

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 04/04/2025
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44020</p> <p>Based on observation, interview, and record review the facility failed to ensure residents received services in the facility with reasonable accommodation of resident needs for 1 of 8 residents (Resident #18) who were observed for call light placement.</p> <p>The facility failed to ensure the call light was within reach for Resident #18.</p> <p>This failure could affect any resident and keep them from calling for help as needed.</p> <p>The findings were:</p> <p>Record review of Resident #18's face sheet, dated 04/02/2025, revealed he was admitted to the facility on [DATE] with diagnoses which included: epilepsy (disorder in which nerve cell activity in the brain is disturbed, causing seizures), unspecified, not intractable, with status epilepticus (a seizure that lasts longer than 5 minutes or when seizures occur in rapid succession without the person regaining consciousness between them), essential hypertension (high blood pressure), muscle weakness generalized, and unspecified dementia (a group of symptoms affecting memory, thinking and social abilities, unspecified severity, without behavioral disturbance, psychotic disturbance and anxiety).</p> <p>Record review of Resident #18's Quarterly MDS assessment, dated 02/21/2025, revealed the resident's BIMS score was 00, which indicated severe cognitive impairment. The Quarterly MDS assessment further revealed Resident #18 was dependent (helper does all of the effort) for toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, personal hygiene, putting on/taking off footwear, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed to chair transfer, tub/shower transfer, and roll left and right.</p> <p>Record review of Resident #18's care plan, last care plan review completed date of 03/31/2025, revealed Resident #18 had a focus of [resident's name] is at risk for fall due to periods of unsteady gait, resident also noncompliant with staff assistance. and interventions read Call light in reach in room and answered promptly. Encourage and remind him to use call light to ask for assistance.</p> <p>Observation on 04/01/2025 at 10:50 a.m. revealed Resident #18 sleeping in his bed, bed in the lowest position to the floor with call light clipped to privacy curtain.</p> <p>Observation on 04/02/2025 at 9:36 a.m. revealed Resident #18 sleeping in his bed, bed in the lowest position to the floor, lying on his side with the call light clipped to the privacy curtain.</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview on 04/02/2025 at 9:57 a.m. CNA E stated Resident #18 would scream a lot at times and would yell for things. CNA E further stated normally he does not use his call light, but she goes in there to check on him during her rounds. CNA E revealed Resident #18 would not have been able to reach the call light if he needed it. CNA E then removed the call light from the curtain and clipped to his blanket and explained to him what she was doing when he began yelling as he was resting in the bed. CNA E stated to Resident #18 I'm giving you your call light, and Resident #18 responded okay as he went back to sleep. CNA E stated the call light was used for residents to ask for help if they needed her and it was her responsibility to place it where he could reach it.</p> <p>During interview on 04/04/2025 at 2:17 p.m. the DON stated the call light should be near the resident where they can grab it. The DON further stated when in the bed it should be always accessible. The DON stated the CNA and the nurse on the floor were responsible for placing it within reach and when they went in the room, they should have seen it and corrected it. The DON stated by being out of reach the resident would not be able to press it if they needed assistances.</p> <p>During an interview on 04/04/2025 at 2:21 p.m. the administrator stated staff in general were responsible for call light placement, but usually the CNA. The administrator further stated when anyone went in or during rounds anyone can place within reach. The administrator stated by not having the call light a resident might not get their needs met. The administrator stated he believed Resident #18 did not use it and the staff rounded on him frequently.</p> <p>Record review of facility's Call Lights policy, no date, read The purpose of this procedure is to respond to the resident's requests and needs., General Guidelines .5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.</p>

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<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44020</p> <p>Based on interview and record review, the facility failed to transmit encoded, accurate, and complete MDS data to the CMS System for 1 of 16 residents (Resident #6) reviewed for MDS transmission.</p> <p>Resident #6's discharge MDS assessment was not completed and transmitted within 14 days of completion.</p> <p>This failure could place residents at risk of not having assessments completed and submitted in a timely manner as required.</p> <p>The findings were:</p> <p>Review of Resident #6's face sheet, dated 04/04/2025, revealed an admitted [DATE] with diagnoses that included: chronic systolic (congestive) heart failure, respiratory failure, unspecified, unspecified whether with hypoxia (state of insufficient oxygen supply to the body's tissues, leading to a deficiency in oxygen delivery) or hypercapnia (occurs when the body's ability to eliminate carbon dioxide through breathing is impaired, leading to a buildup of carbon monoxide in the blood), essential hypertension (high blood pressure), atherosclerotic heart disease of native coronary artery without angina pectoris (symptom, not a disease itself, that indicates a problem with blood flow to the heart muscle), and unspecified dementia, unspecified severity, without behavioral disturbance, mood disturbance and anxiety.</p> <p>Review of Resident #6's Discharge MDS Assessment, dated 01/02/2025, revealed the assessment had not been completed and transmitted to CMS.</p> <p>During an interview on 04/04/2025 at 2:58 p.m. the MDS coordinator revealed the Discharge MDS assessment was open for Resident #6, but it was not finished. The MDS coordinator further stated the Discharge MDS assessment should have been done right away after the resident discharged . The MDS coordinator stated it should be completed by day 14. The MDS coordinator was not sure why it was not completed for Resident #6 after her discharge on 01/02/2025. The MDS coordinator stated she did not really know how was overlooked. The MDS Coordinator stated it was her responsibility to complete the Discharge MDS assessment. The MDS coordinator stated the MDS assessments were for CMS tracking, CMS reporting and by not completing the MDS assessment could affect possibly the QMs (quality measures). The MDS coordinator stated she kept a calendar and clinicals there was a schedule that would give a list.</p> <p>During an interview on 04/04/2025 at 3:10 p.m. the DON stated the MDS coordinator was responsible for the accuracy and completion of MDS assessments. The DON stated monitoring was done by the MDS coordinator, ADON, DON and administrator in the stand-up meeting. The DON was not sure why Resident #6's Discharge MDS assessment would have been missed. The DON did not believe there was another system other than PCC to track the MDS assessments.</p> <p>(continued on next page)</p>		

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<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/04/2025 at 3:19 p.m. the administrator stated the MDS coordinator was responsible for completion of the MDS assessments and the tracking of the MDS assessments. The administrator further stated there was a MDS in progress report in PCC and for some reason Resident #6's Discharge MDS assessment was not showing on the in-progress report in PCC when she pulled up the report. The administrator stated by not completing and submitting the MDS assessments could affect the quality measures of the facility.</p> <p>Record review of facility's policy titled Implementation of the Minimum Data Set (MDS), no date, read It is the policy of this facility to ensure a comprehensive assessment of each resident is completed and submitted according to the RAI guidelines manual set forth by CMS. Procedure: Monitor the schedule of the MDS. Complete a comprehensive, quarterly, significant change or other appropriate MDS according to the guidelines of the RAI manual set forth by CMS.</p>		

