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	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosewood Heights	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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide care, consistent with professional standards of practice, to prevent pressure injuries for 1 (Resident #1) of 5 residents reviewed for pressure injuries. The facility failed to prevent Resident #1 from receiving a shear to her right buttock, which ultimately became a stage 4 pressure ulcer that developed into sepsis (life-threatening condition caused by the body's extreme and dysregulated response to an infection, leading to organ dysfunction and potentially death) due to wound infection, infection due to polymicrobial wound flora, and osteomyelitis (infection that happens when bacteria or fungi infect the bone marrow) of sacrococcygeal wound. This failure placed residents at risk of developing pressure injuries, wound infections, and pain. Findings included: Review of Resident #1's comprehensive MDS assessment dated [DATE] reflected a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of: stroke, kidney failure , neurogenic bladder (loss of bladder control), diabetes, seizure disorder, respiratory failure, dysphagia (difficulty swallowing), cervical disc disorder at C4-C5 level with myelopathy (compression of the spinal cord in the neck, leading to neck pain, weakness, coordination issues), and morbid obesity. Resident #1 was 211 pounds, had a feeding tube which she received 51% or more of her calories from, and had an indwelling catheter. Resident #1 was dependent on staff for all ADLs. Resident #1's skin conditions revealed a formal instrument tool was used, she was at risk of pressure ulcers, and she did not have any unhealed pressure ulcers/injuries. No skin or wound problems were identified , treatments included use of pressure reducing device for chair, and bed, as well as applications of ointments/medications other than to the feet. Resident #1 had a BIMS score of 09, indicating moderately impaired cognition. Review of Resident #1's comprehensive care plan dated 01/09/2026 reflected a focus of being at risk for self-care deficit, falls, skin concerns, pain, infection & nutritional/hydration concerns and emotional distress. Interventions included: monitor/inspect skin for skin breakdown and report to nurse, MD/NP, PCP as indicated to ensure appropriate treatment is in place. Turn and reposition every 2-3 hours or more often as needed. Ensure clean and dry. Provide pressure relieving mattress/cushion as indicated. A focus, initiated by LVN A dated 01/09/2026 revealed an actual skin impairment due to impaired mobility and incontinence secondary to stroke-pressure ulcer to right gluteus. Interventions included therapeutic pressure reducing wheelchair cushion, apply treatment at ordered, keep skin clean and dry and apply skin barrier cream as indicated. Therapeutic pressure reducing mattress, turn and reposition regularly during rounds and more often as needed, handle fragile skin with caution & report to nurse if any skin concerns arise. Review of Resident #1's Braden Scale - for Predicting Pressure Ulcer Risk Evaluation dated 01/16/2026 revealed Resident #1's sensory perception was a.) completely limited: unresponsive to painful stimuli, due to diminished level of consciousness or limited ability to feel pain over most of body surface. Resident #1's moisture (degree to which skin is exposed to moisture) was marked as a.) constantly moist: skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every timeResident #1's activity (degree of physical activity) was marked as a.) bedfast: confined to bedResident #1's mobility (ability to change and control body position was marked as a.) completely immobile: does not make even slight changed in body or extremity position (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
	455503	A. Building B. Wing	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosewood Heights	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 0686 Level of Harm - Actual harm Residents Affected - Few	without assistanceResident #1's nutrition (usual food intake pattern was marked as c.) Adequate: eats over half of most meals. Eats a total of 4servings of protein (meat, dairy products) per day. Occasionally will refuse a meal, but will usually take a supplement when offeredOR is on a tube feeding or TPN regimen which probably meets most of nutritional needs.Resident #1's friction and shear (mechanical force that occurs when two adjacent layers of tissue move in opposite directions) was marked as a.) problem: Requires moderate to maximum assistance in moving. Completelifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity (abnormal muscle stiffness and tightness), contractures (chronic loss of joint mobility) or agitation leads to almost constant