

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 07/27/2024
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 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48753</p> <p>Based on interview and record review the facility personnel failed to provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives for 1 of 6 residents (Resident #1) whose records were reviewed for code status.</p> <p>The facility failed to ensure nursing staff followed emergency protocol and failed to ensure staff provided Resident #1, who had a Full Code in place, CPR, after the resident was found unresponsive with no pulse or respirations, according to professional standards of practice.</p> <p>On [DATE] at 4:51 p.m., and Immediate Jeopardy (IJ) was identified. While the IJ was removed on [DATE] at 4:05 p.m., the facility remained out of compliance due to the facility continuing to monitor the implementation and effectiveness of its Plan of Removal (POR).</p> <p>This failure could place residents at risk of not receiving life-saving measures, decline in health resulting in serious injury and or death.</p> <p>The findings included:</p> <p>Record review of Resident #1's face sheet, dated [DATE], reflected she was an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses to include cerebral infarction (a disruption in the brain's blood flow), dysphagia (inability to speak), hyperlipidemia (high fat levels in the blood) and malignant neoplasm of the colon (tumor). Resident #1's face sheet listed her as a full code.</p> <p>Record review of Resident #1's Quarterly MDS assessment dated [DATE] reflected her BIMS score was 11 indicating moderate cognitive impairment and was usually able to understand others and be understood by others. She required substantial assistance for ADL's. The MDS did not reflect the code status.</p> <p>(continued on next page)</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
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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's care plan, dated [DATE], reflected Resident/Family are requesting full code status. The goal stated resident/family wishes will be honored through next review and CPR will be initiated as needed through next review. The goal had a date initiated [DATE], revision date [DATE] and target date [DATE]. The care plan interventions included: activate EMS as indicated, if transferred out of the facility notify receiving facility and EMS of full code, initiate CPR as indicated, mark chart per facility policy, observe for changes in condition and notify MDs and RP, resident is a full code, observe for change when assisting with care and notify the nurse, review code status with resident/family quarterly and prn. Interventions had an initiation date of [DATE].</p> <p>Record review of Resident #1's admission notes, created by the DON on [DATE] with an effective date of [DATE], reflected Resident #1 was a full code resident and stated resident/family reports code status as full code.</p> <p>Record review of Resident #1's active physician orders for [DATE] reflected she had an order for full code with original date [DATE]. In addition, Resident #1's orders reflected an order to admit to hospice with original date [DATE].</p> <p>Record review of Resident #1's Social Service admission assessment dated [DATE] stated Resident #1 was a full code status and did not have and out of hospital do not resuscitate form, advanced directives or a medical/financial power of attorney. The assessment reflected resident rights were explained to Resident #1.</p> <p>Record review of Resident #1's Social Service quarterly assessment, dated [DATE], reflected Resident #1 was a full code and did not have an out of hospital do not resuscitate form.</p> <p>Record review of Resident #1's [DATE] MAR reflected Advanced Directive: Full Code listed on the top of each page of Resident #1's MAR.</p> <p>Record review of Resident #1's EMR profile reflected Code Status: Full Code listed at top of the profile page directly under resident name, status, physician, and allergies.</p> <p>Record review of Resident #1's paper chart reflected a yellow binder with a green sheet in the front of the chart that stated, Full Code and a copy of Resident #1's face sheet that stated full code.</p> <p>Record review of Resident #1's progress note, dated [DATE] at 10:02 p.m., authored by LVN A read as follows was called to resident room. No breathes assess. No pulse. Call out to [hospice company name]. Awaiting call back. DON informed.</p> <p>Record review of Resident #1's progress note, dated [DATE] at 10:40 p.m., authored by LVN A read as follows upon retrieving residents face sheet out of resident chart, this nurse realized that resident was a full code. Contacted [hospice company name] in regard to code status. They stated they thought she was a DNR and was looking through their paperwork and stated to wait until hospice RN arrived at facility. [10:46 p.m.] Contacted DON in reference to code status. While on phone with DON, [hospice company name] nurse [name]RN entered facility and was informed of code status. She stated she would need to contact her supervisor to see what needed to be done. Hospice Nurse [name] then called 911 per directions of her supervisor and EMS came to the facility. Initiated life saving measures and resident was then pronounced deceased at 12:01 a.mXXX[DATE].