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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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049</p> <p>Based on interview and record review, the facility failed to ensure the assessment accurately reflected the resident's status for 1 of 20 residents (Resident #1) reviewed for assessments:</p> <p>Resident #1's quarterly MDS, dated [DATE], identified the resident had anticoagulant (blood thinner). However, Resident #1 did not have anticoagulant.</p> <p>This failure could place residents at risk for inadequate care due to inaccurate assessments.</p> <p>The findings included:</p> <p>Record review of Resident #1's face sheet, dated 04/04/2025, revealed the resident was [AGE] years old female, originally admitted on [DATE], and readmitted to the facility on [DATE] with diagnoses of urinary tract infection (bladder infection), cerebral palsy (congenital disorder of movement, muscle tone, or posture), heart failure (the heart did not pump enough blood to the body), peripheral vascular disease (narrowed blood vessels reduced blood flow to the limbs), hypothyroidism (low level of thyroid hormone in the body), and cognitive communication deficit.</p> <p>Record review of Resident #1's quarterly MDS, dated [DATE], revealed the resident's BIMS score was 3 out of 15, which indicated the resident had severe cognitive impairment and was taking anticoagulant in Section N (Medications).</p> <p>Record review of Resident #1's physician order, dated 03/01/2025, revealed the resident had the order of Clopidogrel Bisulfate Oral Tablet 75 mg. Give 1 tablet by mouth one time a day for blood thinner.</p> <p>Record review of Resident #1's medication administration record, from 04/01/2025 to 04/30/2025, revealed the resident was receiving Clopidogrel Bisulfate Oral Tablet 75 mg at 9:00 am for blood thinner as ordered.</p> <p>Record review of CMS's RAI version 3.0 Manual for MDS, dated ,d+[DATE], page N-8, revealed Antiplatelets (prevent platelets from sticking together and decrease the body's ability to from blood clots): check if an antiplatelet medication (e.g., aspirin/extended release, dipyridamole, clopidogrel) was taken by the resident at any time during the 7-day observation period (or since admission/entry or reentry if less than 7 days).</p> <p>Interview on 04/04/2025 at 2:43 p.m. with MDS nurse stated Resident #1 was taking Clopidogrel Bisulfate Oral Tablet 75 mg one tablet by mouth once a day at 9:00 am for blood thinner, and it was not anticoagulant but antiplatelet. MDS nurse said that coding it as anticoagulant was MDS nurse's mistake. It should have been coded as antiplatelet, and inaccurate MDS might cause improper care to the resident.</p> <p>Record review of the facility policy, titled MDS, undated, revealed It is the policy of this facility to ensure a comprehensive assessment of each resident is completed and submitted according to the RAI guidelines manual set forth by CMS.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049</p> <p>Based on observation, interviews, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental needs that were identified in the comprehensive assessment, and described services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 20 residents (Resident #58) reviewed for care plans.</p> <p>The facility failed to ensure Resident #58's care plan reflected his smoking status and included a care plan regarding how to take care of the resident's smoking.</p> <p>This failure could place residents at risk for not receiving proper care and services due to inaccurate care plans.</p> <p>The findings included:</p> <p>Record review of Resident #58's face sheet, dated 04/04/2025, revealed the resident was a [AGE] year-old male, originally admitted to the facility on [DATE], and readmitted to the facility on [DATE] with diagnoses of transient cerebral ischemic attacks (temporary blockage of blood flow to the brain), cerebral vascular disease (stroke), hyperlipidemia (high level of fat), hypertension (high blood pressure), and muscle weakness.</p> <p>Record review Resident #58's quarterly MDS, dated [DATE], revealed the resident's BIMS score was 10 out of 15, which indicated the resident had moderate cognitive impairment, and the resident was dependent to most activities of daily living such as eating, sit-to-stand, and chair-to-bed transfer.</p> <p>Record review of Resident #58's smoking assessment, dated 01/31/2025, revealed the resident was a smoker and need for adaptive equipment such as smoking apron when smoking.</p> <p>Record review of Resident #58's comprehensive care plan, dated 01/15/2025, revealed there was no care plan related to smoking.</p> <p>Observation on 04/04/2025 at 11:06 a.m. revealed Resident #58 was smoking at the smoking area with a staff, and he was wearing a smoking apron.</p> <p>Interview on 04/01/2025 at 3:02 p.m. with Resident #58 said the resident was a smoker and used a smoking apron when smoking.</p> <p>Interview on 04/04/2025 at 11:56 a.m. with the MDS nurse stated MDS nurse should have developed Resident #58's comprehensive care plan related to his smoking status because the resident was a smoker. Further interview with MDS nurse said she overlooked it, and it was her mistake. MDS nurse said developing care plan was her responsibility and not care planning potentially caused improper care to Resident #58.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility policy, titled Comprehensive Care plan, undated, revealed The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident medical, nursing, and mental, and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan will describe the following: the services that are to be furnished to attain resident highest practicable physical, mental, and psychosocial well-being.</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049</p> <p>Based on observations, interviews, and record review, the facility failed to ensure a resident who was incontinent of bowel and bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 3 residents (Resident #4) reviewed for incontinence care.</p> <p>When CNA-A was providing incontinent care to Resident #4 on 04/03/2025, CNA-A did not separate the resident's labia and did not clean the base of her labia.</p> <p>This failure could place residents who required incontinence care at risk for cross contamination and the development of new or worsening urinary tract infections.</p> <p>The findings included:</p> <p>Record review of Resident #4's face sheet, dated 04/04/2025, revealed a [AGE] year-old female, admitted to the facility originally on 03/24/2015, and readmitted to the facility on [DATE] with diagnoses of vascular disorder of intestine (blood flow to the intestines slows), pervasive developmental disorder (developmental delays that affect social and communication skills), hemiplegia (brain damage that leads to paralysis on one side of the body), dysphagia (difficulty swallowing), and hyperlipidemia (high level of fat).</p> <p>Record review of Resident #4's quarterly MDS, dated [DATE], revealed the resident's BIMS score was 0 out of 15, which indicated the resident had severe cognitive impairment, the resident had frequently urinary bladder incontinence and always bowel incontinence, and required dependent assistance (helper does all of the efforts) to all activities of daily living such as chair-to-bed and toilet transfer.</p> <p>Record review of Resident #4's comprehensive care plan, dated 07/23/2015, revealed the resident had bowel and bladder incontinence related to impaired mobility - Monitor/document for signs and symptoms of urinary tract infection.</p> <p>Observation on 04/03/2025 at 10:00 a.m. revealed CNA-A cleaned Resident #4's left and right groin area, then just cleaned the middle one of the resident's genital areas without separating the resident's labia area. Further observation revealed CNA-A turned the resident to her left side and cleaned the resident's bottom area, then put a new and clean brief and closed it.</p> <p>Interview on 04/03/2025 at 10:12 a.m. with CNA-A stated she did not separate Resident #4's labia area and did not clean the base of the resident's labia area. Further interview with CNA-A said she forgot to separate the resident's labia area to clean the base of labia because she was so nervous. CNA-a stated she should have separated Resident #4's labia area and cleaned the base of the resident's labia area.</p> <p>(continued on next page)</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 04/03/2025 at 1:56 p.m. the DON stated CNA-A should have separated Resident #4's labia area to clean the base of labia to prevent possible urinary tract infection. Checking CNA-A's skills for perineal care was DON's responsibility, and DON conducted the skill check-off of CNA-A on 03/13/2025, and CNA-A demonstrated correct skills for perineal care on 03/13/2025.</p> <p>Record review of the facility policy, titled Perineal Care, undated, revealed . 9. Female perineal care F. use one gloves hand to stabilize and separate the labia, with other hands wash from front to back.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049</p> <p>Based on observation, interviews, and record review, the facility failed to ensure that a resident who needs respiratory care, is provided such care, consistent with professional standards of practice for 1 of 2 (Resident #20) reviewed for respiratory care.</p> <p>Resident #20's oxygen nasal cannula was not covered in a plastic bag when it was not used on 04/01/2025.</p> <p>This failure could affect residents with oxygen therapy and could lead them to lack of care including possible infection by not following infection control.</p> <p>The findings included:</p> <p>Record review of Resident #20's face sheet, dated 04/04/2025, revealed the resident was a [AGE] year-old female, originally admitted to the facility on [DATE], and readmitted to the facility on [DATE] with diagnoses of hemiplegia and hemiparesis (weakness on one side of the body), heart failure (not pumping blood enough), type 2 diabetes mellitus (not control blood sugar), chronic respiratory failure (lung cannot get enough oxygen), and cerebral vascular disease (stroke).</p> <p>Record review of Resident #20's annual MDS assessment, dated 03/18/2025, revealed the resident's BIMS score was 15 out of 15 which indicated her cognition was intact, and the resident was receiving oxygen therapy.</p> <p>Record review of Resident #20's comprehensive care plan, dated 07/01/2024, revealed the resident had Using oxygen therapy at times per nasal cannula. For intervention - oxygen as ordered and indicated.</p> <p>Record review of Resident #20's physician order, dated 05/28/2024, revealed the resident had the order of as needed oxygen 2 to 5 liter per minutes to maintain oxygen saturation more than 90 %. Further record review of the resident's physician order, dated 05/26/2024, revealed Check if face mask and tubing weekly. May replace if appears soiled or known contamination. Replace personal bag at bedside for items when not in use.</p> <p>Observation on 04/01/2025 at 10:09 a.m. revealed Resident #20 was not in her room. Resident #20's nasal cannula was on the nightstand uncovered.</p> <p>Interview on 04/01/2025 at 11:06 a.m. with LVN-B stated Resident #20's nasal cannula was on the nightstand without a plastic bag. Further interview with LVN-B said the resident's nasal cannula should have been covered in a plastic bag when it was not used to prevent possible infection.</p> <p>Interview on 04/04/2025 at 4:00 p.m. with the DON stated Resident #20's nasal cannula should have been covered in a plastic bag when it was not used to prevent possible infections as ordered. Further interview with the DON said the facility did not have a policy related to specifically covering a nasal cannula and mask in a plastic bag when not used.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049</p> <p>Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 5 of 8 residents (Residents ##28, #25, #37, #31, and #38) reviewed for pharmacy services.</p> <ol style="list-style-type: none"> 1. Resident #28's insulin flex pen (Humalog) for diabetes had an open date of [DATE] found inside the ,d+[DATE]-hall nursing cart on [DATE]. It should have been discarded 28 days after opening. 2. Resident #25's insulin (Lispro) for diabetes had an open date of [DATE] found inside the ,d+[DATE]-hall nursing cart on [DATE]. It should have been discarded 28 days after opening. 3. Resident #37's insulin (Novolog) for diabetes had an open date of [DATE] found inside the ,d+[DATE]-hall nursing cart on [DATE]. It should have been discarded 28 days after opening. 4. Resident #31's insulin (Novolog) for diabetes had an open date of [DATE] found inside the ,d+[DATE]-hall nursing cart on [DATE]. It should have been discarded 28 days after opening. 5. The facility nurses did not administer Resident #38's Lorazepam 0.5 mg oral one tablet at bedtime for anxiety on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE] (total 10 days) because the medication was not available, and nurses did not re-order it on time. <p>These failures could place residents at risk of inaccurate drug administration and not having appropriate therapeutic effects.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Record review of Resident #28's face sheet, dated [DATE], revealed Resident #28 was a [AGE] year-old female and admitted to the facility [DATE] with diagnoses of schizoaffective disorder (mental health problem psychosis as well as mood symptoms), type 2 diabetes mellitus (body does not insulin properly, resulting in high blood sugar levels), muscle weakness, dysphagia (difficulty of swallowing), and hyperlipidemia (high level of fat). <p>Record review of Resident #28's Quarterly MDS assessment, dated [DATE], revealed the resident's BIMS score was 0 out of 15, which indicated the resident had severe cognitive impairment, and the resident was receiving insulin injections every day as ordered.</p> <p>Record review of Resident #28's physician's order, dated [DATE], revealed the resident had the order of Humalog Kwik Pen subcutaneous Solution Pen Injector 100 unit/ml (insulin Lispro) inject as per sliding scale: if ,d+[DATE]=no insulin, ,d+[DATE]=1 units, ,d+[DATE]=2 units, ,d+[DATE]=3 units, ,d+[DATE]= 4 units, if blood sugar over 350 5 units, subcutaneously before meals for diabetes.</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 04/04/2025
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #28's medication administration record, dated from [DATE] to [DATE], revealed Resident #28 was receiving Humalog Kwik Pen subcutaneous Solution Pen Injector 100 unit/ml (insulin Lispro) inject as per sliding scale at 7:00 am, 11:00 am, and 4:00 pm.</p> <p>Observation on [DATE] at 2:41 p.m. revealed Resident #28's insulin Kwik pen (Lispro=Humalog) for diabetes with open date of [DATE] inside the ,d+[DATE]-hall nursing cart.</p> <p>Interview on [DATE] at 2:41 a.m. with LVN-D stated Resident #28's insulin Kwik pen (Lispro=Humalog) for diabetes with open date of [DATE] inside the ,d+[DATE]-hall nursing cart. Further interview, LVN-D said Resident #28's insulin Kwik pen (Lispro=Humalog) for diabetes should have been discarded 28 days after opening, which was [DATE] because the nurses opened it on [DATE]. LVN-D did not know what reason the nurses did not discard the insulin pen.</p> <p>2. Record review of Resident #25's face sheet, dated [DATE], revealed Resident #25 was an [AGE] year-old male and admitted to the facility [DATE] with diagnoses of type 2 diabetes mellitus (body does not insulin properly, resulting in high blood sugar levels), neurocognitive disorder (decreased mental function), psychosis, and hyperlipidemia (high level of fat).</p> <p>Record review of Resident #25's Quarterly MDS assessment, dated [DATE], revealed the resident's BIMS score was 7 out of 15, which indicated the resident had severe cognitive impairment, and the resident was receiving insulin injections every day as ordered.</p> <p>Record review of Resident #25's physician's order, dated [DATE], revealed the resident had the order of Insulin Lispro injection solution subcutaneous - inject as per sliding scale: if ,d+[DATE]=no insulin, , d+[DATE]=2 units, ,d+[DATE]=4 units, ,d+[DATE]=6 units, ,d+[DATE]= 8 units, ,d+[DATE]=10 units if blood sugar over 400 give 12 units and notify doctor, subcutaneously two times a day for diabetes.</p> <p>Record review of Resident #25's medication administration record, dated from [DATE] to [DATE], revealed Resident #25 was receiving Insulin Lispro subcutaneous Solution - inject as per sliding scale at 8:00 am and 8:00 pm.</p> <p>Observation on [DATE] at 2:41 p.m. revealed Resident #25's insulin (Lispro) for diabetes with open date of [DATE] inside the ,d+[DATE]-hall nursing cart.</p> <p>Interview on [DATE] at 2:41 a.m. with LVN-D stated Resident #25's insulin (Lispro) for diabetes with open date of [DATE] inside the ,d+[DATE]-hall nursing cart. Further interview, LVN-D said Resident #25's insulin (Lispro) for diabetes should have been discarded 28 days after opening, which was [DATE] because the nurses opened it on [DATE]. LVN-D did not know what reason the nurses did not discard the insulin pen.</p> <p>3. Record review of Resident #37's face sheet, dated [DATE], revealed Resident #37 was a [AGE] year-old male and admitted to the facility [DATE] and readmitted to the facility [DATE] with diagnoses of paraplegia (inability to voluntarily move the lower parts of the body), radiculopathy (injury or damage to nerve roots in the area where they leave the spine), type 2 diabetes mellitus (body does not insulin properly, resulting in high blood sugar levels), and muscle weakness.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #37's Quarterly MDS, dated [DATE], revealed the resident's BIMS score was 15 out of 15, which indicated the resident's cognition was intact, and the resident was receiving insulin injections every day as ordered.</p> <p>Record review of Resident #37's physician's order, dated [DATE], revealed the resident had the order of Insulin Novolog injection solution subcutaneous - inject 16 units subcutaneously before meals for diabetes.</p> <p>Record review of Resident #37's medication administration record, dated from [DATE] to [DATE], revealed Resident #37 was receiving Insulin Novolog injection solution subcutaneous - inject 16 units subcutaneously before meals for diabetes at 7:00 am, 11:00 am, and 4:00 pm.</p> <p>Observation on [DATE] at 2:41 p.m. revealed Resident #37's insulin (Novolog) for diabetes with open date of [DATE] inside the ,d+[DATE]-hall nursing cart.</p> <p>Interview on [DATE] at 2:41 p.m. with LVN-D stated Resident #37's insulin (Novolog) for diabetes with open date of [DATE] inside the ,d+[DATE]-hall nursing cart. Further interview, LVN-D said Resident #37's insulin (Novolog) for diabetes should have been discarded 28 days after opening, which was [DATE] because the nurses opened it on [DATE]. LVN-D did not know what reason the nurses did not discard the insulin pen.</p> <p>4. Record review of Resident #31's face sheet, dated [DATE], revealed Resident #31 was a [AGE] year-old female and admitted to the facility [DATE] and readmitted to the facility [DATE] with diagnoses of type 2 diabetes mellitus (body does not insulin properly, resulting in high blood sugar levels), hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body), cerebral infarction (disrupted blood flow to the brain due to problems with the blood vessels that supply it), and muscle weakness.</p> <p>Record review of Resident #31's Quarterly MDS, dated [DATE], revealed the resident's BIMS score was 1 out of 15, which indicated the resident had severe cognitive impairment, and the resident was receiving insulin injections every day as ordered.</p> <p>Record review of Resident #31's physician's order, dated [DATE], revealed the resident had the order of Insulin Aspart (Novolog) injection solution subcutaneous - inject as per sliding scale: if ,d+[DATE]=4 units, , d+[DATE]=8 units, ,d+[DATE]=12 units, ,d+[DATE]=16 units, ,d+[DATE]= 20 units and notify doctor, subcutaneously every 6 hours for diabetes.</p> <p>Record review of Resident #31's medication administration record, dated from [DATE] to [DATE], revealed Resident #31 was receiving Insulin Aspart (Novolog) injection solution subcutaneous - inject as per sliding scale: if ,d+[DATE]=4 units, ,d+[DATE]=8 units, ,d+[DATE]=12 units, ,d+[DATE]=16 units, ,d+[DATE]= 20 units and notify doctor, subcutaneously every 6 hours for diabetes at 2:00 am, 8:00 am, 4:00 pm, and 8:00 pm.</p> <p>Observation on [DATE] at 2:41 p.m. revealed Resident #31's insulin (Novolog) for diabetes with open date of [DATE] inside the ,d+[DATE]-hall nursing cart.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on [DATE] at 2:41 p.m. with LVN-D stated Resident #31's insulin (Novolog) for diabetes with open date of [DATE] inside the ,d+[DATE]-hall nursing cart. Further interview, LVN-D said Resident #31's insulin (Novolog) for diabetes should have been discarded 28 days after opening, which was [DATE] because the nurses opened it on [DATE]. LVN-D did not know what reason the nurses did not discard the insulin pen.</p> <p>Interview on [DATE] at 2:42 p.m. the DON stated facility nurses should have discarded insulins for diabetes to 28 days after opening and it was nurse's responsibility. The DON said DON and ADON sometimes reviewed nursing carts, but they did not know what reason these insulins were in the nursing cart. The potential harm was the insulins might be less effective.</p> <p>5. Record review of Resident #38's face sheet, dated [DATE], revealed the resident was a [AGE] year-old male, originally admitted on [DATE], and readmitted to the facility on [DATE] with diagnosis of hypertension (high blood pressure), type 2 diabetes mellitus (body does not insulin properly, resulting in high blood sugar levels), hypokalemia (low level of potassium in the blood), anxiety disorder, muscle weakness, and insomnia (difficulty of sleeping).</p> <p>Record review of Resident #38's Annual MDS, dated [DATE], revealed the resident's BIMS score was 15 out of 15, which indicated the resident's cognitive function was intact and receiving antianxiety medication every day as ordered.</p> <p>Record review of Resident #38's comprehensive care plan, revised [DATE], revealed At risk for side effects to medications, increased anxiety and anxiousness related to his anxiety. For intervention - encourage and remind resident to ask for and provide assistance as needed and monitor for side effects to medications.</p> <p>Record review of Resident #38's physician order, dated [DATE], revealed the resident had the order of Lorazepam oral tablet 0.5 mg - Give one tablet by mouth at bedtime for anxiety.</p> <p>Record review of Resident #38's medication administration record, dated from [DATE] to [DATE], revealed the resident was taking Lorazepam 0.5 mg one tablet by mouth at bedtime for anxiety at 7:00 pm as ordered. However, the resident did not receive his Lorazepam 0.5 mg one tablet by mouth at bedtime for anxiety at 7:00 pm on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE] (total 10 days) because of no medication. Further record review of the medication administration record revealed Resident #38 did not have any anxiety episode and side effect of anti-anxiety medication such as agitation or appetite change for [DATE].</p> <p>Record review of Resident #38's primary care physician's progress note, dated [DATE], revealed Anxiety - on Lorazepam. Will continue on it. No increased anxiety noted. Will monitor for any worsening symptoms and No specific pain issues noted.</p> <p>Interview on [DATE] at 8:53 a.m. with Resident #38 stated that he was supposed to receive his Lorazepam every day for his anxiety but did not receive it some days in [DATE] because nurses said they did not have the medication. However, he was receiving his Lorazepam every day in [DATE] without any issues. Further interview with the resident said he did not have any anxiety or side effects in [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on [DATE] at 3:00 p.m. with LVN-B stated that LVN-B received the list of Resident #38's medications that needed to have refill and gave the list to ADON on [DATE]. The medication aide reported to LVN-B that the medication aide could not give Resident #38's Lorazepam on [DATE] to the resident because the medication was not available. LVN-B re-ordered it by calling to the pharmacy. LVN-B stated per the facility policy, nurses had responsibility to reorder medications before medications ran out. LVN-B did not know what reason nurses did not reorder it before Resident #38's Lorazepam ran out. Resident #38 did not have any sign or symptom related to anxiety.</p> <p>Interview on [DATE] at 3:15 p.m. with ADON stated she did not receive the list of Resident #38's medications that needed to have refill. Per the facility policy, medication aides should click reorder button on the electronic medication administration record before medications ran out. If medications were not delivered on time, medication aides should report it to charge nurses, and charge nurse should contact physician or pharmacy to make sure reorder and gave medications to residents from emergency kit located in the medication room if the emergency kit had medications. Further interview with ADON said lack of communication among nurses and medication aides might cause missing administrations of Resident #38's Lorazepam for 10 days in [DATE].</p> <p>Interview on [DATE] at 3:16 p.m. with DON said DON became aware of missing administrations of Resident #38's Lorazepam for 10 days in [DATE] on [DATE] because the medication was not available. The DON called the primary care physician and reported it, and Resident #38's primary care physician visited and assessed the resident on face to face on [DATE] and noted the resident did not have any problem or negative outcomes regarding missing administrations of Resident #38's Lorazepam for 10 days in [DATE]. There was Resident #38's Lorazepam in the medication aide cart now, and medication aides administered it to the resident as ordered without any problem. However, it was medication error. The facility nurses should have contacted physician or pharmacy before the medication ran out. The DON said not receiving the medication may cause anxiety to Resident #38.</p> <p>Record review of the facility policy, titled Administering medications, undated, revealed . 7. For unavailable, missing or missed medications: a. Notify the charge nurse. b. Unavailable medication: charge nurse will check the ekit to see if dose is available. If not in the ekit, the charge nurse will reach out to facility pharmacy to initiate emergency refill of the cutoff time has already passed for the next scheduled delivery.</p> <p>Record review of the facility's policy, titled Insulin Expiration, undated, revealed . 2. All insulin, once opened or removed from the refrigerator must be dated. 3. All insulin, once or removed from refrigerator expired in 28 days and must be taken out of use and be replaced.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049</p> <p>Based on observations, interviews, and record review, the facility failed to ensure all drugs and biologicals were stored in locked compartments for 4 of 8 residents (Residents #37, #49, #31, and #54) reviewed for storage.</p> <ol style="list-style-type: none"> 1. Resident #37's insulin Glargine (Lantus) for diabetes had no open date, found inside ,d+[DATE]-hall nursing cart on [DATE]. Per the label of the insulin said, Discard 28 days after date opened. 2. Resident #49's insulin Glargine (Lantus) for diabetes had no open date, found inside ,d+[DATE]-hall nursing cart on [DATE]. Per the label of the insulin said, Discard 28 days after date opened. 3. Resident #31's insulin Glargine (Lantus) for diabetes had no open date, found inside ,d+[DATE]-hall nursing cart on [DATE]. Per the label of the insulin said, Discard 28 days after date opened. 4. Resident #54's insulin (Novolog) for diabetes had no open date, found inside ,d+[DATE]-hall nursing cart on [DATE]. Per the label of the insulin said, Discard 28 days after date opened. <p>These failures could place residents at risk of having not therapeutic effects by using old insulins.</p> <p>The findings were:</p> <ol style="list-style-type: none"> 1. Record review of Resident #37's face sheet, dated [DATE], revealed Resident #37 was a [AGE] year-old male and admitted to the facility [DATE] and readmitted to the facility [DATE] with diagnoses of paraplegia (inability to voluntarily move the lower parts of the body), radiculopathy (injury or damage to nerve roots in the area where they leave the spine), type 2 diabetes mellitus (body does not insulin properly, resulting in high blood sugar levels), and muscle weakness. <p>Record review of Resident #37's Quarterly MDS, dated [DATE], revealed the resident's BIMS score was 15 out of 15, which indicated the resident's cognition was intact, and the resident was receiving insulin injections every day as ordered.</p> <p>Record review of Resident #37's physician's order, dated [DATE], revealed the resident had the order of Insulin Glargine (Lantus) subcutaneous solution pen-injector 100 unit/ml - inject 50 unit subcutaneously two times a day for type 2 diabetes mellitus.</p> <p>Record review of Resident #37's medication administration record, dated from [DATE] to [DATE], revealed the resident was receiving Insulin Glargine (Lantus) subcutaneous solution pen-injector 100 unit/ml - inject 50 unit subcutaneously two times a day for type 2 diabetes mellitus at 8:00 am and 8:00 pm.</p> <p>Observation on [DATE] at 2:47 p.m. revealed Resident #37's insulin Glargine (Lantus) for diabetes with no open date inside the ,d+[DATE]-hall nursing cart.</p> <p>(continued on next page)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on [DATE] at 2:51 p.m. LVN-D stated Resident #37's insulin Glargine (Lantus) for diabetes with no open date was inside the ,d+[DATE]-hall nursing cart. Further interview, LVN-D said Resident #37's insulin Glargine (Lantus) for diabetes should have been discarded 28 days after opening per the label. However, LVN-D did not know if he should discard the insulin pen because the insulin pen did not have open date. The LVN-D did not know when the facility nurses opened Resident #37's insulin pen.</p> <p>2. Record review of Resident #49's face sheet, dated [DATE], revealed Resident #49 was a [AGE] year-old male and admitted to the facility [DATE] and readmitted to the facility [DATE] with diagnoses of atherosclerosis of coronary artery bypass graft (over time arteries can become narrowed and hardened by the build-up of fatty called plaques), hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body), type 2 diabetes mellitus (body does not insulin properly, resulting in high blood sugar levels), and hypertension (high blood pressure).</p> <p>Record review of Resident #49's Annual MDS, dated [DATE], revealed the resident's BIMS score was 13 out of 15, which indicated the resident's cognition was intact, and the resident was receiving insulin injections every day as ordered.</p> <p>Record review of Resident #49's physician's order, dated [DATE], revealed the resident had the order of Insulin Glargine (Lantus) subcutaneous solution pen-injector 100 unit/ml - inject 15 unit subcutaneously at bedtime for type 2 diabetes mellitus.</p> <p>Record review of Resident #49's medication administration record, dated from [DATE] to [DATE], revealed the resident was receiving Insulin Glargine (Lantus) subcutaneous solution pen-injector 100 unit/ml - inject 15 unit subcutaneously at bedtime for type 2 diabetes mellitus at 8:00 pm.</p> <p>Observation on [DATE] at 2:47 p.m. revealed Resident #49's insulin Glargine (Lantus) for diabetes with no open date inside the ,d+[DATE]-hall nursing cart.</p> <p>Interview on [DATE] at 2:51 p.m. LVN-D stated Resident #49's insulin Glargine (Lantus) for diabetes with no open date was inside the ,d+[DATE]-hall nursing cart. Further interview, LVN-D said Resident #49's insulin Glargine (Lantus) for diabetes should have been discarded 28 days after opening per the label. However, LVN-D did not know if he should discard the insulin pen because the insulin pen did not have open date. The LVN-D did not know when the facility nurses opened Resident #49's insulin pen.</p> <p>3. Record review of Resident #31's face sheet, dated [DATE], revealed Resident #31 was a [AGE] year-old female and admitted to the facility [DATE] and readmitted to the facility [DATE] with diagnoses of type 2 diabetes mellitus (body does not insulin properly, resulting in high blood sugar levels), hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body), cerebral infarction (disrupted blood flow to the brain due to problems with the blood vessels that supply it), and muscle weakness.</p> <p>Record review of Resident #31's Quarterly MDS, dated [DATE], revealed the resident's BIMS score was 1 out of 15, which indicated the resident had severe cognitive impairment, and the resident was receiving insulin injections every day as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #31's physician's order, dated [DATE], revealed the resident had the order of Insulin Glargine (Lantus) subcutaneous solution pen-injector 100 unit/ml - inject 10 unit subcutaneously two times a day for type 2 diabetes mellitus.</p> <p>Record review of Resident #31's medication administration record, dated from [DATE] to [DATE], revealed the resident was receiving Insulin Glargine (Lantus) subcutaneous solution pen-injector 100 unit/ml - inject 10 unit subcutaneously two times a day for type 2 diabetes mellitus at 10:00 am and 4:00 pm.</p> <p>Observation on [DATE] at 2:47 p.m. revealed Resident #31's insulin Glargine (Lantus) for diabetes with no open date inside the ,d+[DATE]-hall nursing cart.</p> <p>Interview on [DATE] at 2:51 p.m. LVN-D stated Resident #31's insulin Glargine (Lantus) for diabetes with no open date was inside the ,d+[DATE]-hall nursing cart. Further interview, LVN-D said Resident #31's insulin Glargine (Lantus) for diabetes should have been discarded 28 days after opening per the label. However, LVN-D did not know if he should discard the insulin pen because the insulin pen did not have open date. The LVN-D did not know when the facility nurses opened Resident #31's insulin pen.</p> <p>4. Record review of Resident #54's face sheet, dated [DATE], revealed Resident #54 was a [AGE] year-old female and admitted to the facility [DATE] and readmitted to the facility [DATE] with diagnoses of senile degeneration of brain (progressive decline in cognitive function, impacting memory, and reasoning), pneumonia (infection to the lung), type 2 diabetes mellitus (body does not insulin properly, resulting in high blood sugar levels), and muscle weakness.</p> <p>Record review of Resident #54's Quarterly MDS, dated [DATE], revealed the resident's BIMS score was 4 out of 15, which indicated the resident had severe cognitive impairment, and the resident was receiving insulin injections every day as ordered.</p> <p>Record review of Resident #54's physician's order, dated [DATE], revealed the resident had the order of Novolog injection solution 100 unit/ml - inject per sliding scale subcutaneously before meals for type 2 diabetes mellitus.</p> <p>Record review of Resident #54's medication administration record, dated from [DATE] to [DATE], revealed the resident was receiving Novolog injection solution 100 unit/ml - inject per sliding scale subcutaneously before meals for type 2 diabetes mellitus at 7:00 am, 11:00 am, and 4:00 pm.</p> <p>Observation on [DATE] at 2:47 p.m. revealed Resident #54's insulin Novolog for diabetes with no open date inside the ,d+[DATE]-hall nursing cart.</p> <p>Interview on [DATE] at 2:51 p.m. LVN-D stated Resident #54's insulin Novolog for diabetes with no open date was inside the ,d+[DATE]-hall nursing cart. Further interview, LVN-D said Resident #54's insulin Novolog for diabetes should have been discarded 28 days after opening per the label. However, LVN-D did not know if he should discard the insulin pen because the insulin pen did not have open date. The LVN-D did not know when the facility nurses opened Resident #54's insulin pen.</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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on [DATE] at 2:57 p.m. the DON said the facility nurses should have written open dates on insulins when they opened them to discard them 28 days after opened. Nurses would not know when they have to discard insulins if insulins did not have open dates, and it might cause improper use, and residents might not have therapeutic effects. DON said that it was nurse' responsibility, and DON and ADON sometimes reviewed nursing carts, but they did not know what reason nurses did not write the open dates.</p> <p>Record review of the facility's policy, titled Insulin Expiration, undated, revealed . 2. All insulin, once opened or removed from the refrigerator must be dated. 3. All insulin, once or removed from refrigerator expired in 28 days and must be taken out of use and be replaced.</p>

