

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

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Form Approved OMB
No. 0938-0391

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 06/03/2026
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)		
F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review, the facility failed to maintain a quality assessment and assurance committee consisting at a minimum the required committee members for seven (September 2025, October 2025, December 2025, February 2026, March 2026, April 2026, and May 2026) of eight meetings reviewed for QAPI. The facility did not ensure the Medical Director, or a designee attended quarterly QAPI meetings. This failure could place residents at risk for quality deficiencies being unidentified, infections, no appropriate plans of action developed and implemented, and no appropriate guidance developed. Findings include: Record review of the facility's QAPI Committee sign in sheets indicated the Medical Director was absent from the September 2025, October 2025, December 2025, February 2026, March 2026, April 2026, and May 2026 meetings. The Medical Director only attended the January 2026 QAPI meeting. In an interview conducted 06/03/2026 at 8:52 AM, the DON she had been with the facility for a year. The DON stated she was a member of the QAPI Committee and indicated that every department was represented on the committee. She stated that all department heads were required to attend QAPI meetings, along with the owner/administrator. The DON stated that the Medical Director was not usually in the QAPI meetings. When asked if the Medical Director's attendance was required, she responded, Not really. The DON stated that at a previous facility, the same Medical Director attended all QAPI meetings; however, at the current facility, the process was different. The DON stated that the Medical Director reviewed the paperwork but did not typically attend the meetings. She further stated, They told me it's just the way we do it here. In an interview conducted 06/03/2026 at 9:34 AM, the ADON/Infection Preventionist stated she had been at the facility since 2022. She stated she attended each QAPI meeting. The ADON/Infection Preventionist stated the QAPI committee consisted of the DON, ADON, Wound Nurse, MDSC, Administrator, and Director of Rehabilitation. She stated that at the QAPI meetings she attended, the Medical Director was not normally present, and she did not know why, nor had she been told why the MD was not present. The ADON stated she would need to ask the DON. She further stated that the QAPI committee reviewed staffing and infection control issues and made recommendations. In an interview conducted 06/03/2026 at 2:10 PM, the Administrator stated that the QAPI Committee met monthly, although they were only required to meet quarterly. He stated if a required committee member was unable to attend a meeting, the meeting would likely be postponed. The Administrator stated the QAPI Committee attendees typically included the Administrator, DON, Wound Care Nurse, MDSC, and other IDT members. When asked about the potential impact on residents if the Medical Director did not attend QAPI meetings, the Administrator stated he was unaware of any potential effect on residents related to the Medical Director's absence from the meetings. Record review of the facility's policy titled QAPI (Quality Assurance and Performance Improvement) Policy, undated, reflected: Purpose To establish a comprehensive, data-driven Quality Assurance and Performance Improvement (QAPI) (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 676093
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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	program that promotes continuous improvement in resident care, safety, and quality of services in accordance with federal and state requirements.PolicyThe facility will develop, implement, and maintain an ongoing QAPI program that addresses all systems of care and services, focuses on resident outcomes, and involves all departments and staff levels.Procedure1. QAPI Program Structure:- Establish a QAPI committee led by the Administrator and Director of Nursing.- Include interdisciplinary team members (nursing, therapy, dietary, social services, infection control, and other departments).- Hold QAPI meetings at least quarterly or more frequently as needed.