

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675452	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/09/2024
NAME OF PROVIDER OR SUPPLIER  Rosewood Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  7700 Mesquite Pass Converse, TX 78109	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47564</b></p> <p>Based on observation, interview, and record review the facility failed to protect the confidentiality of personal health care information for 1 of 4 residents (Resident #1) reviewed for confidentiality of records during the survey in that:</p> <p>The facility failed to ensure LVN A locked and closed the laptop during the medication pass exposing Resident #1's personal information.</p> <p>This failure could affect residents by placing them at risk for loss of privacy and dignity.</p> <p>The findings included:</p> <p>Review of Resident #1's face sheet dated 3/10/2024 revealed a resident was admitted to the facility on [DATE] with diagnoses which included Cerebral Infarction (a pathological process that results in an area of necrotic, or dead, tissue of the brain), dysphagia (difficulty swallowing foods and/or liquids), depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life).</p> <p>Observation on 03/09/2024 at 12:13 PM of LVN A's medication cart revealed the medication cart was left unattended for approximately 5 minutes while LVN A was not present. The screen showed Resident #1's picture, name and a progress note relating to Resident #1's dietary intake via their PEG tube.</p> <p>Interview on 03/09/2024 at 12:18 PM, LVN A stated she did not remember leaving the laptop open and that she had only left a few minutes ago to get something for an unspecified residents family member. LVN A stated the potential risk would be someone seeing or going into a residents medical records.</p> <p>Interview on 03/09/2024 at 2:01 PM, the DON stated her expectation was for the screen to be set to a privacy screen with no sort of identifiable resident information left on the screen.</p> <p>Record review of a facility's policy titled Confidentiality undated reflected assure that sensitive and personal information about residents is not shared with other residents by staff members.</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  Facility ID: 675452	If continuation sheet Page 1 of 11

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 26869</p> <p>Based on interviews and record review the facility failed to ensure assessments accurately reflected the resident's status for 1 of 1 (Resident #3) residents reviewed for assessments.</p> <p>Resident #3 was discharged and did not have a discharge MDS in the electronic record.</p> <p>This could affect all resident discharged and could result in residents missing services.</p> <p>The findings included:</p> <p>Record review of Resident #3's admission record, dated 03/09/2024, reflected an [AGE] year-old resident with an admitted [DATE], and diagnoses of Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors) and dementia (group of thinking and social symptoms that interferes with daily functioning). The discharge date was 3/14/2024.</p> <p>Record review of Resident #3's telephone order for discharge was signed by the physician on 3/14/2024.</p> <p>Record review of Resident #3's Annual MDS assessment, dated 1/19/2024, reflected Resident #3 had not exhibited behaviors of wandering, and that the residents BIMS score was a 4, indicating the resident was severely cognitively impaired.</p> <p>Record review of Resident #3's chart revealed in the section for MDS's no discharge MDS.</p> <p>Record review of Resident #3's Post discharge plan of care dated 3/14/2024.</p> <p>Record review of Resident #3's Physician discharge summary was signed and dated by the physician on 3/18/2024.</p> <p>In an interview on 4/9/2024 at 4:20 PM with the MDS stated she was the staff responsible for MDS and care plans for the facility. The MDS stated Resident #3's discharge was on 3/14/2024. The MDS stated she did not do hers and should have done it timely. The MDS stated she usually hand writes in a calendar all the resident due dates for the MDS and care plans. The MDS stated she missed the discharge MDS for Resident #3 .</p> <p>In an interview on 4/9/2024 at 4:27 PM with the DON stated, she was not aware Resident #3's discharge MDS was not completed timely .</p> <p>In an interview on 4/9/2024 at 4:46 PM with the Administrator she stated, she was not aware Resident #3's discharge MDS was not completed timely .</p> <p>Record review of the Policy on Implementation of the minim date set (MDS) (no date) was documented It is the policy of thit facility to ensure a comprehensive assessment of each resident is completed and submitted according to the RAI guidelines [NAME] set forth by CMS. Monitor the scheduling of MDS and Complete a comprehensive . MDS according to the guidelines of the RAI [NAME] set forth by CMS.</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 26869</p> <p>47564</p> <p>Based on observation, record review, and interviews, the facility failed to provide adequate supervision, for 1 of 4 residents (Resident #3) reviewed for accidents, hazards, and supervision.