

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455503	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2024
NAME OF PROVIDER OR SUPPLIER The Rosewood Retirement Community		STREET ADDRESS, CITY, STATE, ZIP CODE 5700 E Central Texas Expwy Killeen, TX 76543	

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 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17141</p> <p>Based on 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 (Resident #1) of 3 residents reviewed for treatment of pressure ulcers.</p> <p>The facility failed to recognize and provide treatment, and prevention measure for an open skin area on Resident #1. The area was first noted on 6/25/24 with admission, the first documentation of care being provided to the area was on 7/7/24. On 7/10/24 Resident #1 was diagnosed with a stage III pressure injury (a full thickness loss of skin extending to the subcutaneous tissue).</p> <p>The noncompliance was identified as PNC. The IJ began on 06/25/24 and ended on 07/26/24. The facility had corrected the noncompliance before the survey began.</p> <p>This failure could place residents at increased risk of a wound infection and delay the healing process.</p> <p>Findings included:</p> <p>Review of Resident #1's Face sheet, undated, revealed he was admitted to the facility on [DATE] from a local rehabilitation hospital, with diagnoses including infarction with hemiplegia (paralysis on one side) and hemiparesis (partial paralysis or weakness on one side), depression and PTSD.</p> <p>Record review of Resident #1's MDS dated [DATE] revealed a BIMS score of 11 indicating his cognition was moderately impaired. Section M of the MDS indicated Resident #1 has one unhealed pressure ulcer/injury.</p> <p>Review of Resident #1's Care Plan revealed an area of focus initiated 6/25/24 (date of admission) at risk for skin impairment with actual sites on feet and coccyx.</p> <p>Review of Resident #1's PCC Skin &Wound Total Body Skin Assessments, dated 6/25/24, question #6 Enter the # of New Wounds, the number entered was 0.</p> <p>Review of Resident #1's admission assessment, dated 6/25/24 notes an open wound to his coccyx, circular and approximately 3x3x0.3 cm with an irregular border.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455503	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2024
NAME OF PROVIDER OR SUPPLIER The Rosewood Retirement Community		STREET ADDRESS, CITY, STATE, ZIP CODE 5700 E Central Texas Expwy Killeen, TX 76543	

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 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's Progress Notes from 6/25/24 through 7/26/24 revealed an admission note on the following dates:</p> <p>6/26 NP A notes included a new admission note. The Review of Systems section includes Skin/Breast: No reported skin issues.</p> <p>6/28 NP A notes an acute/follow-up visit the assessment note has the Review of System section includes Skin/Breast: No reported skin issues. The Physical Exam section includes Skin: Inspection: no rashes or ulcers.</p> <p>7/2 The Facility MD noted he had conducted an initial H&P. The Review of Systems section includes Skin/Breast: No reported skin issues.</p> <p>7/3 A medication administration note for pain medication notes Resident c/o pain during wound care treatment, unable to describe or rate. PRN given.</p> <p>7/7 A medication administration note for WC TO COCCYX-CLEAN WITH NS OR WOUND CLEANSER-APPLY COLLAGEN, ALGINATE AND COVER WITH PROTECTIVE DRESSING. CHANGE DAILY.</p> <p>7/9 NP A notes an acute/follow-up visit the assessment note has the Review of System section includes Skin/Breast: No reported skin issues. The Physical Exam section includes Skin: Inspection: no rashes or ulcers.</p> <p>7/10 Nurse noted Resident was seen by the [wound care] NP for wound care consult today.</p> <p>7/11 NP A notes an acute/follow-up visit, the summary includes Appears to be in moderate distress. When asked patient stated that he was in significant pain. Pain level 9/10.</p> <p>7/16 NP A notes an acute/follow up visit, the summary includes Reports from nursing about intermittent noncompliance with nursing care specifically dressing changes for his pressure ulcer. This is of greatest concern as he has a worsening stage III pressure ulcer to the sacrum.</p> <p>7/22 NP A notes an acute/follow up visit, the summary includes Shared with patient that results from wound culture returned positive for bacteria. Wound care NP will follow up regarding treatment.</p> <p>7/23 Nurse notes Called [medical services provider] at this time for midline placement [catheter placed in vein for intravenous access] order.</p> <p>7/23 Nurse notes Resident had Midline placed to his left basilic vein this afternoon and will start IV ABT in the morning.</p> <p>7/25 Social services notes include SW had another careplan meeting with [RP's name]. In attendance: Administrator, DNS, Activities, Therapy, Dietary, MDS nurse, Wound Care and SW All aspects of patients care was discussed and medications reviewed. Nursing tried to explain the current state of Resident #1's wound and the lack of healing being seen. Nursing tried to explain the current state of [Resident #1's] wound and the lack of healing being seen.</p> <p>7/26 nurse noted Resident #1 was transferred to the ED per PR request.</p> <p><i>(continued on next page)</i></p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455503	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2024
