

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676093	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2024
NAME OF PROVIDER OR SUPPLIER Rockdale Estates & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 W. Highway 79 Rockdale, TX 76567	

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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44700</p> <p>Based on observations interview, and record review, the facility failed to provide adequate supervision and to prevent accidents for one resident (Resident #1) of five reviewed for accidents and hazards in that:</p> <p>The facility failed to supervise Resident #1 when she was found walking in the hallway without her walker, resulting in a fall with injuries on 3/13/2024.</p> <p>This failure placed residents at risk of accidents or falls resulting in injuries, pain and hospitalization .</p> <p>Findings included:</p> <p>Review of Resident #1's face sheet dated 3/20/24 reflected an [AGE] year-old female admitted on [DATE] with diagnoses including: Dementia (progressive or persistent loss of intellectual functioning), difficulty in walking, lack of coordination, heart disease, Hypertension (high blood pressure) and Cognitive Communication deficit.</p> <p>Review of Resident #1's MDS dated [DATE] reflected a BIMS of 5 suggesting severe cognitive impairment. Review of the MDS section GG 0120 - Mobility Devices, indicated Resident #1 used a walker. Review of section GG0170 Functional ability/Goals, reflected the activity Walking with a code of 4 indicating supervision or touching assistance was needed for walking. Review of MDS section N - Medications, indicated resident is taking Anticoagulant (a medication that prevents or reduces coagulation time, slowing down clotting time of the blood).</p> <p>Review of Resident #1's care plan, undated reflected the Problem: [Resident #1] had DX of Alzheimer'/Dementia. Resident has (long and short) memory deficits. Needs assistance with decisions. She forgets her walker and needs reminders. Intervention: Use simple direct communication with resident. Offer simple 1-2 item choices. Provide redirection, verbal cue and repeat as needed.</p> <p>Further review of Resident #1's undated care plan reflected the Problem: [Resident #1] has had an actual fall with (minor injury) Poor Balance 3/13/24 in hallway, I forgot my walker, lost balance and tripped over shoe. Hematoma L(Left) eye. Intervention: Ensure that call light is in reach and encourage/remind resident to ask for and provide assistance as needed and keep personal items within reach. continue to visually monitor throughout the day .</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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's orders dated 3/20/2024 reflected a physician order as follows: Apixaban Tablet 5 MG Give 1 tablet by mouth two times a day related to CHRONIC EMBOLISM AND THROMBOSIS OF LEFT POPLITEAL VEIN.</p> <p>Review of Resident #1's Fall Risk assessment dated [DATE] indicated resident had a score of 5, indicating moderate risk for falls.</p> <p>Review of Resident #1's hospital records dated 3/13/24 revealed the results of a cervical spine CT as follows:</p> <p>Soft Tissues: There is extensive soft tissue hematoma involving the left supraorbital and periorbital soft tissues. Dimensions are approximately 6 x 2 cm transversely and 6 cm vertically.</p> <p>Obits: There is a left medial orbital blowout fracture which produces the increased ethmoid soft tissue density. This fracture is new from prior maxillofacial CT of November 2023. Coronal images demonstrate no evidence of extraocular muscle entrapment.</p> <p>or evidence of infraorbital metallic. Indicating Resident had a large bruise above her left eye and orbital (bones around the eye) fracture.</p> <p>During an interview with FM/RP on 3/20/2024 at 2:46 p.m., the FM stated they received a call from the facility on 3/13/2024 notifying them that resident had fallen, had been injured and went to ED. She stated resident has fallen several times in the last year with minor injuries. FM stated this fall really scared her and the rest of the family due to the nature of the injuries. FM stated the facility let her review the video of the fall and Resident #1 walked out of her room without her walker but was holding onto the handrail. She ran out of handrail, took a few steps and tripped and fell flat right to the floor and hit her face on the floor. FM stated Resident #1 does get up in her room and walk without her walker if she is going to the closet and often comes out of her room without her walker. She stated staff will redirect her back to her room or someone will go get her walker and bring it to her.</p> <p>During an interview with TNA B on 3/20/2024 at 4:10 p.m., she stated she had been working back on the memory care unit for 2 weeks. She stated she had received training on fall prevention. She stated they have to keep reminding Resident #1 to use her walker. She stated she had observed Resident #1 leave her room without her walker. She stated she would either have someone stand with the resident and she will go get the walker or she will walk the resident back to her room.