

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675402	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/17/2024
NAME OF PROVIDER OR SUPPLIER  Rockwall Nursing Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  206 Storrs Rockwall, TX 75087	
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45268</b></p> <p>Based on interview and record review the facility failed to ensure each resident was treated with respect and dignity and care in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality and protected and promoted the rights of the resident for two of five residents (Resident #1 and Resident#2) reviewed for resident rights.</p> <p>The facility failed to ensure Resident #1 was treated with respect and dignity when LVN A slammed her hand on the bedside table and yelled Sit at the resident as she walked passed him.</p> <p>This failure could place residents at risk of a diminished quality of life and loss of dignity and self-worth.</p> <p>Findings include:</p> <p>Record review of Resident #1's electronic face sheet, printed 05/17/2024, reflected Resident #1 was a [AGE] year-old male who was initially admitted to the facility on [DATE] and re admitted on [DATE]. Resident #1 had diagnoses which included dementia, unspecified severity with agitation (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), abnormalities of gait and mobility and stroke.</p> <p>Record review of Resident#1's quarterly MDS dated [DATE] reflected a BIMS of 7, which indicated Resident #1 was cognitively impaired.</p> <p>Record review of Resident#1's care plan, with a review date of 3/11/24, reflected Resident #1 had impaired cognitive function or impaired thought processes related to Dementia. The goals section reflected Resident #1 would have needs met in a timely manner, dignity would be maintained, and the current level of functioning. Interventions included administer medications per physician's orders and monitor for unusual/adverse, reactions and effectiveness. Report abnormal findings to the physician, monitor/document/report to physician any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, and mental status changes.</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 0550</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 electronic face sheet, printed 05/17/2024, reflected a [AGE] year- old male who was initially admitted on [DATE] and re admitted on [DATE]. Resident #2 had diagnoses which included depression (low mood or loss of pleasure or interest in activities for long periods of time), dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities) and high blood pressure.</p> <p>Interview and observation on 05/17/2024 at 11:49 AM revealed Resident #1 sitting in the hall in a chair with a bedside table in front of him on the male locked unit. LVN A observed Resident #1 stand up in front of the chair and walked passed him and slammed her hand and on the bedside table and in front of Resident #1 and yelled Sit. LVN A proceeded to help another resident and did not say anything else to Resident #1. An interview with Resident #1 was attempted and revealed he was able to state his name and he had no concerns. A full interview was not able to be complete with Resident #1 due to the resident's cognitive abilities.</p> <p>Interview on 05/17/2024 at 11:52 AM with Resident #2 revealed he did not like the way staff treated him and other people at the facility. Resident #2 stated the staff at the facility treated the residents like dogs by the way they speak to him and other residents. Resident #2 stated staff did not talk to residents in a nice way and he felt like he was ignored a lot.</p> <p>Interview on 05/17/2024 at 12:04PM with the Administrator revealed staff should never yell or hit anything when speaking to a resident. He stated he was not sure if it would be classified as abuse and that would depend on each person's concept of the situation. He stated the staff knew their residents and may be aware of residents responding to certain stimuli.</p> <p>Interview on 05/17/2024 at 12:40PM with LVN A she stated Resident #1 had a history of falling over the bedside table. LVN A stated she saw Resident #1 standing up and she was trying to stop him from falling. She stated she called Resident #1's name, however he did not respond. LVN A stated there were other ways she could have approved Resident #1 and stopped him from falling, however she was busy doing other things and was not able to stop to redirect in a different way. LVN A did not clarify the other ways that she could have redirected Resident#1. LVN#1 stated she was scared seeing him standing since he had a bad fall so that was why her voice was elevated when telling the resident to sit. LVN A stated she hit the table to get Resident #1's attention so he would sit down.</p> <p>In a follow up interview on 05/17/2024 at 3:50 PM with the Administrator, he revealed staff should not be yelling or hitting anything in front of residents. The Administrator stated the risk of staff yelling or hitting items in front of a resident would be resident rights could be violated.</p> <p>Record review of the facility's policy Resident Rights, dated November 2021, reflected Residents of Texas nursing facilities have all the rights, benefits, responsibilities, and privileges granted by the Constitution and laws of this state and the United States. They have the right to be free of interference, coercion, discrimination, and reprisal in exercising these rights as citizens of the United States. You have the right to be treated with dignity, courtesy, consideration and respect.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45268</b></p> <p>Based on observation, interview and record review the facility failed to establish policies, in accordance with applicable, Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also took into account nonsmoking residents for one of four (Resident #3) residents reviewed for smoking.</p> <p>The facility failed to follow their policy regarding residents who smoke always being supervised When Resident #3 was observed smoking outside without staff supervision.</p> <p>This failure could place residents at risk for smoking-related injuries and fires in the facility.