STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455974	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rockport Nursing and Rehabilitation Center	1902 Fm 3036 Rockport, TX 78382

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47371 Based on interview and record review the facility failed to immediately consult with the resident's physician when there was a significant change or a need to alter treatment, for one resident (Resident #1) of three residents reviewed for notification of changes. The facility failed to consult with Resident #1's physician when Resident #1 held her groin, indicating pain, yelling ow ow ow on 07/06/2024. On 07/06/2024 there was indication of groin pain, which was different from 07/05/2024's left and right knee pain. These failures could affect residents who experience a change in condition that require immediate pain assessment and assistance. The findings included: Record review of Resident #1's face sheet dated 12/15/2024, revealed Resident #1 was initially admitted on [DATE], and readmitted on [DATE]. Resident #1 was a [AGE] year-old female who was admitted with diagnosis' fracture of unspecified part of neck of right femur (the bone of the thigh or upper hind limb, articulating at the hip and the knee), subsequent encounter for closed fracture with routine healing, cognitive communication deficit, age-related osteoporosis without current pathological fracture, dementia in other diseases classified elsewhere, moderate, with other behavioral disturbance, and history of falling. Record review of Resident #1's discharge MDS assessment dated [DATE] revealed, a BIMS of empty value indicating unable to complete the interview, and needed substantial assistance with toileting, bathing, dressing, personal hygiene and dependent for bed-to-chair transfer. Additionally, Resident #1 was coded for history of falling. Record review of Resident #1's care plan date initiated 07/06/2024 revealed, Problem: [Resident #1] has had an actual fall r/t impaired cognition, impaired mobility, behaviors, psychotropic drug use, unrealistic sense of abilities. 7/5/24- ambulating without walker; no injuries. Interventions: 7/5/24- Placed sign with resident name on her door due to wandering into other residents' rooms. Will speak to family regarding moving resident closer to nurses' station. (7/8/24- Pelvic x-ray ordered due to increased pain, noted right femoral neck fracture. Resident sent to hospital.) (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455974	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/16/2024
NAME OF PROVIDER OR SUPPLIER Rockport Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1902 Fm 3036 Rockport, TX 78382	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continue interventions on the at-risk plan. For no apparent acute injury, determine and address causative factors of the fall. Monitor/document /report PRN x 72h to MD for s/sx: Pain, bruises, change in mental status, new onset: confusion, sleepiness, inability to maintain posture, agitation. Neuro-checks per policy if applicable. Pharmacy consults to evaluate medications if indicated. Report to nurse any s/sx 72hour post fall: Pain, bruises, change in mental status, sleepiness, inability to maintain posture, agitation. Therapy screening evaluation. Record review of Resident #1's progress note dated 07/05/2024 at 15:32 (3:32PM) revealed, ADON A documented CNA notified Charge nurse that [Resident #1] was ambulating in hallway towards the nurses' station without her walker and upon approaching the resident to redirect and assist her, [Resident #1] then leaned her back against the wall and slid herself to the floor in a soft manner and upright position. Resident was assessed from head to toe and vitals obtained. Assisted to a standing position per staff assist x 1 and ambulated with assist to her room. No complaints voiced at this time. call light in reach. [primary care provider] was notified and no further orders were received. skin intact. Record review of Resident #1's pain evaluation effective date 07/05/2024 at 16:13 (4:13PM) revealed, Resident #1's complaint of right knee (front): description: chronic pain with ambulation; left knee (rear) description: chronic pain with ambulation. 4b: Negative vocalization-occasional moan or groan low-level of speech with a negative or disapproving quality. 4c: Facial expression: Sad/frightened/frown- Sad. Frightened. Frown. Record review of Resident #1's progress notes administration note dated 07/06/2024 at 9:50AM LVN A documented, Tramadol HCL Tablet 50mg. Give 50mg by mouth every 6 hours as needed for pain. Note: Resident crying and yelling out it hurts while rubbing her thighs and knees. Record review of Resident #1's progress notes effective date 07/06/2024 at 13:54 (1:54PM) LVN A documented follow up pain scale was effective and numerical value 0. Record review of Resident #1's progress notes effective date 07/06/2024 at 21:24 (9:24PM) LVN A documented Administration note: Tramadol HCl tablet 50MG: Give 50MG by mouth every 6 hours as needed for pain Resident holding groin and yelling OW OW OW nurse assessed area for any redness or any other irregularity, none noted. Bowel sounds active in all 4 quadrants, no bowel movement at the time no hardened area near anus. Record review of Resident #1's progress note dated 07/07/2024 at 12:37PM LVN A documented Resident refusing to sit up into a complete sitting position yells out in pain when staff assist her to turn. Resident grabbing and holding onto her groin thighs and knees. All medication orders followed with no relief. Nurse attempted nonpharmacological interventions. no changes noted in pain. [Primary Care Provider] notified of increased pain. DON notified of change. Received N.O for Tramadol 50 MG PO Q6H X5 DAYS and Acetaminophen 500 MG PO Q6H X5 DAYS. Resident has accepted all medications. Record review of Resident #1's radiology results report examination dated 07/08/2024 at 14:24 (2:24PM) Impression: The bones are osteoporotic. There is an acute right femoral neck fracture. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455974	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rockport Nursing and Rehabilitation Center	1902 Fm 3036 Rockport, TX 78382