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident had the right to be free from abuse, for one of seven residents (Resident #28) reviewed for abuse. The facility failed to ensure Resident #28 was free from verbal abuse by CNA C when, as reflected on video dated 05/19/2026, CNA C told Resident #28, I am going to f*** you up. This failure could place residents at risk for psychosocial harm and diminished quality of life. Findings included: Record review of Resident #28's face sheet, 06/02/2026, revealed an eighty two year-old female who was admitted to the facility on [DATE] and re-admitted on [DATE] with a diagnosis that included post-polio syndrome (gradual onset of new muscle weakness, joint pain, muscle atrophy, and severe fatigue, requiring symptom management rather than a cure), other sequelae of cerebral infarction(the residual neurological and functional deficits persisting after an ischemic stroke), and cerebral aneurysm (a weak, bulging area in a blood vessel wall within the brain). Record review of Resident #28's MDS (clinical assessment to determine resident's strength and needs) dated 04/23/2025 Nursing Home Comprehensive Section C - Cognitive Patterns revealed a score of 4 indicating severe cognitive issues. Record review of Resident #28's care plan revealed a focus dated 03/27/2026 Resident #28 had behaviors of agitation/anxiety. Review of video, dated 05/19/2026, reflected CNA C pulling Resident #28, who was in a wheelchair, into Resident #28's room. Resident #28's room camera was at CNA C's back. CNA C walked around Resident #28 and was leaving Resident #28's room. As CNA C was walking out of the room, Resident #28 kicked out with her right foot towards CNA C and made an unintelligible statement. CNA C stopped, turned around, pointed her finger, then moved her pointed finger toward Resident #28's upper body and said, I'm going to f*** you up. The video did not reflect any physical contact between CNA C and Resident #28. Record review of TULIP provider investigation report, undated reflected an incident occurred involving CNA C and Resident #28. The facility became aware of the incident at approximately 6:41PM on 05/19/2026. The allegation was reported to CNA E by Resident #28's family. Resident #28's family member provided video footage to CNA E. The video reflected CNA C assisted Resident #28 into Resident #28's room. As CNA C exited the room, the resident kicked toward CNA C. CNA C turned toward Resident #28, pointed her finger near Resident #28 and made a verbal statement to the effect of, I will f*** you up. At the time of the TULIP report, it was unclear whether any physical contact occurred during the interaction and there were no witnesses. Resident #28 was assessed following notification of the incident, and no immediate visible injuries were noted. A full skin assessment was completed, with findings indicating bruising in various stages of healing determined to be pre-existing and not related to the reported incident. Resident #28 continued to be monitored for any physical or psychosocial changes. CNA C was immediately removed from resident care duties pending investigation. The facility initiated a full investigation, including staff and resident interviews and review of all available evidence, including video provided by the family. Review of the video confirmed that CNA C engaged in an inappropriate verbal statement and gesture toward the resident. No physical contact resulting in injury was observed. Upon notification of the allegation, CNA C was immediately contacted by the Administrator and informed that the reported behavior was unacceptable, violated facility policy, and would not be tolerated. CNA C was educated that such conduct was inconsistent with resident rights and expectations for professional behavior and may result in disciplinary action up to and including termination. The CNA verbalized understanding of these expectations. CNA C was immediately (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	removed from all resident care duties pending the outcome of the investigation. Resident #28 was promptly assessed by nursing staff for injury, with no immediate visible injuries noted. A full assessment was completed, and Resident #28 was monitored for any physical or psychosocial changes. Resident #28's RP was notified that the facility was actively investigating the situation and that the staff member involved had been removed from resident care and would have no further contact with Resident #28 during the investigation. Record review of Resident #28's skin assessment dated [DATE] at 7:03 PM reflected bruises in multiple stages of healing on bilateral (having, involving, or affecting two sides) arms. Record review of facility Payroll Input and Personnel Action form, Termination, for CNA C dated 05/20/2026 reflected termination of CNA C's employment reason for separation - conduct against a resident for abuse. Additional notes: conduct unbecoming and unprofessional toward a resident. Conduct against abuse and neglect policy. During an interview on 06/01/2026 at 2:07 PM with Resident #28, she said she did not remember someone who worked at the facility being mean to her or being unkind to her. Resident #28 said she did know CNA C. When asked if CNA C said anything inappropriate to