Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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	03/13/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the resident had the right to reside and receive services with reasonable accommodate of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for 3 of 4 residents (Residents #1, #3 and #4) reviewed for accommodation of needs. The facility failed to place Residents #1, #3 and #4's call-lights within reach. This failure could place residents at risk of not having their needs and preferences met and a decreased quality of life.Findings include: 1. Record review of Resident #3's face-sheet revealed a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included: Unspecified dementia with agitation (a person experiencing memory loss and mental decline alongside significant emotional or physical restlessness) Record review of Resident #3's quarterly MDS, dated [DATE], revealed the resident had minimal difficulty hearing, functional limitations with impaired range of motion on both upper and lower extremities. Resident #3 had a BIMS score of 3 (indicating severe cognitive impairment). Further review of MDS revealed the resident required extensive assist with all ADL's. Record review of Resident #3's care plan, dated 01/08/26, revealed the resident had the potential for falls, dependent on staff for meeting emotional, intellectual, and physical and social needs, ADL self-care performance deficit, limited physical mobility, impaired visual function, risk for falls. The care plan further revealed be sure the resident's call light was within reach and encourage the resident to use it for assistance as needed. Observation on 03/13/26 at 2:00 PM revealed Resident #3 was in bed and awake was not interviewable. Call light was noted in a closed nightstand drawer with bedside table pushed against the drawer and out of reach to resident. Interview on 03/13/26 at 2:47 PM with the DON, she stated per facility policy the call light should be within reach of Resident #3 weather or not he was able to use it or not. It was important for call light to be within reach since it's part of the residents' right and would allow staff to meet his needs in a timely manner. She stated there was a risk of delayed care if the resident was unable to use the call light in emergency situations. Interview on 03/13/26 at 3:05 PM with the ADMIN, he stated the call light should be next to the resident, unless care planned that per resident preference not to have it next to them. Interview on 03/13/26 at 3:23 PM with LVN B, she stated it was important for the call bell to be within reach of each resident in case of emergencies. She stated it should always be accessible even if the resident was incapable of using the call bell. The risk of not having the call light accessible could result in residents needs not met timely or not met at all. Interview on 03/13/26 at 3:27 PM with CNA B, she stated it was important for the call bell to be within reach of the resident to avoid a delay in meeting the resident's needs. If they had an emergency, like a fall or other needs, it could pose a risk if they were not attending too quickly. 2. Record review of Resident #4's face-sheet revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included: Alzheimer's Disease (a progressive, irreversible brain disorder that slowly destroys memory, thinking skills, and eventually the ability to carry out simple tasks), Anxiety disorder (a mental health condition characterized by persistent, excessive, and uncontrollable worry or fear that interferes with daily life). Record review of Resident #4's quarterly MDS, dated [DATE], revealed the resident had a BIMS score of 3 (severe cognitive impairment). (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	Further review of MDS revealed the resident required extensive assistance with all ADLs. Record review of Resident #4's care plan, dated 02/11/26, revealed the resident had the potential for falls, was dependent on staff for meeting emotional, intellectual, and physical and social needs, ADL self-care deficit, limited physical mobility, impaired visual function. The care plan further revealed ; to place resident's call light within reach and encourage the resident to use it for assistance as needed. Observation on 03/13/26 at 3:45 PM, revealed Resident #4's call bell was noted laying across the night side and out of reach of the resident. Interview on 03/13/26 at 3:45 PM with LVN C, she stated the call bell had to be within reach of each resident per the facility policy to enable residents to call for assistance when needed to avoid delays in providing care. 3. Record review of Resident #1's face-sheet revealed a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included: Dementia (an umbrella term for a decline in mental ability-such as memory loss, poor reasoning, and communication difficulties-that is severe enough to interfere with daily life) Record