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/16/2024 at 1:13PM, 1:28PM, 1:49PM attempted interview with LVN A. Additionally, ADON A, DON, and Administrator attempted to contact LVN A, but staff member was not responding. ADON A stated LVN A was on maternity leave. LVN A did not return call prior to exit conference. During an interview on 12/15/2024 at 3:56PM ADON A stated Resident #1 had a witnessed fall on 07/05/2024 and 2 days later, Resident #1began to complain about a lot of pain. ADON A stated after Resident #1's verbalized pain the facility advocated for an x-ray, but that Resident #1 was still walking around up to that point. ADON A stated Resident #1 always complained about her chronic knee pain. ADON A stated Resident #1 would often refuse medications and care, and to persuade Resident #1 to receive an x-ray, for her, was identical to pulling teeth. ADON A stated Resident #1 on 07/05/2024 did not show any indication of unusual pain other than her chronic knee and thigh pain. ADON A stated Resident #1 was seen on 07/06/2024, was seen wandering in the hallway. ADON A stated on 07/07/2024 Resident #1 exhibited signs of severe pain and the primary care physician was notified. ADON A stated on 07/08/2024 Resident #1 again exhibited unmanaged pain to which an x-ray was ordered, and results concluded Resident #1 had an acute fracture. ADON A stated Resident #1 was very hard to treat as Resident #1 would refuse care. ADON A stated while reviewing 07/06/2024's progress note, as LVN A described a different area of pain, the expectation would be for the nurse to notify the practitioner of the pain irregularity. ADON A stated Resident #1's complaints of knee and thigh pain were not out of character. ADON A stated, while reading LVN A's 07/06/2024 progress notes, LVN A should have notified the primary care physician as an effort to advocate for the well-being of Resident #1. ADON A stated LVN A had previously been re-educated on a separate nursing matter concerning documentation, and stated once LVN A returns she will be removed from independently caring for residents and will be retrained with another staff member. ADON A reiterated that LVN A should have notified the primary care physician of Resident #1's groin pain, and potentially compromised the resident's well-being. ADON A stated while reviewing the progress notes, the resident's pain was being managed on 07/06/2024, and it wasn't until the following day on 07/07/2024 that Resident #1 exhibited pain that was then deemed unmanageable, to which the nurses advocated for additional interventions including medications and x-rays. ADON A stated LVN A is out on maternity leave. ADON A stated while, reviewing Resident #1's progress notes if Resident #1 had a change in pain location or an increase in pain, LVN A should have notified the primary care physician to inquire about any additional interventions, and stated LVN A had been educated on notifying physicians. ADON A stated she would want to see that staff was doing something about the pain. ADON A stated she would provide those above mentioned LVN A re-trainings. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455974	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/16/2024
NAME OF PROVIDER OR SUPPLIER Rockport Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1902 Fm 3036 Rockport, TX 78382	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/16/2024 at 3:29PM the DON stated she has worked for this facility since the end of June 2024. The DON stated Resident #1 had horrible knee pain and it was difficult to see Resident #1 endure the pain while Resident #1 walked the hallway. The DON stated she does not know what LVN A was thinking or her intent on 07/06/2024, but that Resident #1 would not be able to verbalize pain. The DON stated the expectation of the facility would be to follow the professional standard of nursing and conduct a thorough head to toe exam and notify the primary care provider if any irregularities are noted. The DON stated she could not provide a definitive answer regarding if pain would be an irregular finding. The DON stated she could not give a definitive answer or what was an abnormal and normal finding regarding a pain assessment. The DON stated Resident #1 was still ambulating on 07/05/2024 and 07/06/2024, but if LVN A found something irregular during her assessment, she should have notified the primary care physician, as an effort to advocate for the well-being of Resident #1. The DON stated the groin is anatomically different from the knees and thighs, and that if she were the nurse taking care of the resident, she would have notified the physician of Resident #1's groin pain. The DON stated any unusual findings on assessment the provider would be notified. The DON stated if LVN A did not notify the physician of Resident #1's complaint of groin pain on 07/06/2024, she could have potentially compromised the well-being of Resident #1, by prolonging pain endurance. The DON stated while reviewing Resident #1's progress notes, on 07/06/2024 Resident #1's pain was being managed, but that there appeared to be no documentation of notifying the physician of Resident #1's groin pain. The DON stated the plan once LVN A returns from maternity leave, is to retrain her with another knowledgeable clinical staff member. During a brief interview on 12/16/2024 at 2:13PM the Administrator stated that she would have to locate LVN A's individual documentation re-training in-service within her in-service binder but alluded to not being able to locate the requested documentation. Additionally, that retraining document for LVN A was not provided by time of exit conference. Record review of the facility's Notification of Changes policy and procedure date implemented 10/24/2022 documents, The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician, and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. Circumstances requiring notification include: 2. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. Record review of the facility's Pain Management policy and procedure date implemented 08/15/2022 documented, the facility must ensure that pain management is provided to resident who require such services, consistent with professional standards of practice, the comprehensive person-entered care plan and the residents' goals and preferences. Recognition: 2. The facility will observe for nonverbal indicators which may indicate the presence of pain. Theses indicators include but are no limited to b. Loss of function or inability to perform activities of daily living (e.g., rubbing a specific location of the body, or guarding a limb or other body parts). Pain Management and Treatment: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455974	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/16/2024
NAME OF PROVIDER OR SUPPLIER Rockport Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1902 Fm 3036 Rockport, TX 78382	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Based upon the evaluation, the facility in collaboration with the attending physician/prescriber, other health care professionals and the resident and/or resident's representative will develop, implement, monitor and revise as necessary interventions to prevent or manage each individual's resident pain beginning at admission.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455974	A. Building B. Wing	12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rockport Nursing and Rehabilitation Center	1902 Fm 3036 Rockport, TX 78382

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47371 Based on interviews and record review the facility failed to notify the resident, resident's representative, and ombudsman of the transfer or discharge and the reasons for the move in writing and in a language and manner they understood before transferring or discharging the resident for 1 of 4 residents (Resident #2) reviewed for transfer and discharge. Resident #2's responsible party and the ombudsman were not notified in writing of the effective date of transfer or discharge for Resident #2, the reason for the transfer/discharge, the location to which the resident would be transferred, or the right of appeal. Resident #2 was discharged on [DATE] to an emergency room hospital for a psychological evaluation. This deficient practice could affect residents who are transferred or discharged from the facility at risk of having their discharge rights violated. The findings included: Record review of Resident #2's face sheet dated 12/15/2024 revealed a [AGE] year-old female who was admitted on [DATE]. Diagnoses included Alzheimer's disease (decline in cognitive abilities that impacts a person's ability to perform everyday activities), and frontotemporal neurocognitive disorder (types of dementia involving the progressive degeneration of the brain's frontal and temporal lobes). Date of discharge 05/21/2024, discharged to behavioral hospital. Record review of Resident #2's Optional State Assessment MDS assessment dated [DATE] reflected a BIMS score of 12 (moderate cognitive impairment) with supervision oversight for bed mobility, transfers, eating, and was not coded for any behavioral issues. Record review of Resident #2's care plan date initiated 5/15/2024 reflected no behaviors including physical or psychological (suicidal ideation, or homicidal ideations) noted. Resident #2 was admitted on [DATE] and discharged [DATE]. The resident has impaired cognitive function/dementia or impaired thought processes. Communicate with the resident/family/caregivers regarding residents' capabilities and needs. Use the resident preferred name. Identify yourself at each interaction. Face the resident when speaking and make eye contact. Reduce any distractions- turn off TV, radio, close door etc. The resident understands consistent, simple, directive sentences. Provide the resident with necessary cues stop and return if agitated. Cue, reorient and supervise as needed. Engage the resident in simple, structured activities that avoid overly demanding tasks. Keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. Record review of Resident #2's progress notes dated 05/21/2024 at 15:37 (3:37PM) revealed, Charge Nurse notified this nurse that [Resident #2] is inconsolable and crying, stated she wanted slit her throat Upon entering the dining area in the tradition's unit, [Resident #2] was sitting at the table and crying. She stated, I want to take a knife and cut my throat When asked what happened she stated she wanted a cigarette, and no one will let me smoke when I want to smoke! this nurse assisted resident to smoking area and she calmed a bit. She continued to express the want to harm herself. Administrator, DON, MD and [family member] notified. Orders received to send to ER for evaluation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455974	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rockport Nursing and Rehabilitation Center	1902 Fm 3036 Rockport, TX 78382

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0623

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Record review of Resident #2's physician's order dated 05/21/2024 revealed, send to ED for further evaluation and treatment.