</p> <p>Resident #3 walked out of the facility through an alarming door without staff responding.</p> <p>This deficient practice placed residents at risk for being unsupervised, accidents, and injury.</p> <p>This failure resulted in the identification of an Immediate Jeopardy (IJ) on 4/8/2024 at 2:05 PM. While the immediacy was removed on 4/9/2024, the facility remained out of compliance at a severity level of potential for more than minimal harm that was not an Immediate Jeopardy and a scope of isolated due to the facility's need to monitor the implementation of the plan of removal.</p> <p>The findings included:</p> <p>Record review of Resident #3's admission record, dated 03/09/2024, reflected an [AGE] year-old resident with an admitted [DATE], and diagnoses of Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors) and dementia (group of thinking and social symptoms that interferes with daily functioning).</p> <p>Record review of Resident #3's Annual MDS, dated [DATE], reflected Resident #3 had not exhibited behaviors of wandering, and that the residents BIMS score was a 4, indicating the resident was severely cognitively impaired.</p> <p>Record review of Resident #3's Wandering Risk Assessment History of Outcomes, dated 03/09/2024, reflected that Resident #3 had consistently scored in the category of being a Moderate Risk of wandering on Resident #3's Wandering Risk Assessments completed on the following dates: 11/26/2020, 03/11/2021, 03/11/2022, 03/10/2023, 06/13/2023, 09/18/2023, 12/19/2023, and 03/07/2024.</p> <p>Record review of Resident #3's Comprehensive Person-Centered Care Plan, dated 03/09/2024, reflected Resident loves to wander around facility with/without purpose d/t her cognitive impairment and 3/7/24 Resident to utilize wander guard with interventions that included if wandering increases and place resident at risk for injury, or leaving facility, Notify MD, RP, ADMIN, DON, SS and assess, discuss possible need for secure unit.</p> <p>In an interview on 03/09/2024 at 4:03 PM, [NAME] C stated that she was taking a break in the smoking area outside when she heard banging and the alarm going off at the fire exit door. [NAME] C stated that when she looked up after a while, she noticed Resident #3 was standing next to her. [NAME] C stated that at this point, the Maintenance Director came over and proceeded to redirect the resident, and that the alarm had been going off for probably 3 or 4 minutes before she or the Maintenance Director noticed. [NAME] C then went on to state they had not had an elopement training at this facility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on 03/09/2024 at 4:12 PM, Maintenance Director stated that while walking up to the facility building from his workshop, which was not connected to the main building of the facility he noticed Resident #3 was standing outside pushing her wheelchair and using it as a walker. The Maintenance Director stated that this is when he realized he heard the door alarm going off, he proceeded to help the resident sit back in her wheelchair and brought her back inside. The Maintenance Director then stated that he brought the resident to the nurses' station and asked the nurses if they heard the alarm, to which they responded no. The Maintenance Director stated that the alarm was easy to hear at the nurses' station, and he was not sure why the nurses did not respond to it. The maintenance director stated he believed the staff may have chosen to ignore the alarm, as it goes off at times while staff members take residents out for smoking break.</p> <p>In an interview on 03/09/2024 at 4:37 PM, CNA D stated that on the date Resident #3 walked out of the facility, she was providing a shower to a resident in a closed shower room down the 100 hallway and heard the alarm going off but did not feel comfortable leaving the resident alone in the shower room to respond to the alarm. CNA D stated that the alarm was loud and easy to hear, and it should be easily heard at the nurse's station. CNA D stated that Resident #3 walked around a lot, but that she has not observed exit seeking behavior from the resident.</p> <p>In an interview on 03/09/2024 at 4:40 PM, CNA E stated that while Resident #3 walked out of the facility, he was with a resident when he heard the alarm going off and was unable to respond to it. CNA E stated the alarm was loud, and you could hear it well from most common areas as it was near the dining room and nurse's station. CNA E stated that Resident #3 walked around a lot and they sometimes had to bring her wheelchair to her because she would walk to another area of the building without it. Otherwise, she has never seen her try to exit the facility. CNA E stated that usually someone was always near Resident #3, so they were able to help her if necessary.</p> <p>Observation on 03/09/2024 at 4:50 PM revealed Resident #3 resting in her bedroom wearing a wander guard.