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	10/21/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for two of ten residents (Residents #1, and #2) reviewed for call systems access. The facility failed to ensure the call light system in Resident #1, and #2's rooms was in a position that was accessible to the residents on 10/21/25. This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency.Findings include: 1. Record review of Resident #1's Face Sheet, dated 10/21/25, reflected she was an [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included fracture of left femur (thigh bone) and muscle weakness. Record review of Resident #1's Quarterly MDS assessment, dated 10/01/25, reflected a BIMS score of 11, moderate cognitive impairment. For ADL care, it reflected the resident required substantial assistance. She had an active diagnosis of fracture of left femur. Record review of Resident #1's Comprehensive Care Plan, dated 10/13/25, reflected the resident's fracture of left femur, and included an intervention of ensuring the resident's call light was within reach. In an observation and interview on 10/21/25 at 8:52 AM revealed Resident #1 was lying in bed and her call light was observed inside her nightstand. She was asked where her call light was located, and she stated it was attached to a chain somewhere. In an interview on 10/21/25 at 9:00 AM, RN R was shown a picture of Resident #1's call light not being within reach of the resident and she stated they completed their rounds every 30 to sixty minutes and they checked to ensure the resident was okay. She stated they check to ensure call lights were within reach of the resident in case they needed assistance. 2. Record review of Resident #2's Face Sheet, dated 10/21/25, reflected she was an [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included muscle weakness and lack of coordination. Record review of Resident #2's Quarterly MDS assessment, dated 8/05/25, reflected a BIMS score of 3, severe cognitive response. For ADL care, it reflected the resident required substantial assistance. Active diagnoses included muscle weakness and lack of coordination. Record review of Resident #2's Comprehensive Care Plan, dated 10/07/25, reflected the resident required ADL care and one of the interventions was to ensure call light was within reach of the resident and to encourage the resident to use it. In an observation and interview on 10/21/25 at 8:52 AM revealed Resident #2 was lying in her bed and her call light was located on the side of the bed, against the wall, and out of reach of the resident. She was asked where her call light was located, and she stated she did not know. In an interview and observation on 10/21/25 at 8:53 PM, revealed CNA G was shown Resident #2's call light location, and she searched for it and pulled it from the side of the bed. She stated the call light needed to be within reach of the residents in case they had an emergency and needed help. She stated they checked to ensure call lights were within reach of the resident when they completed their rounds every two hours and she was about to go around to the rooms to check. In an interview on 10/21/25 at 9:00 AM, the Administrator was advised of Residents #1 and #2 not having their call lights within reach. He stated the staff made their rounds at least every two hours and they checked to ensure the call lights were within reach of the residents. He stated they also conducted Champion rounds daily and the leadership checked for call lights being within reach as well. In an interview on 10/21/25 at 12:00 PM, RN M was told by the Surveyor about Resident #2's call light not being within her reach. She stated she was told by CNA G about the resident's call light not being within her reach. She stated the call light needed to be within the resident's reach for their safety and if they needed anything from the nursing staff. In an interview on 10/21/25 at 12:07 PM, ADON G stated leadership told her about Resident #1 and #2 not having their call light within their reach. She stated she expected the call lights to be within reach of the resident so they could contact staff if they needed anything. She stated a risk of the call light not being in reach was the resident could have an emergency In an interview on 10/21/25 at 12:16 ADON E stated her nursing staff advised her of call lights not being in reach of the residents and she stated her expectation was for the call light to be within reach of every resident. She stated if the call lights were not within reach of the residents, they would not be able to contact staff. In an interview on 10/21/25 at 1:27 PM, the DON was told and shown photos by the Surveyor of the call lights for Residents #1 and #2 not being within reach of the residents. She stated the call light needed to be within the residents reach for their safety. She stated the nursing staff should be checking for this when they made their rounds. The nursing staff provided copy of an in-service with the nursing staff on

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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. (continued on next page)