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have a policy regarding use and storage of foods brought to residents by family and other visitors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049</p> <p>Based on observation, interview, and record review, the facility failed to enact a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption, for 1 (Resident #3) of 3 residents reviewed, in that:</p> <p>Resident #3s personal refrigerator located in her room was observed on 04/01/2025. There was a small plastic cup inside the refrigerator, with no date and no label on the plastic cup.</p> <p>This failure could place residents at risk of foodborne illness due to consuming foods which might be spoiled.</p> <p>The findings included:</p> <p>Record review of Resident #3's face sheet, dated 04/04/2025, reflected the resident was [AGE] years old female and was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses included: type 2 diabetes mellitus (not control blood sugar in the body), cholelithiasis (stone in the gallbladder), rheumatoid arthritis (chronic inflammatory affecting small joints in the hands and feet), intestinal obstruction (digested material is prevented from passing normally through the bowel), and dysphagia (difficulty of swallowing).</p> <p>Record review of Resident #3's annual MDS, dated [DATE], reflected the resident's BIMS score was 15 out of 15 which indicated the resident's cognitive function was intact, and the resident was independent with eating and was dependent (helper does all of the efforts) for dressing and bed mobility.</p> <p>Record review of Resident #3's comprehensive care plan, dated 02/12/2025, revealed the resident had Resident at nutritional risk. On mechanical soft and low concentrated sweet and for interventions - Encourage resident to eat meal out of bed and upright position for intake by mouth.</p> <p>Observation on 04/01/2025 at 10:42 a.m. revealed Resident #3 was on the bed and sleeping in her room. There was a personal refrigerator in the room, and inside the refrigerator there was a small plastic cup with food, but no date and no label on the cup.</p> <p>Interview on 04/01/2025 at 11:13 a.m. LVN-B stated Resident #3's refrigerator in her room had a small plastic cup with food, but it was not dated and labeled. LVN-B said that it looked like some kind of desert. The facility night nurses were supposed to check it every day.</p> <p>Interview on 04/04/2025 at 4:00 p.m. the DON stated facility night nurses were responsible for overseeing Resident #3's personal refrigerator and also responsible for monitoring it daily. The DON stated the resident might have illness due to food.</p> <p>Record review of the facility policy, titled Foods brought by family/visitors, undated, revealed . 6. Perishable foods must be stored in re-sealable containers with tightly fitting lids in the refrigerator. Containers will be labeled with the resident's name, the item, and the use by date.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049</p> <p>Based on observations, interviews, and record review, the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development of communicable diseases and infections for 1 resident (Residents #24) of 7 residents reviewed for infection control practices.</p> <p>MA C did not clean the blood pressure cuff between use and prior to taking Resident #24's blood pressure.</p> <p>These deficient practice could place residents at risk for cross contamination and infections.</p> <p>The findings included:</p> <p>Record review of Resident #24's face sheet, dated 04/04/2025, revealed the resident an [AGE] year-old male and admitted to the facility on [DATE] with the diagnoses of chronic kidney disease (the kidneys cannot filter waste and excess fluid from the body), heart failure (the heart cannot pump blood), type 2 diabetes mellitus (not control blood sugars in the body), and hypertension (high blood pressure).</p> <p>Record review of Resident #24's significant change MDS, dated [DATE], revealed the resident's BIMS was 0 out of 15 which indicated the resident had severe cognitive impairment, and the resident required supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for eating and dependent (helper does all of the effort) to chair-to-bed and toilet transfer.</p> <p>Record review of Resident #24's care plan, dated 05/22/2024, revealed Resident has chronic non-healing wound. This places the resident at an increased risk of transmission of infection and for intervention - change personal protective equipment before caring of other residents.</p> <p>Observation on 04/03/2025 at 9:02 a.m., revealed MAC took a resident's blood pressure and then moved to Resident #24's room. Further observation on 04/03/2025 at 09:18 a.m., revealed MAC entered Resident #24's room and measured the resident's blood pressure without cleaning the blood pressure cuff . MAC then gave a medication to Resident #24 for high blood pressure.</p> <p>Interview on 04/03/2025 at 9:29 a.m., MA C stated she used the same blood pressure cuff of the monitor machine without cleaning it when she measured Resident #24's blood pressure. She said she forgot and she should have cleaned the blood pressure cuff before using it on Resident #24 to prevent possible infection.</p> <p>Interview on 04/03/2025 at 2:01 p.m., the DON stated MA C should have cleaned the blood pressure cuff of the machine before using it on Resident #24 to prevent possible infection.</p> <p>Record review of the facility policy, titled Housekeeping and maintenance, undated, revealed . d. Reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment).</p>		

