

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 01/29/2025
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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44748</p> <p>Based on interview and record review, the facility failed to ensure the right to be free from abuse for one (Resident #1) of two residents reviewed for abuse.</p> <p>The facility failed to ensure Resident #1 was free from abuse. On 01/25/25, Resident #2 hit Resident #1 in the stomach with a closed fist as she was walking past her.</p> <p>This failure could place residents at risk for abuse and psychological harm.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet dated 10/19/24 revealed a [AGE] year-old female with diagnoses including dementia (disease that results in loss of memory, language problem, problem-solving and other thinking abilities that are severe enough to interfere with daily life), muscle wasting, high blood pressure, congenital (present at birth) malformation of brain, and abnormalities of gait and balance.</p> <p>Record review of Resident #1's Admission MDS Assessment, dated 10/24/24, reflected a [AGE] year-old female who admitted on [DATE]. Her BIMS score of 03 indicated the resident had severe cognitive impairment with inattention and disorganized thinking. She required supervision for all ADL 's. She could walk without the use of a wheelchair, walker, or cane. She was occasionally incontinent of urine and frequently incontinent of bowel.</p> <p>Record review of Resident #1's Care Plan dated 11/07/24, reflected Resident #1 was an elopement risk related to degenerative cognitive disease and was appropriate for placement in the secure unit. Resident #1 had a behavior problem r/t degenerative cognitive disease and declined showers and assistance with care. She carried her clothes and items from her room with her keys around unit asking to open door as she had been dismissed.</p> <p>Record review of Resident #2's face sheet dated 07/16/21 revealed an [AGE] year-old female with an original admitted [DATE]. Diagnoses included Alzheimer ' s Disease, dementia, lack of coordination, major depression, Diabetes with glaucoma and neuropathy, anxiety, and spinal stenosis (could not walk).</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record Review of Resident #2's Quarterly MDS Assessment, dated 12/26/24, reflected her BIMS score of 02 indicated the resident had severe cognitive impairment with inattention and disorganized thinking. She required partial assistance with eating and oral hygiene and substantial assistance with all other ADL 's. She utilized a manual wheelchair and required assistance to propel. She was always incontinent of bladder and bowel. She did not display any behaviors at the time (look back period) of the MDS assessment. She took antipsychotic, antianxiety, antidepressant, and anticonvulsant medications.</p> <p>Resident #2's quarterly care plan dated 01/27/25 reflected Resident #2 was the aggressor of physical aggression towards another resident. Resident yelling and throwing drinks at one resident, then punched another resident in the abdomen. Date Initiated: 01/27/25. The goal was the resident would have no long-term issues related to incident through the target date of 12/26/24. Interventions included labs drawn per physician order, referral sent to local psychiatric hospital for in-patient psych evaluation, placed on 1:1 post incident per physician order, and social services to perform a psychosocial assessment. Date Initiated: 01/27/25. Resident #2 was physically aggressive related to anger; resident will occasionally grab other residents by the arms without provocation. Date Initiated: 10/09/20 Revision on: 11/25/24. The goal was the resident would demonstrate effective coping skills through the review date. Date Initiated: 10/09/20 Revision on: 10/24/24 Target Date: 12/26/24. Interventions included place resident on 1:1 due to aggressive episode until discontinued by physician, administer medications as ordered Date initiated 11/25/24, monitor/document for side effects and effectiveness Date Initiated: 10/09/20, analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document. Date Initiated: 10/09/20, assess and address for contributing sensory deficits.</p> <p>Date Initiated: 10/09/20, assess and anticipate resident's needs: food, thirst, toileting needs, comfort level, body positioning, pain etc.</p> <p>Date Initiated: 10/09/20, monitor/document/report PRN any signs or symptoms of resident posing danger to self and others. Date Initiated: 10/09/20, place resident on 1:1 for aggressive episodes as ordered if indicated. Date Initiated: 11/25/24. Resident #2 required a structured environment in the secure unit related to cognitive deficit Date Initiated: 09/16/24, Revision on: 12/27/24. The goal was the resident safety would be maintained through review date. Date Initiated: 10/03/24. Revision on: 12/27/24. Target Date: 12/26/24. Interventions included encourage activity participation, explain what you are going to do before touching the person with cognitive loss, speak calmly. Date Initiated: 10/03/24. Revision on: 12/27/24. The resident had impaired cognitive function and impaired thought processes related to dementia with behavior issues and delusions. Date Initiated: 09/11/20. Revision on: 09/25/24. Interventions included cue, reorient and supervise as needed, Date Initiated: 09/11/20. 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 to decrease confusion. Date Initiated: 01/20/21. Monitor/document frustration level. Wait 30 seconds before providing resident with word. Date Initiated: 09/16/20.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation of Residents #1 and #2 in the secure unit on 01/29/25 from 1:40 pm to 2:30 pm revealed Resident #2 was sitting at a table with no one next to her, but across the table from her. She was pulling the hem out of her dress. Three different residents walked near or toward Resident #2 and LVN G was quick to intervene by approaching each of them calmly and redirecting them away from Resident #2. Resident #2 would intermittently burst out laughing for no apparent reason. Resident #2 would stare at everyone and occasionally, she would look at the television. Resident #1 was independently ambulating around the secure unit with a steady gait. She had shoes on, she was braless but well kempt otherwise, and had a large purse over her left shoulder. The purse appeared to be stuffed full. She was smiling, cheerful, and talkative.