</p> <p>(continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 4:54 p.m., the Hospice Executive Director revealed the Hospice Triage RN received a call from LVN A at 10:06 p.m. on [DATE] and was told there was a patient death at the facility. Hospice triage RN told LVN A that an RN would be headed to the facility as soon as she finished another case. The Hospice Executive Director stated the Hospice RN arrived at the facility at 10:58 p.m., spoke to LVN A who was on the phone with the Hospice Triage RN again, and said LVN A told them the patient was a full code, and she did not start CPR and did not know what to do. The Hospice Executive Director said the Hospice RN spoke to the DON who stated she was twenty minutes away and did not know what to do. The Hospice RN called 911 at 11:10 p.m. and then called and reported the incident to the Hospice Executive Director at 11:17 p.m. The Executive Director stated Resident #1 admitted to hospice services on [DATE] and was a full code status from the time of admission. The Hospice Executive Director stated a full code status means a resident should be resuscitated.</p> <p>During an interview, [DATE] at 4:48 p.m., the Law Enforcement Officer stated the police department received a call regarding a deceased female around 11:30 p.m. on [DATE]. The Officer stated when he arrived, he was told by EMS staff that the facility nurse said she thought Resident #1 was a DNR and did not initiate CPR since she was on hospice. The Officer stated the Hospice RN and EMS said no one had initiated CPR at the facility for Resident #1 until the EMS personnel arrived around 11:30 p.m. The Officer stated he was notified by a staff member, Resident #1 had been checked on around 9 p.m. prior to being found unresponsive at 10 p.m. on [DATE].</p> <p>During an interview, [DATE] at 5:36 p.m., the Hospice RN revealed she received a text from the Hospice Triage RN stating there was a death at this facility. The Hospice RN stated she finished providing care to another patient and then arrived at this facility at 10:58 p.m. on [DATE]. When she arrived, she stated LVN A was on the phone and very distraught and said, I didn't realize the patient was a full code and I called your office again to find out what to do. Hospice RN said she asked LVN A what the facility protocol was, and LVN A said she did not know and the DON was on the way. LVN A called the DON and Hospice RN spoke to the DON and asked her what the protocol was when this happens and Hospice RN said the DON said, I am not sure. The Hospice RN said she told the DON, I am not comfortable with this and I am calling EMS, and the DON said ok. Hospice RN said she called EMS and notified them of the situation and that Resident #1 had been passed away for over an hour. Hospice RN stated EMS arrived at the facility at 11:23 p.m., ran a lead (refers to the process of attaching and monitoring electrocardiogram leads on a patient) on Resident #1 at 11:29 p.m. The result revealed the patient was deceased. Hospice RN stated EMS called their EMS command and were instructed to initiate CPR. Hospice RN said EMS performed CPR for 31 minutes and then the EMS physician pronounced Resident #1 deceased at 12:01 a.m. on [DATE]. Hospice RN stated hospice records reflect Resident #1 was a full code and Resident #1 was listed as a full code at the facility and had a yellow binder with a green sheet in the front indicating Resident #1 was a full code. Hospice RN stated the facility should have initiated CPR for Resident #1.</p> <p>(continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview, [DATE] at 11:49 a.m., CNA D revealed she had checked on Resident #1 around 9:35 p. m. and Resident #1 was lying in bed and CNA D said, she looked ok, and I made sure she was clean and dry. CNA D said she made a final round at 10:00 p.m. and when she entered Resident #1's room, CNA D observed blackish brown liquid emesis on Resident #1's chest and CNA D said Resident #1 looked like she was gone. CNA D stated she yelled for LVN A to come to the room and when LVN A entered the room CNA D said, I gave LVN A space to check on her and I stepped out of the room. CNA D said she did not recall how long LVN A was in the room but said LVN A exited the room and said, she's gone. CNA D said she was aware Resident #1 was a full code and said a resident's code status is located in the EMR chart. CNA D was asked if anyone performed CPR and she said I don't know if anyone did, I went to get items to clean her up. All I know is I was told she was gone and that's it. When asked if she had received any training on code status or been contacted by leadership to discuss the incident she responded no. CNA D said full code status meant that a resident should get CPR if unresponsive.