NAME OF PROVIDER OR SUPPLIER The Rosewood Retirement Community		STREET ADDRESS, CITY, STATE, ZIP CODE 5700 E Central Texas Expwy Killeen, TX 76543	
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 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's Order Summary Report, from 6/25/24 to 7/27/24 revealed the following regarding wound care:</p> <p>-7/6 WC to coccyx-cleanse with NS or wound cleanser, apply collagen, alginate (alginic acid) and cover with a protective dressing. Change daily, every dayshift.</p> <p>-7/17 Wound panel (detects pathogens found in infected wounds) lab, collected 7/17/24.</p> <p>-7/17 WC to coccyx-cleanse with Dakin's (sodium hypochlorite) or vashe (hydroperic acid) wound cleansers, apply Santyl (collagenase) & honey to slough (yellow tissue on wound bed), apply collagen powder to granulation (new tissues in wound), cover with alginate sheets, cover sacral foam dressing and foam dressing, apply barrier cream to peri wound (skin around wound) every day, night shift and if soiled.</p> <p>-7/23 Imipenem/cilastatin (antibiotic that interferes with bacterial cell walls) intravenous solution reconstituted 500mg. Use one application intravenously four times a day for infection for 10 days.</p> <p>-7/24 Stat x-ray (electromagnetic radiation used to generate an image) of sacrum coccygeal (relating to coccyx) 3 view to rule out osteomyelitis (bone infection).</p> <p>-7/24 WC to coccyx-cleanse with Dakin's or vashe wound cleansers, apply Santyl & honey, pack with alginate sheets, cover with sacral foam dressing, apply barrier cream with collagen powder to peri wound every day, night shift and if soiled.</p> <p>Review of Resident #1's MAR for July 2024 revealed on 7/24/24 an order was added, Imipenem-Cilastatin Intravenous Solution Reconstituted 500MG. Use one application intravenously four times a day for infection for 10 days.</p> <p>Review of Resident #1's TARs for June 2024 contained No order data found for TREATMENT ADMINISTRATION RECORD. There was no monitoring by nursing included for area identified to buttocks.</p> <p>July 2024 had entries for coccyx wound care starting on 7/7 WC TO COCCYX-CLEANSE WITH NS OR WOUND CLEANSER-APPLY COLLAGEN, ALGINATE AND COVER WITH PROTECTIVE DRESSING. On 7/13 and 7/14 there are blank areas with no initials indicating wound care had not occurred.</p> <p>-On 7/17 new orders were implemented: WC TO COCCYX- cleanse with Dakin's/vashe, Apply Santyl & honey to slough, apply collagen powder to granulation, cover with alginate & foam dressing, Apply barrier cream to peri wound. Every day and night shift.</p> <p>-On 7/24 a new order was implemented WC TO COCCYX cleanse with Dakin's/ vashe, apply Santyl & honey, pack with alginate sheets, cover sacral foam dressing. Apply barrier cream w/[with] collagen powder to peri wound. every day and night shift. Continued review revealed the same order written for as needed changes if soiled.</p> <p>Review of the Wound Care visit reports written by the Wound Care NP revealed the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455503	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2024
NAME OF PROVIDER OR SUPPLIER The Rosewood Retirement Community		STREET ADDRESS, CITY, STATE, ZIP CODE 5700 E Central Texas Expwy Killeen, TX 76543	
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 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>7/10/24 initial visit reveals, Patient is being seen today for evaluation of a wound to his coccyx. Per nursing patient has been non-compliant with turns and has been refusing care. As a result, patient has developed a wound. The active problem lists, and the diagnoses section contain, Pressure ulcer of the sacral region. The physical exam section includes Wound #1 is a Stage 3 Pressure Injury Pressure Ulcer and has received the status of Not Healed. Initial wound encounter measurements are 4cm length x 3.5cm width x 0.2cm depth, with an area of 14 sq cm and a volume of 2.8 cubic cm. There is a moderate amount of Sero-sanguineous drainage [blood and serum] noted which has a Mild odor. Wound bed has 1-25%, granulation, 26-50% slough, 1-25% epithelialization[the process of repairing epithelial tissue].</p> <p>7/17/24 follow-up of a wound to coccyx includes, Very strong odor noted to patient's wound this visit with increased dimensions. The NP noted that a wound panel is being collected. Wound Assessment section includes wound measurement of 7cm in length x 7.2 cm width x 0.3cm depth, with an area of 50.4 sq cm and a volume of 15.12 cubic cm. There is a Moderate amount of sero-sanguineous drainage noted which has a strong odor. Wound bed has 1-25 % ,granulation, 26-50 % slough , 1-25% epithelialization. The wound is deteriorating.