</p> <p>Attempted interview with Resident #2 on 01/29/25 at 2:00 pm was unsuccessful. She stared at this surveyor and did not answer any questions. She maintained a flat affect.</p> <p>In an interview with Resident #1 on 01/29/25 at 2:15 pm, she said she did not remember ever being hit by anyone. She said she was carrying her purse (packed with her clothes) because she was leaving for home today.</p> <p>In an interview with the ADM on 01/29/2025 at 10:55 am, she said Resident #2 was referred to a behavioral hospital either locally or in another town. She said the facility had exhausted interventions (no roommate, seating during meals at her own table and not allowing others within arm 's reach of her in the common areas). She said Resident #2 ' s family refused to allow her out of the secured unit even as a trial because the secure unit was all females there and the family was adamant about keeping her there.</p> <p>In an interview with LVN G on 01/29/2025 at 1:42 pm she said staff in the secure unit were monitoring Resident #2 by making sure she was always in eyesight unless she was in bed. LVN G said she took Resident #2 with her when she needed to give meds or go down the hall. She said Resident #2 was not left unattended. LVN G said she had bruising on her right forearm from 01/26/25 during Resident #2 ' s incident, but she knew she could step away, whereas the residents did not know to get out of harm ' s way. She said the residents in the secure unit did not understand their behavior, why, or how to behave in certain circumstances. She said the main thing was to keep others away from Resident #2. She said she only worked in the secure unit.</p> <p>In an interview with RN F on 01/29/2025 at 2:12 pm, she said staff in the secure unit were monitoring Resident #2 by making sure she was always in sight of a CNA or nurse and making sure others (residents) were not within Resident #2 ' s arm ' s reach. She said Resident #2 ' s demeanor would change frequently. She said it was difficult to pinpoint triggers with Resident #2. She said some days she would not see those behaviors and she never knew when Resident #2 would act out. She said nurses documented behaviors daily in their progress notes. She said the 1:1 ordered over the weekend was discontinued the next day because Resident #2 ' s behaviors dissipated. She said the behavior monitoring came from the physician orders but did not trigger to go into the care plan. She said she was informed about Resident #2 ' s 1:1 and continuing monitoring from the charge nurse (LVN G). She said Resident #2 had her nails done yesterday with no problems. She said the resident was seated at the end of the table, the others were on the sides of the table, out of arm ' s reach. She said she had not experienced Resident #2 throwing objects but had been cussed out by her before. She said she was surprised to hear Resident #2 had hit Resident #1 in the stomach on 01/25/25.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In a phone interview with LVN H on 01/29/2025 at 3:15 pm, she said she was the nurse on duty on 01/25/25 and Resident #1 did not start the altercation on 01/25/25. She said 2 other residents had begun dicking at the table in the common area of the secure unit. She said she was in the process of removing Resident #2 from the situation as a de-escalation tactic. She said as she was locking the brakes on Resident #2 ' s wheelchair (LVN ' s back was toward the hallway), Resident #1 came walking around the corner from the hallway and Resident #2 stuck out her fist hand, striking Resident #1 in the center of her upper abdomen. She said she saw a red mark on Resident#1 ' s upper abdomen when she assessed her. She said Resident #1 denied any pain but said she got the wind knocked out of her-she was not in any distress. She said not very aggressive for me. Neither of them remembered what had occurred. LVN H said she tried to keep an eye on all of them equally. She said Resident #2 was not typically aggressive for her. She said she heard about Resident #2 ' s aggression from others.</p> <p>In an interview with the DON on 01/29/25 at 4:13 pm, she said for the most part because it was a secure and behavioral unit, the nurses were aware of the ones that tended to have more behaviors than others. Staff monitored them a little more closely- they do not need to necessarily keep them in their line of sight. She said all residents there had constant behavior that would require that kind of monitoring. Staff kept a close eye on Resident #2 and there were a lot of residents around the area when the incident occurred. She said there was a heightened awareness with Resident #2. The residents with a history of aggressive behaviors were monitored more closely than residents without aggressive behaviors. She said they have tried medication adjustments but were not seeing the improvements that we needed to see for her to remain at the facility. She said before the incident on 01/25/25, she thought there was still a chance Resident #2 could have stayed, but afterwards she did not feel Resident #2 could stay there to keep everyone safe. She said she did not know if LVN H could have prevented the punch. She said Resident #1 happened to be walking by. She said Resident #2 had a specialty wheelchair with a high back. She said LVN H assessed a slight red mark on Resident #1 that dissipated quickly. She said Resident #2 went on 1 to 1 after the incident and was discontinued by the physician on Monday, 01/27/25 because Resident #2 was no longer displaying aggressive behaviors. She said staff had not identified any type of trigger for her outbursts. She said staff in the secure unit tried to keep her more distant from other residents without isolating her. She said there has been some heightened awareness since this incident. She said the family had been very difficult throughout this ordeal with a lot of denial. They don't see the