</p> <p>During an interview, [DATE] at 12:12 p.m., the Hospice Triage RN stated she received a call from the answering service at 10:02 p.m. on [DATE] and was notified to contact LVN A. The Hospice Triage RN called LVN A at 10:04 p.m. and LVN A said a resident on hospice services passed away. She said the conversation was very brief and they did not discuss code status because the Hospice Triage Nurse said, we would send a nurse out regardless of code status, so the facility is responsible for following their protocol for code status, and LVN A did not mention code status or CPR. The Hospice Triage RN notified the Hospice RN and the Hospice RN she would go to the facility as soon as she finished care with another patient. The Hospice Triage RN revealed another call came in around 10:48 p.m. to the answering service. The Hospice Triage RN said she called the facility back and spoke to LVN A at 10:55 p.m., at which time, LVN A told the Hospice Triage RN that Resident #1 was a full code, and she did not start CPR or call EMS. The Hospice Triage RN said she told LVN A she needed to follow facility protocol and LVN A said the Hospice RN had arrived and hung up the phone. The Hospice Triage RN revealed that Hospice RN called her at 10:59 p.m. and said Resident #1 was a full code and the Hospice Triage RN said she told her to hang up and call 911 and notify the Hospice Director of the incident and that the facility did not follow their protocol. When asked what a licensed nurse should do if they find a hospice patient unresponsive, the Hospice Triage RN said they should follow their facility protocol for responding to DNR and full code status and stated a full code resident should receive full resuscitation.</p> <p>Record review of the facility active staff roster, dated [DATE], reflected LVN A's name, position, status, hire date and phone number were not listed.</p> <p>During an interview, [DATE] at 12:25 p.m., the Administrator was asked by the surveyor why LVN A's name was not listed on the employee roster. The Administrator stated, that is because she was terminated. The Administrator stated LVN A was terminated on [DATE] and provided the surveyor LVN A's phone number.</p> <p>(continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 12:44 p.m., the DON revealed she received a call around 10 p.m. on [DATE] from LVN A who notified her that Resident #1 was deceased , and hospice was on the way to pronounce Resident #1. The DON stated she received another call from LVN A approximately 40 minutes later and LVN A said, I made a mistake. The DON said she asked LVN A what she meant and LVN A revealed Resident #1 was a full code and then hung up the phone stating the Hospice RN had arrived. The DON said she left her home to go to the facility and when she arrived, EMTs were performing CPR on Resident #1 and pronounced her deceased at 12:01 a.m. on [DATE]. The DON stated no one performed CPR for Resident #1 from 10:02 p.m. until the EMT's arrive and started CPR at 11:30 p.m. The DON was asked what the facility protocol was for finding a resident unresponsive and the DON stated the nurse should verify the resident code status, go to the room and assess the resident, and initiate CPR if the resident is a full code, and instruct another person to call 911. When asked if LVN A checked Resident #1's code status at the time she was found unresponsive, the DON said LVN A reported she did not check Resident #1's EMR or chart for the correct code status. The DON stated the resident code status is listed on the resident profile in the EMR, on the face sheet, MAR/TAR, care plan and in the paper binder labeled with a red or green sheet as a code status identifier. When asked why it is important for staff to adhere to a resident's code status preference, the DON stated, because the resident has the right to choose whether we perform CPR or not. The DON was asked about prior code status training for the licensed nurses, and she stated the licensed nurses had received training in February 2024 on code status, how to respond to a code, where to find code status in resident charts and where to input the order so it populates throughout the EMR. The DON stated she suspended LVN A after the incident on [DATE] and terminated LVN A's employment on [DATE] for not performing CPR on a full code resident. The DON was asked if the facility completed an investigation or gathered statements of the incident and the DON said no.</p> <p>Record review of facility document titled Employee Disciplinary Action Form, dated [DATE], reflected LVN A was terminated on [DATE] for failure to follow facility policy regarding code status and to provide full code response for a resident that was found unresponsive. The document was signed by the DON and Administrator. The document stated LVN A refused to sign.</p> <p>Record review of LVN A's CPR certification reflected LVN A had successfully completed the requirements in accordance with American Health Care Academy's curriculum for the course, Healthcare Provider CPR/AED: Adult, Child, Infant and First Aide (BLS). The certification was completed [DATE] and valid until [DATE].