</p> <p>7/24/24 follow-up to a wound visit includes, Significant deterioration noted to patients wound this visit. [Resident] was started on IV Imipenem 500 mg q 6hrs x10 days yesterday based on findings from recent wound panel. An x-ray is being ordered this visit of patients sacrococcygeal region to r/o[rule out] OM[osteomyelitis]. Measurements of the wound are 8.2 cm x 7.6cm x 3.4 cm depth with an area of 62.32 sq cm and a volume of 211.888 cubic cm. There is a Moderate amount of purulent [pus/exudate fluid indicating an infection] drainage noted which has a strong odor. Wound bed has 1-25 % ,granulation, 51-75% slough , 1-25% epithelialization. The wound is deteriorating.</p> <p>Review of the local hospital Emergency Medicine note, dated 7/26/24, notes an ED clinical impression of a skin ulcer of sacrum with necrosis [death of body tissue] of muscle. And Patient will be stasured as inpatient due to sacral ulcer and osteomyelitis.</p> <p>During an interview on 7/27/24 with the FM at 10:10am revealed at the time of admission the plans were to have Resident #1 in a nursing home till he became strong enough to come home with home health. The FM stated now instead of stronger he was weaker. He has developed an infected wound that goes down to the bone due to the facility not taking care of the area. The FM stated she was at the facility frequently and no one told her about the condition of this wound. When Resident #1 was admitted into the facility the area was the size of a thumbnail now it was the size of a palm. The hospital has already done surgery once and was discussing if a second surgery was needed.</p> <p>During an interview on 7/27/24 at 1:15 pm LVN C she stated she was an agency nurse and has been a while since she has worked at this facility. She was notified by the agency and the facility that she needed to complete in-services prior to working the floor. She already knew but the in-services stated the charge nurse was to do wound care if there was not a wound care nurse. When an assessment was done it has to be accurate and from an eye on description of the resident's skin. For any issues, the size needs to be documented. LVN C stated he nurse was to notify the NP or MD of any new changes or issues They will know, whether there is a change, by reviewing the orders and previous documentation.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455503	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2024
NAME OF PROVIDER OR SUPPLIER The Rosewood Retirement Community		STREET ADDRESS, CITY, STATE, ZIP CODE 5700 E Central Texas Expwy Killeen, TX 76543	
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 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/27/24 at 2:08pm the WC Nurse/LVN revealed although she was an agency nurse she has started recently as the wound care nurse, she works weekdays M-F. The WC/LVN stated the facility was now assigning someone to do wound care treatments on the weekend. She stated she was not providing wound care to Resident #1 until sometime at the end of or after the first week in July. She stated prior to that she was not aware that he had a wound. The WC/LVN stated when she became aware, she began treatments, the NP and Physician had been notified and she had orders for the treatment. She assessed the wound and noted the size. The WC NP was notified about the wound soon after she had been notified. The WC Nurse/LVN stated she received in-services on July 26th on what to do if the wound care nurse was not available. She stated in-services included that admissions must have a thorough assessment and they need to report any issues to the NP or MD. If no response from NP or MD they are to notify the DNS. Everything must be documented. The WC/LVN stated she will be assisting the DNS with doing second assessments on new admissions to make sure initial assessment was accurate.</p> <p>During an interview on 7/27/24 at 2:51pm with the WC/NP revealed he became aware of Resident #1's wound on 7/7/24. He stated he does not provide wound care on all skin issues so the wound may not have been significant enough to report to him earlier for care. In meeting Resident #1 and the nurses reports he believes part of the issue was that the resident was noncompliant with care which allowed the wound to progress. When the WC/NP saw it for the first time on 7/10/24 it was a stage III because he saw subcutaneous tissue, since then it has become progressively worse. On 7/17/24 the wound had declined and had a strong odor. He had ordered a wound panel and changed the wound care orders. On 7/24/24 it had again deteriorated, and the wound was unstageable. The WC/NP stated he ordered an x-ray to rule out osteomyelitis and an intravenous antibiotic. The x-ray did not show evidence of osteomyelitis. The WC/NP stated he did not feel Resident #1 needed to go to the hospital as they were providing treatment there at the facility. The wound may have been different if he started treating the area sooner but the first time that he assessed it there was no infection so it probably would have concluded with the same results.