aggressive behaviors. We had a lot of talks with them (the family) while adjusting medications. She said the facility did not have a behavioral agreement with the family. She said the aides in the secured unit were very consistent-they were very familiar with the residents back there and their propensity for different behaviors. She said increased monitoring was not added to the care plan after the incident on the 25th. She said the nurses in the secure unit should say that they were monitoring Resident #2 more closely now after the incident. She said if Resident #2 was out of her room, then she would want to have a line of sight on her. When asked why that was not in the care plan the DON did not respond. She said it was important to keep the care plan updated to keep everyone on the team on the same page. She said if everyone was not on the same page, then someone could miss a specific intervention that was recently added. She said every resident at the facility had a right to be free from abuse.</p> <p>(continued on next page)</p>		

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<p>F 0600</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 dated 08/15/22, titled Abuse, Neglect, and Exploitation revealed under policy. It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse .Abuse means the willful infliction of injury with resulting physical harm, pain or mental anguish, which can include certain resident to resident altercations. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. Willful' means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Physical Abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking. Policy Explanation and Compliance Guidelines: The facility will develop and implement written policies and procedures that: Prohibit and prevent abuse . The facility will make individual determinations in consideration of current staffing patterns, staff qualifications, competency and knowledge, clinical resources, physical environment, and equipment. Existing staff will receive annual education through planned in-services and as needed. Prevention of Abuse, Neglect and Exploitation: The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves:</p> <p>B. Identifying, correcting and intervening in situations in which abuse . is more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms; D. The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect. VI. Protection of Resident: The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: A. Responding immediately to protect the alleged victim and integrity of the investigation. Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed. C. Increased supervision of the alleged victim and residents. D. Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator. F. Providing emotional support and counseling to the resident during and after the investigation, as needed. G. Revision of the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44748</p> <p>Based on interviews and record reviews, the facility failed to ensure that the comprehensive care plans were reviewed and revised by the interdisciplinary team after each assessment, for 1 resident (Resident #2) of 5 residents whose care plans were reviewed for timing and revision.</p> <p>The facility failed to include heightened monitoring strategies to Resident #2 ' s care plan after she hit another resident on 01/25/25.</p> <p>This failure could place residents at risk of not receiving appropriate care to meet their current needs.</p> <p>Findings included:</p> <p>Record review of Resident #2's face sheet dated 07/16/21 revealed an [AGE] year-old female with an original admitted [DATE]. Diagnoses included Alzheimer ' s Disease, dementia, lack of coordination, major depression, Diabetes with glaucoma and neuropathy, anxiety, and spinal stenosis (could not walk).</p> <p>Record Review of Resident #2's Quarterly MDS Assessment, dated 12/26/24, reflected her BIMS score of 02 indicated the resident had severe cognitive impairment with inattention and disorganized thinking. She required partial assistance with eating and oral hygiene and substantial assistance with all other ADL ' s. She utilized a manual wheelchair and required assistance to propel. She was always incontinent of bladder and bowel. She did not display any behaviors at the time (look back period) of the MDS assessment. She took antipsychotic, antianxiety, antidepressant, and anticonvulsant medications.</p> <p>(continued on next page)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #2's quarterly care plan dated 01/27/25 reflected Resident #2 was the aggressor of physical aggression towards another resident. Resident yelling and throwing drinks at one resident, then punched another resident in the abdomen. Date Initiated: 01/27/25. The goal was the resident would have no long-term issues related to incident through the target date of 12/26/24. Interventions included labs drawn per physician order, referral sent to local psychiatric hospital for in-patient psych evaluation, placed on 1:1 post incident per physician order, and social services to perform a psychosocial assessment. Date Initiated: 01/27/25. Resident #2 was physically aggressive related to anger; resident will occasionally grab other residents by the arms without provocation. Date Initiated: 10/09/20 Revision on: 11/25/24. The goal was the resident would demonstrate effective coping skills through the review date. Date Initiated: 10/09/20 Revision on: 10/24/24 Target Date: 12/26/24. Interventions included place resident on 1:1 due to aggressive episode until discontinued by physician, administer medications as ordered Date initiated 11/25/24, monitor/document for side effects and effectiveness Date Initiated: 10/09/20, analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document. Date Initiated: 10/09/20, assess and address for contributing sensory deficits. Date Initiated: 10/09/20, assess and anticipate resident's needs: food, thirst, toileting needs, comfort level, body positioning, pain etc. Date Initiated: 10/09/20, monitor/document/report PRN any signs or symptoms of resident posing danger to self and others. Date Initiated: 10/09/20, place resident on 1:1 for aggressive episodes as ordered if indicated. Date Initiated: 11/25/24. Resident #2 required a structured environment in the secure unit related to cognitive deficit Date Initiated: 09/16/24, Revision on: 12/27/24. The goal was the resident safety would be maintained through review date. Date Initiated: 10/03/24. Revision on: 12/27/24. Target Date: 12/26/24. Interventions included encourage activity participation, explain what you are going to do before touching the person with cognitive loss, speak calmly. Date Initiated: 10/03/24. Revision on: 12/27/24. The resident had impaired cognitive function and impaired thought processes related to dementia with behavior issues and delusions. Date Initiated: 09/11/20. Revision on: 09/25/24. Interventions included cue, reorient and supervise as needed, Date Initiated: 09/11/20. 