STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455503	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Rosewood Retirement Community	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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44317 Based on interview, and record review, the facility failed to maintain medical records in accordance with accepted professional standards and practices, which are complete and accurately documented for 1 of 3 residents (Resident #1) reviewed for documentation. 1-Resident #1's September 2024 MAR was documented inaccurately. Staff documented the resident received 2 enteral feedings at the same time. 2- Resident #1's weight record documentation was incomplete. Staff failed to document an admission weight, failed to document a weight on Wednesday as ordered by the physician, and failed to ensure documented weights were accurate. The RD assessment was incomplete with no weight documented. 3-Resident #1's September 2024 TAR documentation was incomplete. Staff did not document or sign off on the cleaning the j-tube, monitoring surgical site for infection, and cleaning skin tear to right arm. These failures could result in inaccurate records, errors in care, decline in health and quality of life. Findings included: 1. Review of Resident #1's admission MDS assessment dated [DATE] reflected the following: *Section A (Identification Information) reflected, a [AGE] year-old female who admitted to the facility on [DATE]. *Section I (Active Diagnoses) reflected her diagnoses included malnutrition, anxiety (intense and excessive worry and fear), pneumonia (an infection in the lungs), cancer, Barrett's Esophagus (inflammation of the esophagus), and dysphagia (difficulty swallowing). *Section C (Cognitive Patterns) reflected a BIMS score of 13 indicating intact cognition. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Section K (Swallowing/Nutritional Status) reflected a height of 61 inches and a weight of 81 pounds. While a resident, she received 51% or more of her total calories through a tube feeding. Review of Resident #1's Comprehensive Care Plan , reflected a focus created on 09/12/24 reflected, I require a feeding tube r/t need to gain weight. The goal reflected, I will not experience any complications associated with my feeding tube or enteral nutrition/hydration through my next review date. The interventions included, HOB should be elevated when in bed, avoid flat while feeding is on/ pump running. NPO - Nothing by mouth - see nurse for questions. Provide local care to G-tube site as ordered and monitor for s/s of infection. RD to evaluate as indicated. Report to MD all abnormal findings as indicated. Review of Resident #1's physician Order Recap Report printed on 10/02/24 reflected the following orders: *Enteral feed order every shift Nutren 2.0 via J-tube at 40ml/hr continuously for 24 hours a day. Start date 09/16/24, end date 09/24/24. *Enteral Feed Order every shift 2 cal HN at 40ml.hr continuous via J-tube. Start date 09/12/24, end date 09/19/24. Review of Resident #1's September 2024 MAR reflected she received the enteral feeding 2cal HN at 40ml/hr on 9/16/24, 9/17/24 and 9/18/24. The MAR reflected she also received Nutren 2.0 at 40ml/hr on 9/16/24, 9/17/24 and 9/18/24. During an interview on 10/01/24 at 1:08 PM, DON A stated Resident #1's tube feeding was often paused because of nausea and vomiting. She stated the resident frequently refused the water flushes because she was not tolerating the fluids well. DON A stated the resident did not get two feedings at the same time because she did not always tolerate one feeding. During an interview on 10/02/24 at 10:27 AM, Corp RN stated Resident #1 did not receive two different enteral feedings at the same time. She stated incorrect documentation was the issue. She stated the DON was responsible for monitoring documentation and tube feedings. During an interview on 10/02/24 at 10:40 AM, DON B stated it was not possible to give two different enteral feedings at the same time. She stated the DON was responsible for reviewing all new orders daily. She stated if there were two orders for different enteral feedings, the orders should have been clarified. During an interview on 10/02/24 at 10:40 AM, LVN C stated Resident #1 did not have two enteral feedings at the same time, it was an error with the documentation. During an interview on 10/02/24 at 12:27 AM, LVN D stated she had worked at the facility for about three months and she had worked with Resident #1. LVN D stated she noticed the two different enteral feed orders when she worked on 09/19/24 and she notified DON A. She stated the resident did not have two different feedings running at the same time. (continued on next page)

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F 0842

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

During an interview on 10/02/24 at 12:52 PM, the NP stated she was not aware that the facility had documented two different enteral feeds at the same time. She stated she did not see two feedings running at the same time. She stated Resident #1 already had nausea and vomiting and did not always tolerate the feeding well. She stated she was told by two CNAs and a nurse that the documented weights were accurate. She stated she recalled the weight from the acute hospital was in the mid to upper 80's. She stated the resident was sent out for evaluation once prior to being discharged to another acute hospital on 09/22/24.

2.

Review of Resident #1's physician Order Recap Report reflected, Admission weights x 3 weeks in the morning every Wednesday for 3 weeks. Order date 09/11/24.

Review of Resident #1's weight record log reflected on Tuesday 09/17/24 at 2:14 PM the resident weighed 106.7 pounds using a lift scale. The record reflected on Thursday 09/19/24 at 11:34 AM the resident weighed 80.6 pounds using a wheelchair scale. The change in weight reflected a 26.1-pound (or 24.46%) weight loss in two days. There was no re-weight in the record. There was no admission weight documented on 9/11/24. There was no weight documented on Wednesday 09/18/24 as ordered.

