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	07/22/2025

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	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the comprehensive care plan was developed and implemented within a timely manner for each resident consistent with resident rights to include measurable objectives and timeframes to meet residents medical, nursing, mental, and psychosocial needs identified in the comprehensive assessment for 1 (Resident #1) out of 5 residents reviewed for care plans. The facility failed to update or revise Resident #1's care plan to reflect Resident #1's verbal and combative behavior of resistant to care or refusal of care. This failure could place resident at risk for receiving inadequate care and services. Findings included:Record review of Resident #1's face sheet dated [DATE] revealed a [AGE] year-old female with an admission date of [DATE]. Diagnoses included Alzheimer's with Late Onset (a chronic condition which primarily affects memory, thinking, and behavior), Dementia (decline in cognitive function which affects daily life, memory, reasoning, and language skills), Cognitive Communication Deficit (difficulties in communication which arise from impaired cognitive functions, such as attention, memory, reasoning, and problem-solving), and Need for Assistance with Personal Care.Record review of Resident #1's quarterly MDS assessment, dated [DATE], revealed BIMS was not conducted as Resident #1 was rarely or never understood. The language section of the MDS revealed the preferred language was Vietnamese, and MDS was unable to determine if an interpreter was needed to communicate with a doctor or health care staff.Record review of Resident #1's current care plan initiated [DATE] and revised [DATE] revealed a care plan for resident resistive to care related to dementia, Resident #1 yelled at staff during incontinent care and refused to allow staff to shower her, obtain vitals, or weigh her. Care plan goal initiated [DATE] revealed Resident #1 would cooperate with care through next review. Care Plan interventions initiated [DATE] revealed: allow resident to make decisions about treatment, encourage participation, and if resident resists ADLs, reassure her, leave and return 5-10 minutes later to try again. Goals and Interventions were added[DATE]. Care plan also revealed Resident #1 had a communication problem related to a language barrier, initiated [DATE], and revised [DATE]. Interventions for communication problem care plan, initiated [DATE], included anticipate and meet Resident #1's needs, Resident #1 preferred to communicate in Vietnamese, and Resident #1 required communication cue cards located in nightstand.Record review of Resident #1's progress note dated [DATE] revealed RN-A was called to Resident #1's room by the CNA, who had reported Resident #1 had slid off bed after incontinent care. Resident #1 was noted to be on the floor on the left side of her bed, lying on her left side with her sheet wrapped around her. Resident #1 was alert and yelling in Vietnamese, as well as moving her arms and legs. CNA attempted to use an electronic translator to attempt to interview resident, but translator was unable to produce a response. No visible injuries were noted, skin assessment performed, and Resident #1 was assisted by 2 staff back into bed, and incontinent care was provided. Resident refused to allow blood pressure or oxygen to be taken, but pulse was 74 and respirations were 18. Record review of Resident #1's Kardex (a quick reference or an extension of the care plan, derived from the care plan, used by CNAs and other staff to stay updated on residents key needs and care) dated [DATE] revealed a communication section with interventions to include: ask yes or no questions to determine resident's needs, Resident #1 prefers to communicate in Vietnamese, Resident #1 required communication cue cards which were located in the bedside table and ensure availability and functioning of adaptive communication equipment. In an interview on [DATE] at 10:05 AM, CNA-B stated Resident #1 spoke Vietnamese, so she could not understand her, but she would smile in response when spoken to like she understood some things which were said to her in English, but other than this, the staff had no way to formally communicate with this resident or understand what Resident #1 was saying to them or needing from them. CNA-B stated Resident #1 would get worked up frequently and yell, but she had never seen her get combative. CNA-B stated she walked into Resident #1's room on [DATE] after Resident had fallen out of bed. She stated she had offered assistance with the resident since she had showered her earlier in the day and had a good rapport with her. She stated Resident #1 was talking and yelling in Vietnamese but was not crying or grimacing like she was in pain. She stated she had no other way to communicate with her or understand her, as CNA-C had already tried the translator device, and it had not worked. It was not typically used for this resident as it would not pick up what she was saying or yelling. She did say she could answer some simple yes or no questions if they point to things and asked, such as pointing to or rubbing stomach and asking if it hurt. In an interview on [DATE] at 10:39 AM, CNA-C stated after Resident #1 fell out