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 to decrease confusion. Date Initiated: 01/20/21. Monitor/document frustration level. Wait 30 seconds before providing resident with word. Date Initiated: 09/16/20.</p> <p>In an interview with the ADM on 01/29/2025 at 10:55 am, she said Resident #2 was referred to a behavioral hospital either locally or in another town. She said the facility had exhausted interventions (no roommate, seating during meals at her own table and not allowing others within arm ' s reach of her in the common areas). She said Resident #2 ' s family refused to allow her out of the secured unit even as a trial because the secure unit was all females there and the family was adamant about keeping her there.</p> <p>In a phone interview with RMDS on 01/29/25 at 1:00 pm, she said Resident #2 did not display any behaviors at the time (look back period) of the MDS assessment on 12/26/24.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with LVN G on 01/29/2025 at 1:42 pm she said staff in the secure unit were monitoring Resident #2 by making sure she was always in eyesight unless she was in bed. LVN G said she took Resident #2 with her when she needed to give meds or go down the hall. She said Resident #2 was not left unattended. LVN G said she had bruising on her right forearm from 01/26/25 during Resident #2 ' s incident, but she knew she could step away, whereas the residents did not know to get out of harm ' s way. She said the residents in the secure unit did not understand their behavior, why, or how to behave in certain circumstances. She said the main thing was to keep others away from Resident #2. She said she worked only in the secure unit. She said she did not update care plans. She said care plans should be updated whenever something changed with a resident.</p> <p>In an interview with RN F on 01/29/2025 at 2:12 pm, she said staff in the secure unit were monitoring Resident #2 by making sure she was always in sight of a CNA or nurse and making sure others (residents) were not within Resident #2 ' s arm ' s reach. She said Resident #2 ' s demeanor would change frequently-it could be daily or several times a day or not for days. She said it was difficult to pinpoint triggers with Resident #2. She said some days she would not see those behaviors and she never knew when Resident #2 would act out. She said nurses documented behaviors daily in their progress notes. She said the behavior monitoring came from the physician orders but did not trigger to go into the care plan. She said she was informed about Resident #2 ' s 1:1 and continuing monitoring from the charge nurse (LVN G). She said she did not update care plan and nothing had changed with Resident #2.</p> <p>In a phone interview with LVN H on 01/29/2025 at 3:15 pm, she said she was the nurse on duty on 01/25/25 and Resident #1 did not start the altercation on 01/25/25. She said 2 other residents had begun dicking at the table in the common area of the secure unit. She said she was in the process of removing Resident #2 from the situation as a de-escalation tactic. She said as she was locking the brakes on Resident #2 ' s wheelchair (LVN ' s back was toward the hallway), Resident #1 came walking around the corner from the hallway and Resident #2 stuck out her fisted hand, striking Resident #1 in the center of her upper abdomen. She said she saw a red mark on Resident#1 ' s upper abdomen when she assessed her. She said Resident #1 denied any pain but said she got the wind knocked out of her-she was not in any distress. She said not very aggressive for me. Neither of them remembered what had occurred. LVN H said she tried to keep an eye on all of them equally. She said Resident #2 was not typically aggressive for her. She said she heard about Resident #2 ' s aggression from others. She said she did not update care plans.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with the DON on 01/29/25 at 4:13 pm, she said, For the most part, because it was a secure and behavioral unit, the nurses were aware of the residents that tended to have more behaviors than others. Staff monitored them a little more closely- they did not necessarily need to keep them in their line of sight. She said all residents there (in the secure unit) had constant behavior that would require monitoring. Staff kept a close eye on Resident #2. She said there was a heightened awareness with Resident #2. The residents with a history of aggressive behaviors were monitored more closely than residents without aggressive behaviors. She said she did not know if anyone could have prevented the punch. She said Resident #2 had a specialty wheelchair with a high back. She said Resident #2 went on 1 to 1 after the incident. She said staff had not identified any type of trigger for her outbursts. She said staff in the secure unit tried to keep her more distant from other residents without isolating her. She said the facility did not have a behavioral agreement with the family. She said increased monitoring was not added to the care plan after the incident on the 25th. She said the nurses in the secure unit should say that they were monitoring Resident #2 more closely now after the incident. She said if Resident #2 was out of her room, then she would want to have a line of sight on her. When asked why that was not in the care plan the DON did not respond. She said it was important to keep the care plan updated to keep everyone on the team on the same page. She said if everyone was not on the same page, then someone could miss a specific intervention that was recently added. She said every resident at the facility had a right to be free from abuse.</p> <p>Record review of the facility policy dated 10/24/22, titled, Care Plan revisions Upon Status Change. 1. The comprehensive care plans will be reviewed and revised as necessary when a resident experiences a status change.</p>		