</p> <p>During an interview on 7/28/24 at 3:10pm with LVN D stated they have had all kinds of in-services since yesterday. She was an agency nurse. LVN D stated she did work with Resident #1, he was not always willing to cooperate with what they needed to do. She does recall doing dressing changes for Resident #1 stating there were orders on treatment when she worked with him. They all got notification yesterday from the agency to review in-services and that they cannot work until sign all in-services. The in-services were on assessments, doing accurate descriptions size, shape, location, and condition. On Admissions the MD and/or the NP must be notified of any skin issues and orders obtained to monitor at minimum. The RP must be notified of any issues.</p> <p>During an interview on 7/28/24 at 3:19pm with RN B revealed she was not an agency nurse. She stated she was the only nurse working today that was not agency. She believes that maybe part of the problem with communication in the case of Resident #1. RN B stated she believes that the bandages were being changed daily but the problem was there was no documentation indicating that was occurring. The nurse admitting Resident #1 should have notified the NP or MD about the site and documented the notification. Every nurse, including agency nurses was given in-services yesterday and every resident was assessed for skin issues whether the skin assessment was due or not. There were no other skin issues identified. The in-services were over admissions, assessments and accuracy, NP or MD notification.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455503	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2024
NAME OF PROVIDER OR SUPPLIER The Rosewood Retirement Community		STREET ADDRESS, CITY, STATE, ZIP CODE 5700 E Central Texas Expwy Killeen, TX 76543	
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 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/28/24 at 3:30pm with LVN E revealed she was an agency nurse. She stated she was notified yesterday that to work here she had to take several in-services. LVN E stated the in-services were very detailed. They included admission details and assessments must be accurate and notify the MD or NP and family of any skin issues. Document description and that the notifications were made.</p> <p>During an interview on 7/28/24 at 3:18 pm with the facility DNS when asked if she could provide any documentation regarding interventions and/or precautions put in place at admission to monitor skin area identified, she stated it was being done but the nurses were not documenting it. It was not included on the TAR at admission. The DNS stated the weekend supervisor notified her on 7/6/24 of the wound she found during her assessment. New orders for wound care were added to TAR on 7/7/24. Wound Care NP saw on 7/10/24. Her expectation and the in-services/training they have provided includes the admission nurse notifying the NP or MD of any skin issues at the time of admission. The initial assessment must include specific descriptions and measurements of the area of skin issues/wounds. The nurse can initiate standing orders that can be used for all residents. Once the area was resolved it can be taken from the TAR. In this case she believes the wound care was occurring but was not being documented regularly and was not on the TAR. On 7/3/24 a nurse documented Resident #1 complained of pain during a dressing change. The DNS pointed out that the wound was not infected when first identified and when first seen by the wound care NP. The weekly skin assessments ask for new wounds the existing wounds should be being monitored for any changes. She and the LNAC will be doing random audits of skin assessments and treatments to verify the assessment is correct. With each new admission an assessment will be conducted by herself, the LNAC or the wound care nurse to ensure the accuracy of the admission nurses' assessment. All new admissions were discussed in the morning meetings. She and the LNAC will review skilled nurses' notes at each of the morning meetings for appropriate documentation.</p> <p>During an interview on 7/28/24 at 11:36 am with the facility LNAC/LVN revealed that they were going to review every new admission in morning meeting which happens 5 days a week if a new admission comes in on the w/e they will call the nurse. We are going to make sure they MD or NP because they must verify orders and if there was any wound. Me and/or the DON will be doing an eye on skin assessment by one of us. Measurements are done if they are pressure ulcers, and they would be on our wound care sheet. Done weekly. Admission nurse cannot say pressure ulcer or stage the wound, but the area should be described in detail. They will also be randomly checking 3 people a week for any new skin issues by doing a skin assessment.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455503	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2024
NAME OF PROVIDER OR SUPPLIER The Rosewood Retirement Community		STREET ADDRESS, CITY, STATE, ZIP CODE 5700 E Central Texas Expwy Killeen, TX 76543	