Review of Resident #1's RD Nutritional Assessment reflected the Most Recent Weight was blank. The Weight Changes/Weight Variance section reflected, Significant wt loss per res - states she weighed 200 at one time - res did not state time line. [sic]

During a telephone interview on 10/01/24 at 12:17 PM, a FM stated Resident #1 had weighed over two hundred pounds when she first got sick in 2022 then began losing weight because she did not eat. The FM stated since November 2023, Resident #1 has weighed between 80 and 90 pounds. She stated the resident had been trying to gain weight with no success and she did not believe the 106.1-pound weight was accurate.

During an interview on 10/01/24 at 1:08 PM, DON A stated the documented weights for Resident #1 were accurate. She stated the 26.1-pound weight loss in two days was because the resident had not tolerated the tube feeding and had vomited multiple times. She stated she did not reweigh the resident to verify the weight because, Well, she had been sick. She stated she would look for a policy regarding weights.

During an interview on 10/01/24 at 2:00 PM, DON A had a note paper with 83.9 written on it. She stated Resident #1's admission weight was 83.9 pounds. She stated the weight came from the report they received from the acute hospital prior to admission. She stated the 106.7-pound weight was an error. She stated she did not know how or when she confirmed the error. She stated, Now the chart is closed, I can't strike through the error or add the admission weight. She stated the aides or the nurse were responsible for getting the weights.

During an interview on 10/02/24 at 10:40 AM, DON B stated it was customary to do a weight on admission. She stated if a weight increased or decreased by 5 pounds or more, the resident should have been reweighed and the doctor notified.

During an interview on 10/02/24 at 10:40 AM, LVN C stated if documentation, such as a weight, was documented incorrectly, it could have led to improper documentation going forward.

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NAME OF PROVIDER OR SUPPLIER The Rosewood Retirement Community		STREET ADDRESS, CITY, STATE, ZIP CODE 5700 E Central Texas Expwy Killeen, TX 76543	

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of Resident #1's physician Order Recap Report printed on 10/02/24, reflected the following orders: *Cleanse J-tube with NS, pat dry, apply gauze dressing and monitor for s/s infection QD, every shift. Order date 09/13/24. *Monitor surgical site for infection Q shift steri-strips in place to surgical site every shift. Order date 09/12/24. *Skin tear to right anterior forearm: Cleanse with WC, pat dry and monitor for s/s of infection q shift every shift for 10 days. Order date 09/13/24. Review of Resident #1's September 2024 TAR reflected the j-tube site treatment was not completed as ordered on 9/14/24, 9/15/24, 9/21/24, and 9/22/24. The TAR reflected the surgical site was not monitored as ordered 9/14/24, 9/15/24, 9/21/24, and 9/22/24. The TAR reflected the skin tear to the right forearm was not treated as ordered on 9/15/24, 9/21/24, and 9/22/24. During an interview on 10/02/24 at 12:27 AM, LVN D stated if a treatment was not initialed on the TAR, that meant the treatment was not done. She stated the treatment may have been done but if it was not documented, there was no way to tell. She stated if a wound was not monitored, it could worsen or develop complications. During an interview on 10/02/24 at 10:40 AM, DON B stated she expected treatments were completed and documented accurately. She stated there were codes on the MAR and TAR that the nurses should have used to document accurately. There were codes if the resident refused or if they were in the hospital and other codes. Those codes should have been used instead of leaving the space blank. During an interview on 10/02/24 at 11:00 AM, the ADM stated she expected accurate documentation. She stated DON B had just started working at the facility on Monday (09/30/24) and together they had identified opportunities for training and progressing. She stated LVN C and DON B were responsible for monitoring documentation and orders. She stated depending on the documentation error, there could be negative effects for the resident if documentation was inaccurate. Review of the policy Nutrition and Weight Measurement, revised January 2023 reflected in part, The community ensures that each resident maintain acceptable parameters of nutritional status, bodyweight, and protein levels, unless the resident's clinical condition demonstrates that doing so is not possible . The community should collect a once-a-month weight, unless otherwise specified and the weight will be reviewed to determine the need for appropriate interventions. The following suggested parameters for evaluating significance of unplanned and undesired weight loss during varying time intervals: 1 month - Greater than 5%, 3 months - Greater than 7.5%, 6 months - Greater than 10. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy Enteral Nutrition, revised January 2023 reflected in part, The community ensures that each resident maintain acceptable parameters of nutritional status, bodyweight, and protein levels, unless the resident's clinical condition demonstrates that doing so is not possible . GUIDELINES 3. The nurse checks the orders for the enteral feeding, enteral flush frequency orders for pre and post meds and free water orders for enteral nutrition/hydration . 5.the nurse administers the enteral feeding regimen according to formula, system type, and method of delivery ordered by the physician 6. Nursing and dietary routinely monitor the following factors for evaluation of the therapeutic efficacy, adverse effects, and clinical changes: a. Weight b. Hydration . 8. The skin surrounding a gastrostomy or jejunostomy should be kept clean and free from irritation and/or infection. The site should be evaluated for sighs of erythema (redness of skin), tenderness, drainage .