review of Resident #1's quarterly MDS, dated [DATE], revealed the resident had a BIMS score of 6 (severe cognitive impairment). Further review of MDS revealed the resident had weakness on both lower extremities required partial to moderate assistance with all ADLs. Record review of Resident #1's care plan, dated 01/05/26, revealed the resident had a risk for multiple falls, impaired cognitive function (intervention: Resident will have needs met in a timely manner), dependent on staff for meeting emotional, intellectual, and physical and social needs, ADL self-care deficit, limited physical mobility and impaired visual function. Observation on 03/13/26 at 3:55 PM, revealed Resident #1's call bell was laying on the nightstand on the floor out of reach of the resident. Interview on 03/13/26 at 4:00 PM with CNA C, he stated they did rounds regularly to check on the residents and per facility policy and ensure call bells remains within reach of every resident to allow immediate assistance and prevent any delay in care. Interview on 03/13/26 at 4:05 PM with LVN D, he stated every staff member was responsible for making sure the residents call bells were in place. He stated the facility policy required all residents to have immediate access to their call bells to avoid delays in care and prevent emergencies. Interview on 03/13/26 at 4:15 PM with the DON, she stated per facility policy, call bells must always be within reach to ensure residents received timely assistance and avoided potential emergencies. All staff were responsible for making sure residents' needs were met. Interview on 03/13/26 at 4:20 PM with the ADMIN, he stated to prevent emergencies and care delays, residents must always have immediate access to their call bells to ensure timely care and prevent emergencies. Staff must ensure call bells are accessible before leaving the room.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for 2 of 4 residents (Resident #2 and #4) reviewed for resident rights. The facility failed to keep the privacy curtain for Resident #2 and Resident #4 in clean and sanitary condition. This failure could place residents at risk of an unsafe, unsanitary, non-homelike environment and decreased quality of life.Findings include: Record review of Resident #4's face-sheet revealed a [AGE] year-old female who was admitted to facility on 11/25/2016. Her diagnosis included: Alzheimer's Disease (a progressive, irreversible brain disorder that slowly destroys memory, thinking skills, and eventually the ability to carry out simple tasks), Anxiety disorder (a mental health condition characterized by persistent, excessive, and uncontrollable worry or fear that interferes with daily life). Record review of Resident #4's quarterly MDS, dated [DATE], revealed the resident had a BIMS score of 3 (severe cognitive impairment). The resident required extensive assistance with all ADLs. Record review of Resident #4's care plan, dated 02/11/26, revealed the resident had the potential for falls, was dependent on staff for meeting emotional, intellectual, and physical and social needs, ADL self-care deficit, limited physical mobility, impaired visual function. The care plan further revealed to place Resident's call light within reach and encourage the resident to use it for assistance as needed. Observation on 03/13/26 at 3:45 PM, revealed Resident #4's privacy curtain was noted with several large brown stains. Interview on 03/13/26 at 3:46 PM with LVN C, she stated everyone was responsible for making the facility a homelike environment for the residents. They conducted rounds and informed maintenance and housekeeping staff of needed maintenance and cleaning. She stated if the resident environment was not kept clean, it might affect their dignity and emotional wellbeing. 2. Record review of Resident #2's face-sheet revealed a [AGE] year-old male who was admitted to facility on 01/23/2025. His diagnosis included: Alzheimer's disease (a progressive, irreversible brain disorder that slowly destroys memory, thinking skills, and eventually the ability to carry out simple tasks), Major depressive disorder a serious mental health condition characterized by persistent, intense sadness and a loss of interest in activities, lasting at least two weeks. Record review of Resident #2's quarterly MDS, dated [DATE], revealed residents had a BIMS score of 5 (severe cognitive impairment). The resident had weakness on both lower extremities, dependent to substantial / maximal assistance all ADLs. Record review of Resident #2's care plan, dated 01/14/26, revealed the resident was at risk for falls, had impaired cognitive function, and ADL self-care performance deficit. Observation on 03/13/26 at 3:57 PM revealed Resident #2's privacy curtain was noted with red stains on it. Interview on 03/13/26 at 4:00 PM with CNA C, he stated everyone was responsible for informing housekeeping of cleaning needs of the resident's room. They conducted regular rounds to identify needs