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 01/29/2025
NAME OF PROVIDER OR SUPPLIER Rockport Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1902 Fm 3036 Rockport, TX 78382	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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** 50039</p> <p>Based on observation and interviews, the facility failed to ensure all drugs and biologicals were stored in accordance with currently accepted professional principles for 1 of 2 medication rooms (Medication room [ROOM NUMBER]).</p> <p>The facility failed to keep Medication room [ROOM NUMBER] free from the employee personal food items on 01/28/25 as there were sunflower seeds, coke, and a tumbler cup in the room.</p> <p>This deficient practice could place residents at risk of receiving medications contaminated by food and drinks.</p> <p>The findings included:</p> <p>During an observation of Medication room [ROOM NUMBER] on 01/28/25 at 4:30 PM, this state surveyor found an opened box designed to hold 12 bags of sunflower seeds containing 5 sealed individual bags of sunflower seeds, a 12-pack of coke cans with 8 unopened cans remaining in the 12-pack, and a [NAME] cup. The box of sunflower seeds had MA D's name written on the top. The items were all in lower cabinets inside Medication room [ROOM NUMBER].</p> <p>In an interview with the ADON on 01/29/25 at 9:53 AM, the ADON stated employee personal food items should not be stored in the medication rooms. The ADON stated employee personal food items should be stored in the employee break room. The ADON stated personal food items should not be stored in the medication rooms because it could cause cross contamination and become an infection control problem. The ADON stated MA D's name was written on the box of sunflower seeds. The ADON stated the [NAME] cup belonged to CNA E. The ADON stated she did not know who the cans of coke belonged to. The ADON stated CNA E did not have access to the medication rooms.</p> <p>In an interview with MA D on 01/29/25 at 10:01 AM, MA D stated she did not put the box of sunflower seeds in Medication room [ROOM NUMBER]. MA D stated she did not know the coke was in Medication room [ROOM NUMBER] either. MA D stated she went in Medication room [ROOM NUMBER] about once per shift, but only opened the top cabinets that contained the medications. MA D stated the sunflower seeds were a gag gift given to her about 2 weeks ago by an anonymous person at the facility. MA D stated she did eat sunflower seeds at the facility on her break in the employee break room. MA D stated she kept her sunflower seeds in her backpack in the employee break room. MA D stated the last time she remembered seeing the box of sunflower seeds was about a week ago at the 200-hall nurse's station. MA D stated she was going to take the box home, but someone removed it from the 200-hall nurse's station, and she was not worried about it so she did not search for it. MA D stated personal food items did not belong in the medication rooms. MA D stated employee personal food items could go in the break room. MA D stated personal food items were not allowed in the medication room because of a risk for cross contamination.</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 - Few</p>	<p>In an interview with CNA E on 01/29/25 at 10:12 AM, CNA E stated it was her [NAME] cup that was found in Medication room [ROOM NUMBER]. CNA E stated she did not have access to either medication room. CNA E stated the last time she had the cup was at the facility on Sunday, 01/26/25 when she worked from 6:00 AM to 6:00 PM. CNA E stated she always stored her [NAME] cup in the break room. CNA E stated she thought she left her [NAME] cup at the 200-hall nurse's station before she left work on 01/26/25. CNA E stated another employee must have seen it at the nurse's station and put it in the lower cabinet in Medication room [ROOM NUMBER]. CNA E stated personal food items should not be kept in the medication room because it was a contamination risk.</p> <p>In an interview with the DON on 01/29/25 at 10:22 AM, the DON stated personal food items should not be stored in the medication rooms. The DON stated employee personal food items should be stored in the break room. The DON stated they go in the medication rooms and clean them out every few weeks. The DON stated she did not know who put the sunflower seeds, coke, or [NAME] cup in Medication room [ROOM NUMBER]. The DON stated personal employee food items should not be stored in the medication rooms because of the potential for cross contamination. This state surveyor requested a facility policy regarding the proper storage of medications in the medication room or proper storage of employee personal food items. The DON reported on 01/29/25 at 1:50 PM that she was unable to find any facility policy covering the requested parameters.</p> <p>In an interview with the ADM on 01/29/25 at 1:55 PM, a facility policy was requested regarding the proper storage of medications in the medication room or proper storage of employee personal food items. The ADM reported on 01/29/25 at 2:40 PM that she was unable to find any facility policy covering the requested parameters.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44748</p> <p>Based on observation, interviews and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed and 1 of 1 resident refrigerator/freezer reviewed for storage, preparation and sanitation.