Record review of Resident #2's Transfer/Discharge notice on Resident #2's electronic health record dated 05/21/2024 at 16:00 (4:00PM) revealed, 1. On this date 05/21/2024, the facility representative is notifying a. Resident and b. Resident Representative of a transfer/discharge. 3. The resident is being discharged /transferred for the reasons below: a. Emergency transfer to Acute Care setting. 4. Bed Hold Policy Provided. 5. CC: Facility Ombudsman.

Requested on 12/15/2024 at 11:16AM for DON and ADON A to provide the written notification of Resident #2's discharge to Resident #2's responsible party and ombudsman. No documentation was provided by exit conference.

Requested on 12/15/2024 at 12:34PM for the Administrator to provide the written notification of Resident #2's discharge to local ombudsman and responsible party. No documentation was provided by exit conference.

Record review of the facility's Complaint/Grievance Follow-up Report date received 06/11/2024, date of initial contact: 06/11/2024, Name of Person Contacted: [Ombudsman B], Name of person Assigned to Resolve Compliant/grievance: Administrator, Nature of Complaint: Ombudsman stating she filed complaint with state for improper discharge of resident to behavioral hospital and now facility does not have a bed available for her on secure unit. Follow up: Comments: Please see attached document. The attached document is the Resident Admission Agreement revised: 10/14/2021, with a highlighted portion on page 10 entitled Bed Hold stating Consequently it is the responsibility of the Medicaid recipient or responsible party to reserve a bed at this healthcare facility and to [ay bed hold charges as stated in this agreement .The first notice is provided upon admission or readmission to the facility. The second notice is provided at the time of transfer for hospitalization or therapeutic leave that does not meet the criteria for Medicaid payment. There were no other documents attached to grievance complaint.

During an interview on 12/15/2024 at 11:57AM and on 12/16/2024 at 11:41AM the SW stated she started her employment at the facility in late March 2024. The SW stated once a resident is admitted /readmitted to the facility she will conduct a series of assessments including demographic information, and transitional planning care form. The SW stated she is not involved in the discharge process if the resident is transferred to an emergency room but does play a part in facility-to-facility transfer, and when a resident is discharged to home. The SW stated she was notified during a morning meeting of Ombudsman B's concern of improper discharge of Resident #2. During a morning clinical meeting and stated she does not recall the date of the meeting. The SW stated on 5/21/2024 Resident #2 was discharged to the emergency room for a psych evaluation. The SW stated once the resident is outside of the facility, she does not follow up with outside facility entities. The SW stated if a resident verbalized suicidal ideations, the clinical staff would advocate for a psychological evaluation and treatment for the well-being of the resident. The SW stated during June 2024 she recalls speaking with the Ombudsman A about the concern of not receiving the discharge list from the facility. The SW stated she does not recall the specific details when she spoke to Ombudsman A. The SW stated, when the residents are discharged home, she will provide a discharge summary and when they need to follow up with the PCP. The SW stated maybe the hospital nurse case manager may provide discharge notification something, but it is more for home discharge, but she herself does not send any written notification to RPs if a resident is being transferred to another facility after the hospital.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455974	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/16/2024
NAME OF PROVIDER OR SUPPLIER Rockport Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1902 Fm 3036 Rockport, TX 78382	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/16/2024 at 11:26AM the BOM stated she does not send out any discharge/transfer written notifications to the RP or Ombudsman. The BOM stated her scope of practice, within the electronic health record was to ensure the electronic health record is complete to which she will then close out the record to reflect the resident is no longer within the facility. The BOM stated her normal practice is to close out the electronic health record, the day after the resident is transferred/discharged . The BOM stated that is the extent of her role regarding the discharge process. During an interview on 12/16/2024 at 12:20PM the Admissions Director/Coordinator stated she does not send out any discharge/transfer written notifications to the RP or Ombudsman. The Admissions Director stated she is not a part of the discharge process. During an interview on 12/16/2024 at 12:36PM the Administrator stated Resident #2 was transferred to a hospital for a psychological evaluation on 05/21/2024 as she was voicing suicidal ideations. The Administrator stated she was unaware that the facility needed to notify the RP and Ombudsman in written form about the discharge/transfer of Resident #2. The