

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  11/25/2025
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)
F 0600  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.  (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review the facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for two (Resident #1 and Resident #2) of 10 residents reviewed for abuse and neglect. The facility failed to ensure Resident #1 was free from abuse when Resident #2 slapped her on the face on 09/20/2025. This failure could place residents at risk of abuse and emotional stress. The findings include: Record review of Resident #1's Face Sheet, dated 09/26/2025, reflected the resident was an [AGE] year-old female who admitted on [DATE]. Resident #1 had diagnoses which included dementia (decline in cognitive function that interferes with daily life), cognitive communication deficit (impacts how a person processes and conveys information), and the need for assistance with personal care. Resident #1 resided in the memory care unit. Record review of Resident #1's Quarterly MDS (tool used to assess health status) Assessment, dated 08/26/2025, reflected severely impaired cognition with a BIMS (screening tool to assess cognitive status) score of 04. Section E (Behavior) reflected verbal behavioral symptoms directed toward others occurred 1 to 3 days. Record review of Resident #1's Comprehensive Care Plan, dated 09/26/2025, reflected The resident has potential to demonstrate physical behaviors Dementia, Poor impulse control. Resident involved in a resident-to-resident event - this resident was hit by another resident. Date initiated 09/20/2025. Interventions included monitor right check, neuros initiated. Date initiated 09/20/2025. Psychiatric/Psychogeriatric consult as indicated. Date initiated 09/20/2025. Skin and trauma assessment. Date initiated 09/20/2025. Review of Resident #2's Face Sheet, dated 09/26/2025, reflected the resident was a [AGE] year-old female who admitted on [DATE]. Resident #2 had diagnoses which included dementia (decline in cognitive function that interferes with daily life), schizophrenia (mental health disorder that affects how a person thinks, feels, and behaves), bipolar disorder (extreme mood swings, including emotional highs and lows), on), and cognitive communication deficit. Resident #2 resided in the memory care unit. Review of Resident #2's Quarterly MDS Assessment, dated 08/27/2025, reflected severely impaired cognition with a BIMS score of 02. Section E (Behavior) reflected verbal behavioral symptoms directed toward others occurred 4 to 6 days, but less than daily. Review of Resident #2's Comprehensive Care Plan, dated 08/28/2025, reflected The resident has potential to demonstrate physical behaviors Dementia, Poor impulse control. Resident involved in a resident to resident event - this resident hit another resident. Date Initiated: 09/20/2025. Interventions included Psychiatric/Psychogeriatric consult as indicated. Residents separated and this resident placed on 1-1 monitoring. COMMUNICATION: provide physical and verbal cues to alleviate anxiety; give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, encourage seeking out of staff member when agitated. Evaluate for side effects of medications. Review of Resident #2's Provider Progress Notes, dated 09/22/2025, reflected an increase to the risperdal for mood. It may also help with Pt's sleep issues. Pt may be taken off 1:1 as long as there is no physical aggression, threats, SI, HI for at least 24 hours. Re-fer for psychological counseling for anger management. Continue current appropriate treatment. All psychoactive medications were reviewed for continued need or dosage adjustment. Gradual dose reduction or medication reduction not recommended at this time due to ongoing signs/ symptoms. Continue to monitor mood, behaviors and potential SEs of medications. Follow up next visit or PRN. Record review of Resident #2's progress notes reflected she had not hit any other resident since she hit Resident #1 on 09/20/2025. During an interview on 09/26/2025 at 10:41 AM, RN D stated she was not working when Resident #2 hit Resident #1. She stated she worked the day shift Monday to Friday in the female memory care unit. She stated Resident #2 cursed and yelled at other residents at times. She stated Resident #2 was ok most of the time and she had not seen her hit another resident. She stated if Resident #2 seemed agitated, they directed her to her room or took her to therapy. RN D stated the other residents were not afraid of Resident #2. She stated Resident #1 was calm and had displayed no behaviors of yelling or hitting. During an observation and interview on 09/26/2025 at 11:10 AM, Resident #2 was sitting at a table with another resident in the main living area of the memory care unit. When asked if she had an issue with any of the residents, she pointed at a resident at another table and stated the resident called her a bitch and she (Resident #2) hit her on the shoulder. She stated they put her on restriction after that. When asked what that meant, she replied she could not go out with her parents. When the surveyor pointed at Resident #1 and asked how they got along, Resident #2 stated she don't bother me and denied hitting Resident #1 During an observation and interview</p>		

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F 0607  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft.  (continued on next page)

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews, and record review, the facility failed to implement written policies and procedures that prohibited and prevented abuse for 2 (Resident #1 and Resident #2) of 10 resident reviewed for abuse and neglect. The facility failed to implement their policies and procedures to ensure Resident #2 did not slap Resident #1 on the face on 09/20/2025. This failure could place residents at risk of continued abuse and neglect. Findings included: Record review of Resident #1's Face Sheet, dated 09/26/2025, reflected the resident was an [AGE] year-old female who admitted on [DATE]. Resident #1 had diagnoses which included dementia (decline in cognitive function that interferes with daily life), cognitive communication deficit (impacts how a person processes and conveys information), and the need for assistance with personal care. Resident #1 resided in the memory care unit. Record review of Resident #1's Quarterly MDS (tool used to assess health status) Assessment, dated 08/26/2025, reflected severely impaired cognition with a BIMS (screening tool to assess cognitive status) score of 04. Section E (Behavior) reflected verbal behavioral symptoms directed toward others occurred 1 to 3 days. Record review of Resident #1's Comprehensive Care Plan, dated 09/26/2025, reflected The resident has potential to demonstrate physical behaviors Dementia, Poor impulse control. Resident involved in a resident to resident event - this resident was hit by another resident. Date initiated 09/20/2025. Interventions included monitor right check, neuros initiated. 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Re-fer for psychological counseling for anger management. Continue current appropriate treatment. All psychoactive medications were reviewed for continued need or dosage adjustment. Gradual dose reduction or medication reduction not recommended at this time due to ongoing signs/ symptoms. Continue to monitor mood, behaviors and potential SEs of medications. Follow up next visit or PRN.During an interview on 09/26/2025 at 10:41 AM, RN D stated she was not working when Resident #2 hit Resident #1. She stated she worked the day shift Monday to Friday in the female memory care unit. She stated Resident #2 cursed and yelled at other residents at times. She stated Resident #2 was ok most of the time and she had not seen her hit another resident. She stated if Resident #2 seemed agitated, they directed her to her room or took her to therapy. RN D stated the other residents were not afraid of Resident #2. She stated Resident #1 was calm and had displayed no behaviors of yelling or hitting. During an observation and interview on 09/26/2025 at 11:10 AM, Resident #2 was sitting at a table with another resident in the main living area of the memory care unit. When asked if she had an issue with any of the residents, she pointed at a resident sitting at another table and stated the resident called her a bitch and she (Resident #2) hit her on the shoulder. She stated they put her on restriction after that. When asked what that meant, she replied she could not go out with her parents. When the surveyor pointed at Resident #1, Resident #2 stated she don't bother me and denied hitting her. During an observation and interview on 09/26/2025 at 11:17 AM, Resident #1 was sitting quietly in a chair near a window in the main living area of the memory care unit. When asked if she felt safe. Resident #1 replied yes</p>		