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	04/18/2025

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 0655 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44317 Based on observation, interview, and record review, the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective person-centered care of the resident that meet professional standards of quality of care within 48 hours of a resident's admission including the minimum healthcare information necessary to properly care for one (Resident #1) of five residents reviewed for baseline care plans. The facility failed to develop and implement a baseline care plan with interventions within 48 hours of admission for Resident #1 that addressed her high fall risk status. The facility failed to complete an admission assessment and baseline care planning, and ensure staff had adequate knowledge and access to care plans. The facility failed to ensure effective use of the Kardex system as a reference tool by failing to ensure adequate staff knowledge in the updating and referencing of the Kardex. Resident #1 fell from her wheelchair on 03/29/25 and hit her head and was admitted to the acute care hospital. There was a likelihood of a serious adverse outcome for the resident due to multiple systemic failures. An IJ was identified on 04/03/25. The IJ template was provided to the facility on [DATE] at 3:11 PM. While the IJ was removed on 04/04/25, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm because all staff had not been trained on the plan of removal. These failures placed residents at risk of not having their needs identified, serious physical harm, injury, and/or death. Findings included: Review of Resident #1's face sheet, printed on 04/02/25, reflected a [AGE] year-old female admitted to the facility on [DATE] and discharged on [DATE]. Her diagnoses included weakness, cerebral edema (brain swelling), nontraumatic intracerebral hemorrhage (brain bleed), acute respiratory failure with hypoxia (not enough oxygen in the body), and unspecified abnormalities of gait and mobility. Review of Resident #1's MDS assessment list reflected her admission-, five day-, and discharge assessments were all in progress. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of Resident #1's baseline care plan, initiated on 03/29/25 and created on 04/02/25, reflected in part - Focus: I am at risk for falls r/t Balance problems noted, chronic health problem and comorbid medical problems, debility and weakness, cognitive impairment noted, difficulty moving / propelling self in w/c. 03/29/25 - actual fall, sent to ER. Goal: I will be free from falls and / or will not experience significant injuries associated with falls through next review date. Interventions/Tasks: Provide resident with no touch call bell. Do not leave resident alone in her room when she is up in her wheelchair. Anticipate and meet needs and keep call bell within reach as indicated. Bed at appropriate height when unattended . Review of Resident #1's acute care discharge orders dated 03/24/25, reflected and order, Place patient on fall precautions. Review of Resident #1's Nursing Admission assessment completed 03/25/25, Section B (Clinical/Health Conditions) reflected the resident had comorbidities that included CVA (stroke) and Hemiplegia/Hemiparesis (weakness or paralysis on one side of the body). Section C (Physical Assessment) reflected the resident required a mechanical lift and two team members for transfers. Section E (Communication) reflected the resident was incoherent, unaware of her own needs and wants. Section K (Fall Risk Review) reflected recent falls were unknown, the resident was taking two of the medications listed, the resident appeared severely affected by one or more of the psychological factors listed, and her cognitive status was impaired. The Automatic High Risk Status: Box #1 was checked, Recent change in functional status and/or medications with the potential to affect safe mobility. Box #6 was checked, Check if the resident/patient is a high risk for falls. Section O (Initial and 48 Hour Plan of Care) reflected #10 Fall risk, had no boxes checked - no focus, no goals, and no interventions. Review of Resident #1's progress note dated 03/27/25 at 10:00 AM, written by the NP, reflected in part, Patient demonstrates impulsivity and has made attempts to transfer self. She has been moved to room (number) for increased visibility by staff. Will continue to monitor cognitive status and implement safety measures. Review of Resident #1's progress note written by LVN D, reflected a late-entry note dated 03/29/25 at 11:30 AM, This nurse observed resident on floor in resident's room. Resident observed on floor face down and resident's wheelchair position on resident's upper back. Resident stated, I hit my head and face. Head to toe assessment completed and nystagmus observed and resident alert and oriented x2 and some confusion noted of situation. Check for head injuries, nystagmus noted, EMS was called no redness or bruises to resident's face or head .Resident feels pain on left side of face and head .transported to (hospital) for evaluation and treatment. Review of Resident #1's Kardex printed on 04/04/25, reflected in part - Special Instructions: Resident must be up in dining room for meals. Do not leave alone with any food or drinks. Asperation [sic] precautions. Safety - I must be up for all meals. The Kardex did not reflect any fall precautions. Review of Resident #1's Order Summary Report printed 04/02/25, reflected no order for fall precautions. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 04/02/25 at 1:28 PM, the MDS Nurse stated the admitting nurse was responsible for initiating the baseline care plan. She stated she then had seven or eight days to review the baseline care plan. The MDS Nurse stated she expected to see transfer status, how they ambulate, any skin issues, fall risk, nutrition, or g-tube, and whatever was pertinent to taking care of the resident on the baseline care plan. She stated in the care plan meeting they reviewed care plans and made sure everything relevant was documented. She stated the administrative nurses had a meeting every morning where they reviewed new admissions. During an interview on 04/02/25 at 1:49 PM, RN B stated she had completed the admission assessment on Resident #1. She stated she was the treatment nurse at the facility and did not routinely conduct admission assessments. She stated she believed she had marked the box indicating the resident was a high fall risk. She stated she believed that checking that box would trigger the fall risk to go to the baseline care plan and Kardex. She stated she did not know how to open the care plan to even see what was on the care plan. She stated the fall risk would be passed on in report and the CNAs would have the information on the Kardex. She stated she did not have all the information needed to complete the assessment and believed the management team would have reviewed and completed the admission assessment including the baseline care plan the next day. During an observation and interview on 04/02/24 at 2:15 PM, CNA A was observed as she signed into the computer and opened a Kardex for a resident. She stated she did not see Fall Risk on the Kardex. She opened six more records of residents who she knew had fallen and did not see where the residents were identified as a fall risk. She stated they usually got fall risk information in report every morning from the nurse. She stated, They tell us to look at the Kardex, but I don't see it. During an interview on 04/02/25 at 3:22 PM, the DON stated the admitting nurse was responsible for the admission assessment and the baseline care plan. She stated she and the other administrative nurses met daily and reviewed the admission and baseline care plans the day after admission to ensure they were completed. She stated she did not remember if they had reviewed Resident #1's baseline care plans the day after admission. She stated it was her expectation that the admission assessment, including the baseline care plan, were completed timely. The DON stated every resident who came into their building was a fall risk and every resident had a fall risk care plan with interventions in place. She stated she had in-serviced staff multiple times, and the CNAs all knew that everyone was a fall risk. The DON stated she had educated on the need to get the residents out of their rooms and engaged as most falls happened when residents were left alone. The DON stated she updated Resident #1's fall care plan earlier in the day, 04/02/25, to document the actual fall on 03/29/25. The DON stated there was no fall risk care plan in place prior to her documentation. The DON did not identify any potential adverse outcomes from not having a care plan for fall risk. She stated the CNAs attended a huddle meeting and got report and information about falls from the nurses during the meeting. She stated the CNAs got Resident #1 up in her wheelchair for lunch 0n 03/29/25. They left her alone in her room and that was when she fell . During an interview on 04/03/25 at 10:00 AM with the DON, she stated they had found that companywide, the Kardex did not reflect the words Fall Risk but there were fall interventions listed in the safety box. She stated they had found a way to update the Kardex to reflect Fall Risk and they were in process of updating. A policy specific to baseline care plans was requested. A specific policy was not provided but the general care plan policy was provided prior to survey exit. (continued on next page)

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F 0655 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 04/03/25 at 10:15 AM, the NP stated it was important to have fall interventions in place. Without the interventions, a resident could have fallen and been injured. During an interview on 04/03/25 at 10:41 AM, LVN D stated she was aware that Resident #1 was a fall risk because of the report she received from the previous shift. She stated the resident was moved to her hall, so the resident had a room closer to the nurse's station. She stated section O of the admission was completed on admit because that was the baseline care plan. She stated the Kardex was what the CNAs reviewed to see what care the residents required and that information came from the admission assessment. Review of the Care Plans policy, revised January 2023, reflected in part - The care plan should be initiated upon admission, continued to be developed during the initial 48-72 hours, . Review of the Standards of Nursing Practice Observations and Data Collection policy, revised January 2023, reflected in part - .The delivery of nursing care in the community is based on an assessment of the resident to identify his or her care needs. Once resident needs are identified, a comprehensive care plan shall be developed to attain individualized resident goals. The care plan shall be implemented by the interdisciplinary team and is continually evaluated for effectiveness .It is the role of the nursing staff to implement physician prescribed interventions and monitor the resident for their response or any complications .A care plan shall be developed with actions designed to address nursing and collaborative problems or risk areas identified for the resident . Review of the Falls Prevention Guideline, updated 03/28/22, reflected in part, Purpose - To establish a process that identifies risk and establishes interventions to mitigate the occurrence of falls. Process - On admission - - Newly admitted or readmitted residents are assessed for fall risk. - When a risk factor for falls is identified a corresponding intervention addressing that risk factor is developed. - When the risk is identified and intervention determined, it is documented on the care plan and on the Kardex. - The intervention is initiated. An Immediate Jeopardy (IJ) was identified on 04/03/25. The ADM, DON, and RDCO were notified of the Immediate Jeopardy on 04/03/25 at 3:11 PM and a IJ template was provided to the ADM on 04/03/25 at 3:11 PM. A Plan of Removal was accepted on 04/04/25 3:26 PM and read as follows: Plan of Removal (continued on next page)

