STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675402	A. Building B. Wing	10/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rockwall Nursing Care Center	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)
F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50222 Based on interviews, observations, and record reviews the facility failed to obtain laboratory services to meet the needs of its residents for one (Resident #13) of three residents reviewed for laboratory services. The facility failed to collect a urine specimen for a UA for Resident #13 as ordered by the physician on 9/23/24. This failure could place residents at risk for urinary tract infections, renal failure, and pain. Findings included: Record review of Resident #13's quarterly MDS assessment dated [DATE] revealed the resident was [AGE] years old, was admitted to the facility on [DATE], and had a BIMS score of 03 (suggested severe cognitive impairment). The MDS also revealed Resident #13 was frequently incontinent and had a diagnosis of Alzheimer's disease. Record review of Resident #13's care plan, updated on 09/24/24, revealed Resident #13 was incontinent and should be monitored for symptoms of a UTI. Record review of Resident #13's physician order dated 09/23/24 revealed an order to obtain a UA. No other orders related to UA collection was noted or related to a UTI. (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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and observation on 10/08/24 at 3:29 p.m., the DON reported that the UA for Resident #13 was cancelled on 9/26/24, and she did not know why the lab cancelled it. The DON stated maybe the resident was fighting staff, and they were unable to collect it. The DON reported that if they were unable to collect the UA then the doctor should have been notified to see if there was an alternative. The DON stated staff should have continued to try to collect the UA and should have notified the doctor after the first day if they were not able to collect it. The DON stated the NP was notified on 9/26/24 that the urine collected was contaminated multiple times, but she did not know what the NP's response was. The DON stated the UA could have been contaminated at the point of collection or in the specimen cup, and she did not know how many times it was contaminated. The DON stated that she did not see anything else documented after 9/26/24 except that the lab was pending. Observed the DON look at the laboratory website, and she reported the lab was never obtained. The DON stated that if a resident has a UTI that is not diagnosed or treated then it could make them sick, but she did not know for sure because she was not a doctor. The DON stated that the nurses are responsible for monitoring the labs and obtaining the UAs. The DON stated nurses should log into the lab website to check the status of labs. The DON did not state how often the nurses should check the lab website. Record review of Resident #13's progress note dated 9/26/24 by LVN A revealed multiple attempts to collect the UA were unsuccessful due to cross contamination. The note also indicated the resident was visited by a NP but did not indicate the NP was notified of the unsuccessful attempts to obtain the UA. In an attempted interview on 10/09/24 at 10:53 a.m., a telephone call was made to LVN A and voicemail left. No return call received. In an interview on 10/09/24 at 9:55 a.m., LVN C stated she did not usually work with Resident #13. LVN C reported the nurses would collect the UA and the lab would call the nurse if it was contaminated. LVN C reported nurses would then have to collect the UA again. LVN C reported nurses would know what labs are needed by checking the lab website and by the report received from the previous shift's nurse. LVN C reported if the UA was collected several times and contaminated then the nurse would call the doctor to see if the doctor would give new orders, discontinue the UA order, or would prescribe an antibiotic without the UA. LVN C stated if the UA was not obtained then it would be unknown if the resident had a UTI. LVN C reported that a UTI could have caused increased confusion, sepsis, or increased risk for falls. In an interview on 10/09/24 at 12:58 p.m., ADON D reported that the nurses are responsible for obtaining the UAs and that she would assist in ensuring the labs were collected by the nurses after she completed her training. ADON D stated it was hard to say what the risks to the residents would be if a UTI was undiagnosed and untreated because there are too many things that could happen. ADON D reported she was not a doctor and could not diagnose what might happen. ADON D stated the doctor should have been notified if nurses were unable to obtain a UA. ADON D did not state how labs were monitored. In an interview on 10/09/24 at 11:06 a.m., NP B stated that she saw Resident #13 at least once a month. NP B reported she noticed Resident #13 had increased agitation, so she ordered a UA. NP B stated she was unaware the facility was unable to collect the UA and that the staff usually reported if they were unable to collect a UA within a few days. NP B stated that an undiagnosed UTI could place the resident at risk for kidney infection and going to the hospital. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/09/24 at 11:14 a.m., a representative for the company providing lab services stated the UA for Resident #13 was cancelled because the lab attempted to pick up the specimen on 9/24/24, 9/25/24, and 9/26/24. The representative stated that each time there was no UA collected by the facility and their policy was that labs would be cancelled after three failed attempts. Record review of a photograph of the incomplete lab status report dated 9/24/24, 9/25/24, and 9/26/24 revealed specimen was not collected by the facility on 9/24/24, 9/25/24, and 9/26/24. A lab representative and a facility nurse signed each date. The bottom of the lab status report stated labs would be obtained the third day or cancelled. Record review of the lab status print out from the lab website dated 10/08/24 revealed the lab was cancelled on 9/26/24. Record review of emergency department provider notes dated 10/04/24 revealed Resident #13 visited the hospital for unrelated event and was diagnosed with a UTI. The hospital record also revealed Resident #13 was prescribed antibiotics for seven days and was discharged back to the facility on [DATE]. In an interview on 10/09/24 at 3:17 p.m., the DON stated a UTI could increase the risk of falls, but it depends on the individual. The DON also stated Resident #13 had previous falls without a UTI. In an interview on 10/09/24 at 3:22 p.m. with the ADM, UA, diagnostic tests, lab, and UTI policies were requested from the ADM. In an interview on 10/09/24 at 3:42 p.m., the ADM reported they did not have a policy for labs, UAs, or UTIs. Review of facility policy titled Notifying the Physician of Change of Status, with a revision date of 3/11/2013, stated 7. The nurse will document all attempts to contact the physician, all attempts to notify the family and/or legal representative, the physician's response, the physician's orders and the resident's status and response to interventions.