</p> <p>In an interview on 03/10/2024 at 11:06 AM, LVN F stated she was at the nurse's station when Resident #3 walked out of the door, looked at the doors in and out of the facility when the alarm went off until the maintenance director brought Resident #3 inside. LVN F stated she heard the alarm, and that Resident #3 had not tried to exit seek before but would walk around the facility a lot.</p> <p>In an interview on 03/10/2024 at 1:09 PM, the DON stated that the expectation was that if staff heard the door alarm, they need to investigate why the alarm went off. The DON stated they have not had an in-service training relating to elopement since the event. She then stated that RN I was unavailable for interview and that RN I would call as soon as she was available for an interview. The DON stated that they did not treat this as a true elopement. She stated they did not notify the physician or the resident's representative as the resident did not leave the property, and thus did not create an incident report. The DON stated a true elopement was when the resident leaves the property entirely. The DON stated they assessed the resident when she returned inside the facility, and this was when the wander guard was placed.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on 03/10/2024 at 1:18 PM, the Administrator stated that the expectation was that all staff who heard the door alarm were to respond to it and investigate as to why it went off. The administrator stated they did not treat this as a true elopement and did not notify the physician or the resident's representative as the resident did not get very far outside. The administrator stated there was no incident report made.</p> <p>In an interview on 03/10/2024 at 1:40 PM, RN I stated she was at the nurses' station when Resident #3 walked out of the door. RN I stated that she and LVN F were documenting in residents charts and realized they had been hearing a beeping. RN I stated this was when she began to look around for a moment and saw the maintenance director bring in Resident #3. RN I stated that she and LVN F were caught up in report and talking that by the time they realized the alarm was going off, the maintenance director was bringing Resident #3 back inside. RN I stated it was the expectation that when any beeping or any kind of alarm was going off you were to answer it.</p> <p>Record review of a policy titled, Elopement, undated, reflected Nursing personnel must report and investigate all reports of missing residents.</p> <p>This was determined to be an Immediate Jeopardy (IJ) on 4/8/2024 at 2:05 PM The facility Administrator and the DON were notified. The Administrator was provided with the IJ template on 4/8/2024 at 2:05 PM.</p> <p>The following Plan of Removal submitted by the facility was accepted on [4/9/2024 at 5:09 PM ]:</p> <p>Plan of Removal Guidelines</p> <p>Events Leading to the Alleged Deficient Practice:</p> <p>On 04/08/2024, Surveyor entered the facility to change an IJ issued on 3/22/24 to a current IJ. IJ was called at 2:05pm for the following as quoted on the IJ template:</p> <p>F689</p> <p>The facility failed to ensure Resident #3 was as free of accident hazards as was possible and received adequate supervision to prevent accidents in that Resident #3 walked out of the facility through an alarming door without staff responding.</p> <p>The alleged failure is as follows (summary format, bullet points)</p> <ol style="list-style-type: none"> <li>1. Staff failed to respond to a door alarm when a resident was exiting out the door.</li> </ol> <p>The Medical Director, was notified at 2:20pm on 4/8/2024. No additional instructions or plans obtained. Facilities response was discussed. Medical Director was notified of the incident regarding Resident#3 on March 9th, 2024.</p> <p>What action was taken for the staff directly involved in the failure? Staff will be educated/trained on door alarm response.</p> <p>Alleged Failure #1 - Staff failed to respond to a door alarm that was activated by a resident.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In-servicing/education provided in response (bullet point narrative):</p> <ul style="list-style-type: none"> <li>- Start/stop time and date:</li> <li>- On 3/11/2024 at 9:00am education began for all staff in regards to responding to a door alarm.</li> <li>- What will you do for staff not present?</li> <li>o Staff that aren't present will be in-serviced before the start of their next regularly scheduled shift</li> <li>- What will you do with newly hired staff?</li> <li>o The education/in-service for Door Alarm Response will be included in the new hire process for all staff.</li> <li>- Who did the education/in-servicing?</li> <li>o The education will be completed by Administrator.</li> <li>- What time did the education/in-servicing complete?</li> <li>o All the education on this topic was completed by 3/22/2024.</li> </ul> <p>How will you monitor for effectiveness of the Plan of Removal?</p> <ul style="list-style-type: none"> <li>- Administrator will randomly perform door alarm testing for staff response.</li> <li>o Start date March 11, 2024, Weekly on various shifts for 6 weeks, ending April 20th, 2024.