

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 06/17/2025
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for three (Resident #10, Resident #11, and Resident #12) of twenty-two residents reviewed for reasonable accommodation of needs.</p> <p>The facility failed to ensure the call light system in Resident #10, #11, and #12's rooms were in a position that was accessible to the residents on 06/17/2025.</p> <p>This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency.</p> <p>Findings included:</p> <p>Resident #10</p> <p>Record review of Resident #10's Face Sheet, dated 06/17/2025, reflected the resident was a [AGE] year-old male who admitted to the facility on [DATE]. Resident #10 had diagnoses which included dementia (decline in cognitive function that interferes with daily life) and cognitive communication deficit (impacts how a person processes and conveys information).</p> <p>Record review of Resident #10's Quarterly MDS (tool used to assess functional capabilities and health needs) Assessment, dated 03/25/2025, reflected severely impaired cognition with a BIMS (tool used to assess cognition) score of 01. Section GG (functional abilities) indicated Resident #10 required substantial assistance with self-care needs.</p> <p>Record review of Resident #10's Comprehensive Care Plan, dated 05/13/2025, reflected Resident #10 was at risk for falls related to balance/gait problems. Some interventions were anticipate and meet the resident's needs and ensure the resident was wearing appropriate footwear when ambulating or mobilizing in wheelchair.</p> <p>During an observation 06/17/2035 at 9:05 AM, Resident #10 was lying in bed. The resident's call light was on the nightstand next the resident's bed and not within reach. An attempt was made to interview Resident #10, but the resident was unable to participate because of his cognitive status.</p> <p>Resident #11</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #11's Face Sheet, dated 06/17/2025, reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE]. Resident #11 had diagnoses which included Alzheimer's disease (loss of memory and cognitive ability that interferes with daily life) and muscle wasting and atrophy (loss of skeletal muscle mass).</p> <p>Record review of Resident #11's Quarterly MDS Assessment, dated 04/05/2025, reflected a BIMS Assessment was not appropriate because the resident was rarely/never understood. The staff assessment reflected severely impaired cognition with daily decision making. Section G (functional status) indicated Resident #11 required extensive assistance with acts of daily living.</p> <p>Record review of Resident #11's Comprehensive Care Plan, dated 05/29/2025, reflected Resident #11 had the potential for impaired visual function related to vision deficit. One intervention was to keep the call light in reach when Resident #11 was in her room or bathroom.</p> <p>During an observation on 06/17/2025 at 9:13 AM, Resident #11 was lying in bed asleep. The call light was wrapped around the call light fixture on the wall and not within the resident's reach.</p> <p>Resident #12</p> <p>Record review of Resident #12's Face Sheet, dated 06/17/2025, reflected the resident was a [AGE] year-old male who admitted to the facility on [DATE]. Resident #12 had diagnoses which included cerebral infarction (stroke: interruption of blood flow to the brain) and hemiparesis (weakness on one side of the body) affecting the left non-dominant side.</p> <p>Record review of Resident #12's Quarterly MDS Assessment, dated 05/30/2025, reflected moderately impaired cognition with a BIMS score of 08. Section GG (functional abilities) indicated Resident #12 required substantial assistance with self-care needs.</p> <p>Record review of Resident #12's Comprehensive Care Plan, dated 05/13/2025, reflected Resident #12 was at risk for falls related to gait/balance problems and paralysis. One intervention was ensure the resident's call light was within reach and encourage the resident to use it for assistance as needed.</p> <p>During an observation and interview on 06/19/2025 at 9:17 AM, Resident #12 was lying in bed. The call light was in the top drawer of the nightstand next to the resident's bed and not within the resident's reach . Resident #12 stated he used the call light at times but staff didn't always answer it.</p> <p>During an interview on 06/17/2025 at 9:35 AM, the CNA stated at the beginning of each shift she rounded on all her residents. She stated she always checked to be sure the call lights were in reach and it was a miss on her part. She stated it was important for the residents to be able to reach staff if they needed a drink or snack, needed changed, or needed to be repositioned in bed. The CNA stated it was important to monitor residents' call lights to ensure they were within reach. She stated if a resident could not reach their call light, staff would not know they needed help.</p> <p>During an interview on 06/17/2025 at 1:15 PM, the ADON stated she expected all staff to monitor call light placement during rounds. She stated it was important for residents to have the call light in reach so they could tell staff what they needed.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/17/2025 at 1:40 PM, the RN stated residents' call lights should always be within reach so anytime the resident had a need they could reach staff. She stated if the resident could not reach their call light, staff would not be able to respond right away. She stated a resident might fall trying to get to their call light.</p> <p>During an interview on 06/17/2025 at 2:51 PM, the Administrator stated it was important to ensure residents' call lights were in reach. He stated sometimes staff moved a call light when providing care and forgot to put it back. He stated CNAs should regularly round and correct that. He stated if a resident did not have their call light, there could be a delay in providing assistance to the resident.</p> <p>The facility did not have a policy specifically related to call lights.</p>		