of residents. The residents' room should be cleaned since it's their home. A dirty room could negatively impact the residents and their visitors negatively. Interview on 03/13/26 at 4:05 PM with LVN D, he stated the resident room should be cleaned and it was everyone's responsibility to make sure it happened. Housekeeping was responsible for cleaning, but staff made rounds and reported any cleaning needs to them. Interview on 03/13/26 at 4:15 PM with the DON, she stated every staff member shared the responsibility of maintaining a homelike environment to preserve resident dignity and emotional well-being. To ensure this, the team conducted regular rounds and coordinated with maintenance and housekeeping to address any cleaning or repair needs. Interview on 03/13/26 at 4:20 PM with the Administrator, he stated everyone was responsible for informing housekeeping of cleaning needs, which were identified through regular rounds to ensure a clean, comfortable home for residents. Maintaining a tidy room was essential, as a dirty environment negatively impacted the well-being of residents and their visitors. Record review of the facility provided infection control plan (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	overview, stated the following: The facility will establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infection for 2 of 4 residents (Residents #1 and #2) reviewed for infection control. 1. LVN A failed to change gloves when going from dirty to clean task during perineal care of Resident #1's incontinent care. 2. LVN A failed to sanitize his hands after removing his dirty gloves and before donning clean gloves during Resident #2's incontinent care. 3. LVN A failed to sanitize the bedside table and change covering linen when moving the table from Resident #1's room to Resident #2's room. These deficient practices could place residents at risk for cross contamination and/or spread of infection. Findings include: 1. Record review of Resident #1's face-sheet revealed a [AGE] year-old male who was admitted to facility on 09/01/2022. His diagnosis included: Dementia, (an umbrella term for a decline in mental ability-such as memory loss, poor reasoning, and communication difficulties-that is severe enough to interfere with daily life). Record review of Resident #1's quarterly MDS, dated [DATE], revealed the resident had a BIMS score of 6 (severe cognitive impairment). The resident had weakness on both lower extremities and required partial to moderate assistance with all ADLs. Record review of Resident #1's care plan, dated 01/05/26, revealed the resident had risk for multiple falls, impaired cognitive function (intervention: Resident will have needs met in a timely manner), dependent on staff for meeting emotional, intellectual, and physical and social needs, ADL self-care deficit, limited physical mobility and impaired visual function. Record review of Resident #2's face-sheet revealed a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included: Alzheimer's disease (a progressive, irreversible brain disorder that slowly destroys memory, thinking skills, and eventually the ability to carry out simple task). Record review of Resident #2's quarterly MDS, dated [DATE], revealed the resident had a BIMS score of 5 (Severe cognitive impairment). The resident had weakness on both lower extremities and was dependent to substantial / maximal assistance all ADLs. Record review of Resident #2's care plan, dated 01/14/26, revealed the resident was at risk for falls, had impaired cognitive function, and ADL self-care performance deficit. During observation on 03/13/26 at 12:40 PM to 12:50 PM revealed LVN A failed to change gloves and sanitize their hands and did not don a clean glove, he applied cream to the perineal area of Resident #1 after cleaning the dirty area with the same gloves During observation on 03/13/26 at 12:55 PM to 1:10 PM revealed LVN A did not sanitize the bedside table before moving it to Resident #2's room from Resident #1's room. During perineal care for Resident #2, he applied cream peri area, removed gloves, and donned clean gloves and did not sanitize hands, applied cream to groin area, removed gloves, donned clean gloves, and did not sanitize hands. Interview on 03/13/26 at 1:15 PM with LVN A, he stated the importance of sanitizing hands after glove changes, changing gloves when going from dirty to clean task and sanitizing the bed side table when going from one room to another was to prevent spreading of infection from resident to resident. He stated they were trained during Inservice with the policy and procedure of incontinence care and infection prevention to change gloves and sanitize hands when going from a dirty to clean task. Interview on 03/13/26 at 1:25 PM with CNA A, she stated when using the same bedside table and same linen for 2 residents in separate rooms, it should be sanitized when going from one room to another because of the risk of spreading infection. Interview