

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  09/09/2024
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 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 44671</p> <p>Based on interview and record review, the facility failed to ensure 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 one of five residents (Resident #1) reviewed for medications.</p> <p>The facility failed to remove Resident #1 discontinued order Of Labetalol HCL 300 MG from the med cart.</p> <p>This failure could place residents at risk for irregular heartbeat, low blood pressure, rapid or slow heartbeat, and lightheadedness.</p> <p>Findings include:</p> <p>Record review of Resident #1's, undated, face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included diabetes (pancreas not producing enough insulin) and Essential Primary Hypertension (high blood pressure).</p> <p>Record review of Resident #1's care plan initiated 08/21/2024 and revised 09/06/2024 reflected Resident #1 had diabetes and was at risk for complications associated with diabetes.</p> <p>Record review of Resident #1's MDS admission initiated on 08/25/2024 reflected a BIMS score 15, which indicated cognitively intact cognition.</p> <p>Record review of Resident #1's medication discontinued order dated 08/30/2024 reflected Labetalol HCL Oral Tablet 300 MG Give 1 tablet by mouth three times a day for HTN HD if SBP less than 120 or HR less than 60.</p> <p>Record review of Resident #1's medication active order date 08/30/2024 reflected Labetalol HCL Oral Tablet 200 MG Give 2 tablet by mouth three times a day for HTN HD if SBP less than 120 or HR less than 60.</p> <p>In an interview on 09/06/2024 at 1:14 PM with Resident #1 was unsuccessful because he was asleep. The FM was in the room with Resident #1.</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>In an interview on 09/06/2024 at 1:15 PM with Resident #1's FM on Wednesday 09/04/2024 revealed Med Tech A was going to administer Resident #1 the discontinued Labetalol 300 along with the current order of Labetalol 200. Resident #1's FM stated the Med Tech was going to administer 1000 MG and the dosage was over 600. Resident # 1's FM stated the current order was for 400 MG total. Resident # 1's FM stated she stopped Med Tech A from giving the wrong dose of medication because she asked for LVN B to take Resident # 1's blood pressure. Resident # 1's FM stated LVN B removed the two 300 MG tablets and apologized to the FM.</p> <p>In an interview on 09/06/2024 at 1:30 PM the ADM stated she did not know anything about Med Tech A almost giving Resident # 1 too much medication. The ADM stated she should have been notified by the DON in the attempt wrong dosages of medications so staff in-service could have been started. The ADM stated the expectations of passing medications Med Tech A should have verified with the MAR to prevent from having medications errors.</p> <p>In an interview on 09/06/2024 at 3:30 PM Med Tech A sated Resident #1's FM had pointed out to LVN B she was going to administer 2 tablets at 400 MG and 2 tablets at 600 MG of Labetalol to Resident # 1. Med Tech A stated she didn't realize she had the same medication on the medication cart with different dosages. Med Tech A stated the FM wanted the nurse to take Resident # 1's blood pressure and that's when LVN B stated to her that it was two different MG of the same medication that was being administered. Med Tech A stated she already administered Labetalol in the cup but failed to check the MAR of two different MG. Med Tech A stated she didn't pay full attention to the MAR and that was no excuse, and she must pay closer attention. Med Tech A stated she was rushing and made a mistake and was going to administer the Labetalol 600 mg over. Med Tech A stated the same medication with the different MG was what confused her. Med Tech A stated if the FM would not have caught it, Resident # 1 would have taken over 600 and possibly would become ill.</p> <p>In an interview on 09/07/2024 at 10:30 AM, the ADM stated an audit of the medication cart was done and it was determined that the old order for Labetalol 300 MG was still on the cart. The ADM stated the charge nurses were responsible for removing discontinued medications off the medication cart. The ADM stated the expectations were for discontinued medications to be removed from the medication cart. The ADM stated LVN B should have let the DON</p> <p>know immediately when this issue had occurred on 09/04/2024.</p> <p>In an interview on 09/07/2024 at 1:15 PM, the DON stated she did not know anything about Med Tech A administrating medication wrong to Resident # 1. The DON stated she was told yesterday,09/06/2024, by the ADM. The DON stated it was determined by the medication cart audit the discontinued and the current order for Labetalol was still on the medication cart. The DON stated LVN B discarded two individual tablets of 300 MG of Labetalol. The DON stated Med Tech A should have verified with the MAR to make sure she was giving the correct dosage to Resident #1. The DON stated it was expected for LVN B to let her know of the possible medication error, so she would report to the ADM and start staff education.</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>In an interview on 09/07/2024 at 2:14 PM, LVN B stated on Wednesday, 09/04/2024 Resident #1's FM questioned the medications Med Tech A was going to administer to Resident # 1. LVN B came in the room to take Resident #1's blood pressure. LVN B stated it was determined the old order was still on the medication cart. LVN B stated she discarded the two 300 MG of Labetalol. LVN B stated she failed to tell the DON about the incident because the situation was fixed, and Resident # 1 did not take the wrong dosage because the FM had a medication dosage concern.</p> <p>In an interview on 09/07/2024 at 5:37 PM, the MD stated taking 600 MG over in Labetalol would have dropped Resident #1's blood pressure dangerous low. The MD stated Resident #1 may have gone to the hospital for interventions to monitor blood pressure, monitor vitals, and to get fluids. The MD stated interventions to keep the blood pressure from dropping would also include the Labetalol being held. The MD stated with any medication depending on the resident, the reactions may be different.</p> <p>Record review of the facility's policy and procedure titled Medication Administration dated 03/2019 and revised 01/2024, reflected the following: Resident medications are administered in an accurate, safe, timely, and sanitary manner.