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<p>F 0940</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop, implement, and/or maintain an effective training program for all new and existing staff members.</p> <p>46677</p> <p>Based on interview and record review the facility failed to develop, implement, and maintain an effective training program for all new and existing staff for 11 of 23 (Housekeeper N, CMA F, CNA G, LVN H, Dietary Aide I, RN J, CNA K, CNA L, LVN M, LVN/MDS, Dietary Manager) employees reviewed for training requirements.</p> <p>The facility failed to implement and maintain a training program that ensured Housekeeper N, CMA F, CNA G, LVN H, Dietary Aide I, RN J, CNA K, CNA L, LVN M, LVN/MDS, Dietary Manager received required trainings annually.</p> <p>The facility failed to implement and maintain a training program that ensured Dietary Manager received required trainings upon hire.</p> <p>This failure could affect residents and place them at risk of being uninformed due to lack of staff training.</p> <p>Findings include:</p> <p>Record review of the personnel records for Housekeeper N revealed a hire date of 10/04/2016. Review of a training in-services for Housekeeper N from the previous 12 months, provided by the HR Coordinator revealed no evidence of communication training, QAPI training, ethics training, or falls training being provided annually.</p> <p>Record review of the personnel records for CMA F revealed a hire date of 01/27/2020. Review of a training in-services for CMA F from the previous 12 months, provided by the HR Coordinator revealed no evidence of communication training, QAPI training, HIV training, restraint training or emergency preparedness training being provided annually.</p> <p>Record review of the personnel records for CNA G revealed a hire date of 07/31/2023. Review of a training in-services for CNA G from the previous 12 months, provided by the HR Coordinator revealed no evidence of communication training, QAPI training or ethics training being provided annually.</p> <p>Record review of the personnel records for LVN H revealed a hire date of 09/14/2023. Review of a training in-services for LVN H from the previous 12 months, provided by the HR Coordinator revealed no evidence of communication training being provided annually.</p> <p>Record review of the personnel records for Dietary Aide I revealed a hire date of 12/08/2022. Review of a training in-services for Dietary Aide I from the previous 12 months, provided by the HR Coordinator revealed no evidence of QAPI training or behavioral health training being provided annually.</p> <p>Record review of the personnel records for RN J revealed a hire date of 02/17/2023. Review of a training in-services for RN J from the previous 12 months, provided by the HR Coordinator revealed no evidence of QAPI training or Ethics training being provided annually.</p> <p>(continued on next page)</p>