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 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/28/24 at 10:18am with the facility NP A revealed she did not recall if she signed off on the admission orders for Resident #1 or if it was the Doctor. She stated she did recall that the admission paperwork was scarce with the minimal amount of information. NP A stated her initial skin assessment was her assessing Resident #1 as he sat in a chair, he was not compliant with a full assessment. Her progress notes were based on her assessment and the nurses' assessment, she would ask him every time she saw him and all other residents do you allow me to do my assessment today. NP A stated she first saw the wound via a picture that the wound care nurse had taken. She does not recall the date, but it was documented in her progress notes. NP A stated she had ordered a full panel lab, but it was not able to be done because Resident #1 refused the lab draw. Nursing assessment do expect that the nurses do an eye on assessment. NP A stated she has been told that hers need to be eye on assessments too, which she was already doing unless the resident refuses. Her expectation was that if a resident has an open area it needs to be reported to her or the doctor as soon as it was noted, they could have implemented interventions sooner as opposed to addressing a declining condition. NP A stated she thinks it was a possibility that they could have prevented the wound from the current state. She was surprised about finding out about the wound initially when it was at a stage III. NP A stated she thinks that part of the problem was nursing staff were constantly agency nurses, it was a hit or miss on whether they report issues. NP A stated she was surprised by this situation but not surprised at the same time. NP A stated they had addressed the wound not being reported way before Friday the 7/26, was at the beginning of the week before or around 7/17.</p> <p>During an interview on 7/28/24 at 9:11am with the facility DCO/Regional Nurse stated that the nursing staff had known Resident #1's pressure ulcer was declining. A chart review occurred because Resident #1 was going to the hospital at the family's request. When they reviewed the EHR they realized that there was not a treatment order in place at the time of admission. The Charge Nurse on duty at the admission should have done a head-to-toe assessment and reported to the NP or MD and the family of the skin issue. An appropriate plan of care could have been implemented, which may have included orders to treat. The DCO stated they did address that the skin concern needs to have an accurate description including size and description, documentation of notification of the physician and weekly skin assessments. The in-service training included correct accurate documentation and the wound being included on the skilled notes. The DNS has let nursing staff know the expectation was that they do an eye on assessment. The DNS will review and then validate the correctness of the assessment by eye with a head-to-toe assessment of her own, validating notification and documentation of notifications. The DCO stated the MD was told what they were in servicing on, he attended the Ad-hop QAPI meeting on 7/26 where the issues identified in the 4-step plan was reviewed. The DNS stated she became aware of the issue on 7/7 that there was no documentation of wound care. The DCO stated she was not sure what all the DNS did after the 7th. From this point on they will be in servicing for at least the next two months each nursing staff before they work. She comes in to validate that the processes were in place and was typically there on a weekly basis.</p> <p>During an interview on 7/28/24 with the MD at 11:05 am revealed he became aware of the pressure ulcer Resident #1 had when the NP started providing care. The wound was a stage III when he was notified, he was shocked because that was a significant wound. The MD stated he gave orders for the WC NP to treat the wound. The MD stated he was at the facility weekly, his role was more of an Administration role but will see the residents within the first 5 days usually. He was at an Ad-Hoc QAPI meeting on 7/26 regarding this situation and the training that needed to occur. His expectation was that the appropriate care was documented and that the nurses do eye on assessments and notify him or the NP of any skin care issues/open areas. The MD stated they possibly could have prevent Resident #1's wound from worsening had they had known about it earlier.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455503	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2024
NAME OF PROVIDER OR SUPPLIER The Rosewood Retirement Community		STREET ADDRESS, CITY, STATE, ZIP CODE 5700 E Central Texas Expwy Killeen, TX 76543	