Administrator stated on 5/21/2024 the RP was notified verbally of Resident #2's transfer to the hospital for a psychological evaluation, but stated she was unaware that she needed to additionally notify the ombudsman. The Administrator stated she does not recall discharge written notifications being sent out for Resident #2. The Administrator did not provide a definitive answer when asked how could not providing the written discharges/transfer notifications affect the residents. The Administrator reiterated she was unaware that she needed to provide written notifications to RPs and Ombudsman. The Administrator stated once the resident is transferred/discharged out of the facility to another facility she, herself, does not have a follow up process. The Administrator stated she will attempt to locate written discharge documents for Resident #2 to RP and Ombudsman. Record review of the facility's Discharge Summary and Place of Care date implemented 10/24/2022 reflected it does not include the process for providing documentation upon discharge.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455974	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/16/2024
NAME OF PROVIDER OR SUPPLIER: Rockport Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1902 Fm 3036 Rockport, TX 78382	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47371 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives and time frames to meet residents' physical, mental, and psychosocial needs, for 1 resident (Resident #3) of 4 residents reviewed for care plans. The facility did not care plan Resident #3's refusal of care nor his aggressive behaviors. These failures could place residents at risk for not receiving necessary care and services. The findings included: Record review of Resident #3's Face Sheet dated [DATE] documented an [AGE] year-old male initially admitted on [DATE] and readmitted on [DATE] with the diagnoses of: Alzheimer's disease (cognitive deficits), dementia (cognitive deficits), mood disorder due to physiological condition with depressive features, dementia in other diseases classified elsewhere, moderate, with psychotic disturbance, and generalized anxiety disorder. Resident #3 was discharged [DATE]. Record review of Resident #3's Quarterly Minimum Data Set assessment dated [DATE] revealed Resident #3 had a brief interview of mental status score of 3 (severe impaired cognition). Resident #3 was coded for rejection of care occurring 1 to 3 days, but not coded for verbal/physical behaviors directed to others (including: hitting, kicking, pushing, scratching, grabbing, abusing other sexually, threatening other, screaming at others, or cursing at others). Resident #3 was additionally coded for needing substantial assistance for toileting, showering, dressing, and personal hygiene. Resident #3 was coded for needing partial/moderate assistance for transferring from chair/bed-to-chair transfer. Record review of Resident #3's Care Plan date initiated [DATE] refelcted care plans [resident] uses antipsychotic medication (Seroquel) related to behaviors. However, there are no specific behaviors (including verbal or physical aggressiveness) noted throughout the care plan. Nor is there any plan of care for Resident #3's refusal of care. Record review of Resident #3's Progress note dated [DATE] at 15:58 (3:58PM) the Administrator documented Admin and DON spoke with [family member] that nursing staff will be instructed to notify her of any updates regarding resident, including when resident refuses ADL care. Record review of Resident #3's Progress note dated [DATE] at 8:18AM revealed LVN C documented CNA reported that resident refused to go to dining room for breakfast, yelling and telling staff to get out of his room. Reapproached by nurse and assisted to dining room, pleasant mood, good appetite, no further refusal of care. X1 extensive assist with shower. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455974	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/16/2024
NAME OF PROVIDER OR SUPPLIER Rockport Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1902 Fm 3036 Rockport, TX 78382	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #3's Progress note dated [DATE] at 11:57 AM revealed LVN B documented Spoke with [family member], to inform that [Resident #3] has refused his shower x2, she informed me he was probably tired from being gone all day yesterday and it was alright if he does not have a shower today, but if he refuses on his next shower day on Monday to call her so she can help. Record review of Resident #3's Progress note dated [DATE] at 1:32AM LVN D documented, Phlebotomist in facility to obtain ordered labs for procedure. Resident refusing to have labs drawn. Attempted to call [family member] x2 to speak with resident. No answer left voicemail. Attempted to encourage resident to allow labs to be drawn after explaining the purpose and resident became combative and attempted throwing remote at this nurse. Repeatedly screaming to get the f*** out and don't come back. Left the room with the phlebotomist and attempted calling RP again. No answer. Will update when call is returned. Record review of Resident #3's Progress note dated [DATE] at 11:50AM, the SW