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<p>F 0940</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the personnel records for CNA K revealed a hire date of 01/29/2024. Review of a training in-services for CNA K from the previous 12 months, provided by the HR Coordinator revealed no evidence of ethics training, falls training, restraint training or emergency preparedness training being provided annually.</p> <p>Record review of the personnel records for CNA L revealed a hire date of 03/18/2022. Review of a training in-services for CNA L from the previous 12 months, provided by the HR Coordinator revealed no evidence of ethics training being provided annually.</p> <p>Record review of the personnel records for LVN M revealed a hire date of 02/10/2015. Review of a training in-services for LVN M from the previous 12 months, provided by the HR Coordinator revealed no evidence of ethics training being provided annually.</p> <p>Record review of the personnel records for LVN/MDS revealed a hire date of 03/18/2022. Review of a training in-services for LVN/MDS from the previous 12 months, provided by the HR Coordinator revealed no evidence of ethics training, HIV training, or emergency preparedness training being provided annually.</p> <p>Record review of the personnel records for Dietary Manager revealed a hire date of 10/23/2024. Review of a training in-services for Dietary Manager from the previous 12 months, provided by the HR Coordinator revealed no evidence of behavior health training or HIV training being provided upon hire.</p> <p>Interview with the HR Coordinator on 04/04/2025 at 1:34 PM, revealed she initiates in-service trainings every month and every month was a different topic. The HR Coordinator stated she presented the in-services to the department heads, and they present them to their staff. The HR Coordinator stated it was the responsibility of the department heads to complete the in-services and her responsibility to verify all staff have completed the assigned in-service each month. The HR Coordinator stated staff were notified they need to complete in-service trainings only when department heads present the trainings to them. The HR Coordinator stated she followed an on-boarding checklist for new employees that includes trainings. The HR Coordinator stated she was not sure why all Dietary Manager's trainings were not completed upon hire. The HR Coordinator stated it was important that staff received their initial and annual trainings to ensure they are providing quality care to the residents. The HR Coordinator stated this could affect the residents leaving them vulnerable to abuse, neglect, and exploitation.</p> <p>Interview with the DON on 04/04/2025 at 2:34 PM, revealed she received the in-services from the HR Coordinator monthly and presented them to her staff. The DON stated it is the responsibility of department heads to present the in-services to their staff. The DON stated once the in-services were complete the HR Coordinator verifies all employees had completed the in-service. The DON stated completing the in-services was important to ensure staff had the knowledge to complete their jobs effectually and safely. The DON stated if staff were not trained annually, it could leave resident's vulnerable to receiving poor care.</p> <p>(continued on next page)</p>		

