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	11/01/2024

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45268 Based on interview and record review, the facility failed to ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment including both the comprehensive assessment and quarterly review assessments for one (Resident #1) of four residents were reviewed for comprehensive care plans. The facility failed to ensure the interdisciplinary team revised and reviewed the care plan after each assessment. This failure could affect residents by placing them at risk for not having their individual needs met. Findings included: Record review of Resident #1's Face Sheet printed 11/01/2024, reflected a [AGE] year-old male who was admitted to the facility initially 10/14/2022 and readmitted on [DATE] with diagnoses to include but not limited to Dementia, unspecified severity without behavioral disturbance , psychotic disturbance, mood disturbance (term used to describe a group of symptoms affecting memory, thinking and social abilities), acute kidney failure(a condition in which the kidney stops working suddenly) and difficulty in walking. Record review of Resident #1's annual MDS, dated [DATE], reflected a BIMS score of 3 which indicated severe cognate impairment. Functional abilities included supervision/ touching assistance with eating, oral hygiene, toileting, upper body dressing and person hygiene. Resident#1 required partial/moderate assistance with shower/baths, lower body dressing, putting on/taking off footwear. Review of section J health conditions revealed Resident #1 had two or more falls since admission/ reentry. Record review of Resident #1s care plan revised 08/05/2024 reflected, Resident #1 at risk for multiple falls with interventions that included educate resident, family and caregivers about safety, floor mat while resident is in bed, remind resident to use call light for Review of Resident #1's care plan conference revealed the last care plan was held 5/23/2024. (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/01/2024 at 1:16 PM with the Social Worker revealed care plan conferences were conducted every 3 months. The Social Worker stated the last care plan meeting was held in May 2024 for Resident #1 and the next one should have been completed in August 2024. The social worker stated he had no explanation as to why the care plan conference had not been held stating he looked over it. The social worker stated if care plan meetings were not conducted quarterly then the family or resident would not be aware of the care the resident was receiving. Interview on 11/01/2024 at 2:24 PM with the Administrator revealed the Social Worker was responsible for ensuring the care plan meetings were held quarterly. The Administrator stated the Social Worker dropped the ball and there was no reason that the care plan conference was not held. Review of the policy Comprehensive Care Plans undated revealed The resident's care plan will be reviewed after each Admission, Quarterly, Annual and/or Significant Change MDS assessment, and revised based on changing goals, preferences and needs of the resident and in response to current interventions.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45268 Based on observations, interviews, and record reviews, the facility failed to ensure residents received adequate supervision and assistance devices to prevent accidents for one (Resident #1) of five residents reviewed for accidents. The facility failed to ensure Resident #1 who was a fall risk, had precautions in place to prevent Resident #1 from falling in the dining room on 10/30/2024. Resident #1 was left alone in the dining room by staff and fell out of his wheelchair. He sustained a bilateral subdural hematoma and was hospitalized . Resident #1 had a fall on 10/28/24 from his bed in which he sustained a hematoma. The noncompliance was identified as PNC IJ. The noncompliance began on 10/30/24 and ended on 10/31/24. The facility had corrected the noncompliance before the investigation began. This failure could place residents at risk of injury and a decreased quality of life. Findings included: Record review of Resident #1's Face Sheet printed 11/01/2024, reflected an [AGE] year-old male who was admitted to the facility initially on 10/14/2022 and readmitted on [DATE] with diagnoses to include but not limited too Dementia, unspecified severity without behavioral disturbance , psychotic disturbance, mood disturbance (term used to describe a group of symptoms affecting memory, thinking and social abilities), acute kidney failure(a condition in which the kidney stops working suddenly) and difficulty in walking. Record review of Resident #1's annual MDS, dated [DATE], reflected a BIMS score of 3 which indicated severe cognate impairment. Functional abilities included supervision/ touching assistance with eating, oral hygiene, toileting, upper body dressing and person hygiene. Resident#1 required partial/moderate assistance with shower/baths, lower body dressing, putting on/taking off footwear. Review of section J health conditions revealed Resident #1 had two or more falls since admission/ reentry. Record review of Resident #1s care plan revised 08/05/2024 reflected, Resident #1 at risk for multiple falls with interventions that included educate resident, family and caregivers about safety, floor mat while resident is in bed, remind resident to use call light for assistance, therapy evaluation as needed. Review of nursing notes dated 10/28/24 at 4:49 AM authored by LVN A revealed CNA went in to do his rounds and noted resident on the floor beside his floor mate. Upon assessment, nurse noted a hematoma and some bleeding at the right side of resident's forehead. Resident was restless and agitated, refusing first aid. Resident report pain to his head. EMS was called in for resident to be transported for further evaluation in the Hospital. Vitals were, BP 149/107, Pulse 77, 02 96, R 20 and T 97.9. Dr [name of Dr], DON and Family notified. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's fall risk assessment dated [DATE], reflected a score of 16, which indicated a high risk for falling. Review of hospital records dated 10/28/2024 revealed Resident #1 had a fall 10/28/24 due to rolling out of bed and hitting his head, resident was transferred to hospital and diagnosed with Hematoma of the scalp. Review of Resident #1's nursing notes dated 10/30/24 at 4:40PM authored by LNV A revealed BP-143/48. T-97.8. P-80. R-18. BS-na{Sic].Resident had a fall. Location: Dining Room. Fall information: Unwitnessed, Hit Head, Cognition / Behavior at Time of Event: Cognitive Impairment, The fall caused a skin tear to Lateral forehead. New / bleeding, At 14:40 staff was taking residents to dining room for dinner. While bringing other residents to the dining room they noted [Resident #1] on the floor. Other residents stated he stood up from his w/c in attempt to walk and stumbled. Resident is sometimes impulsive and forgets his gait is unsteady. Resident was lying on his left side in the dining area. Laceration noted to left forehead with some bleeding. Emergency first aid rendered and 911 called. Neuro [SIC] implemented. Resident sent [SIC] ER Appears and/or states to be in pain. Describes the pain as: Initial Treatment/New Orders: Resident has UTI and is being treated with antibiotics. Resident Statement: Resident has dementia and unable to state what happened .Name of MD/NP notified:[physician name] Date/time of notification: 10/30/2024 4:43 PM . Name of RP notified:[family member name] Date/time of notification: 10/30/2024 2:42 PM. Review of the nursing notes dated 10/01/2024- 11/01//2024 revealed the resident had fall on 02/19/2024, 4/13/2024, 9/19/2024, 10/28/2024 and 10/30/24. Review of hospital records dated 10/30/2024 revealed Resident #1 went to hospital and was diagnosed with bilateral subdural hematoma due to a fall in the dining area and was asymptomatic however due to having advance dementia and DNR resident was unlikely a candidate for operative intervention if needed. Per hospital notes resident was transferred to another hospital for higher level of care due to two falls which resulted in Hematomas. Interview on 11/01/2024 at 12:30 PM with LVN D revealed there was typically a nurse sitting at the dining area during meal times and CNA's on the hall assiting residents to the dining area. LVN D stated she was not on shift when Resident #1 fell in the dining area. LVN D stated she did particpate in a in- service yesterday regarding fall prevention and change in condition. LVN D stated all residents who were a fall risk had fall mats beside, lowered beds and call ligts within reach. Interview on 11/01/2024 at 1:38 PM with CNA D revealed she was not working when Resident #1 fell . CNA D stated she particpated in the in-service regarding fall prevention and change in condition. CNA D stated for residents who were a fall risk fall mats were beside, bed at lowest position and call lights were within reach. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 11/01/2024 at 2:14PM with LVN B revealed he was the nurse working on 10/30/2024. He stated CNA C and himself were taking residents to the dining area. He stated he and CNA C were out of the dining area around the same time getting other residents and a resident pulled the fire alarm. He stated when he got back to the dining area Resident#1 was on the floor. He stated he assessed Resident #1 for injures and called 911 due to bleeding from the head. LVN B stated Resident #1 tried to stand up from his wheelchair and fell according to other residents in the dining area. LVN B stated typically there was one person always in the dining area with residents however it just happened that he and CNA C were out of the dining area at the same time. LVN B stated Resident #1 was a fall risk and always wanted to stand up however LVN B stated he was not aware that Resident #1 had strength to stand on his own. LVN B stated Resident #1 did have a fall mat beside his bed due to being a fall risk. LVN B stated the facility conducted a in- service regarding fall prevention and change in condition. LVN B stated for residents that were a fall risk, fall mats were bedside, beds at the lowest position and call lights were within reach. Interview on 11/01/2024 at 2:24 PM with the administrator revealed Resident #1 had a fall from his bed on 10/28/2024 however interventions such as fall mat, lowered bed and call light within reach were in place and no new interventions were added. The Administrator stated on 10/30/2024 Resident #1 fell from his wheelchair attempting to stand up which was different from previous falls. The administrator stated the interventions that were in place were due to falls from the bed or sitting and not standing falls. The Administrator stated following the fall on 10/30/2024 new interventions would be put in place to include a helmet for Resident #1. The Administrator stated Residents do not have one on supervision and there was no way staff could always have eyes on Resident #1. In phone interview on 11/05/2024 at 11:48 AM via phone with CNA C revealed she had worked in the facility for 1 year. She stated she did not always work on Resident #1's hall however when she had worked with him she did not know that he was a fall risk. CNA A stated she was not sure if Resident #1 had a fall mat beside his bed. CNA C stated Resident #1 was in the dining area while she left to get another resident changed and transferred to the dining area. She stated she was gone about 5-7 minutes and when she returned Resident #1 was on the floor. CNA C stated she alerted the nurse immediately and the resident was assessed by the nurse. The facility self-reported the 10/30/2024 fall and completed a quapi meeting on 10/31/2024. On 10/31/2024 the facility updated fall risk assessments and care plans for all residents who were fall risk. The facility completed in- services all staff on 10/31/2024 on preventive strategies to reduce falls, falls/ ambulation difficulty, change in condition. Review of the facility policy Preventive Strategies to Reduce Fall Risk revised October 5, 2016, revealed After risk is assessed, individualized nursing care plans will be implemented to prevent falls. The resident and/or family members will be educated on methods to prevent falls. Interventions will focus on manipulating the environment, educating the resident/family, implementing rehabilitation programs to improve functional ability, and care monitoring of medication side effects.