</li> </ul> <p>What will be the procedure in the event the door alarm is activated?</p> <ul style="list-style-type: none"> <li>o Staff will respond by going to the door in which the alarm is activated.</li> </ul> <p>Who will be the point of contact to report door alarm activity.</p> <ul style="list-style-type: none"> <li>o The staff member(s) that respond to the alarmed door and they will notify the Administrator or the Director of Nursing.</li> </ul> <p>Verification of Plan:</p> <p>Observations:</p> <p>Observations on 3/22/2024 at 3:30 PM and 5:09 PM revealed no door alarms were sounding and no residents were outside in front or side of the building.</p> <p>Observations on 4/8/2024 at 1 PM revealed no door alarms were sounding and no residents were outside in front or side of the building.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Observations on 4/9/2024 at 9 AM revealed no door alarms were sounding and no residents were outside in front or side of the building.</p> <p>Observation on 4/9/2024 at 10:51 AM revealed a mock door alarm was opened in the dining area by the Administrator and 5 staff immediately responded and went towards the door.</p> <p>Records:</p> <p>Resident #3 was discharged on [DATE] to a facility with a secure unit. Record review of Resident #3's consolidated physician orders and care plan for wander guard was dated 3/7/2024.</p> <p>In-service sheets with staff signature. In service dated 3/11/2024 Door Alarm Response, Elopement (nursing personnel must report and investigate all reports of missing residents).</p> <p>Record review of In-services signed by staff:</p> <p>73 out of 74 of their staff were in-serviced. (part-time and full time). One staff person was out on FMLA and when they return to work, they will be in-serviced.</p> <p>8 out of 11 therapy staff have been in-serviced. The other 3 staff had not been to work.</p> <p>5 out of 6 agency staff that had worked had been in-serviced. One agency staff that normally worked has not been into work.</p> <p>Staff interviews:</p> <p>Interview on 4/9/2024 at 4:07 PM with MD stated the facility did notify her of the current IJ and when Resident #3 had left out a door in the facility. MD stated she was not sure why it was a an IJ. MD she had nothing else to say.</p> <p>Interviewed a total of 18 out of 74 regular staff.</p> <p>Interviewed all 3 shifts, including 2 CMA, 7 CNA's, 4 LVNS, 1 RN, 2 dietary aide, 1 housekeeper, and 1 staffing coordinator, 3 therapy staff, and 2 agency staff.</p> <p>Interviewed a total of 23 staff on all 3 shifts, prn, weekends, therapy, and agency staff that have been on the schedule since 3/7/ 2024.</p> <p>In an interview on 3/22/2024 at 5:28 PM with CNA A (6-2 PM, 2-10 PM) he stated he was in-serviced on door alarms, immediate check if alarm doors sounded, and make sure residents were not trying to go out. If resident does go out, staff were to bring back the resident. Staff were to guide the resident back safely and notify the Administrator or charge nurse.</p> <p>In an interview on 3/22/2024 at 5:34 PM with dietary aide B (6-2 PM) stated she was in-serviced on the door alarm and if a resident leaves the facility via the door. Dietary aide B stated if she heard the alarm sound, she would go check the door, and look to see if the resident left the facility. Dietary aide B stated she would bring the resident back in the facility and notify the nurse or DON.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on 3/22/2024 at 5:36 PM with housekeeper C (3-8 PM, prn) stated she was in-serviced when she started her shift at the facility. Housekeeper C stated the in-service was about making sure no residents go out the door and they did a demonstration of the process. She was to notify the DON/nurse/manager of any residents leaving through the doors.</p> <p>In an interview on 3/22/2022 at 5:43 PM with RN D (6-2 PM) stated she did receive the in-service for checking the door if it alarms, immediately go see if a resident was nearby or had left the facility. If they did see a resident, bring back the resident inside the SNF and notify the Administrator. The nurses have a daily reminder to check for residents that were trying to go out the door.</p> <p>In an interview on 3/22/2022 at 5:47 PM with LVN E (2-10 PM) he stated he had been in-serviced on checking the door alarm if a resident had gone out, go over to resident, and re-direct the resident if the resident did not want to come into the facility. LVN E stated he would notify the Administrator, RP, and MD and document event.</p> <p>In an interview on 3/22/2022 at 6 PM with CNA F (2-10 PM) she stated she was in-serviced on if an alarm door sounds, she will go see which door it was, see if resident had gone out of the facility, and bring them back in the facility. CNA F stated if the resident did not want to come back in, CAN F would re-direct the resident back inside, stay with the resident to make sure they don't go back outside, and notify the nurse.