friction. Review of Resident #1's hospital after visit summary dated 01/09/2026 revealed diagnoses of subarachnoid hemorrhage ,(subarachnoid hemorrhage) and acute respiratory failure requiring reintubation (medical procedure of re-inserting an endotracheal tube). Active wound care orders indicated applying wound barrier ointment and nystatin powder to the peri area, and topical ointment to the breast area due to contact dermatitis (itchy rash caused by direct contact with a substance or an allergic reaction to it) . No additional skin or wound issues or orders were documented. Review of Resident #1's nursing admission assessment dated [DATE] conducted by LVN A revealed a Transfer/Lift Status of total lift-passive mechanical lift. Under Head to Toe Skin assessment Resident #1's skin was indicated as being dry, intact with no identified skin issues, with an incision/surgical wound (no location written), no pressure injuries were identified. She was indicated as having no sensory perception impairment, and a problem of friction and shear was identified and required moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures, or agitation leads to almost constant friction.Review of Resident #1's January 2026 TAR revealed the following: Clean MASD to sacrum (triangular bone in the lower back formed from fused vertebrae) (full thickness) with wound cleanser. Pat dry. Apply Triad paste with collagen particles daily and PRN with incontinent episodes. one time a day for Wound care-Start Date-01/28/2026 8:00am , documented with check marks on 1/28-1/31, indicating administered. Clean right buttock with wound cleanser. Pat dry. Apply collagen and extra thin DuoDerm dressing. one time a day every Tue, Thu,Sat for wound care-Start Date-01/22/2026 9:00am-D/C Date-01/27/2026 3:00pm, documented with check marks on Thu 1/22, Sat 1/24, and Tues 1/27.Clean right buttock with wound cleanser. Pat dry. Apply collagen and extra thin DuoDerm dressing. as needed may reapply PRN ifbandage falls off-Start Date-01/21/2026 12:45am-D/C Date-01/27/2026 3:00pm, documented with a check mark on 1/25.Weekly Skin Check 0 - for No Skin issues 1 - for No new Skin issues 2 - New skin issue identified every day shift every Fri for SkinIntegrity-Start Date-01/16/2026 6:00am, documented with ?0' on 1/16, ?0' on 1/23, and '0' on 1/30 .incontinence associated dermatitis to buttocks: apply barrier cream and collagen powder every shift-Start Date-01/16/2026 6:00pm-D/C Date-02/11/2026 10:10am, documented with check marks beginning in the evening of 1/16, and twice a day through 1/31Review of Resident #1's progress notes revealed, 1/10/2026 documented by the NP SKIN- No rashes, No itching, No skin discoloration, No bruising, No lesions 1/11/2026 documented by LVN A Skin : Fragile skin observed, patient is at risk for skin failure / breakdown. Skilled nursing provides therapeutic interventions to minimize risk, relieve pressure, promote skin health as well as on-going monitoring efforts.1/14/2026 documented by the DON, Skin: Fragile skin observed, patient is at risk for skin failure / breakdown. Skilled nursing provides therapeutic interventions to minimize risk, relieve pressure, promote skin health as well as on-going monitoring efforts.1/20/26 documented by RN B, Skin Issues: Skin Issue: #001: New skin Issue. Location: Right gluteus. Issue type: Other skin issue. Other skin issue description: Trauma wound Progress: New: new wound. Wound acquired in-house. Length (cm): 3.39 Width (cm): 3.63 Depth (cm): 0 Area (cm2): 9.39 Undermining (tissue destruction that extends beneath the intact skin surrounding a wound): No. Tunneling (formation of a narrow channel or tract extending from the surface of a wound into deeper tissue layers): No. Skin (continued on next page)

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	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosewood Heights	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 0686 Level of Harm - Actual harm Residents Affected - Few	Issues Note: Wound to right buttock with new orders per wound care NP. New orders received and noted. [RP] notified with wound and wound care orders.Review of Resident #1's skin issue assessment dated [DATE] documented by RN B revealed a new issue on the right gluteus, identified as other skin issue described as trauma wound, and it was in-house acquired. Review of Resident #1's wound care note dated 01/20/2026 documented by WCD E revealed: [Resident #1] is a 72 y/o F with a PMHx of HTN, and T2DM. Patient is being seen today for an initial wound care visit and evaluation of a wound to her right buttock. Patient's wound appears to be the result of trauma, which likely occurred when patient was being transferred via [mechanical] lift. Patient denies any complaints of discomfort to the area. No s/s of infection noted at this time. Will continue to follow until wound is