</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44671</b></p> <p>Based on interview and record review, the facility failed to ensure residents were free of any significant medication errors for one of five residents (Resident #1) reviewed for medications.</p> <p>The facility failed to remove Resident #1 discontinued order Of Labetalol HCL 300 MG from the med cart. This failure resulted in Med Tech A preparing to give and having to be stopped by LVN B from administering an additional 600 mg of Labetalol on 09/04/2024 that had been discontinued on 08/30/2024.</p> <p>This failure could place residents at risk for irregular heartbeat, low blood pressure, rapid or slow heartbeat, and lightheadedness.</p> <p>Findings include:</p> <p>Record review of Resident #1's, undated, face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included diabetes (pancreas not producing enough insulin) and Essential Primary Hypertension (high blood pressure).</p> <p>Record review of Resident #1's care plan initiated 08/21/2024 and revised 09/06/2024 reflected Resident #1 had diabetes and was at risk for complications associated with diabetes.</p> <p>Record review of Resident #1's MDS admission initiated on 08/25/2024 reflected a BIMS score 15, which indicated cognitively intact cognition.</p> <p>Record review of Resident #1's medication discontinued order dated 08/30/2024 reflected Labetalol HCL Oral Tablet 300 MG Give 1 tablet by mouth three times a day for HTN HD if SBP less than 120 or HR less than 60.</p> <p>Record review of Resident #1's medication active order date 08/30/2024 reflected Labetalol HCL Oral Tablet 200 MG Give 2 tablet by mouth three times a day for HTN HD if SBP less than 120 or HR less than 60.</p> <p>In an interview on 09/06/2024 at 1:14 PM with Resident #1 was unsuccessful because he was asleep. The FM was in the room with Resident #1.</p> <p>In an interview on 09/06/2024 at 1:15 PM with Resident #1's FM on Wednesday 09/04/2024 revealed Med Tech A was going to administer Resident #1 the discontinued Labetalol 300 along with the current order of Labetalol 200. Resident #1's FM stated the Med Tech was going to administer 1000 MG and the dosage was over 600. Resident # 1's FM stated the current order was for 400 MG total. Resident # 1's FM stated she stopped Med Tech A from giving the wrong dose of medication because she asked for LVN B to take Resident # 1's blood pressure. Resident # 1's FM stated LVN B removed the two 300 MG tablets and apologized to the FM.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 09/06/2024 at 1:30 PM the ADM stated she did not know anything about Med Tech A almost giving Resident # 1 too much medication. The ADM stated she should have been notified by the DON in the attempt wrong dosages of medications so staff in-service could have been started. The ADM stated the expectations of passing medications Med Tech A should have verified with the MAR to prevent from having medications errors.</p> <p>In an interview on 09/06/2024 at 3:30 PM Med Tech A sated Resident #1's FM had pointed out to LVN B she was going to administer 2 tablets at 400 MG and 2 tablets at 600 MG of Labetalol to Resident # 1. Med Tech A stated she didn't realize she had the same medication on the medication cart with different dosages. Med Tech A stated the FM wanted the nurse to take Resident # 1's blood pressure and that's when LVN B stated to her that it was two different MG of the same medication that was being administered. Med Tech A stated she already administered Labetalol in the cup but failed to check the MAR of two different MG. Med Tech A stated she didn't pay full attention to the MAR and that was no excuse, and she must pay closer attention. Med Tech A stated she was rushing and made a mistake and was going to administer the Labetalol 600 mg over. Med Tech A stated the same medication with the different MG was what confused her. Med Tech A stated if the FM would not have caught it, Resident # 1 would have taken over 600 and possibly would become ill.</p> <p>In an interview on 09/07/2024 at 10:30 AM, the ADM stated an audit of the medication cart was done and it was determined that the old order for Labetalol 300 MG was still on the cart. The ADM stated the charge nurses were responsible for removing discontinued medications off the medication cart. The ADM stated the expectations were for discontinued medications to be removed from the medication cart. The ADM stated LVN B should have let the DON</p> <p>know immediately when this issue had occurred on 09/04/2024.</p> <p>In an interview on 09/07/2024 at 1:15 PM, the DON stated she did not know anything about Med Tech A administrating medication wrong to Resident # 1. The DON stated she was told yesterday,09/06/2024, by the ADM. The DON stated it was determined by the medication cart audit the discontinued and the current order for Labetalol was still on the medication cart. The DON stated LVN B discarded two individual tablets of 300 MG of Labetalol. The DON stated Med Tech A should have verified with the MAR to make sure she was giving the correct dosage to Resident #1. The DON stated it was expected for LVN B to let her know of the possible medication error, so she would report to the ADM and start staff education.</p> <p>In an interview on 09/07/2024 at 2:14 PM, LVN B stated on Wednesday, 09/04/2024 Resident #1's FM questioned the medications Med Tech A was going to administer to Resident # 1. LVN B came in the room to take Resident #1's blood pressure. LVN B stated it was determined the old order was still on the medication cart. LVN B stated she discarded the two 300 MG of Labetalol. LVN B stated she failed to tell the DON about the incident because the situation was fixed, and Resident # 1 did not take the wrong dosage because the FM had a medication dosage concern.</p> <p>In an interview on 09/07/2024 at 5:37 PM, the MD stated taking 600 MG over in Labetalol would have dropped Resident #1's blood pressure dangerous low. The MD stated Resident #1 may have gone to the hospital for interventions to monitor blood pressure, monitor vitals, and to get fluids. The MD stated interventions to keep the blood pressure from dropping would also include the Labetalol being held. The MD stated with any medication depending on the resident, the reactions may be different.</p> <p>(continued on next page)</p>		

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