</p> <ul style="list-style-type: none"> -The facility failed to ensure plastic dishes were clean on the clean rack in the kitchen. -The facility failed to ensure staff personal food items were kept out of the resident's refrigerator and freezer in the activities area. -The facility failed to ensure food items in the resident's refrigerator and freezer were labeled and dated. -The facility failed to ensure food items in the resident's refrigerator and freezer were not expired. -These failures could place residents at risk for complications from food contamination. <p>Findings included:</p> <p>Observations during the initial tour of the kitchen on [DATE] at 10:30 am revealed 50 of 50 plastic cups had thick white or yellowish substances stuck to the insides and bottoms on the clean rack. The dirty bowls also had scratches on the insides and bottoms. One of them had what appeared to be melted plastic in the bottom of it. There was an open box of breakfast cereal mix on a prep table.</p> <p>Observation of the locked resident refrigerator and freezer on [DATE] 9:22 am in the activities area had 7 unlabeled ice cream sandwiches, 16 popsicles, a 3-pound tub of frozen cookie dough labeled with a staff member's name, a 2.7-pound box of another cookie dough labeled with a staff member's name, a half-melted popsicle that was unlabeled and undated, an unlabeled 22-count bag of frozen flour tortillas expired on [DATE], and an undated zip-type plastic bag of 4 eggrolls covered with frost inside the bag and covering the food. There was a large, partially full pitcher of a light red liquid dated [DATE], an unlabeled 10-ounce container of small tomatoes, an unlabeled, partially full 15.38-ounce container of hot sauce expired [DATE], a 12-ounce container of electrolyte drink labeled with a staff member 's name, an unlabeled 13-ounce can of whipped cream expired [DATE], 1 unlabeled stick of butter, an unlabeled 10-ounce bag of shredded carrots expired on [DATE], an unlabeled 1-ounce bag of potato chips, an unlabeled 14-ounce container of chocolate drink expired on [DATE], an unlabeled and expired 24-ounce half-full jar of pasta sauce, and an unlabeled half-full jar of grape jelly.</p> <p>In an interview with DA on [DATE] at 10:32 am, she said the dirty bowls were on the clean rack and it was the dishwasher's responsibility to check the dishes for cleanliness. She said she was the dishwasher today but did not look at the bowls that were already on the clean rack.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview with the DM on [DATE] at 10:33 am, she said the dirty bowls were on the clean rack and it was the dishwasher's responsibility to check the dishes for cleanliness. She said she was responsible for monitoring the dishwashing staff but had not done so recently. She said the dirty bowls on the clean rack were old and had been there forever. She said those particular bowls should have been thrown away. She said the dirty bowls could harbor bacteria and could make residents sick if they were served from the dirty dishes. She said she had new bowls in the supply room. She did not have an answer to why the dirty bowls had not been thrown away. Kitchen policies and in-services requested at this time. In-services regarding the kitchen were not provided.</p> <p>In an interview with the [NAME] on [DATE] at 10:35 am, she said she opened the box of breakfast cereal mix yesterday and did not put it away properly. She said the open box of breakfast cereal mix could cause cross contamination and make residents sick. She said cross contamination could occur because the breakfast cereal mix could attract bugs.</p> <p>In an interview with the AD on [DATE] at 9:22 am, she identified the items in the locked refrigerator and freezer in the activities area as belonging to the staff. She identified the locked refrigerator and freezer in the activities area as being strictly for the residents. She said she told staff they could not use this refrigerator or freezer for personal items, but she found items in there frequently. She said she was the only one with the key for the refrigerator and the code for the freezer. The AD did not answer when asked how the staff items got inside the refrigerator and/or freezer. She said she did not have any training regarding the activities area refrigerator/freezer.</p> <p>In an interview with the ADM on [DATE] at 9:59 am, she said the AD was responsible for the activities room refrigerator/freezer and with other staff putting their belongings in there without her knowing was not acceptable. She said cross contamination of resident and staff items could cause illness to both parties, especially the residents.</p> <p>In an interview with MR on [DATE] at 10:12 am, she said she owned the tub of cookie dough in the resident's freezer. She said she had donated it to the activities department and was not sure how long ago-she thought less than a year. She said resident and staff food was not allowed together because of cross contamination and could make the resident's sick.</p> <p>In an interview with the SW on [DATE] at 10:16 am, she said she owned the box of cookie dough in the resident's freezer and she had forgotten about it. She said she bought it as a school fund-raiser from another staff member ' s child last year. She said she knew the activities area refrigerator/freezer was used for resident's but did not know she could not place her things in there because of infection control-like allergies or cross contamination. She said cross contamination could make the residents sick. She said monthly all-staff meetings were informative of not storing personal belongings with resident belongings but was not sure the last time they talked about it, but was sure they talked about it. She said she was going to take the dough home the day she got it but forgot. She said she asked the AD for the code to the freezer and the AD gave it to her.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview with the ADIR on [DATE] at 10:31 am, she said she sold the cookie dough to staff last November, and it was delivered in [DATE]. She said one person donated her dough (MR) to the activities department for the residents. She said the activities area refrigerator/freezer was for residents only. She said staff had training on personal belongings not too long ago, so it was common knowledge. She said we (staff) could not put anything in that refrigerator/freezer because it was specifically for the residents only. She said everything had to be labeled and dated with their names to keep cross- contamination from happening and the residents could get sick. We just don't do it.