activity and difficulty adjusting. The DON stated the new staff were trained by going with an existing staff until they learn the residents. The DON said additional information was communicated during stand-up meeting because it was a small facility and the staff communicated constantly, that there was not a lot of chain of command, then things were reported. The DON stated new issues were always taken into the morning meeting even if there were interventions by the morning because if there was a trigger the staff needed to know. The DON stated all department heads were in the morning meeting except for Therapy because it was too disruptive to the residents. The DON stated if something came up the therapist needed to know it was communicated and if something the department heads needed to know the Therapy department called nursing immediately. The DON said she was unaware that the COTA was aware history of trauma in residents overall prior to the (continued on next page)		

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	conversation with surveyor. The DON stated the COTA immediately reported when a resident was in acute distress. Interview on [DATE] at 3:12 PM, the AIT and Administrator were informed of trauma-informed care concerns. The Administrator asked if the trauma informed care was the next step in culture change. Review of the facility's policy and procedure on Comprehensive Person Care Plans, undated, revealed: The facility will develop and implement a comprehensive person centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident' medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Trauma informed care and Trigger Identification. Care planning to address the past trauma, including the need for the facility to collaborate with the resident and their families is appropriate. Trigger-specific interventions with examples of such should be included. Key elements the facility is to ensure are: Identify cultural preferences in collaboration with the trauma survivor; Identify past history of trauma; Identify triggers to trauma and can cause traumatization; Approach trauma survivors with culturally competent and trauma-informed care. Identify and document Events that may have contributed may include the thread of physical or psychological harm and/or severe neglect. These could occur once or repeatedly over time. Experiences from what the resident determines as their traumatic event. A traumatic event for one may not be traumatic for another. Individual interpretation determines the experience as traumatic. Determine the result of the event. The long-lasting adverse effects are critical to the components of trauma. These events can be immediate or a delayed onset and can last a short or long term.		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview and record review the facility failed to ensure that certified nurse aide were able to demonstrate competency in skills and techniques to provide nursing and related services for 1 of 4 residents (Residents #36) by 1 of 2 certified staff (CNA A) reviewed for competent staff, in that: While providing incontinent care for Resident #36, CNA A did not perform peri-care to Resident #36's vaginal area. These failure could place residents at risk for not receiving nursing services by adequately trained and certified aides and could result in infections. The findings included: During record review of Resident #36's admission record, dated 09/16/2025, revealed an admission date of 08/31/2020, and a readmission date of 09/07/2025, with diagnoses which included: Dementia and muscle weakness. She was [AGE] years of age. During record review of Resident #36's annual MDS, dated [DATE], revealed the resident had a BIMS score of 5 indicating severe impairment. Resident #36 was frequently incontinent of bladder and bowel. During record review of Resident #36's care plan dated 12/20/25 indicated in part: Resident is at risk for skin breakdown r/t decreased mobility, incontinence, equipment, nutritional status. Resident will have no reports of skin breakdown through next review date. Provide assistance for toileting/incontinence checks every 2 hours and PRN. Provide peri--care as needed. Apply barrier cream to peri-care, buttocks are post incontinent episode per facility policy. During an observation on 09/16/2025 at 11:02 AM CNA A and NA B performed incontinent care for Resident #36. Both aides entered the resident's room, sanitized their hands, put on gloves and provided privacy for the resident. CNA A removed Resident #36's brief by turning the resident on her left side and NA B assisted by holding the resident on her side. Resident #36's brief was noted to be wet with urine. NA B handed CNA A some wet wipes and the CNA wiped the resident's buttocks and rectal area. NA B then took a pull up type of brief and put it on the resident. CNA A then removed her gloves, covered the resident with a blanket and was done with the care. CNA A did not perform peri-care to the resident's vaginal area before they fastened the new brief on the resident. During an interview on 09/18/2025 at 9:54 AM CNA A said when she had performed the incontinent care for Resident #36 she had mostly wiped the resident's bottom. CNA A said she was able to wipe some of the resident's vaginal area from the back but she should have turned the resident on her back and performed a more thorough peri-care of the vaginal area. CNA A said she had gotten nervous and that made her forget some of the steps. CNA A said not performing peri-care to the resident's vaginal area could lead to infections as it was not cleansed during the care. During an interview on 09/18/2025 at 1:10 PM the ADON said it was expected for the CNA to cleanse the vaginal area with some wipes to prevent the possibility of a urinary tract infection. The ADON said the CNAs received skills checks and at that time she would observe the staff perform the task such as incontinent care. The ADON said she believed the failure occurred because the CNA got nervous and did not perform the peri-care as needed. During a telephone interview on 09/18/2025 at 3:12 PM the DON said it was expected for the CNA to perform peri-care to the vaginal area to prevent any type of infections. The DON said each CNA knew how to do their job and the CNA probably got nervous and forgot to do the care correctly. The DON said the staff received yearly skills checks and they were done by the ADON. During an interview on 09/18/2025 at 4:38 PM the Administrator stated the CNA should have performed peri-care to the resident's vaginal area and that she probably failed to do it because she had gotten nervous. Record review of the certified nurse aide annual skills check for CNA A indicated CNA A passed competency for Perineal care/incontinent care female with or without catheter on 05/15/2025. Record review of facility undated policy, titled Perineal care, indicated in part: The purpose of this procedure are to provide cleanliness and comfort to the resident to prevent infections and skin irritation and to observe the resident's skin condition. Steps in procedure. Unfasten the used brief or underwear and begin perineal care. For a female resident. Clean perineal (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	area, wiping from front to back. Use incontinence cleaner as needed. Separate labia and wash area downward from front to back. Continue to wash perineum moving from inside outward to and including thighs alternating from side to side and using downward strokes. Do not reuse the same wipe to clean the urethra or labia. Gently dry perineum, instruct or assist the resident to turn on her side with her top leg slightly bent if able. Cleanse the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks. Do not use the same wipe to clean the labia. Record review of facility document titled Job description certified nursing assistant and dated 01/13/2025 indicated in part: The following is a non-exhaustive criterion that relates to the job of a certified nursing assistant, and it is consistent with the business needs of the facility. These are legitimate measures of the qualifications for a certified nursing assistant and are related to the functions that are essential to the job of a certified nursing assistant. Knowledge base: accountable for personal care (i.e., grooming, bathing, catheter care, peri-care and dressing.) and observations of residents within patient care policy guidelines. Identify and report any condition requiring management attention. Signed by CNA A.		