</p> <p>Record review of an in-service training attendance roster, dated [DATE], reflected the topic of the in-services was patient code status and how to enter a code in the EMR. The in-service also included a document that stated every resident's code status is located in the EMR toward the top of the screen under allergies and provided visual references of the EMR. The in-service was signed by LVN A.</p> <p>Record review of facility document titled Cardiopulmonary Resuscitation (CPR), undated, listed steps for licensed nurses that included 1. Determine unresponsiveness by tapping or gently shaking resident and shouting are you ok? If you suspect a neck or spinal injury, do not shake the resident. 2. If the resident does not respond, call out for help. 3. Delegate a specific individual to check the resident's orders and care plan for CPR or no CPR order, have individual call paramedics, attending physician and administrative personnel per facility procedure and report back to you as soon as possible. 4. Do not start cardiopulmonary resuscitation (CPR) if the resident is breathing and has a pulse. 5. Place the resident on his or her back, supporting head and neck, on a hard surface. Perform CPR if the resident is unresponsive and not breathing or no normal breathing (i.e., only gasping).</p> <p>(continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>This was determined to be an Immediate Jeopardy (IJ) on [DATE] at 4:51 p.m. The Administrator was notified at 4:51 p.m. and was provided with the IJ template on [DATE].</p> <p>During an interview, [DATE] at 6:15 p.m., LVN A verified she was the charge nurse for Resident #1 on [DATE]. LVN A said the last time she observed Resident #1 was around 8 p.m. when she administered a medication and said Resident #1 spoke to her and her vitals were within normal limits. LVN A said CNA D came to her at 10 p.m. and said she needed to go check on Resident #1 and CNA D said she did not think Resident #1 was breathing. LVN A said she entered the room and observed the patient with no pulse and no breath. LVN A said she thought Resident #1 was a DNR and did not go and check her code status. LVN A said she called the DON and hospice and proceeded with doing an end of shift report. LVN A said about 40 minutes later, she went to Resident #1 chart to document and realized Resident #1 was a full code and that I never started CPR. LVN A said she called hospice and was told to wait for the RN to arrive. LVN A said the Hospice RN arrived and LVN A told her what happened, and Hospice RN called 911. LVN A said she called the DON again and was informed that the DON was on her way to the facility. LVN A said, I don't know why I did not do anything, when I realized it, it was too late. LVN A was asked what the facility protocol was for finding a resident unresponsive and/or without a pulse and she said, we are supposed to look at the chart and the computer to verify code status. LVN A said she received training on code status around February or March. LVN A was asked what the facility protocol was if a resident is found unresponsive and is a full code and she said I should of verified the code status and I should have started CPR but it had already been 40 minutes by that time. I was pulling out her face sheet to make a copy and that is when I noticed the error I made LVN A stated she was CPR certified and just renewed my certification last week. LVN A said she was suspended on [DATE] and quit on [DATE]. LVN A stated she was aware that a patient can be on hospice and be a full code.</p> <p>The following Plan of Removal (POR) was accepted on [DATE] at 12:20 p.m. and indicated the following:</p> <p>Events Leading to the Alleged Deficient Practice (narrative format):</p> <p>On [DATE], State Surveyor entered [Facility name] at 8:22am on a Complaint investigation. IJ was called at 4:51pm for the following as quoted on the IJ template:</p> <p>F678 Quality of Life</p> <p>The facility failed to provide a full code resident (Resident #1) with CPR when resident was observed without a pulse from 10:02pm till EMS arrived at 11:23pm.</p> <p>The alleged failure is as follows (summary format, bullet points)</p> <ol style="list-style-type: none"> 1. Failed to initiate Full Code procedures timely when Nurse found resident unresponsive. <p>The Medical Director, [Physician name] was notified at 12:02pm on [DATE]. No additional instructions or plans obtained. Facilities response was discussed.</p> <p>What action was taken for the staff directly involved in the failure? Nurse was terminated.</p> <p>(continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Staff will be educated/trained in regard to Resident Code Status and Hospice Services and initiating CPR timely for resident who are a Full Code. A 100% audit of Resident Code Status for all residents was completed by [name], Director of Nursing in which Code status on Resident Face Sheet was verified by order for code status and if code status is a DNR the executed OOHNR document was verified in Miscellaneous section in [EMR name] and copy verified in Resident hard chart. An audit will be completed monthly by the Director of Nursing.</p> <p>Alleged Failure #1 - Failed to follow facility policy regarding code status and initiate CPR/Full Code procedures timely when resident was found unresponsive.