</p> <p>Record review of the facility ' s policy dated [DATE], titled, General Kitchen Sanitation revealed All nutrition and food service employees will maintain clean, sanitary kitchen facilities in accordance with the state and United States Food Codes in order to minimize the risk of infection and food borne illness.</p> <p>Record review of the facility policy dated [DATE], titled, Mechanical Cleaning and Sanitizing of Utensils and Portable Equipment revealed 3. Rinse or scrape equipment and utensils and, when necessary, soak to remove gross food particles and soil prior to being washed.</p> <p>FDA Food Code 2022 Ch. ,d+[DATE] Preventing contamination from the premises ,d+[DATE].11 Food Storage (A) Except as specified in (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD: (2) Where it is not exposed to splash, dust, or other contamination.</p> <p>Ch. ,d+[DATE] Cleanability ,d+[DATE].11 Food-Contact Surfaces.</p> <p>Frequency ,d+[DATE].11 Equipment Food-Contact Surfaces and Utensils. (A) food-contact surfaces and utensils shall be cleaned: (5) At any time during the operation when contamination may have occurred.</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** 49157</p> <p>Based on observation, interview and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 (Resident #178) of 4 residents reviewed for infection control in that:</p> <p>1. The facility failed to ensure that Resident #178 had EBP (Enhanced Barrier Precautions) signage and PPE (Personal Protective Equipment) available for staff providing care to Resident #178 on 1/27/25 and 1/28/25 due to Resident #178 having an indwelling urinary catheter.</p> <p>Findings included:</p> <p>Observation on 1/27/25 at 11:00am reflected EBP signage and a PPE cart on the door of Resident 178's original room which was shared with a roommate who also required EBP.</p> <p>Observation on 1/28/25 at 9:00am and 3:30pm reflected that Resident #178 had been moved to another room. That room did not have any EBP signage or PPE available for staff.</p> <p>Record review of Resident #178's admission record reflected a [AGE] year-old female that was admitted to the facility on [DATE]. Diagnoses included acute transverse myelitis (acute inflammation of the spinal cord that causes pain, weakness, sensory problems and bladder/ bowel dysfunction) in demyelinating disease (condition that causes damage to the protective layer of the spinal cord) of the central nervous system, paraplegia (inability to move the legs), and urinary retention (difficulty urinating and completely emptying the bladder).</p> <p>Record review of Resident #178's admission MDS dated [DATE] reflected Resident #178 had a BIMS score of 15 which indicated no cognitive impairment.</p> <p>Record review of Resident #178's Initial Nursing Evaluation dated 1/23/25 at 9:52pm reflected the presence of an indwelling catheter upon admission to the facility.</p> <p>Record review of Resident #178's Initial Baseline/Advanced Care Plan form dated 1/24/25 at 12:28am reflected in part:</p> <p>Problem: The resident has an Indwelling Catheter.</p> <p>Goal: The resident will be/remain free from catheter-related trauma through review date.</p> <p>Goal: The resident will show no s/sx of Urinary infection through review date.</p> <p>Record review of Resident #178's order skilled nurse's note dated 1/24/25 at 9:20am reflected in part:</p> <p>E. BLADDER/GU</p> <p>(continued on next page)</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>1. Bladder Function:</p> <p>a. Bladder function unchanged</p> <p>2. Catheter</p> <p>b. Foley Catheter with care provided</p> <p>c. Catheter patent, draining and insitu.</p> <p>Record review of Resident #178's care plan on 1/27/25 at 2:23pm reflected in part:</p> <p>Problem:</p> <p>Resident #178 has an indwelling catheter r/t urinary retention.</p> <p>Initiated: 1/24/25.</p> <p>Interventions:</p> <p>Position catheter bag and tubing below the level of the bladder and away from entrance room door.</p> <p>Check tubing for kinks each shift.</p> <p>Monitor and document output as ordered.</p> <p>Initiated 1/24/25.</p> <p>Problem:</p> <p>Resident #178 has a urinary tract infection.</p> <p>Initiated: 1/24/25.</p> <p>Interventions:</p> <p>Administer antibiotic medications as ordered.</p> <p>Maintain universal precautions when providing resident care.</p> <p>Initiated: 1/24/25.</p> <p>Record review of Resident #178's Order Summary Report on 1/28/25 at 1:51pm reflected the following orders:</p> <p>Check foley catheter every shift.</p> <p>Foley cath care q shift and PRN as needed.</p> <p>(continued on next page)</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>Foley cath care q shift and PRN every shift.</p> <p>Foley catheter: Change 16F with 10ml bulb as needed for PRN plugged or out.</p> <p>Foley: Document output for foley catheter Q shift every shift.</p> <p>Foley: Foley catheter: Irrigate foley catheter with 60ml of NS as needed.</p> <p>Monitor for privacy bag placement everyy shift.</p> <p>Monitor that collection bag is off the floor and hung below bladder level every shift.</p> <p>There were no orders for any type of precautions or PPE use listed.</p> <p>In an interview on 1/28/25 at 3:34pm, CNA A stated that she was not aware that Resident #178 should have been on enhanced barrier precautions and that she had not been wearing any PPE while performing resident care activities such as brief changes, hygiene, and transfers. CNA A was not able to tell me specifically what EBP was for but was able to recall with prompting. CNA stated that infection control in-services were done monthly and were also part of their required online quarterly training and the last in-service was approximately one month ago. CNA A stated if PPE was not used with residents who had indwelling devices, it could lead to infections and possibly hospitalization s.