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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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record reviews, the facility failed to provide adequate supervision and assistance to prevent accident hazards for one of ten residents (Resident #3) reviewed for accidents and hazards. CNA A failed to follow Resident #3's care plan and mechanical lift instructions of using two people to perform the transfer on 09/27/25, which resulted in the resident falling and fracturing 5 ribs. The non-compliance was identified as PNC on 10/21/25 and the IJ template was provided to the facility on [DATE] at 4:30 PM. The noncompliance began on 09/27/25 and ended 09/29/25. The facility corrected the non-compliance before the investigation began. This failure placed the resident at risk of serious harm, injury and death. Findings included: Record review of Resident #3's Face Sheet, dated 10/21/25, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnosis included obesity and lack of coordination. Record review of Resident #3's Quarterly MDS assessment, dated 10/09/25, reflected a BIMS score of 11, a moderate cognitive impairment. For ADL care, it reflected the resident required maximal assistance and a two-person assist. Active diagnosis included obesity and muscle weakness. Record review of Resident #3's Comprehensive Care plan, dated 9/11/25, reflected the resident required ADL care and an intervention included the requirement of 2 people for mechanical lift participation with transfers. Record review of LVN K's witness statement, dated 9/30/25, reflected Upon entering the room, this nurse observed the resident on the floor flat with sling attached to all four hooks on the Hoyer lift, with hook piece on resident's chest. The Hoyer was laying sideways on the floor near resident. The sling was under resident and shower bed was in corner of the room. Record review of the hospital records, dated 9/29/25, reflected Resident #3 was seen in the emergency room and was treated for Mildly displaced fractures of the seventh, eighth, ninth, tenth, and eleventh ribs. In an interview on 10/21/25 at 9:00 AM, the Administrator stated he received a report from the DON on 09/29/27 that on 09/27/25, CNA A had used a Hoyer lift by herself to provide Resident #3 a shower. He stated when the CNA was attempting to transfer the resident back into her bed the Hoyer lift had fallen while the resident was in the Hoyer lift and the Hoyer collapsed, sending the resident to the floor and the mechanical lift landed on top of the resident. He stated the facility conducted an x-ray on 9/27/25 and there were no concerns observed, which was verified by the surveyor. He stated the resident was complaining of pain the next day and wanted to send the resident to the ER but the resident refused. He stated the resident was complaining of pain while at the dialysis clinic, and they persuaded her to go to the ER on [DATE]. He stated he received a report that their x-rays revealed the resident had suffered five fractured ribs. He stated they kept the resident for five days for pain management. The Administrator stated he interviewed CNA A and she initially stated she attempted to get someone to assist her with the Hoyer lift but could not find anyone. He stated CNA A admitted to using the Hoyer lift by herself. He stated he interviewed all of the CNAs on shift at the time, and all of them denied CNA A asking for assistance to operate the Hoyer lift for Resident #3. The Administrator stated CNA A was initially suspended, and after the internal investigation was completed, they decided to terminate her. He stated the facility always required two people to operate the Hoyer lift. He stated the resident had been able to attend her dialysis appointments since she had returned and continued to be monitored for pain management. The Administrator stated on 9/29/25 he completed in-services with the nursing staff on mechanical lift transfers, pain management, bed to chair transfers, trauma informed care, abuse and neglect reporting procedures, incident reporting, and change in conditions. The Administrator provided copies of staff competencies conducted on gate belt transfers and Hoyer lift transfers. He stated he implemented a monitoring process which required the nursing leadership to observe ten ADL care to residents to ensure transfers, feeding, and bed repositioning were done accurately. In an interview on 10/21/25 at 12:28 PM, CNA A stated she had no intention in harming Resident #3, and it was an unfortunate accident. She stated they were always short-staffed, and it was difficult to get a second person to assist her with the Hoyer lift. She stated the resident was insistent on getting a shower, she could not wait any longer, and her intention was to give the resident a successful shower. She stated she thought she would get in trouble if she did not give the resident a shower. She stated two people were required to use the mechanical lift and she had seen other CNAs using the Hoyer lift by themselves all the time. She stated two people were required for the Hoyer lift for the transfer, but she did not know the risk if two people were not used. In an interview and observation on 10/21/25 at 11:40 AM, Resident #3 stated CNA A was providing her a shower on 09/27/25. She stated the CNA used the Hoyer lift by herself to lift her out of the