documented [Resident #3 was on the schedule to see optometry today ([DATE]). He declined. I called his [family member] to inform her. Record review of Resident #3's Progress note dated [DATE] at 22:38 (10:38PM) RN A documented Refused to be assessed by this nurse. Yelling at aides and roommate. Record review of Resident #3's Progress note dated [DATE] at 7:30AM LVN D documented, CNA attempted to assist resident to change brief and resident grabbed CNAs wrist and began yelling at her to get out of his room. This nurse went into room to intervene and attempted to find out why he is upset, and he immediately became verbally aggressive again yelling to get out of his room and to leave him alone. Attempted to encourage help due to being fall risk, resident continued with agitation. Record review of Resident #3's Progress note dated [DATE] at 14:40 (2:40PM) revealed LVN C documented Resident continues with increased agitation at times. Much reorientation, redirection, and reapproach when needed. Resident arguing with residents at lunch table where he normally sits, moved to another table. Record review of Resident #3's Progress note dated [DATE] at 10:00AM revealed LVN C documented Resident sitting in recliner refusing assistance with toileting and incontinent care. Different staff members attempted to assist, and resident continues to refuse care. Resident stated I know I am wet. This is my body and I do not want you to touch me. Record review of Resident #3's Progress note dated [DATE] at 10:30AM revealed LVN C documented Call to [family member] and notified that resident continues to refuse care after several attempts . Record review of Resident #3's Progress note dated [DATE] at 12:00PM revealed LVN C documented Resident allowed OT to transfer to wheelchair and to dining room, continued to refuse incontinent care. Record review of Resident #3's Progress note dated [DATE] at 15:32 (3:32PM) revealed LVN C documented Call to [physician] reported that resident continues to refuse care with episodes of anxiety and agitation/ aggression. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455974	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/16/2024
NAME OF PROVIDER OR SUPPLIER Rockport Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1902 Fm 3036 Rockport, TX 78382	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #3's Progress note dated [DATE] at 13:01 (1:01PM) revealed LVN C documented Reported to [primary care provider] continuation of behaviors including refusing care, easily agitated, argumentative, episodes of anxiety. During an interview on [DATE] at 1:25PM LVN C stated Resident #3 would refuse care often. LVN C stated Resident #3 was diagnosed with dementia. LVN C stated when Resident #3 would refuse care, she would instruct the CNAs to revisit and offer showers, with different people. LVN C stated CNAs would document refusal for shower in Resident #3's electronic health record. LVN C stated the CNA, would notify her each time Resident #3 refused care. LVN C stated Resident #3 was combative with several CNAs but does not recall specific names. LVN C stated if she were to encounter any care refusals, she would document in nurses' notes. LVN C also stated she would also notify the administration during daily care meetings, and Administrator was made aware of all concerns, and addressed them in care plan meetings. LVN C stated she does not edit resident care plans, and stated the care plans are updated by the MDS Coordinator and possibly the managerial administration. LVN C stated care plans afford the nursing clinical staff to know what the plan of care is for each of their residents. LVN C stated if a resident was exhibiting certain behaviors, the nurse could review the care plan and see which interventions were viable for taking care of those specific resident behaviors. LVN C stated if care plans are not updated accordingly, there could be a potential negative effect on the resident's well-being. LVN C stated she could not recall when she was last in-serviced about care plans. During an interview on [DATE] at 3:12PM ADON A stated Resident #3 was physically aggressive towards staff. ADON A stated Resident #3's family member would be notified each time Resident #3 was refusing showers, and when he was exhibiting aggressive behaviors. ADON A stated Resident #3 would chronically refuse brief changes, transfers from bed to chair, showers, became very confused, and would become angry and combative with staff and family. ADON A stated care plans were utilized to notify the clinical staff that there is a problem, and interventions needed to fix the issues. ADON A stated care plans were in place to communicate what goal is warranted for each resident. ADON A stated Resident #3's chronic refusals of care would be something to care plan. ADON A stated, while reviewing the care plan for Resident #3, Resident #3's chronic refusals of care should have been care planned. ADON A stated she did not see the chronic refusal behavior on Resident #3's care plan, nor did she see any interventions for Resident #3's aggressive behavior. ADON A stated the care plan would be updated by the MDS Coordinator. ADON A stated care plans would aid in interventions, like if family