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<p>F 0940</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with the Administrator 04/04/2025 at 2:43 PM revealed the facility provides staff with an in-service each month and each month the in-service reflected a different required training topic. The Administrator stated HR Coordinator initiated each in-service and provided them to the department heads so that they could train their staff. The Administrator stated it was the responsibility of department heads to train their staff each month and the responsibility of the HR Coordinator to verify each staff completed the in-services. The Administrator stated having untrained staff could lead to negative outcomes such as staff not knowing how to comminate or care for residents properly.</p> <p>Record review of facility policy titled In-Service Education, undated, revealed 1. Each year the administration or other designee will develop and implement an educational calendar to include (but not limited to) the following topics:</p> <ol style="list-style-type: none"> 1. Range of Motion 2. Communication 3. QAPI Program 4. Sensory and Communication Impairments 5. Dementia Care/ Alz management (Quarterly: see Dementia Education Policy 20.01) 6. Resident Rights 7. Skin Care and Pressure Ulcer Prevention 8. Universal/Standard Precautions 9. AED Training (Nurses Quarterly; use manufacturers recommendation) I 0. Fire Safety 11. Toileting Programs 12. Incontinence 13. Disaster Plan/Emergency Preparedness 14. Wandering/Elopement 15. General Safety Precautions 16. Smoking Policy 17. Infection Control Program 18. Grievance Policy <p>(continued on next page)</p>		

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	19. Incidents and Accidents 20. Mechanical Transfers and Lifts (use manufacturers recommendation) 21. Falls and Fall Prevention 22. Infection Diseases (TB Hep B overview incl. vaccinations) 23. Sexual Harassment 24. Professional & Appropriate Communication 25. Geriatric Pharmacology (Nurses/CMAs) 26. Advanced Directive and Guardianship 27. Pain Assessment and Management 28. ADL's 29. Catheter Care 30. Urinary and Fecal Incontinence 31. Workplace Violence 32. Constipation 33. HIV/AIDS 34. UTIs 35. Unusual Occurrences Policy 36. Material Safety Data Sheets (MSDS) 37. Nutrition and Hydration 38. HIPAA 39. Abuse, Neglect, Exploitation Prevention and Reporting Program 40. Compliance and Ethics Program 41. Behavior Interventions 42. Intellectual/Mental Disability (continued on next page)

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<p>F 0940</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>43. Trauma Informed Care</p> <p>44. Hand Washing Return Demonstration</p> <p>45. Appropriate use of PPE</p> <p>46. Restraints</p> <p>47. Antibiotic Stewardship Policy</p> <p>48. HR 49 - 1105B - Elder Justice Act</p> <p>49. Facility Assessment</p> <p>50. Respiratory and Trach Care (Nurses)</p> <p>51. Narcan (naloxone) (Nurses)</p> <p>52. Enhanced Barrier Precautions</p> <p>53. Psychological Changes of Aging</p> <p>54. Common Emergencies in Geriatrics</p> <p>55. IV Therapy (Nurses)</p> <p>56. Assisting Residents with Eating</p>