</p> <p>Findings include:</p> <p>Record review of Resident #3's electronic face sheet reflected a [AGE] year-old female who was admitted to the facility initially on 11/06/09 and re admitted [DATE]. Resident #3 had diagnoses which included dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), Alzheimer's late onset (progressive mental deterioration that can occur in middle or old age, due to generalized degeneration of the brain), parkinsonism (brain conditions that cause slowed movements, rigidity [stiffness] and tremors.)</p> <p>Record review of Resident #3's quarterly MDS dated [DATE] reflected a BIMS score of 03, which indicated the resident was severely impaired.</p> <p>Record review of Resident #3's care plan, last reviewed on 3/11/24, reflected Resident #3 was a smoker and the goal was to ensure Resident #3 smoked without causing injury. Interventions included: ensure smoking occurred in designated smoking areas, ensure no oxygen was located in the smoking area while the resident was smoking, ensure the resident and/or responsible party was made aware of the facility smoking policy, No smoking materials or igniter's will be stored in the resident rooms, safe Smoking Assessment every month, the resident will be supervised by a visitor or facility staff member at all times.</p> <p>Record review of Resident #3's smoking assessment, dated 05/04/2024, reflected Resident #3 required direct supervision while smoking at all times.</p> <p>Observation on 05/17/2024 at 11:30 AM of CNA B outside with the residents who were smoking. CNA B retrieved the men who were outside smoking and left the women's locked unit to take the men back to their hall of the locked unit. CNA B left Resident #3 outside alone actively smoking.</p> <p>Observation and interview on 05/17/2024 at 11:34 AM of Resident #3 outside smoking alone. LVN A was at her medication cart which was located across the room against the wall near the entrance of the locked unit. LVN A was getting something out of the medication cart which required her back to be turned toward Resident #3 while she was outside smoking. Interview with Resident #3 revealed she had no concerns. A full interview with Resident #3 was not able to be complete due to Resident #3's cognitive abilities.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/17/2024 at 1:22 PM with CNA B revealed when supervising residents while smoking a staff member should always be outside with the residents. CNA B stated she was outside with the residents while they were smoking however, she left to take the male residents back to their unit. CNA B stated she informed LVN B that she was taking the male residents back to their hall and at that point LVN B would have been responsible for supervising Resident #3 while smoking.</p> <p>Interview on 05/17/24 at 2:15 PM with LVN A revealed the smoke break was done late which was why Resident #3 was still outside after the men left the smoke area. LVN A stated residents were able to be left outside without supervision as long as they were within eyesight. LVN A stated she was completing her blood sugar checks which was why she was at her cart. LVN A stated she was supposed to cover the supervision for smokers, however she could not do everything at one time. LVN A stated Resident #3 was not able to light her own cigarette but was able to smoke on her own. LVN A stated based off Resident #3's smoking assessment Resident #3 was able to smoke safely. LVN A stated she left Resident #1 outside to smoke and when she noticed the cigarette was getting short she would go outside to bring Resident #3 inside.</p> <p>Interview on 05/17/24 at 3:28 PM with the Administrator revealed staff should have a clear line of sight to residents while smoking. The Administrator stated if staff did not smoke it would be violating their rights to have them outside monitoring while smoking. The Administrator stated smoking assessments were done quarterly by nursing staff and supervision while smoking was based on the assessment. The Administrator stated the risk of not supervising residents based off the smoking assessment would be that residents could burn themselves.</p> <p>Record review of the facility's policy Smoking Policy, revised 11/01/2017, reflected A safe smoking assessment will be done regularly for each resident who smokes. Smoking by residents classified as unsafe will be prohibited except when the resident will be directly supervised by facility personnel or visitors who are aware of the resident's limitations with smoking. The resident must be within direct view of the smoking supervisor, in reasonably close proximity of the supervisor, and the supervisor must be able to quickly respond in the event of an emergency. Additionally, the supervisor, whether staff or visitor must be aware of these responsibilities.</p>		

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Post nurse staffing information every day.</p> <p>45268</p> <p>Based on observation, interview and record review the facility failed to post on a daily basis information that included the facility name, the current date and the number and the actual hours worked by registered nurses, licensed practical nurses or licensed vocational nurses, certified nurse aides and the resident census for one of twenty -three days (05/17/24) reviewed for nursing services and postings.</p> <p>The facility failed to update the daily staffing information posting on 05/17/24.</p> <p>This failure could place residents at risk of not having access to information regarding staffing data and facility census.</p> <p>The findings include:</p> <p>Observation on 05/17/24 at 3:15 PM of the building revealed the daily nursing staff posting was posted near the front entrance nursing station with a date of 04/23/24.</p> <p>In an interview on 05/17/24 at 3:40 PM with the ADON revealed she was responsible for posting the staffing ratio daily. The ADON stated she usually printed the staffing ratio daily, however, she needed to make corrections to the posting for today (5/17/24). The ADON stated the staffing ratio was posted for previous days, however, she took them down every day. The ADON stated she forgot to take the posting down from April and would put the current date on top without removing the April posting. The ADON stated there was not a risk of not posting the staffing ratio daily.</p>