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure that residents, who needed respiratory care, were provided care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for four of seven residents (Residents #1, #3, and #4) reviewed for respiratory care. The facility failed to ensure Residents #1, #3, and #4 nasal cannulas and breathing devices were properly stored in a bag when not in use on 10/21/25. This failure could place residents at risk for respiratory infection and not having respiratory needs met.Findings include: 1. Record review of Resident #1's Face Sheet, dated 10/21/25, reflected she was an [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included Supraventricular Tachycardia (irregular heartbeat). Record review of Resident #1's Quarterly MDS assessment, dated 10/01/25, reflected a BIMS score of 11, a moderate cognitive impairment. For ADL care, it reflected the resident required substantial assistance. She had an active diagnosis of atrial fabulation fracture (irregular heartbeat). Record review of Resident #1's physician's orders, dated 10/21/25, reflected Ipratropium Bromide Inhalation Solution 0.02%, 1 vial orally every 8 hours as needed for wheezing In an observation and interview on 10/21/25 at 8:52 AM revealed Resident #1's breathing mask for her nebulizer was observed sitting on top of the nebulizer, which was located on a chair. She stated she used the nebulizer twice a day and had already used it in the morning and would not use it again until later in the day. 2. Record review of Resident #3's Face Sheet, dated 10/21/25, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnosis included Hyperkalemia (excessive potassium). Record review of Resident #3's Quarterly MDS assessment, dated 10/09/25, reflected a BIMS score of 11, moderate cognitive impairment. For ADL care, it reflected the resident required maximal assistance. Active diagnosis included obesity. Record review of Resident #3's physician's orders, dated 10/21/25, reflected May use oxygen @ 2 l/m via nasal canula during night for Oxygen therapy. In an observation on 10/21/25 at 8:54 PM, revealed Resident #3's nasal canula was observed on the floor, near the oxygen device, unbagged. 3. Record review of Resident #4's Face Sheet, dated 10/21/25, reflected he was an [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnosis included COPD. Record review of Resident #4's Quarterly MDS assessment, dated 8/08/25, reflected his BIMS score of 9, moderate cognitive impairment. The resident had an active diagnosis of heart failure. Record Review of Resident #4's physician's orders, dated 10/21/25, reflected Comb/vent Aerosol 18-103 MCG/ACT, 2 puff inhale orally every 4 hours as needed for SOB. In an observation on 10/21/25 at 8:57 PM, revealed Resident #4's breathing treatment inhaler was observed sitting inside a nightstand, unbagged. In an interview on 10/21/25 at 9:00 AM, RN R was shown pictures of Resident #1, #3, and #4's breathing devices unbagged while not in use. She stated the nasal cannulas and breathing devices should be bagged when not in use to avoid infection control. She stated all nurses should check for this when making their rounds. In an interview on 10/21/25 at 12:00 PM, RN M was told by the Surveyor about Resident #1, #3, and #4's breathing devices unbagged while not in use. She stated nasal cannulas and breathing devices should be bagged when not in use to avoid infection control. She stated it was the nurses responsibility to ensure the devices were bagged when not in use. In an interview on 10/21/25 at 12:07 PM, ADON G was shown photos of Resident #1, #3, and #4's breathing devices not being bagged when not in use. She stated all breathing devices should be bagged to avoid the residents getting an infection. She stated the nurses check to ensure the breathing devices were bagged when making their rounds. In an interview on 10/21/25 at 12:16, ADON E was told by the Surveyor of Resident #1, #3, and #4's breathing devices not being bagged when not in use. She stated the nurses were required to ensure breathing devices were bagged for infection control. In an interview on 10/21/25 at 1:27 PM, the DON was told by the Surveyor of Resident #1, #3, and #4's breathing devices not being bagged when not in use. She stated she expected all breathing devices to be bagged when not in use for infection control purposes. She stated all nurses, including the ADONs and DON was expected to check for this when making rounds. Review of the facility's policy Respiratory Care Policy, undated, reflected Purpose - To ensure that all residents requiring respiratory care in the long-term care facility receive safe, evidence-based, and individualized respiratory services that optimize respiratory function, prevent complications, and improve quality of life.