her, cursed at her, or was verbally ugly to her, Resident #28 said she had a family member whose name sounded like CNA C's, but he did not say anything bad to her. Resident #28 said no one hurt her feelings and she felt like she was okay at the facility. During an interview on 06/01/2026 at 2:58 pm with the ADON, she said CNA C was dismissed from her employment at the facility about 30 minutes after the facility learned of the video. The ADON said she was not at the facility when the incident occurred. She was the on-call manager, and it was reported to her by CNA E. The ADON said in the video CNA C was about to walk out of Resident #28's room and Resident #28 kicked out at CNA C. In the video it looked like CNA C was poking Resident #28 in the face, but it was not clear that CNA C touched Resident #28. When CNA C was pointing at Resident #28, CNA C said, I am going to f*** you up. The ADON said that was verbal abuse and emotional abuse. The ADON said she learned about the incident when CNA E phoned her. The ADON said CNA E learned about it when she received a text and the video from Resident #28's RP. The ADON said there was no indication that CNA C had previously abuse Resident #28 or other residents in the facility. The ADON said after the incident they immediately in-serviced the entire facility on abuse, neglect, and exploitation. During an interview on 06/02/2026 at 7:39 AM with CNA E, she said when she got to work on 05/19/2026 she received a text message from a family member of Resident #28 with a video attachment that reflected the incident with CNA C and Resident #28. CNA E said as soon as she watched the video, she sent the video to the on-call manager, the ADON and the ADON sent the video to the Administrator. The ADON and she sent the video to the Administrator. CNA E said the video reflected that CNA C wheeled Resident #28 into Resident #28's room. CNA E said as CNA C walked away Resident #28 lifted her leg toward CNA C and told CNA C to get out of here. CNA E said CNA C pointed towards Resident #28 but because Resident #28's back was to the video and CNA C was in front of Resident #28 she was unable to see if CNA C touched Resident #28 when she pointed at her. When CNA C pointed at Resident #1 CNA C said, I am going to f*** you up. and CNA C left Resident #28's room. CNA E said that was verbal and emotional abuse. CNA E said she went with RN B when RN B did the skin assessment after the incident. CNA E said Resident #28 did not seem upset, angry, or frustrated and Resident #28 she did not express that she had a bad day. CNA E said RN B did not find any marks on Resident #28 to cause RN B to think that Resident #28 was struck CNA C. CNA E said she received abuse, neglect, and exploitation training at the facility when she was hired and was in-serviced an abuse, neglect, and exploitation after the incident occurred. CNA E said the Administrator was the abuse and neglect coordinator, but she reported to the on-call manager, the ADON in lieu of the Administrator not being at the facility. CNA E said she did not wait 60 seconds (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	after reading the message and looking at the video to report to the ADON. CNA E said prior to the incident she had no concern about CNA C's behavior with any residents. CNA E said CNA C was removed from the facility immediately after the incident was reported to the Administrator. During an interview on 06/02/2026 at 8:12 AM with RN B, she said she assessed Resident #28 after the incident on 05/19/2026 between CNA C and Resident #28. RN B said it was difficult to see in the video if CNA C touched Resident #28 but all the bruising on Resident #28 was on the opposite side of where it was reflected in the video that CNA C pointed at Resident #28 and might have touched Resident #28. RN B said when CNA C told Resident #28, I'm going to f*** you up. this was abuse and threatening to Resident #28. RN B said Resident #28 was calm during the skin assessment after the incident. RN B said she did not mention the incident with CNA C. RN B said she just went forward with the assessment like it was a regular skin assessment. During an interview on 06/02/2026 at 10:10 AM with Resident #28's RP, she said she would peek at Resident #28's in room video but did not monitor it all the time. Resident #28's RP said she noticed that Resident #28 was in her room, when Resident #28 was usually not in her room, so she looked at the video. Resident #28's RP said she brought the incident to the attention of the facility and they addressed it immediately. Resident #28's RP said she was surprised that the facility took action so quickly. Resident #28's RP said she never mentioned the incident to Resident #28 and Resident #28 did not mention anything to her. Resident #28's RP said Resident #28 regularly did not remember anything. During