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<p>F 0941</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members.</p> <p>46677</p> <p>Based on interview and record review, the facility failed to provide communications training for 4 of 23 employees (Housekeeper N, CMA F, CNA G, LVN H) reviewed for training, in that:</p> <p>The facility failed to ensure effective communication training was provided to Housekeeper N, CMA F, CNA G and LVN H annually.</p> <p>This failure could affect residents and place them at risk of being uninformed due to lack of staff training.</p> <p>Findings include:</p> <p>Record review of the personnel records for Housekeeper N revealed a hire date of 10/04/2016. Review of a training in-services for Housekeeper N from the previous 12 months, provided by the HR Coordinator revealed no evidence of communication training being provided annually.</p> <p>Record review of the personnel records for CMA F revealed a hire date of 01/27/2020. Review of a training in-services for CMA F from the previous 12 months, provided by the HR Coordinator revealed no evidence of communication training being provided annually.</p> <p>Record review of the personnel records for CNA G revealed a hire date of 07/31/2023. Review of a training in-services for CNA G from the previous 12 months, provided by the HR Coordinator revealed no evidence of communication training being provided annually.</p> <p>Record review of the personnel records for LVN H revealed a hire date of 09/14/2023. Review of a training in-services for LVN H from the previous 12 months, provided by the HR Coordinator revealed no evidence of communication training being provided annually.</p> <p>Interview with the HR Coordinator on 04/04/2025 at 1:34 PM, revealed she initiates in-service trainings every month and every month was a different topic. The HR Coordinator stated she presented the in-services to the department heads, and they present them to their staff. The HR Coordinator stated it was the responsibility of the department heads to complete the in-services and her responsibility to verify all staff have completed the assigned in-service each month. The HR Coordinator stated staff were notified they need to complete in-service trainings only when department heads present the trainings to them. The HR Coordinator stated she followed an on-boarding checklist for new employees that includes trainings. The HR Coordinator stated she was not sure why all Dietary Manager's trainings were not completed upon hire. The HR Coordinator stated it was important that staff received their initial and annual trainings to ensure they are providing quality care to the residents. The HR Coordinator stated this could affect the residents leaving them vulnerable to abuse, neglect, and exploitation.</p> <p>(continued on next page)</p>		

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<p>F 0941</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with the DON on 04/04/2025 at 2:34 PM, revealed she received the in-services from the HR Coordinator monthly and presented them to her staff. The DON stated it is the responsibility of department heads to present the in-services to their staff. The DON stated once the in-services were complete the HR Coordinator verifies all employees had completed the in-service. The DON stated completing the in-services was important to ensure staff had the knowledge to complete their jobs effectually and safely. The DON stated if staff were not trained annually, it could leave resident's vulnerable to receiving poor care.</p> <p>Interview with the Administrator 04/04/2025 at 2:43 PM revealed the facility provides staff with an in-service each month and each month the in-service reflected a different required training topic. The Administrator stated HR Coordinator initiated each in-service and provided them to the department heads so that they could train their staff. The Administrator stated it was the responsibility of department heads to train their staff each month and the responsibility of the HR Coordinator to verify each staff completed the in-services. The Administrator stated having untrained staff could lead to negative outcomes such as staff not knowing how to comminate or care for residents properly.</p> <p>Record review of facility policy titled In-Service Education, undated, revealed 1. Each year the administration or other designee will develop and implement an educational calendar to include (but not limited to) the following topics: 2. Communication</p>

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<p>F 0944</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program.</p> <p>46677</p> <p>Based on interview and record review the facility failed to include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of it's QAPI program for 5 of 23 employees (Housekeeper N, CNA G, Dietary Aide I, CMA F, RN J) employees reviewed for training requirements.</p> <p>The facility failed to ensure required QAPI trainings was provided to Housekeeper N, CNA G, Dietary Aide I, CMA F, and RN J annually.</p> <p>This failure could affect residents and place them at risk of being uninformed due to lack of staff training.</p> <p>Findings include:</p> <p>Record review of the personnel records for Housekeeper N revealed a hire date of 10/04/2016. Review of a training in-services for Housekeeper N from the previous 12 months, provided by the HR Coordinator revealed no evidence of QAPI training being provided annually.</p> <p>Record review of the personnel records for CMA F revealed a hire date of 01/27/2020. Review of a training in-services for CMA F from the previous 12 months, provided by the HR Coordinator revealed no evidence of QAPI training being provided annually.</p> <p>Record review of the personnel records for CNA G revealed a hire date of 07/31/2023. Review of a training in-services for CNA G from the previous 12 months, provided by the HR Coordinator revealed no evidence of QAPI training being provided annually.</p> <p>Record review of the personnel records for Dietary Aide I revealed a hire date of 12/08/2022. Review of a training in-services for Dietary Aide I from the previous 12 months, provided by the HR Coordinator revealed no evidence of QAPI training being provided annually.</p> <p>Record review of the personnel records for RN J revealed a hire date of 02/17/2023. Review of a training in-services for RN J from the previous 12 months, provided by the HR Coordinator revealed no evidence of QAPI training being provided annually.</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 04/04/2025
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 0944</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with the HR Coordinator on 04/04/2025 at 1:34 PM, revealed she initiates in-service trainings every month and every month was a different topic. The HR Coordinator stated she presented the in-services to the department heads, and they present them to their staff. The HR Coordinator stated it was the responsibility of the department heads to complete the in-services and her responsibility to verify all staff have completed the assigned in-service each month. The HR Coordinator stated staff were notified they need to complete in-service trainings only when department heads present the trainings to them. The HR Coordinator stated she followed an on-boarding checklist for new employees that includes trainings. The HR Coordinator stated she was not sure why all Dietary Manager's trainings were not completed upon hire. The HR Coordinator stated it was important that staff received their initial and annual trainings to ensure they are providing quality care to the residents. The HR Coordinator stated this could affect the residents leaving them vulnerable to abuse, neglect, and exploitation.</p> <p>Interview with the DON on 04/04/2025 at 2:34 PM, revealed she received the in-services from the HR Coordinator monthly and presented them to her staff. The DON stated it is the responsibility of department heads to present the in-services to their staff. The DON stated once the in-services were complete the HR Coordinator verifies all employees had completed the in-service. The DON stated completing the in-services was important to ensure staff had the knowledge to complete their jobs effectually and safely. The DON stated if staff were not trained annually, it could leave resident's vulnerable to receiving poor care.</p> <p>Interview with the Administrator 04/04/2025 at 2:43 PM revealed the facility provides staff with an in-service each month and each month the in-service reflected a different required training topic. The Administrator stated HR Coordinator initiated each in-service and provided them to the department heads so that they could train their staff. The Administrator stated it was the responsibility of department heads to train their staff each month and the responsibility of the HR Coordinator to verify each staff completed the in-services. The Administrator stated having untrained staff could lead to negative outcomes such as staff not knowing how to comminate or care for residents properly.</p> <p>Record review of facility policy titled In-Service Education, undated, revealed 1. Each year the administration or other designee will develop and implement an educational calendar to include (but not limited to) the following topics: 3. QAPI Program</p>

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<p>F 0946</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide training in compliance and ethics.</p> <p>46677</p> <p>Based on interview and record review, the facility failed to provide mandatory ethics training for 7 of 23 employees (Housekeeper N, CNA G, RN J, CNA K, CNA L, LVN M, LVN/MDS) employees reviewed for training, in that:</p> <p>The facility failed to ensure ethics training was provided to Housekeeper N, CNA G, RN J, CNA K, CNA L, LVN M, and LVN/MDS annually.</p> <p>This failure could affect residents and place them at risk of being uninformed due to lack of staff training.</p> <p>The findings include:</p> <p>Record review of the personnel records for Housekeeper N revealed a hire date of 10/04/2016. Review of a training in-services for Housekeeper N from the previous 12 months, provided by the HR Coordinator revealed no evidence of ethics training being provided annually.</p> <p>Record review of the personnel records for CNA G revealed a hire date of 07/31/2023. Review of a training in-services for CNA G from the previous 12 months, provided by the HR Coordinator revealed no evidence of ethics training being provided annually.</p> <p>Record review of the personnel records for RN J revealed a hire date of 02/17/2023. Review of a training in-services for RN J from the previous 12 months, provided by the HR Coordinator revealed no evidence of Ethics training being provided annually.</p> <p>Record review of the personnel records for CNA K revealed a hire date of 01/29/2024. Review of a training in-services for CNA K from the previous 12 months, provided by the HR Coordinator revealed no evidence of ethics training being provided annually.</p> <p>Record review of the personnel records for CNA L revealed a hire date of 03/18/2022. Review of a training in-services for CNA L from the previous 12 months, provided by the HR Coordinator revealed no evidence of ethics training being provided annually.</p> <p>Record review of the personnel records for LVN M revealed a hire date of 02/10/2015. Review of a training in-services for LVN M from the previous 12 months, provided by the HR Coordinator revealed no evidence of ethics training being provided annually.</p> <p>Record review of the personnel records for LVN/MDS revealed a hire date of 03/18/2022. Review of a training in-services for LVN/MDS from the previous 12 months, provided by the HR Coordinator revealed no evidence of ethics training being provided annually.</p> <p>(continued on next page)</p>		