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 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/28/24 at 11:19 am the Administrator revealed she became aware of the severity of the nursing issues at the point the DNS became aware of the issues. The Administrator stated she does not know of any documentation by the DNS. She oversees the DNS and was her supervisor. The DCO supervises in respect to training and guidance. The Ad-Hoc QAPI meeting they reviewed the 4-point areas of nursing needing to be addressed. The in-services were sent out to all staff and the nursing agencies that they use. All were informed the in-services were to be completed prior to working a shift.</p> <p>Review of the Facility Skin and Wound Prevention and Management policy dated 3/14/19 revealed the Guideline statement includes, Each resident will receive the care and services necessary to retain or regain optimal skin integrity. The Skin Prevention Program will:</p> <p>Identify associated risks for alteration in skin integrity or development of pressure ulcer injuries.</p> <p>Identify early onset skin breakdown so that the IDT may implement appropriate interventions as clinically indicated.</p> <p>Implement interventions designed to stabilize, reduce, or remove underlying risk factors.</p> <p>Ongoing evaluation of the plan of care and modifying or changing interventions as appropriate.</p> <p>Guidelines include, Assessment of a resident's skin condition helps determine prevention strategies.</p> <p>Review of the facility's Ad-Hoc QAPI agenda, dated 7/26/24, reflected the ADM, DNS, MD, and key nursing leadership were in attendance. They discussed notification of change in condition and Skin Management. A 4 Step Plan was initiated on 7/26/24.</p> <p>Review of facility 4-points,</p> <p>7/26/24</p> <p>It is the policy of this community to provide safe and quality nursing/medication administration practices to minimize and/or prevent less than quality of care provided to the residents we serve.</p> <ol style="list-style-type: none"> 1. Resident not currently in the community. 2. 100% skin assessments completed on all residents. Skin assessments updated. Outcome: No negative outcomes identified. Completed 7/26/24 3. Education provided to all licensed nurses related to the process for system management to include: <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455503	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2024
NAME OF PROVIDER OR SUPPLIER The Rosewood Retirement Community		STREET ADDRESS, CITY, STATE, ZIP CODE 5700 E Central Texas Expwy Killeen, TX 76543	
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 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Administrative nurses (DNS and Nurse Leader LNAC received re-education by the DCO (Regional Nurse) ensuring that identified new admissions treatment orders are verified with the accepting MD/NP upon admission/readmission, communicating changes in condition to the medical provider, to include newly identified and/or deteriorating wounds. Thus, ensuring appropriate documentation of the identified wound status and medical provider's wound care orders are noted within the E.H.R accordingly. Date completed 7/26/24.</p> <p>Administrative nurses(DNS and Nurse Leader LNAC received re-education by the DCO (regional nurse) on the importance the administrative nurses will notify the charge nurses on shift of their responsibility to administer wound care and complete assigned skin assessments for that shift in the event the wound care nurse calls off shift. DNS (Director of nursing will monitor this process to validate appropriate communication and to ensure patient care needs are met.</p> <p>DNS (director of nurses) educated the licensed nurses on ensuring that identified new admission treatment orders are verified with the accepting MD/NP upon admission/readmission, communicate changes in condition to the provider to include newly identified and/or deteriorating wounds. Thus, ensuring appropriate documentation of the identified wound status and medical provider's wound care orders are noted within the E.H.R accordingly. Date completed 7/26/24 and ongoing.</p> <p>DNS (director of nurses) educated the licensed nurses on the importance the administrative nurses will notify the charge nurses on shift of their responsibility to administer wound care and complete assigned skin assessments for that shift in the event the wound care nurse calls off shift. DNS (director of nursing will monitor this process to validate appropriate communication and ensure patient care needs are met. Date completed 7/26/24 and ongoing.</p> <p>DNS (director of nurses) educated the licensed nurses on clinical documentation review upon admit/readmit noting pressure injury/skin concerns identified. A full body skin assessment -intentionally assessing the resident head to toe for evidence of any pressure injury or skin concerns identified. Completed 7/26/24 and ongoing.</p> <p>DNS (director of nurses) educated the licensed nurses on the Braden Risk Assessment to be completed by the assigned nurse upon admission, significant change of condition and quarterly reviews in addition to routine re-assessment the Braden Risk Assessment will be completed upon identifying a new onset of pressure related skin injury. Completed 7/26/24 and ongoing.</p> <p>DNS (director of nurses) educated the licensed nurses on conducting weekly skin assessments/evaluations shall be completed upon admission/readmit at least every 7 days thereafter and as clinically indicated thereafter. Head to toe skin assessments -consist of conducting a head -to-toe skin assessment to identify actual skin concerns, such as a pressure injury or other skin concerns. After completing the assessment, the nurse will document accordingly. PCP and RP notification and follow through with any new orders. Plan of care will be updated. Completed 7/26/24 and ongoing.</p> <p>DNS (director of nurses) educated the licensed nurses on conducting weekly skin assessments should be conducted by the designated nurse and/or designated wound care nurse and follow up with new communication to PCP and others accordingly. Sign out for weekly skin assessments on the MAR and signing out the treatments as ordered and administered by licensed nurse. Completed 7/26/24 and ongoing.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455503	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2024
