STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675452	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosewood Rehabilitation and Care Center	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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42402 Based on interviews and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that were complete and accurately documented for 1 of 6 residents (Resident #1) reviewed for accuracy of medical records. The facility failed to ensure Resident #1 had physician orders for crushed medications on the electronic medication administration record (EMAR). This deficient practice could affect residents whose records were maintained by the facility and could place them at risk for errors in care and treatment. The findings included: Record review of Resident #1's face sheet, and Health Record information revealed an admitted [DATE] with diagnosis to include Alzheimer's disease. Record review of Resident #1's initial MDS dated [DATE] revealed a BIMS score of 00/15 which indicated unable to perform due to cognitive status. Record review of Resident #1's care plan dated 5/17/24 revealed needs anticipated by the staff. Required total assistance with activities of daily living. Record review of Resident #1's physician orders provided by hospice dated 5/17/2024, revealed order for Medication pass: crush medications. Record review of Resident #1's EMAR dated 5/17/2024- 5/18/2024 showed no order for medications to be crushed . During an interview on 5/21/2024 at FM of Resident #1 stated he required his medications to be crushed as he had difficulty in swallowing pills. She further revealed she had informed a staff member at the facility. She could not remember the name of the staff member. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/21/2024 at 2:45 pm LVN B stated she assisted LVN A with admission paperwork for Resident #1 and LVN C placed Resident #1's physician orders in his EMAR. She further revealed Hospice Nurse E informed her that Resident #1 required his medications to be crushed. She stated there should have been an order placed in the EMAR so that the staff would know to crush Resident #1's medications. She further revealed it was the practice of the facility to place a separate order in the EMAR for medications to be crushed if the physician orders indicated that . LVN B stated it was the responsibility of the primary nurse to make sure physician orders were properly placed in the computer. She further revealed Resident #1 could potentially choke if his medications were not crushed. During a telephone interview on 5/22/2024 at 9:16 am LVN A stated she was the charge nurse on 5/18/2024 for Resident #1 when she was asked by Agency CMA if his medications were crushed before administering them. LVN A stated she learned from Resident #1's FM (Family Member) that he could not swallow pills without them being crushed . During an interview on 5/22/2024 at 10:31 am LVN C stated he entered the medication orders for Resident #1 in the EMAR on 5/17/2024. He further revealed he did not place a separate order saying to crush medications for Resident #1 . LVN C stated I thought I checked all of the boxes. He further revealed if a resident has an order to crush medications then they should have them crushed so that they did not choke. During a telephone interview on 5/22/24 at 10:05 am Agency CMA D stated she was working 5/18/2024 on the 2-10 pm shift and Resident #1's FM asked her to give him a pain medication. She stated she obtained a Hydrocodone-Acetaminophen tablet to give to Resident #1. She stated the daughter stopped her and said you need to crush the pill he cannot swallow it whole. She stated there was no indication on Resident #1's EMAR to crush the medications before giving them. She said she then went to ask LVN A if Resident #1 needed his medications crushed and an order was found in his EMR. She further revealed normally there [NAME] an order on any other residents EMAR that says to crush medications so that she knows to crush the medications. She stated she did not know why there was no order for medications to be crushed on Resident 1's EMAR . Agency CMA D further revealed residents can choke if they need their medications crushed and they are not. During an interview on 5/22/2024 at 10:22 am the facility DON stated when a resident's medication [NAME] to be crushed, put in another order, and have it trigger to the resident's electronic medication record so that the staff know to crush medications . She further revealed the admitting nurse should check physician order entries and make sure they are correct. If physician orders are not followed a resident can be at risk for harm. Record review of the facility's undated policy titled Administering medication-oral: To ensure that medications [NAME] administered within the restrictions of employee licensure and per regulation and best practice in the industry. Section 5: Follow the SIX Rights of medication administration. Right Patient, Right Drug, Right Dose, Right Route, Right Time, Right Documentation. Assessments: 1. Check medication card or MAR against physician's orders or medication Kardex.