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F 0655 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	F655 Baseline Care Plan 4/3/2025 F655 - The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must be developed within 48 hours of a resident's admission. Immediate Response: o The identified resident transferred to the hospital on: o All admissions/readmissions from__3/3/25__ to 4/3/2025 charts were reviewed for completion of the admission/readmission assessment to include completion of the baseline care plans and all baseline care plans were complete with no other findings. Results: Complete Date completed: 4/3/25 o Director of Nursing Services/Assistant Director of Nursing conducted an audit for all resident's who currently reside in the community care plans to validate accuracy of each residents ADL care needs and no other discrepancies noted. Date completed: 4/3/25 o The Regional Director of Clinical Operations immediately educated the Director of Nursing Services/Assistant Director of Nursing/Reimbursement Nurses on the process for validating the completion of all admission/readmissions timely. In addition, education was extended to include the completion of the baseline care plan to ensure it includes effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must be developed within 48 hours the resident's admission. The in-service education and an acknowledgment statement of the baseline care plan was signed as an acknowledgement of comprehension, and a summary of the training material. Date of completion: 4/3/25 o The Regional Director of Clinical Operations immediately educated the Director of Nursing Services/Assistant Director of Nursing/Reimbursement Nurses on Abuse/Neglect and Residents Rights. The in-service education was signed as an acknowledgement of comprehension, and a summary of the training material. Date completed: 4/3/25 o Director of Nursing Services/Assistant Director of Nursing Services provided immediate education to all licensed nurses on the process of completion of admissions/readmissions in its entirety. In addition, education was extended to include the completion of the baseline care plan to ensure it includes effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must be developed within 48 hours the resident's admission. (continued on next page)

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F 0655 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Date commenced: 4/3/25 Date completed: 4/4/25 Community will ensure all licensed nurses on leave/agency/PRN staff are in serviced prior to working their shift. Community will ensure administrative nursing staff in the community to provide in-service/education prior team members working their assigned shift. The community will ensure all residents who require respiratory care are provided such care. Risk Response: All new admissions/readmissions have the potential to be affected by this deficient practice. Systemic Response: o Director of Nursing Services/Assistant Director of Nursing conducted an audit for all resident's care plans who currently reside in the community to validate accuracy of each residents ADL care needs. Date completed: 4/4/25 o Director of Nursing Services/Assistant Director of Nursing Services provided immediate education to all licensed nurses on the process of completion of admissions/readmissions in its entirety. In addition, education was extended to include the completion of the baseline care plan to ensure it includes effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must be developed within 48 hours the resident's admission. Date commenced: 4/3/25 Date completed: 4/4/25 Monitoring Response: o The Director of nurses/Assistant Director of Nurses will conduct weekly skills validations of accuracy and completion of admissions/readmission/baseline care plans of 2-3 nurses, 1-7 days a week for 2 months. o Director of Nurses/Assistant Director of Nurses will review all admission/re-admission orders daily in the clinical meeting to validate accuracy and completion of admission/readmission/baseline care plans 1-7 days a week for 2 months. o This plan and all education and auditing tools will be placed in binder and kept with the Administrator or Director of Nursing Services. o This plan will remain in place for the next 2 months to ensure compliance or to identify any further training needs. (continued on next page)