an interview on 06/03/26 at 10:37 am with CNA C, she said Resident #28 was very combative on the day of the incident. CNA C said Resident #28 was in another resident's room and Resident #28 did not want to leave. CNA C said Resident #28 was in the restroom and took off all her clothing and when CNA C was helping Resident #28 pull her pants up, Resident #28 hit CNA C in the head. CNA C said when she took Resident #28 into her room she kicked at CNA C and told Resident #28, If you don't stop doing that I'm going to f*** you up. CNA C said she knew she should not have said that to Resident #28. CNA C said she was contacted by the Administrator about 6:30 PM or 7:00 PM on 05/19/2026 and told her employment was terminated. During an interview on 06/03/2026 at 10:46 AM with the Administrator, he said he learned about video and the incident between CNA C and Resident #28 at about 6:30 PM on the evening on 05/19/2026 and immediately called CNA C. He said he saw the video and the comment CNA C made to Resident #28 and he could not tolerate that behavior and she could not work in the building. The Administrator said the comment CNA C made to Resident #28 was verbal abuse. The Administrator said the facility immediately began in-servicing the staff on zero tolerance for abuse and neglect. During an interview on 06/03/2026 at 1:38 pm with the SW, she said she did not feel Resident #28 suffered any psychosocial harm. The SW said she had asked Resident #28 about the incident and talked to Resident #28 and Resident #28 did not seem to be affected. The SW said Resident #28 did not display she was afraid of anyone, either staff or residents. The SW spoke to Resident #28's RP about the incident to find out if the RP had any concerns or any residual effects and Resident #28's RP told her no. Record review of facility Abuse, Neglect, and Exploitation Prevention & Reporting policy reflected the facility maintains zero balance tolerance for abuse, neglect, exploitation, or mistreatment of residents. All residents have the right to be free from physical, verbal, mental, and emotional abuse. Abuse: willful infliction of injury, intimidation, punishment causing harm. Verbal abuse: use of threatening or inappropriate language toward a resident. Mental abuse; Conduct causing fear or emotional distress.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record reviews, the facility failed to ensure all Pre-admission Screening and Resident Review (PASRR) Level I residents with a mental illness was completed correctly and were provided with a PASRR Level II assessment for one (Resident #19) of 5 residents reviewed for PASRR assessments. The facility failed to ensure the accuracy of the PASRR Level I for Resident #19. The PASRR Level 1 did not indicate a diagnosis of mental illness, although the diagnoses (major depressive disorder, single episode, unspecified (experience major depressive episode with no history of previous depressive episodes - sadness, loss of interest in daily activities) and post-traumatic stress disorder(a mental health condition that some people develop after they experience a terrifying event) diagnosis were present upon Resident #19 admission date on 04/14/2025. This failure could place residents at risk of not receiving a needed assessment (PASRR Evaluation), individualized care, or specialized services to meet their individual needs. Findings included : Record review of Resident #19's face sheet, dated 06/01/2026, reflected a [AGE] year-old male, initially admitted [DATE] and readmitted [DATE], with the following diagnoses: hemiplegia and hemiparesis following unspecified cerebrovascular disease (loss of movement or paralysis on one side of body ,muscle weakness) ,major depressive disorder, single episode, unspecified (a serious mental health condition characterized by intense feelings of sadness, worthlessness, and loss of interest in activities, lasting at least 2 weeks), insomnia (a common sleep disorder characterized by persistent difficulty falling asleep, staying asleep, or waking up too early and struggling to return to sleep, resulting in poor sleep quality and significant daytime impairment), post-traumatic stress disorder(a mental health condition that some people develop after they experience a terrifying event)and suicidal ideation (recurring thoughts of ending one's life).Record review of Resident #19's Annual MDS Assessment, dated 02/05/26, reflected Resident #19 to have a BIMS score of 14, indicating his cognition was intact. The MDS also indicated Resident #19 was taking an antidepressant (medication used to treat mental health conditions like depression, anxiety, and PTSD). Record review of Resident #19's PASRR Level 1 screening, completed 04/08/2025 by the RN case manager of the referring facility, reflected the resident did not have a mental illness. Record review of