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	12/19/2024

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 45268 Based on observations, interviews, and record review the facility failed to protect the confidentiality of personal and medical records for one (LVN A) of three staff observed for confidentiality of records. The facility failed to ensure LVN A locked and closed the laptop during the medication pass exposing resident on the female locked unit's personal information. This failure could affect residents by placing them at risk for loss of privacy and dignity. The findings included: Observation on 12/19/2024 at 11:55AM revealed the computer on Medication Cart 1 was unlocked and unattended on the female locked unit which displayed resident medications that were being passed. The computer was unattended near the front door of the locked unit while LVN A assisted a resident to the dining table and went to another resident's room. LVN A also walked past the unlocked computer on Medication Cart 1 to assist another resident to a sitting area. Several residents walked past the unlocked computer on Medication Cart 1 which was facing toward the common area. Interview on 12/19/2024 at 11:57AM with LVN A revealed she had worked in the facility off and on since 2017. LVN A stated she was aware the computer should have been locked however she did not think any of the residents would get into the computer. LVN A stated the risk of leaving the computer unlocked would be that someone would have access to resident information. Interview on 12/19/2024 at 3:30PM with the Administrator revealed the computer screen on the medication cart was to be locked whenever not sight of LVN A. The Administrator stated the risk of leaving the computer unlocked would be that resident information could be accessed. Review of the facility policy Nursing facility resident rights revised November 2021, revealed you have the right to have facility information about you maintained as confidential.

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 0689 Level of Harm - Minimal harm or potential for actual harm 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 observation, interviews, and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 4 residents (Resident #1) reviewed for accidents and hazards. The facility failed to ensure Resident #1's shoes were on properly to avoid falls. This failure could place residents at risk of their needs not being met. Findings included: Record review of Resident #1's electronic face sheet printed 12/19/2024 revealed an [AGE] year- old female admitted to the facility on [DATE] with diagnoses that included Alzheimer's (most common cause of dementia, causes brain cells to die over time and the brain to shrink), unspecified abnormalities of gait and mobility, and history of falling. Record review of Resident #1's care plan revised 12/11/2024 revealed focus: risk for falls with intervention that included anticipate needs, ensure footwear worn appropriately when ambulating or mobilizing in wheelchair. Record review of Resident #1's admission MDS assessment dated [DATE] revealed a BIMS of 03 which indicated severe cognitive impairment. Review of section GG functional abilities revealed Resident #1 required supervision or touching assistance with putting on and taking off footwear and upper and lower body dressing. Review of Resident #1's admission fall risk assessment dated [DATE] revealed a score of high risk. Observation and interview on 12/19/2024 at 11:55 AM revealed Resident #1 observed with her heels not completely in the shoes and walking around the common area. Resident #1 stated she did not receive any assistance with putting her shoes on. A full interview with Resident #1 was not completed due to cognitive abilities. Interview on 12/19/2024 at 11:57 AM with CNA B revealed Resident #1 dressed herself and would often put on shoes incorrectly. CNA B stated when she noticed Resident #1's shoes were off she would try to put the shoes on correctly if Resident #1 allowed. CNA B stated she was not aware of Resident #1 having any falls recently. Interview on 12/19/2024 at 3:30PM with Administrator revealed staff should have been using Resident #1's plan of care to determine fall risk interventions. The administrator stated if a resident was a fall risk, they should have no slip socks or shoes with resistance. The administrator stated if staff were aware of Resident #1 wearing shoes improperly, they should attempt to intervene and correct the shoes. The administrator revealed the risk of Resident #1's shoes not being on properly could be that the Resident could fall, and intervention put in place would not be effective. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy comprehensive care planning undated revealed The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that Includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Review of the facility policy Preventive Strategies to Reduce Fall Risk revised October 5, 2016, revealed Footwear, shoes, slippers, etc., worn by residents should fit properly and have slip resistant soles. When foot problems prohibit proper-sized shoes, residents will be referred for podiatry care to remedy the problem. To accommodate foot problems, the resident may be prescribed therapeutic footwear.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 45268 Based on observation, interview and record review, the facility failed to store all drugs and biologicals in locked compartments for one (Medication Cart 1) of three medication carts reviewed for medication storage. The facility failed to lock Medication cart 1 leaving all medications on the cart accessible. These failures could place residents at risk for possible drug diversions. Findings included: Observation on 12/19/2024 at 11:55AM revealed the Medication Cart 1 was unlocked and unattended on the female locked unit. The Medication on Cart 1 was accessible to residents and staff on the unit due to the drawers being able to be pulled open. Medication Cart 1 was unattended near the front door of the locked unit while LVN A assisted a resident to the dining table and went to another resident's room. LVN A also walked past unlocked Medication Cart 1 to assist another resident to a sitting area. Several residents walked past unlocked Medication Cart 1 which was facing toward the common area. Interview on 12/19/2024 at 11:57AM with LVN A revealed she had worked in the facility off and on since 2017. LVN A stated she was aware Medication Cart 1 should have been locked however she did not think any of the residents would mess with the cart. LVN A stated the risk of leaving the medication cart unlocked would be that someone would have access to the medication. Interview on 12/19/2024 at 3:30PM with the Administrator revealed the medication cart should have been locked whenever not in sight of LVN A Review of the policy Medication administration procedure revised 10/25/17 revealed, After the medication administration process is completed, the medication cart must be completely locked, or otherwise secured.