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F 0655 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	o Findings of those observations will be reported to the QAPI committee during monthly meeting for the next 2 months. The Surveyor monitored the POR from 04/04/25 through 04/18/25 as followed: Review of the admission/readmission list for admissions from 03/03/25 to 04/03/25, reflected 26 charts were reviewed, on 04/03/25, for completion of the admission/readmission assessment and baseline care plan, with no additional findings. Review of the in-services dated 04/03/25 reflected the Regional Director of Clinical Operations educated the DON, ADON, and MDS nurse on validating completion of admission assessments, base line care plans with person-centered care being completed withing 48 hours of the resident's admission, and Abuse/Neglect and Resident Rights. Review of the in-service initiated on 04/03/25 and continuing 04/04/25, reflected the DON and ADON provided education to licensed nurses on the process of completing the admission/readmission assessment in its entirety and completion of the baseline care plan within 48 hours. Nurses from all shifts were in-serviced. During interviews on 04/04/25 from 4:17 PM to 6:22 PM, 4 LVNs and 3 RNs from both shifts stated they had been in-serviced on the Kardex, baseline care plans, and resident-centered interventions. The nurses were able to state the baseline care plans were developed within 48 hours after admission. The nurses stated the care plans included information, including fall interventions, needed to care for the residents. The nurses stated fall interventions included reminding the resident to use the call light to call for assistance, not leaving the resident alone in the room while up in a wheelchair, anticipating needs, and keeping items within reach. The nurses stated the Kardex was like a guidebook or snapshot of care the residents needed. During an interview on 04/04/25 at 5:13 PM, the DON stated she had been in-serviced by the RDCO on baseline care plans. She stated the baseline care plans were completed within 48 hours and interventions, including fall interventions, were implemented. She stated she had been in-serviced on the process of validating the completion of admission/readmission assessments and ongoing monitoring. The information was discussed in the morning meeting to confirm the interventions were in place to meet the resident needs. The DON stated she had been in-serviced on ANE. She was able to speak to the policy. The DON stated after she was in-serviced, she and other administrative nurses in-serviced other nursing staff on the same topics. The ADM was notified on 04/04/25 at 7:15 PM that the IJ had been removed. While the IJ was removed, the facility remained at a scope of isolated an a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44317 Based on interviews and record reviews, the facility failed to ensure residents received adequate supervision to prevent accidents for one (Resident #1) of five residents reviewed for accidents and supervision. The facility failed to ensure staff implemented Resident #1's hospital discharge order upon admission to be placed on fall precautions. The facility failed to develop and implement a baseline care plan with interventions within 48 hours of admission for Resident #1 that addressed her high fall risk status. The facility failed to complete an admission assessment and baseline care planning, and ensure staff had adequate knowledge and access to care plans. The facility failed to ensure effective use of the Kardex system as a reference tool by failing to ensure adequate staff knowledge in the updating and referencing of the Kardex. On 03/29/2025 Resident #1 was left unsupervised in her room which resulted in a fall from her wheelchair where she hit her head resulting in pain and nystagmus and was admitted to the acute care hospital. There was a likelihood of a serious adverse outcome for the resident due to multiple systemic failures. An IJ was identified on 04/03/25. The IJ template was provided to the facility on [DATE] at 3:11 PM. While the IJ was removed on 04/04/25, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeoopardy because all staff had not been trained on the plan of removal. This failure could place residents at risk for serious injury or harm due to lack of appropriate supervision. Findings included: Review of Resident #1's face sheet, printed on 04/02/25, reflected a [AGE] year-old female admitted to the facility on [DATE] and discharged on [DATE]. Her diagnoses included weakness, cerebral edema (brain swelling), nontraumatic intracerebral hemorrhage (brain bleed), acute respiratory failure with hypoxia (not enough oxygen in the body), and unspecified abnormalities of gait and mobility. Review of Resident #1's MDS assessment list reflected her admission, five day, and discharge assessments were all in progress. Review of Resident #1's baseline care plan, initiated on 03/29/25 and created on 04/02/25, reflected in part - Focus: I am at risk for falls r/t Balance problems noted, chronic health problem and comorbid medical problems, debility and weakness, cognitive impairment noted, difficulty moving / propelling self in w/c. 03/29/25 - actual fall, sent to ER. Goal: I will be free from falls and / or will not experience significant injuries associated with falls through next review date. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Interventions/Tasks: Provide resident with no touch call bell. Do not leave resident alone in her room when she is up in her wheelchair. Anticipate and meet needs and keep call bell within reach as indicated. Bed at appropriate height when unattended . Review of Resident #1's acute care discharge orders dated 03/24/25, reflected and order, Place patient on fall precautions. Review of Resident #1's Order Summary Report printed 04/02/25, reflected no order for fall precautions. Review of Resident #1's Nursing Admission assessment completed by RN B, 03/25/25, Section B (Clinical/Health Conditions) reflected the resident had comorbidities that included CVA (stroke) and Hemiplegia/Hemiparesis (weakness or paralysis on one side of the body). Section C (Physical Assessment) reflected the resident required a mechanical lift and two team members for transfers. Section E (Communication) reflected the resident was incoherent, unaware of her own needs and wants. Section K (Fall Risk Review) reflected recent falls were unknown, the resident was taking two of the medications listed, the resident appeared severely affected by one or more of the psychological factors listed, and her cognitive status was impaired. The Automatic High Risk Status: Box #1 was checked, Recent change in functional status and/or medications with the potential to affect safe mobility. Box #6 was checked, Check if the resident/patient is a high risk for falls. Section O (Initial and 48 Hour Plan of Care) reflected #10 Fall risk had no boxes checked - no focus, no goals, and no interventions. Review of Resident #1's progress note dated 03/27/25 at 10:00 AM, written by the NP, reflected in part, Patient demonstrates impulsivity and has made attempts to transfer self. She has been moved to room (number) for increased visibility by staff. Will continue to monitor cognitive status and implement safety measures. Review of Resident #1's progress note written by LVN D, reflected a late-entry note dated 03/29/25 at 11:30 AM, This nurse observed resident on floor in resident's room. Resident observed on floor face down and resident's wheelchair position on resident's upper back. Resident stated, I hit my head and face. Head to toe assessment completed and nystagmus (rapid eye movements) observed and resident alert and oriented x2 and some confusion noted of situation. Check for head injuries, nystagmus noted, EMS was called no redness or bruises to resident's face or head .Resident feels pain on left side of face and head .transported to (hospital) for evaluation and treatment. Review of a physician progress note from the acute hospital, dated 04/01/25, reflected Resident #1 presented from another hospital ED on 03/29/25 due to persistent left side weakness, left facial deficits, and bleed ing noted. She was admitted for evaluation of new bleed vs residual findings. Case and imaging reviewed with stroke neurology and findings determined to be expected findings of the recent CVA. Review of Resident #1's Kardex (the information used by the aides that provides key information such as safety, eating, mobility, and ADL assistance) printed on 04/04/25, reflected in part - Special Instructions: Resident must be up in dining room for meals. Do not leave alone with any food or drinks. Asperation [sic] precautions. Safety - I must be up for all meals. The Kardex did not reflect any fall precautions. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 04/02/25 at 1:28 PM, the MDS Nurse stated the admitting nurse was responsible for initiating the baseline care plan. She stated the baseline care plan should include the fall risk and interventions. She stated the residents could fall and get injured if the information was not documented in the care plan or Kardex. After review of Resident #1's Kardex she stated there were no interventions listed to prevent falls. During an interview on 04/02/25 at 1:49 PM, RN B stated she had completed the admission assessment on Resident #1. She stated she was the treatment nurse at the facility and did not routinely conduct admission assessments. She stated she believed she had marked the box indicating the resident was a high fall risk. She stated she believed that checking that box would trigger the fall risk to go to the baseline care plan and Kardex. She stated she did not know how to open the care plan to even see what was on the care plan. She stated the fall risk would be passed on in report and the CNAs would have the information on the Kardex. She stated she did not have all the information needed to complete the assessment and believed the management team would have reviewed and completed the admission assessment including the baseline care plan the next day. During an observation and interview on 04/02/24 at 2:15 PM, CNA A was observed as she signed into the computer and opened a Kardex for a current resident. She stated she did not see Fall Risk on the Kardex. She opened six more records of residents who she knew had fallen and did not see where the residents were identified as a fall risk. She stated they usually got fall risk information in report every morning from the nurse. She stated she had assisted another CNA with Resident #1 before she was transferred to the new room. She stated the resident required two staff and a mechanical lift for transfers. During a telephone interview on 04/02/25 at 3:05 PM, the hospitalist (doctor) caring for Resident #1 at the acute hospital stated it was his first day working with her and he had briefly reviewed the neurology notes before calling. He stated he was not sure what caused the fall, but she had a known bleed. He stated with her diagnosis of amyloid angiopathy (a buildup of proteins in the walls of the blood vessels in the brain), she would continue to have bleeds in the future. During an interview on 04/02/25 at 3:22 PM, the DON stated, Everyone who comes in this building was a fall risk, especially for the first three days and for three days after a room change. She stated Resident #1 admitted on [DATE] and they moved her to a different room on 03/26/25. She stated the resident was moved to a room closer to the nurses' stations so she could be monitored more closely. She stated it was her expectation that fall interventions were in place for all residents. She stated the nurses would see the interventions on the care plan and the CNAs would see the interventions on the Kardex. She stated Resident #1 did not have fall interventions on the care plan or Kardex, but they had moved her room and given her a touch call light and those were some of the interventions . She stated she had in-serviced staff multiple times, and the CNAs all knew that everyone was a fall risk. The DON stated she had educated on the need to get the residents out of their rooms and engaged as residents were at risk for falls left alone. She stated when the resident fell , the nurse noted nystagmus which was a change, so she was sent out to the hospital. (continued on next page)