</p> <p>In an interview on 3/22/2022 at 6:06 PM with CMA G (2-10PM) she stated she was in-serviced on the door alarm. If she heard the alarm, she would locate the door, and see if a resident went outside. If she did see that a resident was outside, or near the door, she would re-direct the resident back inside into a safe place. CMA G stated she would notify the nurse.</p> <p>In an interview on 3/22/2022 at 6:09 PM with LVN H (agency) (6-2 PM, 2-10 PM) she stated she was in-serviced when she first started her shift on the door alarms. LVN H stated she would go see where the sound was coming from, she would immediately see if resident went out, and if a resident did re-direct them. LVN H stated she would assess the resident for an injury, if no injury re-direct them back to the SNF. If the resident had an injury, she would call 911, notify the charge nurse that resident left out the door and document.</p> <p>In an interview on 3/22/2022 at 6:16 PM with CNA I (2-10 PM) she stated she was in-serviced on the door alarm, if it alarms, she would walk towards the door to see if the resident went outside or not. If the resident did bring them back in, give them something to eat or drink and notify the nurse.</p> <p>In an interview on 3/22/2022 at 6:20 PM with MA J (2-10 PM) she stated she was in-serviced on the door alarm. MA J stated if she heard the door alarm, go see if resident went outside, and if so bring them back in. If resident refused, let the nurse know and stay with resident.</p> <p>In an interview on 3/22/2022 at 6:34 PM with CNA K (2-10 PM) he stated he was in-serviced on the door alarm. CNA K stated he would go outside immediately to door that was alarming, to see if the resident went outside. If the resident did go outside, he would bring the resident back inside. He would make sure the resident was safe and notify the nurse.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on 3/22/2022 at 6:37 PM with HR coordinator L (8-5 PM) she stated she was in-serviced on door alarms. If a door alarm were heard she would go towards the door, to see if the resident went outside the facility. If the resident did go outside the facility, she would bring them back, and notify the nurse and/or the DON/Administrator.</p> <p>In an interview on 3/22/2022 at 7:30 PM with LVN M (2-10 PM) she stated she was in-serviced for door alarms. LVN M would immediately go to door to see if the resident was outside, bring the resident back in, she would notify the Administrator, the MD/family, and document.</p> <p>In an interview on 3/22/2022 at 7:31 PM with Staffing Coordinator N (8:30-5:30 PM) she stated she was in-serviced on door alarms, exit doors alarms (15 minutes egress alarm), and to go to door to see if resident was outside of the door. If resident was outside, go out immediately and secure the resident, bring the resident back in, and notify the DON.</p> <p>In an interview on 3/22/2022 at 7:35 PM with ADON O (7-4 PM) she stated she had an in-service training on door alarms. Staff should get up immediately if they heard the alarm and make sure all the residents were in the building. Check to see if a resident got out, then bring the resident back, re-direct the resident, staff stay out there with the resident, notify Administrator, the nurse, family, the DON, the ADON, the STATE, and the MD.</p> <p>In an interview on 3/22/2022 at 7:39 PM with CNA P (10-6 AM) she stated she was in-serviced on the door alarms. CNA P was to check all exit doors and secure the doors and make sure no residents were outside. If a resident was outside, bring them back in and notify the nurse.</p> <p>In an interview on 3/22/2022 at 7:41PM with CNA Q (10-6 AM) he stated he had training on the door alarms. To make sure residents did not get out of the building, re-direct into building, keep the resident safe, and notify the nurse and management.</p> <p>In an interview on 4/9/2024 at 11:41 AM with LVN R (6-2pm, prn) she stated she worked as needed at the facility. LVN R stated she had training on the door alarm and stated he would go to door and make sure a resident did not exit. LVN R stated all staff should check where the alarm was sounding and watch the exit doors. LVN R stated she would to make sure resident does not go out, and, if resident was outside, she would bring the resident back inside the facility. LVN R stated she would notify the chain of command, the Administrator, DON, family, charge nurse and document.</p> <p>In an interview on 4/9/2024 at 11:51 AM with CNA S (6-2 PM) stated she was in-serviced on the door alarms. CNA S stated she would see which door it was and look to see if a resident went outside. CNA S stated if resident went outside, she would go outside with resident and would bring them back into the facility. CNA S would notify the nurse and the Administer/DON.</p> <p>Interview on 4/9/2024 at 12:06 PM with CNA T (agency) (6-2 Pm, 2-10 PM) stated she was in serviced when she started work on the floor on door alarms. CNA T stated she would go to door that was alarming, see if resident were near the door or outside. CAN T stated if she saw a resident outside, she would bring them back to their room, and notify the nurse.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675452	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/09/2024