</p> <p>In an interview on 1/28/25 at 3:40pm, CNA B stated that Resident #178 should have had EBP (after prompting). CNA B stated she had not been wearing PPE when helping with Resident #178's transfers or peri-care. CNA B stated the last in-service for infection control was about a month ago and that it was also part of the monthly in-services. CNA B stated if EBP was not observed with residents who had urinary catheters it could lead to the resident getting a urinary tract infection.</p> <p>In an interview on 1/28/25 at 3:45pm, RN C stated that EBP was used to protect the resident from infections. RN C stated that EBP was used with residents that had surgical wounds or open wounds. RN C recalled that EBP was also used for residents that had urinary catheters, feeding tubes, and/or external dialysis catheters after prompting. RN C stated she had been working at this facility for approximately six months and that staff was in-serviced on infection control upon hire and quarterly and that her last in-service was 3 months ago. RN C stated maybe Resident #178 was not on EBP because she had just gotten here three days ago and it had been overlooked.</p> <p>In an interview on 1/28/25 at 3:50pm, the DON stated when R#178 was in the original room, the EBP covered both residents. She was moved to another room due to her roommate's wound culture requiring her to be placed on contact precautions, the EBP signage did not get re-posted. The DON stated that EBP should have been ordered and care planned and she was not sure why the EBP order did not get put in or care planned for Resident #178. The DON stated in-services on infection control were done pretty frequently and it was part of staff's ongoing HealthStream (online) training. The DON stated if EBP was not utilized for residents that required it, those residents could potentially contract an infection that could lead to sepsis, hospitalization , and/or death.</p> <p>(continued on next page)</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>In an interview on 1/29/25 at 10:51am, the IP stated Resident #178 was moved to another room due to her roommate's wound culture results indicating that she needed to be placed on contact precautions. Resident #178 was on EBP along with her roommate prior to the move, however staff just overlooked the need to place her back on EBP. The IP stated it was important to place residents with indwelling devices on EBP so that they did not acquire any infections. The IP further stated if staff did not use appropriate PPE and the resident developed an infection it could lead to sepsis, hospitalization, or even death. The IP stated staff was in-serviced on infection control upon hire, at least monthly, and as needed. The IP stated that the EBP should have been ordered and care planned when the resident arrived and that it had been ordered and care planned prior to this interview. The IP stated that she thought that Resident #178 had come in over the weekend and that they started reviewing all the orders for the weekend admissions on Monday morning. The IP stated that she was going to in-service staff on EBP during this week.</p> <p>In an interview on 1/29/25 at 11:17am, the ADM stated it was important to place residents with indwelling devices on EBP to prevent them from developing an infection that may be inadvertently passed along by staff. The ADM stated if staff failed to utilize EBP, it could lead to residents developing infections which could cause sepsis. The ADM stated the IP oversaw all of the precautions and/or isolations for the facility and the charge nurses for each hall were responsible for making sure that the precautions or isolations are implemented. The ADM stated it is up to all staff to ensure that appropriate precautions are being implemented for residents and if a staff member came across a resident who should have some type of precautions but did not, they were responsible for making the charge nurse aware so that the orders and care plan could be updated and the signs and PPE put into place. The ADM stated education and in-services are done upon hire and then monthly and as needed as well as in staff's online training quarterly.</p> <p>Record review of the facility's Enhanced Barrier Precautions policy dated 4/5/24 reflected in part:</p> <p>Policy:</p> <p>It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms.</p> <p>Policy Explanation and Compliance Guidelines:</p> <ol style="list-style-type: none"> 1. Prompt recognition of need: <ol style="list-style-type: none"> a. All staff receive training on enhanced barrier precautions upon hire and at least annually and are expected to comply with all designated precautions. b. All staff receive training on high-risk activities and common organisms that require enhanced barrier precautions. c. The facility will have the discretion on how to communicate to staff which residents require the use of EBP, as long as staff are aware of which residents require the use of EBP prior to providing high-contact care activities. 2. Initiation of Enhanced Barrier Precautions: <p>(continued on next page)</p>		

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 01/29/2025
NAME OF PROVIDER OR SUPPLIER Rockport Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1902 Fm 3036 Rockport, TX 78382	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b. An order for enhanced barrier precautions will be obtained for residents with any of the following:</p> <p>i. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO.</p> <p>3. Implementation of Enhanced Barrier Precautions:</p> <p>a. Make gowns and gloves available immediately near or outside of the resident ' s room. Note: face protection may also be needed if performing activity with risk of splash or spray (i.e., wound irrigation, tracheostomy care).</p> <p>b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident ' s room.</p> <p>e. The Infection Preventionist will incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education.</p> <p>4. High-contact resident care activities include:</p> <p>a. Dressing</p> <p>b. Bathing</p> <p>c. Transferring</p> <p>d. Providing hygiene</p> <p>e. Changing linens</p> <p>f. Changing briefs or assisting with toileting</p> <p>g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes</p> <p>9. Enhanced barrier precautions should be used for the duration of the affected resident ' s stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk.</p>