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	455503	A. Building B. Wing	04/18/2025

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 04/03/25 at 10:15 AM, the NP stated it was important to have fall interventions in place. Without the interventions, a resident could fall and get injured. The NP stated while the resident was at the facility, her orientation waxed and waned. She stated the resident was impulsive and not always cognizant of her surroundings. She stated the resident was a fall risk because she made attempts to get up unassisted and did not follow commands. She stated she had read the notes from Resident #1's fall on 03/29/25. She stated she was not on call that day and did not assess the resident after the fall. She stated it was reported that the resident had nystagmus after the fall, and she did not have nystagmus prior to the fall. She stated the resident had a seizure in acute care, and a seizure could have caused the nystagmus. She stated a fall with a head injury could also cause nystagmus. During an interview on 04/03/25 at 10:41 AM, LVN D stated she was aware that Resident #1 was a fall risk because of the report she received from the previous shift. She stated the resident required assistance with transfers and used a mechanical lift which put her at risk for falls. She stated the resident was moved to her hall, so the resident had a room closer to the nurse's station and was more visible. She stated the resident needed frequent visual checks and supervision with meals due to aspiration precautions. She stated on 03/29/25, she heard Resident #1 call out for help and went to the room where the resident was found on the floor, face down. She stated the wheelchair was nearby and the mechanical lift sling was still in the wheelchair. She stated the resident could not say what had happened but complained that her head/face hurt and pointed to the left cheekbone . She stated CNA E and NA C worked the day of the fall. LVN D stated if a resident hit their head during a fall, it could have caused a head injury. A telephone interview was attempted on 04/03/25 at 11:52 AM. A voice message was left for CNA E, but the call was not returned prior to the survey exit. During a telephone interview on 04/03/25 at 11:56 AM, NA C stated she had worked at the facility about a month. She stated worked with Resident #1 on the day she fell . She stated she helped a CNA and a nurse get the resident up with the lift. She stated the resident was up in her wheelchair and her family member was visiting in the room. She stated she did not know when the family member left the room or how long the resident was alone in the room. She stated the nurse or other CNA told her who was a fall risk when she worked. She stated Resident #1 wore grippy sock the day of the fall but did not remember other fall interventions in place. During an interview on 04/03/25 at 1:03 PM, the DON stated she or the other administrative nurses entered the orders into their computer system for new admissions. She stated she did not remember ever seeing an order for a resident to be on fall precautions but if she had seen that order, she would have placed the resident on fall precautions. The DON stated Resident #1 fell because she had a seizure and that was why she had nystagmus . She stated there was no other head injury. She stated she had not witnessed the fall or a seizure because it happened on the weekend. During a telephone interview on 04/04/25 at 12:19 PM, the NP stated she could not answer if a fall where the resident hits their head could exacerbate or worsen the bleed the Resident #1 already had. She stated she did not see or examine Resident #1 after the fall, so she was not aware of any injuries or bruising from the fall. She stated the neurologist would have been more able to answer that question. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During a telephone conversation on 04/04/25 at 12:29 PM, the receptionist at the neurology department of the acute care hospital transferred the call to the patient relations department. A voice message was left requesting a return call. During a telephone conversation on 04/04/25 at 2:31 PM, a staff member from the patient relations department at the acute care hospital returned the call. He stated he would send the request to speak with Resident #1's neurologist to the head of the neurology department. A return call from a neurologist was not received prior to the survey exit. Review of the Falls Prevention Guideline, updated 03/28/22, reflected in part, Purpose - To establish a process that identifies risk and establishes interventions to mitigate the occurrence of falls. Process - On admission - - Newly admitted or readmitted residents are assessed for fall risk. - When a risk factor for falls is identified a corresponding intervention addressing that risk factor is developed. - When the risk is identified and intervention determined, it is documented on the care plan and on the Kardex. - The intervention is initiated. An Immediate Jeopardy (IJ) was identified on 04/03/25. The ADM, DON, and RDCO were notified of the Immediate Jeopardy on 04/03/25 at 3:11 PM and a IJ template was provided to the ADM on 04/03/25 at 3:11 PM. Review of a physician progress note from the acute hospital, dated 04/03/25, and received after the IJ was called, reflected in part, Patient was trying to get up out of her wheelchair felt dizzy and fell hitting the right side of her head . Resolving known R temporal IPH, no new hemorrhage . A Plan of Removal was accepted on 04/04/25 at 3:26 PM and read as follows: Plan of Removal 4/3/2025 Immediate Jeopardy 4/3/2025 F689 Accidents and Supervision The facility failed to ensure each resident receives adequate supervision and assistance devices to prevent accidents. Immediate Response: o Resident #1 no longer resides in the community. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	o Physician notification by licensed nurse of the fall Date completed: 3/29/2025 o Responsible party notified by licensed nurse of the fall Date completed: 3/29/2025 o Resident sent to the hospital. Date completed: 3/29/2025. o Director of Nursing Services/Assistant Director of Nursing Services/Registered Nurse Assessment Coordinator conducted a 100% Audit of all residents who reside in the community to review Fall Risk Assessments. All residents identified as a fall risk care plans were reviewed to ensure person centered interventions were in place falls and no other residents/patients identified. Date completed: 4/3/2025 o Director of Nursing Services, and administrative nurses provided immediate education by way of in-service. The in-service education was signed as an acknowledgement of comprehension, and a summary of the training material for the nurse involved in completing the resident's admission and all other nurses on Abuse Neglect, Residents Rights, initiating interventions to prevent a fall and Fall Prevention Guidelines. All admissions will be reviewed during daily clinical connect meeting to ensure interventions are initiated to prevent a fall for those residents identified as a fall risk by Director of Nursing Services/Designee. Date completed: 4/3/2025 and ongoing. o The Director of Nursing Services/Administrative Nursing is responsible for ensuring compliance and oversight of monitoring and education to ensure compliance. o The Director of Nursing Services/Administrative Nurses initiated education by way of in-service. The in-service education was signed as an acknowledgement of comprehension, and a summary of the training material to all nurses on initiating interventions to prevent a fall, Fall Prevention Guidelines, Resident Rights, Abuse and Neglect. o Direct care team to include licensed nurses, certified nurse assistants, certified medication aides, and nurse aides in training educated on review of the Kardex before providing care to all residents assigned to them to ensure proper assistance and interventions are utilized according to the resident's need and adherence to the resident's plan of care. Reporting any concerns or inaccuracies to the charge nurse/licensed nurse for additional direction prior to care provided. The expectation is for all direct care staff to include licensed nurses, certified nurse assistants/certified medication aides/nurse aides in training to review the Kardex prior to providing care. o Licensed nurses will initiate interventions to prevent falls for those identified as a fall risk upon admission and/or as indicated. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	o All nursing staff will receive the in-service prior to working next shift. o All newly hired nursing staff will receive in-service training prior to assuming shift responsibility during orientation process. o All agency nursing staff will receive in-service training prior to assuming shift responsibility. o Director of Nursing Services/Administrative nurses conducted 100% skills validation all nurse aides in training and certified nurse assistants of accessing the Kardex by Date completed: 4/3/2025 and ongoing Community will ensure all staff on leave/agency staff /PRN/new hires staff are in serviced prior to working their shift. No licensed nurse, nurse aides in training and certified nurse aide will assume an assignment of patient care until they have passed skills validation of accessing the Kardex. Community will ensure administrative nursing staff in the community to provide in-service/education prior team members working their assigned shift. These trainings will also be conducted with new hires. To include licensed nurses, nurse aide in trainings and certified nurse aides. Risk Response: All residents who currently reside in community potentially can be affected by the deficient practice. Systemic Response: o Director of Nursing Services/administrative nurses provided immediate education to direct care team to include licensed nurses, certified nurse assistants, certified medication aides, nurse aide in training on: Fall Prevention Guidelines/Abuse Neglect/Residents Rights, Kardex Use prior to providing care to the residents. Date completed: 4/3/2025 o Director of Nursing Services/Administrative Nurses is responsible for ensuring compliance and oversight of monitoring and education to ensure compliance of education. All Nursing Team Members including PRN/Agency/New Hires were educated on providing care to residents and were re-educated/re-trained by the Director of Nursing/administrative nurses on the following: o Review of the Kardex before providing care to all residents assigned to them to ensure proper assistance and interventions are utilized according to the resident's need and adherence to the resident's plan of care. Reporting any concerns or inaccuracies to