resolved. Review of Resident #1's dietitian recommendations dated 1/22/26 reflected: Problem: Decreased H2O flushes for hydration. Recommended: Increase H2O flushes to 250 cc q 6 hrs.Review of Resident #1's February 2026 TAR revealed the following: Clean MASD to sacrum (full thickness) with wound cleanser. Pat dry. Apply Triad paste with collagen particles daily and PRN with incontinent episodes. one time a day for Wound care-Start Date-01/28/2026 8:00am -D/C Date-02/03/2026, documented with check marks on 2/1 and 2/2, indicating administered.Clean sacral wound with wound cleanser. Pat dry. Apply Medihoney, silver alginate and cover with sacral foam dressing one time a day for wound care-Start Date-02/04/2026 8:00am-D/C Date-02/10/2026, documented with check marks 2/4-2/9, indicating administered.Clean sacral wound with wound cleanser. Pat dry. Apply Santyl, calcium alginate and cover with sacral foam dressing. one time a day for wound care-Start Date-02/11/2026 8:00am -D/C Date-04/01/2026, documented with check marks 2/11-2/28, indicating administered.Santyl External Ointment 250 UNIT/GM (Collagenase) Apply to sacrum topically one time a day for sacral wound see treatment order-Start Date-02/21/2026 8:00am -D/C Date-04/01/2026, documented with check marks 2/21-2/28, indicating administered.Weekly Skin Check 0 - for No Skin issues 1 - for No new Skin issues 2 - New skin issue identified every day shift every Fri for Skin Integrity-Start Date-01/16/2026 6:00am -D/C Date-04/01/2026, documented with ?1' on 2/6, ?1' on 2/13, ?1' on 2/20, and ?1' on 2/27incontinence associated dermatitis to buttocks: apply barrier cream and collagen powder every shift-Start Date-01/16/2026 6:00pm-D/C Date-02/11/2026, documented with check marks twice a day 2/1-2/2, a ?9' (indicating ?other' nurse verbally informed), and check marks twice a day 2/4-2/10.Review of Resident #1's wound care note dated 02/03/2026 documented by WCD E revealed: [Resident #1] is being seen today for continued evaluation and management of a wound to her sacrum. Patient is lying in bed this morning and is watching TV. Patient reports that she is feeling well. Significant deterioration noted to patient's wound this visit despite patient stating that she is frequently repositioning herself. No s/s of infection noted at this time. Patient began utilizing new air mattress yesterday, which will also hopefully alleviate some pressure concerns.Review of Resident #1's wound care note dated 02/10/2026 documented by WCD E revealed: [Resident #1] is being seen today for continued evaluation and management of a wound to her sacrum. Patient is laying in bed this morning and is resting peacefully. Patient appears to be in no acute distress. Continued deterioration noted to patient's wound this visit. There is some concern at this time for possible wound infection, as a strong odor was noted during dressing changes. Nursing advised to collect a wound panel. Patient's wound surgically debrided (remove damaged tissue or foreign objects from a wound) during time of visit, which patient tolerated well. [Resident #1] denied any complaints of discomfort. Nursing advised to continue pressure relieving interventions. Review of Resident #1's wound care note dated 02/17/2026 documented by WCD E revealed: Patient is being seen today for continued evaluation and management of a wound to her sacrum. [Resident #1] is laying in bed this morning and appears to be in no acute distress. Patient reports that she is doing well. Significant improvements noted to patient's wound this visit. [Resident #1] was recently started on IV Meropenem per wound panel findings. Patient appears to be responding well to the medication. No odors noted to patient's wound. Patient's wound surgically debrided during time of visit, which patient tolerated well. Patient (continued on next page)

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	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosewood Heights	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 0686 Level of Harm - Actual harm Residents Affected - Few	expressed minimal discomfort. Nursing advised to continue pressure relieving interventions. Patient has approx. 