NAME OF PROVIDER OR SUPPLIER  Rosewood Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  7700 Mesquite Pass Converse, TX 78109	

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on 4/9/2024 at 5:01 PM with the DON/Administrator stated the expectations for the door alarms were if it should sound all staff were responsible for immediately going to the door that was alarming. If staff were busy with resident care, there were other staff in the building that could respond to the alarm from the exit doors. When the door alarms alarm, the staff should notify the DON/Administrator about why the door alarm was sounding and what they did. They stated they would notify the resident physician and family if a resident was to elope. The Admin/DON stated they were responsible for ensuring staff were educated/trained on door alarms and ensuring residents were safe. The DON stated the risk of if a resident eloped would be that they would get hurt. The Administrator provided a copy of the Random Door Alarm testing LOG.</p> <p>In an interview on 4/9/2024 at 4:40 PM with the Administrator she stated, education was started for staff on 3/11/2024 responding to the door alarm. The Administrator/DON stated as staff were hired and work on the floor, she would educate the staff and the new hire process would include the door alarm response education/training. The Administrator stated she had a door alarm record log that she kept for the random door alarm checks on staff. The Administrator stated when the door alarm sounds, staff were to go to the door that was sounding off. She stated the egress exits doors have a 15 second delay. The staff were educated on making the response to the door alarm urgent and immediately. The Administrator stated any staff should go to door that was alarming and all staff must respond unless caring for a resident. The Administrator stated all staff were to notify the Administrator/DON if a false alarm or why the alarm sounded and what they did. The Administrator stated she would provide oversight to her staff in regard to the door alarms and responses. The Administrator and the DON were in charge of the training /education of staff. If not here the point of contact was the charge nurse, then the charge nurse would notify the Administrator/DON. The Medical Director would be contacted if the resident was harmed or impacted. The Administrator stated she notified the Medical Director of the IJ.</p> <p>The Administrator was informed the Immediate Jeopardy was removed on 4/9/2024 at 5:09 PM. The facility remained out of compliance at a severity level of potential for more than minimal harm that was not Immediate Jeopardy and a scope of isolated due to the facility's need to monitor the implementation of the plan of removal.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>47564</p> <p>Based on observations, interviews, and record reviews the facility failed to store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys, for 1 of 2 medication cart s (Medication Cart 4), reviewed for security, in that,</p> <p>A medication cart was unattended and unlocked.</p> <p>This failure placed residents at risk for harm by misappropriation of property and not receiving the therapeutic effects of their medications.</p> <p>The findings included:</p> <p>During an observation on 03/09/2024 at 12:13 PM, it was revealed that the medication cart assigned to LVN A was unattended and unlocked. The medication cart was observed to have the lock button unengaged and unlocked.</p> <p>During an interview on 03/09/2024 at 12:18 PM, LVN A stated she was assigned to the medication cart. LVN A stated she had only been gone for a few minutes and was getting something for a resident's family member. LVN A stated that the medication cart should have been locked.</p> <p>During an interview on 03/09/2024 at 01:06 PM, RN B stated that she was the RN Supervisor at the facility this weekend and that it was the expectation for medication carts to be locked if they are unattended . She further stated that she ensures medication carts are locked by observing them on the floor. RN B stated the risk to residents could include residents getting in to medication carts and taking medication that was not theirs.</p> <p>During an interview on 03/09/2024 at 2:01 PM, the DON stated her expectations were for all nursing staff who have control of medications, secure the medications and to lock medication carts when left unattended. The DON stated the risk for harm to residents were varied and could include residents getting into the medication cart and taking medications out of it.</p> <p>A record review of the facility's undated Storage of Medications policy revealed, Procedure: . Compartments containing medications are locked when not in use. Trays or carts used to transport such items are not left unattended. (Compartments include, but are not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.)</p>		