</p> <p>During an interview with CNA C on 3/20/204 at 4:18 p.m., she stated she had been at the facility 5 months and was aware Resident # 1 was a fall risk. She stated she had received training on fall prevention. She stated she had seen Resident #1 walking without her walker it has happened very frequently while in her room and sometimes she leaves her room without her walker. She stated when she found the resident without her walker she will use a gait belt or redirect her/assist her back to her room or get another staff to get the walker and bring it to her. CNA C stated Resident #1 was very good at following directions from staff and could be redirected with no problem.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with Resident #1 on 3/20/2024 at 4:34 p.m., she stated she did not remember what happened and denied being in any pain. Resident #1 was observed to have bruising on the left side of her face and a large swollen lump above her left outer eye - the skin was not broken. Resident #1 was unable to tell this investigator how she got the bump on her head and bruises on her face. FM was visiting with Resident #1 and stated Resident #1 doesn't remember what happened when we ask her, and she has not complained of any pain.</p> <p>During an interview with LVN A on 3/20/2024 at 5:07 p.m., she stated she was at work on 3/13/2024 on the memory care unit and had been making rounds on the unit. She stated she came out of another resident's room and saw Resident #1 walking down the hall holding onto the handrail without her walker. She stated she went up to Resident #1 and asked her to stay there and wait for her to go to her room and get her walker. She stated Resident #1 will often come out of her room without her walker and will usually wait for staff to bring her walker to her. She stated she turned away from Resident #1 and went to her room to get the walker. When LVN A got back, Resident #1 was in a sitting position on the floor and another person was with her. LVN A stated she did not see Resident #1 fall but when she assessed Resident #1 she noticed injuries to her left eye and a bump above her left eyebrow. She stated she called EMS to have resident sent to the ED for further evaluation. LVN A stated she had received training on fall prevention and knew resident was a fall risk. She stated Resident #1 was very good about listening to staff when they asked her to wait for them to get her walker and she had no reason to believe Resident #1 would not wait for her to get the walker this time.</p> <p>During an interview with the DON on 3/20/2024 at 5:29 p.m., she stated the facility uses a yellow indicator to indicate fall risk by residents name plate and on their wheelchair or walker. The DON stated Resident #1 was a fall risk and had had a few falls with either no injuries or minor injuries. She stated Resident #1 was often seen leaving her room without her walker and staff would go assist her. She stated Resident #1 would typically follow commands from staff and it wouldn't have been out of the question for the nurse to say wait right here and go get Resident #1's walker. She stated if she had seen Resident #1 in the hall walking without her walker, I probably would have stayed with her and she would have sent another staff to go get her walker or walk Resident #1 back to her room and get the walker.</p> <p>During an interview with AD on 3/20/2024 at 3:30 p.m., he stated LVN A acted appropriately when she saw Resident #1 without her walker. He stated Resident #1 is typically very agreeable with staff and will follow directions. He stated in the same circumstances he would have done the same thing as there was no reason to believe that Resident #1 would not wait for staff to bring her walker to her.</p> <p>During an observation and interview with the AD on 3/20/2024 at 6:16 p.m., he provided video review of Resident #1's fall. In the video, a Nurse was seen going into a resident's room and came out to find Resident #1 walking down the hall with her hand on the handrail. The nurse was seen going up to the resident and speaking with her then walking away down the hall out of sight. Resident #1 continued walking down the hall with her hand on the handrail. Resident #1 is seen getting to the end of the handrail where it follows the wall off to the left and Resident #1 was observed continuing to walk straight and not following the handrail. Resident #1 walked a few more steps, appeared to trip over her feet and then fell face first to the floor. Resident #1 pushed herself into a sitting position and another caregiver was seen coming up and sitting her with her. Shortly after her fall, the nurse was seen back in the frame carrying Resident #1's walker and then provided care.</p> <p>(continued on next page)</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of Policy titled Fall Prevention Program dated 3/1/2024 indicated: Each Resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls.		