8 days remaining of IV abx.Review of Resident #1's dietitian recommendations dated 2/20/26 reflected: Problem: TF/Wound/Wt Loss - Res w/wt loss x 30 days wound improving. Recommend: Rec increase EN feeding to 70 cc/hr feeding will provide 2520 kcal, 138 gms pro and 2275 cc H2O.Review of Resident #1's wound care note dated 02/24/2026 documented by WCD E revealed: Patient is being seen today for continued evaluation and management of a wound to her sacrum. [Resident #1] is laying in bed this morning and reports that she is doing well. Minimal improvements noted to patient's wound at this time. No apparent deterioration, however wound depth was notably increased since last visit (likely d/t continued removal of devitalized tissue (dead or non-viable tissue that has lost its blood supply and cannot support living cells) Patient's wound surgically debrided during time of visit, which patient tolerated well. IV Meropenem will be extended an additional 7 days. Nursing advised to collect CBC and CMP. Continue pressure relieving interventions. Review of Resident #1's wound care note dated 03/10/2026 documented by WCD F revealed: Pt is being seen today for continued evaluation and management of sacral wound. Pt reports that she is feeling well and denies any acute concerns at this time. Wound improving; will continue current plan of care.Review of Resident #1's wound care note dated 03/17/2026 documented by WCD F revealed: Pt is being seen today for continued evaluation and management of sacral wound. Pt reports that she is feeling well and denies any acute concerns at this time. Wound stable; will continue current plan of care.Review of Resident #1's last wound care note dated 03/24/2026 documented by WCD F revealed: Pt is being seen today for continued evaluation and management of sacral wound. Pt reports that she is feeling well and denies any acute concerns at this time. Patient still on IV ceftriaxone. Wound stable; will continue current plan of care. Review of Resident #1's active doctor's orders as of 03/26/2026 reflected: Order Date-1/9/26-Complete the Braden AssessmentOrder Date-1/9/26- Foley catheter care with perineal wipes and/or soap and water every shift for Foley Catheter CareOrder Date-1/9/26- Weekly Skin Check 0 - for No Skin issues 1 - for No new Skin issues 2 - New skin issue identified everyday shift every Friday for Skin IntegrityOrder Date 2/10/26-Clean sacral wound with wound cleanser. Pat dry. Apply Santyl, calcium alginate and cover with sacral foam dressing. one time a day for wound careOrder Date 3/16/26-Regular diet Puree texture, Thin/Regular consistency, Resident is receiving Glucerna 1.5 cont. 24/hr via Peg tube for DietOrder Date 2/20/26-Santyl External Ointment 250 UNIT/GM (Collagenase) Apply to sacrum topically one time a day for sacral wound see treatment orderReview of Resident #1's infectious disease consultation dated 3/29/2026 revealed Resident #1 was assessed for sepsis due to wound infection-without organ dysfunction-without shock, infection due to polymicrobial wound flora, and osteomyelitis of sacrococcygeal wound. Additional documentation by the IDP revealed sepsis with complex MDRO organisms, and still with exposed wound, and osteo concerns. Full-thickness sacral decubitus ulcer.Review of Resident #1's hospital AVS dated 4/7/2026 reflected: You were diagnosed with: sepsis, sacral wound, foley catheter in place, G tube feedings, osteomyelitis, pressure ulcer of sacral region, unspecified stage, osteomyelitis of vertebra, sacral and sacrococcygeal regionDischarge diagnoses: Sepsis without acute organ dysfunction, due to unspecified organism Principal Problem: Sepsis without acute organ dysfunction, due to osteomyelitis of sacrococcygeal region secondary to infected stage 4 decubitusActive Problems: Insulin dependent type 2 diabetes mellitus (Chronic), Mild intermittent asthma in adult without complication (Chronic), Essential hypertension (Chronic), GERD without esophagitis (Chronic), Oropharyngeal dysphagia (Chronic), S/P percutaneous endoscopic gastrostomy (PEG) tube placement (Chronic), Chronic anemia, History of nontraumatic subarachnoid hemorrhage (Chronic), Quadriplegia after hemorrhagic stroke (Chronic), Seizure with onset of Subarachnoid hemorrhage (Chronic)BMI 32.0-32.9, adult (Chronic), Infected sacrococcygeal decubitus ulcer, stage 4, Osteomyelitis of sacral and sacrococcygeal region, HyponatremiaIn an observation/interview on 04/16/2026 at 11:25am, Resident #1 was at a CCH with a wound vac (vacuum-assisted closure that applies negative pressure to a wound to promote healing) (continued on next page)

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	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosewood Heights	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 0686 Level of Harm - Actual harm Residents Affected - Few	attached to Resident #1's right buttock area, the wound was covered by black foam and held to the skin with clear tape. She had inflatable boots (specialized orthopedic device) on both feet. Resident #1 stated that she had a stroke, and was in the hospital for a couple months, and had another stroke while there. She stated she lost track of how long she was in the hospital, but her family told her it was for 3 months. She stated that she could feel pain in her bottom and legs and was able to point to it. She stated she could not move her legs at all due to her condition. She stated that when she was admitted to the nursing facility, the staff said she had wounds, but she could not feel them. She stated she could not