the charge nurse/licensed nurse for additional direction prior to care provided. o Licensed nurse will initiate interventions to prevent falls upon admission and as indicated for those that are at risk for falls. o Director of Nursing Services/Administrative nurses conducted 100% skills validation to direct care staff to include certified nurse assistants, certified medication aides, and nurse aides in training on accessing the Kardex (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Date completed: 4/3/2025 and ongoing. Community will ensure all staff on leave/agency/PRN staff /new hires are in serviced prior to working their shift. No licensed nurse, certified medication aide or certified nurse aide will assume an assignment of patient care until they have passed skills validation of accessing the Kardex. Community will ensure administrative nursing staff in the community to provide in-service/education prior team members working their assigned shift. These trainings will also be conducted with new hires Monitoring Response: o Director of Nursing Services/Administrative nurses will review Admission/Readmission Assessments 5-7 days a week in the Daily Clinical Connect meeting to ensure residents/patients that are at risk for falls have interventions in place to prevent falls and documented using a monitoring tool. o The Administrator/Director of Nursing Services will conduct random audits of 3 care plans review a week for 4 weeks and 1 care plan review weekly for 8 weeks to validate fall intervention care plans are in place for residents/patients at risk for falls. o The Director of Nursing Services/Administrative Nurses/Designee will conduct random skills validations regarding Kardex use 3-7 days a week for 2 months to ensure direct staff is compliant with the use of the Kardex. o Policies are followed to ensure the safety and wellbeing of our residents. Additional education will take place based on needs observed during this process. All findings will be reported to the QAPI committee during monthly meeting until there is 100% compliance observed during observations. The Surveyor monitored the POR on 04/04/25 through 04/18/25 as followed: During interviews on 04/04/25 from 4:17 PM - 7:05 PM, three RNs, four LVNs, and 9 CNAs from all shifts stated they were in-serviced before their shifts on fall precautions, falls, using the Kardex, and abuse/neglect. They all stated the Kardex was to be reviewed prior to providing care to know what type of care the resident required and any precautions identified. They stated they could also utilize the residents' care plans for that information. Staff reported fall interventions including reminding the resident to call for assistance, call light within reach, bed in low position, and non-slip socks. Staff stated performing frequent rounds, anticipating needs, and getting residents up and in common areas. The staff were able to speak to the abuse and neglect policy and name the ADM as the abuse coordinator. During an interview on 04/04/25 at 5:13 PM, the DON stated she was in-serviced by the RDCO on baseline care plans. She stated the baseline care plans were completed within 48 hours and interventions, including fall interventions, were implemented. She stated she had been in-serviced on the process of validating the completion of admission/readmission assessments and ongoing monitoring. The information was discussed in the morning meeting to confirm the interventions were in place to meet the resident needs. The DON stated she had been in-serviced on ANE. She was able to speak to the policy. The DON stated after she was in-serviced, she and other administrative nurses in-serviced other nursing staff on the same topics. The DON stated she would be reviewing all admission/readmission assessments going forward to ensure all interventions for falls were place. She stated she would also be conducting audits frequently on care plans to validate the fall interventions. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 04/04/25 at 5:47 PM, the ADON stated she was in-serviced by the RDCO on the process that validated the completion of admission/readmission assessments including head to toe assessment and baseline care plan to ensure interventions were in place. She stated she was in-serviced on abuse and neglect and was able to speak to the policy. Review of the Fall Risk Assessment audit dated 04/03/25, conducted by the administrative nursing staff, reflected the residents identified as a fall risk had interventions in place. Review of in-service education conducted by the administrative nursing staff, dated 04/03/25, reflected licensed nurses, CNAs, MAs, and nurse aides in training, were in-serviced on Fall Prevention Guidelines, Abuse and Neglect, Resident Rights, and Kardex use. Review of the skills validation, conducted by the administrative nursing staff, dated 04/03/25, reflected nurse aides in training and CNA were able to demonstrate access to the Kardex. Review of the undated Monitoring Tool reflected the form used for monitoring fall risk interventions in place for admissions/readmissions. During observations of residents, including newly admitted residents on 04/18/25 between 12:35PM and 1:12 PM , revealed beds in low positions, call lights within reach, anti-slip strips on the floor, and clear, uncluttered pathways in the rooms. Review of the care plans and Kardex of residents observed on 04/18/25, reflected fall interventions in place on the documents matched the interventions observed. The ADM was notified on 04/04/25 at 7:15 PM that the IJ had been removed. While the IJ was removed, the facility remained at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.