Resident #19's PASRR Level 1 screening entered in resident's records file by the facility's MDSC on 5/01/2026 reflected the resident did not have a mental illness. In an interview on 06/02/26 at 3:53 PM, the MDSC stated the PASRR Level 1 that was provided had the correct information for Resident #19. The MDSC stated Resident #19 did not meet the criteria to have a yes, marked for mental health diagnosis. She stated the resident did not have a hospitalization in the last two years nor a significant disruption to his daily activities. In an interview conducted 6/03/2026 at 12:41 PM, the MDSC stated she had been the MDS Coordinator at the facility since 2022. She stated that she was responsible for PASRR referrals to the appropriate state-designated authority when a resident was identified with a mental health diagnosis. When asked whether she knew that Resident #19's diagnoses of Major Depressive Disorder and PTSD would trigger a positive PASRR screening, she stated that she was currently working to correct the error. However, she explained that a PASRR specialist informed her that the resident did not meet the PASRR criteria at that time. The MDSC stated that when a resident was identified as having a newly evident or possible mental health diagnosis, ID, or related condition after admission, the MDS Coordinator was responsible for completing a PL1 and submitting the referral for PASRR review. She stated Resident #19 was not referred as she did not think he met the criteria. In an interview conducted 6/03/2026 at 2:21 PM, the (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator stated that the facility identified residents with newly evident or possible serious mental illness, IDD, or related conditions after admission through information received from hospitals and other referral sources. He stated that the MDS Nurse was typically responsible for completing the PASRR screening and submitting the required documentation to the state, and following the recommendations provided through the PASRR process. The Administrator further stated that diagnoses such as Major Depressive Disorder and Post-Traumatic Stress Disorder would trigger a positive PASRR screen and require further review. Review of the facility's policy titled, PASSAR (Preadmission Screening and Resident Review) Policy reflected: Purpose To ensure compliance with federal and state requirements for the Preadmission Screening and Resident Review (PASSAR) process, identifying residents with serious mental illness (SMI) and/or intellectual disabilities (ID) and ensuring appropriate placement and services. Procedure 1. Level I Screening:- A Level I PASSAR screening will be completed prior to admission for all applicants.- The screening will identify indications of serious mental illness (SMI), intellectual disability (ID), or related conditions.- Documentation of the screening will be maintained in the resident record. 2. Level II Evaluation:- If Level I is positive, a Level II evaluation will be completed by the appropriate state authority before admission unless an exemption applies.- The facility will not admit the resident until Level II results are received when required.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 6 residents (Residents #11) reviewed for care plans. The facility failed to have a comprehensive person-centered care plan for Resident #11 to address his repeated behavior of pulling on his catheter, putting the catheter tubing in his mouth, or disconnecting the catheter tubing from the catheter bag. This failure could place residents at risk of not receiving care and services to meet individualized, behavioral, medical and nursing needs. Findings included: Record review of Resident #11's face sheet, undated, revealed a [AGE] year-old male who was admitted to the facility on [DATE] with a diagnosis that included bladder neck obstruction (occurs when a blockage or muscle dysfunction prevents the bladder neck from opening properly), acute kidney failure (sudden loss of your kidneys' ability to filter waste from your blood) and dementia) an umbrella term for a decline in cognitive abilities-such as memory, language, and problem-solving-that is severe enough to interfere with daily life). During an interview on 06/02/2026 at 11:56 AM with CNA D, she said Resident #11 pulled on his catheter, pulled the catheter tubing apart from the bag, and put his catheter tubing in his mouth. CNA D said that was not good because of infection control and a higher risk for a UTI. CNA D said when Resident #11 pulled on his catheter, staff re-directed him and asked him if he felt the urgency to urinate. CNA D said she advised him to leave the catheter alone. CNA D said the behavior had been going on for about a month and a half. CNA D said CNAs were not involved in care plans. CNA D said she looked at the Kardex (a