feel the sacral wound now, unless someone was messing with it. She stated there was not a wound care doctor or nurse seeing her at the nursing facility and she did not recall anyone going in her room and providing care to her wound. She stated she thought she had a debridement at the nursing facility, because the word sounded familiar, and she remembered the nurses talking about it with a doctor, but she did not know if she had it done. She stated she did not remember if she had a feeding tube and a catheter at the nursing facility.In an interview on 04/16/2026 at 11:40am with the RP of Resident #1 revealed, that Resident #1 had the G tube and catheter for approximately 5 months. She stated that Resident #1 would wear inflatable boots on and off at the nursing facility and that the staff rotated having them on, and they would also use wedges and pillows for Resident #1. She stated that she was being informed on Tuesdays, by a wound care doctor, about Resident #1's wound condition. She stated that the wound care doctor was informing her the wound was healing. She stated that when she would go visit Resident #1, she did not think it was getting better because she would see pus and mucus. She stated that she thought she was seeing pus, not slough (dead tissue that accumulates in a wound, often appearing as yellow, tan, or white fibrous material). In an interview on 04/16/2026 at 1:30pm with the DON she stated that Resident #1 admitted to the facility with a catheter and G-tube. The DON stated that the facility implemented measures prior to Resident #1's admission such as having an air mattress ready for her. She stated that they ran a lot of labs on Resident #1's urine and monitored her CBC for wound infection. Resident #1 was on 2 weeks' worth of wound care IV antibiotics, and they saw that Resident #1's white blood cell count was low, indicating something was wrong. She stated that everything they were doing was not bringing the white count up, She stated they were monitoring the wound the whole time to ensure she would not get septic, but she was having a lot of diarrhea. They were unsure if the diarrhea was due to the new G-tube or infection, and they implemented adding banana chips to her feedings, vitamin c, zinc, and Metamucil. Resident #1 began getting altered mental status, and after they received her labs on 3/26/26, combined with the fever of 99, the facility sent her to the hospital on 3/27/26 because her temperatures had been running about normal her entire stay. She stated that the resident was pretty much immobile, was an obese woman and required someone to reposition her. She stated that she believed barriers to healing included her CVA (sudden loss of blood flow to a part of the brain), immobility, diabetes, stage 3 kidney disease, all prohibited blood being able to get to the wound to heal it. The DON was adamant that the initial injury to Resident #1's sacrum/right buttock was not related to a mechanical lift transfer but rather shear due to Resident #1 being a large person, requiring 2 people to reposition her. She defined shear as when the skin makes skid-like contact with a bed, a sheet, or something under a person; that happened when you cannot lift someone because they are too heavy. In an interview on 04/16/2026 at 10:18am with WCD E he stated that his initial observation of Resident #1's wound was caused from a mechanical lift trauma . He stated that anatomically the wound covered the right buttock, but his notes referred to it as sacral, but he was referring to the same wound. He stated that the second time he visited Resident #1 he believed the wound was more pressure related, and it encompassed more of her sacrum. He stated that Resident #1 required assistance with turning and positioning. He stated that the wound had started to deteriorate, so he debrided it a few times, ordered a wound panel, and from the wound panel results, started Resident #1 on Meropenem (antibiotic). He stated that they would use collagenase, so he was able to see more of the wound bed, and that the cause of the (continued on next page)

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	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosewood Heights	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 0686 Level of Harm - Actual harm Residents Affected - Few	increased wound measurement was due to him removing the bad tissue. He stated that when he last saw Resident #1 on 02/24/2026 before WCD F filled in, he had the wound at unstageable (type of pressure injury where the full-thickness skin and tissue loss is obscured by slough or eschar, making it impossible to determine the extent of the injury). He stated he knew for a fact Resident #1 was being repositioned by staff because he always reminded staff of the need for repositioning, and if he had concerns, he would verbalize them. He stated that a