NAME OF PROVIDER OR SUPPLIER The Rosewood Retirement Community		STREET ADDRESS, CITY, STATE, ZIP CODE 5700 E Central Texas Expwy Killeen, TX 76543	
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 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>DNS (director of nurses) educated the licensed nurses on proper documentation of site, staging as indicated, measurement taken and noting wound bed appearance to be completed on the skin UDA within the E.H.R. Nursing obtaining wound care orders for identified wounds and implementing treatment orders as per MD/NP orders and ensuring that the RP is notified. Completed 7/26/24 and ongoing.</p> <p>DNS, Nurse Leader LNAC, or Wound Care nurse will conduct post admission assessment within 24-72 hours post admission/readmit to validate accuracy of documentation of skin condition noting wound type, presentation, appropriate state for pressure injuries, validation of proper treatment orders is in place and any consultations are made as clinically indicated. Completed:7/26/24</p> <p>Ad hoc QAPI completed with Medical Director to review plan of action. Completed:7/26/24</p> <p>Findings of audits and system management will be reported to the Administrator and the QAPI committee during the monthly meetings for the next 2 months, identifying system compliance or need for further education and clinical oversight. Completed:7/26/24</p> <p>Hospital discharge paperwork to be reviewed, PCP/NP will be contacted to verify admission/readmission orders. Completed:7/26/24</p> <p>If PCP/NP does not call back timely to give orders, contact DNS/Medical Director for orders. Completed: 7/26/24</p> <p>Proper skilled nurse's notes documentation in electronic medical record. Completed 7/26/24</p> <p>If treatment nurse is absent for any reason, licensed nurse will contact DNS/ADNS or nurse leader. DNS/ADNS, Nurse Leader LNAC reassign treatments and verify completion. Completed 7/26/24</p> <p>4. During the daily clinical review meeting held (5-7 days per week) the DNS/Designee will review new admissions and changes in condition (SBARS) r/t skin/wound concerns in order to ensure accuracy and to ensure appropriate follow up interventions are in place.</p> <p>During the daily clinical review meeting held (5-7 days per week) the DNS/LNAC will review skilled nurse's notes 5x week x 8 weeks for proper documentation.</p> <p>DNS/ADNS, Nurse Leader LNAC will conduct weekly random audits 3x week x 8 weeks of resident's skin assessments and treatments to verify</p> <p>assessment is correct, orders are in place, and care plan is up to date.</p> <p>Review of Facility In-service titled Identifying and Reporting Changes in Condition/Notification of Changes/Abnormal Findings, dated 7/27/24 and 7/28/24 regarding 1.) The BON/Nurse Practice Act obligations of a nurse to identify, report and document all changes in condition. 2. Continually monitor for changes in condition. 3. Proper assessment/evaluation and 4. appropriate documentation of changes in condition and ensure all appropriate documentation completed timely, accurately, and completely. There are eleven points included in the 4-points plan above and 2 examples of documentation. The information was delivered to 57 facility staff and 11 agency staff members.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455503	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2024
NAME OF PROVIDER OR SUPPLIER The Rosewood Retirement Community		STREET ADDRESS, CITY, STATE, ZIP CODE 5700 E Central Texas Expwy Killeen, TX 76543	

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 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the Facility In-service titled Skin dated 7/27/24 and 7/28/24 regarding nursing ensuring proper documentation and notification. There are thirteen points included in the 4-point plan above with further guidance to nurses. The information was delivered to 57 facility staff and 11 agency staff members.</p> <p>Review of the Facility WC list, undated revealed there were three residents Resident #1, #2 and #3 listed as have pressure ulcers.</p> <p>Review of Resident #2's</p> <p>Review of Resident #2's Face sheet, undated, revealed he was admitted to the facility on [DATE] from a local hospital, with diagnoses including infarction with pneumonia, sepsis, anxiety, need for assistance with personal care.</p> <p>Interview on 7/27/24 at 12:50 pm with Resident #2 revealed he does have wounds on his back that he developed when he was in the hospital, before admission. He stated he received a dressing change daily to one of the wounds. Resident #2 stated he did not know the condition of the wounds as he could not see [TRUNCATED]</p>