wanted to be called, or if something works, care plans should be updated to reflect current concerns and effective interventions. ADON A stated the well-being of Resident #3 could have been affected negatively since his care plan was not updated accordingly. ADON A stated nurses have access to edit care plans. ADON A stated, while reviewing Resident #3's care plan, that it should have been updated to include specific aggressive behaviors, and his refusal of care. ADON A stated she does not know why Resident #3's care plan was not updated to reflect the two noted concerns. ADON A stated she was certain the care plan was updated to include Resident #3's aggressive behaviors and refusal of care, but does not understand why those two concerns are not in Resident #3's care plan. ADON A stated last month nurses were educated via in-service on the expectation of documenting in care plans. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455974	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/16/2024
NAME OF PROVIDER OR SUPPLIER Rockport Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1902 Fm 3036 Rockport, TX 78382	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 2:35PM the MDS Coordinator/Case Management Specialist (CM), stated , d+[DATE] months before Resident #3 expired, the resident would refuse to shower, eat, and became physically and verbally combative. CM stated Resident #3 was combative with staff, stopped eating, and refused to take showers. CM stated nurses would try hard to advocate for the resident's well-being, but he would refuse. CM stated the family would be notified when Resident #3 would refuse showers. CM stated Resident #3's violent and refusal behaviors were care planned. CM stated, while reviewing Resident #3's care plan, she did not see the behaviors care planned. CM stated Resident #3's refusal for care including incontinent care, and bathing are not care planned. CM stated these behaviors and refusals should be care planned. CM stated nurses, social workers, activities director, ADONs, and DON all have access to edit. CM stated ADONs and DON, and nurses update acute incident/accidents. CM stated this particular care plan for Resident #3 was not updated to reflect Resident #3's refusal of care, and aggressive behaviors. CM stated care plans are utilized to know what is happening with resident, and what is needed to provide an in-depth perspective of what is going on with Resident #3 and is also used to know the facility is doing what they are supposed to do for the resident. CM stated interventions used when Resident #3 was exhibiting aggressive behaviors (including verbal and physical aggression) included offering sandwiches or coffee. CM stated care planning could have helped de-escalate Resident #3's aggression, but continued to state, nothing was helping during Resident #3's progressive decline. CM stated by not editing Resident #3's care plan, Resident #3's well-being could have been negatively impacted. CM stated department heads from the facility were in-serviced by their corporation consultant about care planning last March/April of 2023. During an interview on [DATE] at 3:29PM the DON stated she began her employment with the facility the end of [DATE]. The DON stated aggressive behaviors and refusals would be care planned. The DON stated care plans are tools that communicate to staff interventions if they had questions regarding the care of the resident. The DON gave no definitive answer when asked how non-updated care plans could affect the resident. The DON gave no definitive answer when asked, why Resident#3's care plan was not updated. The DON stated she could not speak to the previous DON's actions or intent. The DON stated if a resident did exhibit aggressive behaviors, she would care plans the specific behaviors, additionally if a resident was exhibiting/verbalizing refusal of care, she would include that concern into the care plan. The DON stated, her process is that if there is a concern, it is addressed during next IDT meeting which happens daily Monday-Friday. The DON stated during the IDT meetings, care plans are updated accordingly. The DON could not recall when the last care plan in-service was conducted. The DON stated the MDS Coordinator, ADONs, and department heads have access to edit care plans, but gave no definitive answer as to why Resident #3's care plan was not updated for his refusal of care nor his aggressive behaviors. Record review of the facility's [DATE], [DATE] Care Plans in-service reviewed. Record review of the facility's Care Plan Revisions Upon Status Change date implemented [DATE] documented, Policy: The purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change 2. Procedure for reviewing and revising the care plan when a resident experience a status change 2d. The care plan will be updated with the new or modified interventions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455974	A. Building B. Wing	12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rockport Nursing and Rehabilitation Center	1902 Fm 3036 Rockport, TX 78382

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2f. Care plans will be modified as needed by the MDS Coordinator or other designated staff member.