barrier to Resident #1's wound healing would be her reliance on being repositioned. He stated that to his knowledge she did not have MASD, because he really tried to get onto staff if he noticed MASD. He stated that every time he visited, he would change the wound dressing himself and there was no concern with soiled dressings.In an interview on 04/17/2026 at 9:39am with LVN A, she stated that she had been working at the facility for about 10 months, and that she conducted the admission skin assessment on 1/9/26 for Resident #1. She recalled a surgical incision on Resident #1's hip, but she could not recall which side. She also recalled Resident #1 having paralysis but could not recall on which side. She stated that Resident #1 admitted with the sacral/right buttock injury, and she identified the next day (1/10/26) that she misread the skin questions on the assessment, but she thought she could not go in and redo it, or initiate a new assessment. She stated she should have documented that the resident had a sore on her sacral area, she could not recall if it was on the buttock or the sacrum. She did not remember if it was shear or an open wound. She stated that the admitting nurse was responsible for accurately completing the assessments, and she was the admitting nurse for Resident #1. She stated that when a wound was identified they should be documenting the location, drainage, size, and smell , which she does, but did not do on Resident #1's skin assessment because she misread the questions.In a follow up interview on 04/17/2026 with the DON, she stated that Resident #1 did not admit to the facility with any wounds, rather the wound was first noticed on 1/20/26. She stated that they would document on the TAR a 0- for no skin issues, 1- for no new skin issues or 2-new skin issue. The DON stated the wound happened because Resident #1 was a very big and heavy lady, and that she had a lot of moisture, and she thought during turning, while repositioning or when using a draw sheet is what caused the shear. In a follow up interview on 04/17/2026 with WCD E, he stated that he could not necessarily say if the injury was avoidable, because accidents happen. He stated that Resident #1 had a lot of loose skin which predisposed her, but with an injury like that, it would not be expected to go to osteomyelitis, and sepsis, but there was an increased risk for other things to happen.In an interview on 04/17/2026 at 10:38am with RN B she stated that she was the wound care nurse, and a CNA (could not recall who) informed her of Resident #1's new skin issue on 01/20/26. She stated that her first impression was that it was MASD, because it was not open, but it was red, and the wound care doctor saw it that same day. She did not recall the CNAs telling her if it was from transfers, because she had always told the CNAs to be honest with her and they could communicate if an accident happened. She stated that Resident #1 was not able to reposition herself, and there was always 2 people assisting the resident. She stated that she always thought there was something under the initial injury. She stated that she had been doing wound care awhile, and that was her impression. She stated that there was no way for her to know what was underneath the wound, the first wound was just the skin taken off, and she could not know what was underneath. She did not recall seeing infection, but she could see it when the doctor debrided it. She stated that she felt confident the CNAs on Resident #1's hall turned and repositioned Resident #1 as ordered. She knew that the wound got better, and then it got worse, and she thought that Resident #1's comorbidities contributed to the worsening of the injury.In an interview on 04/17/2026 at 10:54 am with WCD F, she stated that she picked up wound care on Resident #1 in March 2026. She recalled that Resident #1 had a large pressure wound on her sacrum that appeared to have been there for a while. She stated that the wound was slowly getting better, not deteriorating while she cared for Resident #1. She stated that she did not overtly notice any s/sx of infection, but that Resident #1 was on IV antibiotics every time she saw her. She stated that the wound was progressing as she expected it to. She stated (continued on next page)