</p> <p>In-servicing/education provided in response (bullet point narrative):</p> <p>Start/stop time and date:</p> <p>On [DATE] at 12:30pm education began for Nurses (LVN and RN) staff in regards to Resident Code Status and Hospice Services and initiating CPR timely for resident who are a Full Code.</p> <p>Education Code Status and Hospice: Hospice residents can elect to be a Full Code.</p> <p>Resident with no pulse or respirations: Nurse will check code status in, [EMR name] call the Code Blue, initiate CPR and have another staff call 911. Flow chart of How to respond when a resident has no pulse or is unresponsive is posted at the nurses station as a reminder.</p> <p>When to provide CPR. When resident has no pulse or no respirations, Nurses are to check code status in [EMR name] which will determine how to respond appropriately.</p> <p>What will you do for staff not present?</p> <p>Nurses that aren't present will be in-serviced before the start of their next regularly scheduled shift</p> <p>What will you do with newly hired staff?</p> <p>The education/in-service of facility policy regarding Code Status and Hospice Services and initiating CPR timely for resident who are a Full Code.</p> <p>Who did the education/in-servicing?</p> <p>The education will be completed by [name] Director of Nursing</p> <p>What time did the education/in-servicing complete?</p> <p>All the education on this topic will be complete [DATE] by 5:00pm for Nurse staff present.</p> <p>A 4 question post-test will be given to verify retention of knowledge related Hospice Services and Code Status and initiating CPR timely for resident who are a Full Code.</p> <p>How will you monitor for effectiveness of the Plan of Removal?</p> <p>(continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Administrator will randomly issue post test regarding education/in-service on Hospice Services and Code Status and initiating CPR timely for resident who are a Full Code for 4 weeks to ensure knowledge has been maintained and compliance has been achieved.</p> <p>Director of Nursing will randomly request a Nurse to communicate Code Status on a resident on Hospice and initiating CPR timely for resident who are a Full Code for 4 weeks to ensure knowledge has been maintained and compliance has been achieved. Nurse responses will be documented on a Response LOG that will identify staff name, date, shift, answer/response and if correct, resident name.</p> <p>The facility's POR verification was as follows:</p> <p>During an interview with the DON, [DATE] at 2:19 p.m., the DON stated LVN A was terminated from the facility on [DATE]. The DON stated the Medical Director was notified of the incident on [DATE] at 12:02 p.m. and the Medical Director did not give any additional instructions. The DON stated staff training was initiated on [DATE] and was completed on the morning of [DATE]. The training was provided to 100% of licensed nurses and covered the topics of where to find resident code status in the resident chart, importance of verifying code status if a resident is found unresponsive, what actions to take if a resident is a full code or DNR and hospice resident's right to be full code.</p> <p>During an interview with the Administrator, [DATE] at 2:28 pm, the Administrator stated LVN A was terminated on [DATE]. The Administrator stated the Medical Director was notified of the incident at [DATE] at 12:02 pm and provided no further guidance. The Administrator stated training for licensed nurses was initiated on [DATE] and was completed on the early morning on [DATE] and the training was completed by the DON.</p> <p>Record review of document labeled, Employee Disciplinary Action Form, dated [DATE], revealed the name of LVN A, type of offense is listed as violation of company policy. The document revealed LVN A as suspended on [DATE] at 11 pm and was terminated due to the result of the event on [DATE].</p> <p>Record review of staff roster dated [DATE] reflected 13 licensed nurses (11 full time nurses and 2 prn nurses).</p> <p>Record review of an in-service training attendance roster, dated [DATE], reflected the in-service topics included hospice resident and code status, resident rights and where to find code status. The instructor was facility DON and roster was signed by 16 nurses (3 agency employees). Documents attached to the in-service included an action tree describing how to respond when a resident is found with no pulse or unresponsive and listed the first action as go to [EMR name] and check code status.</p> <p>Record review of a document titled Hospice Residents/Code Status/Resident Rights Post Test listed 4 questions which included 1. What do you immediately check when a patient is found unresponsive? 2. Can you be on hospice and still be a full code? 3. Where do you find the code status? 4. Resident has the right to decide their code status True or False?. There are 18 (13 facility nurses and 5 agency nurses) completed posttests by nurses.</p> <p>Record review of a Hospice list, dated [DATE], reflected 10 resident names. 3 residents are listed as full code.</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 07/27/2024
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.			