on 03/13/26 at 1:30 PM with the DON, she stated if infection prevention protocol was not followed when providing incontinence care to residents, it could result in widespread infection in the facility. It is expected that they staff providing peri care should change gloves and sanitized hands before donning another set of clean gloves when going from dirty to clean area. She stated they were taking corrective action and would provide Inservice to staff on hand hygiene and peri care procedures. Interview on 03/13/26 at 3:05 PM, the ADMIN stated all care staff were required to follow the facility's protocol for hand (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hygiene and infection control when providing care to prevent the spread of infection. Record review of the facility's perineal care policy and procedure documented the purpose of the procedure as follows: The purpose aims to maintain the resident's dignity and self-worth and reduce embarrassment by providing cleanliness and comfort to the resident, preventing infections and skin irritation, and observing the resident's skin condition. Record review of the infection control plan: overview provided by the facility documented the following: The facility will establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. The intent of this policy is to assure that the facility develops, implements, and maintains an Infection Preventionand Control Program in order to prevent, recognize, and control, to the extent possible, the onset and spread of infection within the facility. The program will: Perform surveillance and investigation to prevent, to the extent possible, the onset and the spread of infection;Prevent and control outbreaks and cross-contamination using transmission-based precautions in addition to standard precautions

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview and record review the facility failed to maintain an effective pest control program so the facility was free of pests and rodents for one (Hall 300, the male secure unit) and two of two rooms (Resident #1 and Resident #2's rooms located in Hall 300 male secured unit) reviewed for pest control. The facility failed to ensure Hall 300 to include Resident #1 and #2's rooms were free from gnats. This failure could place residents at risk for the potential spread of infection, cross-contamination, food-borne illness, and a diminished quality of life.Findings include: Observation and interview on 03/13/26 at 12:40 PM to 12:50 PM revealed gnats in Resident #1's room, LVN A and CNA A, both stated gnats were present in the room and stated they called pest control to evaluate the issue, last pest control visit was 03/04/26. Observation and interview on 03/13/26 at 12:55 PM to 1:10 PM revealed gnats in Resident #2's room, LVN A and CNA A, both stated gnats were present in the room and stated they called pest control to evaluate the issue. Interview on 03/13/26 at 1:15 PM with LVN A, he stated the gnats were an issue and they reported to the administrator sometime last week, but was unsure of what day. He stated the risk of having gnats could be infection when it perches on resident food. Interview on 03/13/26 at 1:20 PM with CNA A, she stated the gnats were present for a while in the 300 hall, she stated she reported the presence of gnats to LVN A. She was not sure what gnats did. She stated it was not good to have them in the resident living areas, they could bite the residents and spread infection. Interview on 03/13/26 at 1:25 PM with HK, she stated she reported to the housekeeping supervisor about the persistent gnat problem. She stated she worked in the facility for about a year, and the gnats were a problem since she started working at the facility. She stated the pest control company came once a month, but the problem persisted. Interview on 03/13/26 at 1:30 PM with the DON, she stated she knew the gnats were present and they were working on getting rid of the gnats. She stated gnats could bite the residents and spread infection, they did not need to be around the resident living areas, it's a dignity issue and not conducive for the resident's environment. Interview on 03/13/26 at 3:05 PM with the ADMIN, he stated the gnats were an issue and they were working with pest control to eliminate the issue, however, it still persisted. Record review of pest control service reports for the last 7 months revealed the pest control company did 9 visits from August 2025 to March 2025. They treated for other pest like roaches, rodents, bedbugs, fruit, and fruit flies and not gnats. Record review of 300 Hall (secured male hall) pest control report revealed from 02/18/26 to 03/13/26 several staff reported observations of water bugs and gnats that were not addressed. Record review of the facility's policy, titled Insect and Rodent Control revealed The facility will maintain an effective pest control program in order to provide an insect and vermin free food service department