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	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosewood Heights	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 0686 Level of Harm - Actual harm Residents Affected - Few	that the interventions that were in place, included Resident #1 being on an air mattress, staff were turning and repositioning, WCD E's debridement, and serial wound care (regularly evaluating and treating wounds to promote healing). She stated that barriers to the wounds healing were that she thought Resident #1 was most comfortable laying on her back, which was extensive pressure, also her comorbidities, and diabetes. She recalled the dressings were clean, dry, and intact when she would arrive for wound care. She stated she could not really say if the wound was avoidable. She stated that Resident #1 was debilitating (weak), but ultimately, she thought all pressure ulcers could be avoided. She stated the last time she saw Resident #1, on 03/24/2026 she did not notice any fever, warmth, or redness to the area, but that Resident #1 was on antibiotics. In an interview on 04/17/2026 at 12:25pm with CNA G, she stated that anytime she noticed something different or new she reported it to the RN right away. She recalled first noticing the skin tear on Resident #1 during a brief change. She stated Resident #1 was a 2 person assist and that they always had 2 people assisting the resident. She stated that she could not provide care to Resident #1 by herself because the resident was heavy and was paralyzed. She stated that she went to the charge nurse and notified her. She stated that they are required to check and change every 2 hours, but they also have to reposition other residents. She recalled that Resident #1 used a mechanical lift for transfers. In a follow-up interview on 04/17/2026 at 1:32pm with the DON, she stated that her expectation for a resident who came in with no skin issues, for the facility to maintain their skin integrity, was to conduct weekly skin assessments, regular bathing, lotion, daily skin care, repositioning if the resident could not reposition themselves as well as hydration, nutrition, dietitian evaluations and following their recommendations. She stated that her expectation, if an assessment was incorrectly completed and later identified, was re-training of the team member, and that they could only go back 1 month on an assessment, but they could make a progress note. She stated that if a resident admitted with no skin issues and then acquired a skin issue, the facility would have to provide treatment, and ultimately the resident could get an infection, experience pain, or the resident could acquire sepsis. In an interview on 04/17/2026 at 1:54pm with the ADM, she stated that her expectation to maintain a resident's skin integrity who admitted with no skin issues, was for the DON to educate her staff on how to treat skin and for no skin issues to be acquired. She stated that her expectation if an assessment was incorrectly completed and later identified was for the nurse to correct it, once identified, or they could put in a progress note. She stated that if a resident admitted with no skin issues, and then acquired a skin issue, that potentially the wound could get better, or it could get infected. But that it depended on nutritional status, comorbidities, and whether it would deteriorate or improve. Review of the facility policy titled ?Skin and wound prevention and management' dated January 2026, reflected: An individual's skin is the largest organ of the body. At times skin failure may occur; however, the community will ensure that a resident admitting into the community will evaluated and identify the associated risks that may result in with skin breakdown . The medical provider should consider the resident's current health status, function abilities, comorbidities as well as medications to determine if a pressure ulcer injury should be considered avoidable or unavoidable in etiology. Thus, a plan of care will be developed and implemented based on the identified needs, associated risks, and current skin conditions. Each resident will receive the care and services necessary to retain or regain optimal skin integrity.Skin prevention program will: Identify associated risks for alterations in skin integrity or development of pressure ulcers injuries. Identify early onset skin breakdown so that the IDT may implement appropriate interventions as clinically indicated. Implement interventions designed to stabilize, reduce, or remove underlying risk factors.Considerations and Risk factions to include but not limited to: Diagnoses/Conditions - Below is a list (not all-inclusive) that can affect the development and/or the ability to heal skin conditions. Creating a potential for unavoidable pressure and non-pressure injuries. Impaired/decreased mobility and decreased functional ability Co-morbid conditions, such as end stage renal disease, thyroid disease, or diabetes mellitus Drugs such as steroids that may affect wound healing Impaired diffuse (continued on next page)

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	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosewood Heights	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 0686 Level of Harm - Actual harm Residents Affected - Few	or localized blood flow, for example, generalized atherosclerosis or lower extremity arterial insufficiency Cognitive impairment Exposure of skin