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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record Review of a document labeled [facility name] Ordering Listing Report, dated [DATE] at 8:03am, reflected a list of all facility residents and their code status. The document revealed there are 28 residents with orders for DNR and 31 residents with Full code orders.</p> <p>Record review of resident roster, dated [DATE], reflected 59 resident names.</p> <p>Record review of 59 resident face sheets, dated [DATE], reflected code status on the resident face sheets matched the resident physician order for code status.</p> <p>Interviews conducted with 10 of 11 full time licensed nurse employees (5 -6 a.m.-2p.m., 1- 2 p.m.-10 p.m., 1 - 10 p.m.-6 a.m., 3- double weekends 6 a.m.-10 p.m.). Interviews conducted with 2 agency LVNs (1- 6 a.m.-2 p.m. and 1- 2 p.m.-10 p.m.). 2 PRN employees were unable to be reached by phone and were not on the schedule. The employees interviewed revealed they had received training from the DON regarding where a resident's code status is located in the chart, when to verify code status, what to do if a resident is a full code or DNR and hospice patients can be a full code. The licenses nurses were all able to answer the questions correctly, validating understanding of the in-service topic.</p> <p>During an interview with the Administrator, [DATE] at 2:28 p.m., the Administrator stated the DON would provide training to new hires during the orientation process and would provide training to agency employees prior to their assigned shift. The Administrator stated random post tests would be given to licensed nurses, weekly for 4 weeks, starting on [DATE] by the Administrator. The test would include questions regarding code status and initiating CPR timely for residents that are a full code.</p> <p>During an interview with the DON, [DATE] at 2:19 p.m., the DON stated new hires would receive training on code status, hospice and full code, and what to do when a resident is DNR or full code, during the orientation process and the DON would provide the education. DON stated agency staff would be educated on code status prior to beginning their shift and the DON would be providing the education. DON stated she had created an audit log and would conduct random audits with the licensed nurses. The audit would include asking the nurse to identify the residents code status, identify if the patient is on hospice, identify if the resident is a full code and how the nurse would respond to the code status.</p> <p>Record review of a document titled Monitoring for Knowledge Retention, undated, listed the names of all facility nurses and had a section for agency staff. There are 4 forms listed as week 1, 2, 3, and 4 and stated it will be conducted by the Administrator.</p> <p>Record review of audit logs labeled Week 1, undated, listed date, shift, nurse, resident, code status, hospice y/n, correctly identified code status y/n and correct response of what to do if full code y/n. There were 5 blank audit lines per sheet. There are 3 additional correlating documents labeled Week 2, Week 3 and Week 4. The audit would be completed by the DON.</p> <p>On [DATE] the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the IJ after verifying their POR had been initiated and/or completed.</p> <p>(continued on next page)</p>		

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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 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The Administrator was informed the Immediate Jeopardy was removed on [DATE] at 4:05 p.m. While the IJ was removed the facility remained out of compliance at a severity level of actual harm that was not an Immediate Jeopardy and a scope of isolated, due to the facility was still monitoring the effectiveness of their Plan of Removal.</p>		