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<p>F 0946</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with the HR Coordinator on 04/04/2025 at 1:34 PM, revealed she initiates in-service trainings every month and every month was a different topic. The HR Coordinator stated she presented the in-services to the department heads, and they present them to their staff. The HR Coordinator stated it was the responsibility of the department heads to complete the in-services and her responsibility to verify all staff have completed the assigned in-service each month. The HR Coordinator stated staff were notified they need to complete in-service trainings only when department heads present the trainings to them. The HR Coordinator stated she followed an on-boarding checklist for new employees that includes trainings. The HR Coordinator stated she was not sure why all Dietary Manager's trainings were not completed upon hire. The HR Coordinator stated it was important that staff received their initial and annual trainings to ensure they are providing quality care to the residents. The HR Coordinator stated this could affect the residents leaving them vulnerable to abuse, neglect, and exploitation.</p> <p>Interview with the DON on 04/04/2025 at 2:34 PM, revealed she received the in-services from the HR Coordinator monthly and presented them to her staff. The DON stated it is the responsibility of department heads to present the in-services to their staff. The DON stated once the in-services were complete the HR Coordinator verifies all employees had completed the in-service. The DON stated completing the in-services was important to ensure staff had the knowledge to complete their jobs effectually and safely. The DON stated if staff were not trained annually, it could leave resident's vulnerable to receiving poor care.</p> <p>Interview with the Administrator 04/04/2025 at 2:43 PM revealed the facility provides staff with an in-service each month and each month the in-service reflected a different required training topic. The Administrator stated HR Coordinator initiated each in-service and provided them to the department heads so that they could train their staff. The Administrator stated it was the responsibility of department heads to train their staff each month and the responsibility of the HR Coordinator to verify each staff completed the in-services. The Administrator stated having untrained staff could lead to negative outcomes such as staff not knowing how to comminate or care for residents properly.</p> <p>Record review of facility policy titled In-Service Education, undated, revealed 1. Each year the administration or other designee will develop and implement an educational calendar to include (but not limited to) the following topics: 40. Compliance and Ethics Program</p>		

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<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>46677</p> <p>Based on interview and record review, the facility failed to ensure CNA received the required minimum 12 hours annual in-service for 3 of 6 CNAs (CNA G, CNA K, CNA L) reviewed for training.</p> <p>The facility failed to provide the required 12 hours of annual training to CNA G, CNA K, CNA L.</p> <p>This failure could affect residents and place them at risk of being uninformed due to lack of staff training.</p> <p>The findings include:</p> <p>Record review of the personnel records for CNA G revealed a hire date of 07/31/2023. Review of a training in-services for CNA G from the previous 12 months, provided by the HR Coordinator revealed no evidence that the facility provided the required 12 hours of in-service trainings including communication training, QAPI training or ethics training being provided annually.</p> <p>Record review of the personnel records for CNA K revealed a hire date of 01/29/2024. Review of a training in-services for CNA K from the previous 12 months, provided by the HR Coordinator revealed no evidence that the facility provided the required 12 hours of in-service trainings including ethics training, falls training, restraint training or emergency preparedness training being provided annually.</p> <p>Record review of the personnel records for CNA L revealed a hire date of 03/18/2022. Review of a training in-services for CNA L from the previous 12 months, provided by the HR Coordinator revealed no evidence that the facility provided the required 12 hours of in-service trainings including ethics training being provided annually.</p> <p>Interview with the HR Coordinator on 04/04/2025 at 1:34 PM, revealed she initiates in-service trainings every month and every month was a different topic. The HR Coordinator stated she presented the in-services to the department heads, and they present them to their staff. The HR Coordinator stated it was the responsibility of the department heads to complete the in-services and her responsibility to verify all staff have completed the assigned in-service each month. The HR Coordinator stated staff were notified they need to complete in-service trainings only when department heads present the trainings to them. The HR Coordinator stated she followed an on-boarding checklist for new employees that includes trainings. The HR Coordinator stated she was not sure why all Dietary Manager's trainings were not completed upon hire. The HR Coordinator stated it was important that staff received their initial and annual trainings to ensure they are providing quality care to the residents. The HR Coordinator stated this could affect the residents leaving them vulnerable to abuse, neglect, and exploitation.</p> <p>(continued on next page)</p>		

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<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with the DON on 04/04/2025 at 2:34 PM, revealed she received the in-services from the HR Coordinator monthly and presented them to her staff. The DON stated it is the responsibility of department heads to present the in-services to their staff. The DON stated once the in-services were complete the HR Coordinator verifies all employees had completed the in-service. The DON stated completing the in-services was important to ensure staff had the knowledge to complete their jobs effectually and safely. The DON stated if staff were not trained annually, it could leave resident's vulnerable to receiving poor care.</p> <p>Interview with the Administrator 04/04/2025 at 2:43 PM revealed the facility provides staff with an in-service each month and each month the in-service reflected a different required training topic. The Administrator stated HR Coordinator initiated each in-service and provided them to the department heads so that they could train their staff. The Administrator stated it was the responsibility of department heads to train their staff each month and the responsibility of the HR Coordinator to verify each staff completed the in-services. The Administrator stated having untrained staff could lead to negative outcomes such as staff not knowing how to comminate or care for residents properly.</p> <p>A policy addressing required minimum 12 hours annual in-service for CNA was requested from the HR Coordinator on 04/04/2025 at 1:34 PM but was not provided prior to exit.</p> <p>A policy addressing required minimum 12 hours annual in-service for CNA was requested from the DON on 04/04/2025 at 2:34 PM but was not provided prior to exit.</p> <p>A policy addressing required minimum 12 hours annual in-service for CNA was requested from the Administrator on 04/04/2025 at 2:43 PM but was not provided prior to exit.</p>

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<p>F 0949</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide behavior health training consistent with the requirements and as determined by a facility assessment.</p> <p>46677</p> <p>Based on interview and record review, the facility failed to provide behavioral health training consistent with the requirements at S483.40 and as determined by the facility assessment at S483.71 for 2 of 28 (Dietary Aide I and Dietary Manager) employees reviewed for training, in that:</p> <p>The facility failed to ensure behavioral health training was provided to Dietary Aide I annually.</p> <p>The facility failed to ensure behavioral health training was provided to Dietary Manager upon hire.</p> <p>This failure could affect residents and place them at risk of being uninformed due to lack of staff training.</p> <p>The findings include:</p> <p>Record review of the personnel records for Dietary Aide I revealed a hire date of 12/08/2022. Review of a training in-services for Dietary Aide I from the previous 12 months, provided by the HR Coordinator revealed no evidence of behavioral health training being provided annually.</p> <p>Record review of the personnel records for Dietary Manager revealed a hire date of 10/23/2024. Review of a training in-services for Dietary Manager from the previous 12 months, provided by the HR Coordinator revealed no evidence of behavior health training being provided upon hire.</p> <p>Interview with the HR Coordinator on 04/04/2025 at 1:34 PM, revealed she initiates in-service trainings every month and every month was a different topic. The HR Coordinator stated she presented the in-services to the department heads, and they present them to their staff. The HR Coordinator stated it was the responsibility of the department heads to complete the in-services and her responsibility to verify all staff have completed the assigned in-service each month. The HR Coordinator stated staff were notified they need to complete in-service trainings only when department heads present the trainings to them. The HR Coordinator stated she followed an on-boarding checklist for new employees that includes trainings. The HR Coordinator stated she was not sure why all Dietary Manager's trainings were not completed upon hire. The HR Coordinator stated it was important that staff received their initial and annual trainings to ensure they are providing quality care to the residents. The HR Coordinator stated this could affect the residents leaving them vulnerable to abuse, neglect, and exploitation.</p> <p>Interview with the DON on 04/04/2025 at 2:34 PM, revealed she received the in-services from the HR Coordinator monthly and presented them to her staff. The DON stated it is the responsibility of department heads to present the in-services to their staff. The DON stated once the in-services were complete the HR Coordinator verifies all employees had completed the in-service. The DON stated completing the in-services was important to ensure staff had the knowledge to complete their jobs effectually and safely. The DON stated if staff were not trained annually, it could leave resident's vulnerable to receiving poor care.</p> <p>(continued on next page)</p>		

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<p>F 0949</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with the Administrator 04/04/2025 at 2:43 PM revealed the facility provides staff with an in-service each month and each month the in-service reflected a different required training topic. The Administrator stated HR Coordinator initiated each in-service and provided them to the department heads so that they could train their staff. The Administrator stated it was the responsibility of department heads to train their staff each month and the responsibility of the HR Coordinator to verify each staff completed the in-services. The Administrator stated having untrained staff could lead to negative outcomes such as staff not knowing how to comminate or care for residents properly.</p> <p>Record review of facility policy titled In-Service Education, undated, revealed 1. Each year the administration or other designee will develop and implement an educational calendar to include (but not limited to) the following topics: 41. Behavior Interventions</p>