quick-reference, centralized system that outlined a resident's current care plan) for resident needs. CNA D said CNAs have reported Resident #11's catheter behavior to the nurses several times. CNA D said she told the ADON, DON, and RN A. Record review of Resident #11's care plan revealed no focus or interventions for behaviors of Resident #11 pulling on his catheter, putting his catheter in his mouth, or disconnecting the catheter tubing from his catheter bag. During an interview on 06/02/2026 at 12:07 PM with the MDSC, she said everyone helped with the care plans, it was a collective effort. The MDSC said the DON, ADON, and wound care nurse were all involved in care plans. The MDSC said they discussed what was going on with residents during the morning IDT meetings. The MDSC defined a care plan as the resident's plan of care. The MDSC said the care plan outlined how the facility would care for the residents with more detail and it included behaviors and interventions on managing behaviors. The MDSC said on 05/25/2026 the IDT discussed Resident #11's behavior with his catheter. The MDSC said she had a note regarding Resident 11's behavior of tugging on his catheter. The MDSC said when Resident #11 tugged on his catheter it could stop the flow of urine which could back up into his balder and cause UTIs. The MDSC said this behavior should have been care planned. The MDSC said she got distracted. During an interview on 06/02/2026 at 12:12 PM the ADON said a care plan included all of the information for how to care for a resident including resident needs and interventions. The ADON said Resident #11 had a behavior of taking his catheter tubing out of his pants. The ADON believed that he did not understand that the urine drained into a bag. The ADON said Resident #11 would fiddle with every part of the catheter from start to end. The ADON said the possible negative effect of this behavior was infection, urine retention and could possibly lead to a UTI. The ADON said Resident #11's behavior should be care planned. During an (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 06/02/2026 at 2:43 PM RN A said Resident #11 had developed a behavior of drinking the urine out of his catheter. RN A said he had seen Resident #11 take his catheter apart and put the bag in the sink. RN A said that was first discussed in the facility daily meeting about 3 weeks ago when Resident #11 had a diagnosis of a UTI. RN A said a care plan looked at what was happening with a resident and what their needs were in relation to the issues of a resident. RN A said all of Resident #11's catheter behaviors should be care planned. RN A said Resident #11's issues were sanitary and health infection issues. During an interview on 06/02/2026 at 3:00 PM the DON she said she worked in the secured unit where Resident #11 lived . The DON said a care plan was what was used to decide the care for the residents. The DON said the IDT was responsible for care plans. The DON said the MDSC, the DON, the ADON, and the wound care nurse were part of the IDT. The DON said if a resident was removing his catheter tubing for the bag or pulling on his catheter, that should be care planned. The DON said the behavior would increase the chance of the resident getting a UTI. The DON said Resident #11 had the behavior of pulling on his catheter and removing the tubing from the bag for about a year and had been mentioned at IDT meetings. The DON said Resident #11's behavior with his catheter should have been care planned. Record review of facility Comprehensive Care Plan Policy, undated, reflected purpose:to ensure all residents receive individualized, interdisciplinary care planning that meets regulatory requirements and promotes optimal health outcomes. Policy:Each resident must have a comprehensive, person-centered care plan developed and implemented by an interdisciplinary team (IDT) within required timeframes and updated as needed.Procedure:1. Initial Assessment:- Complete comprehensive assessment (MDS) within 14 days of admission.- Identify resident needs, preferences, and goals.2. Care Plan Development:- Develop initial care plan within 48 hours of admission.- Develop a comprehensive care plan within 7 days of completing MDS.- Include measurable objectives and interventions.3. Interdisciplinary Team (IDT):- Includes nursing, therapy, dietary, social services, and physician.- Resident and/or responsible party invited to participate.4. Implementation:- All staff must follow care plan interventions.- Care plan accessible to direct care staff at all times.5. Review and Updates:- Review quarterly, annually, and with any significant change.- Update care plan within 7 days of significant change.6. Documentation:- Document all care plan meetings and updates.- Maintain evidence of resident participation or refusal.7. Compliance:- Ensure compliance with CMS Develop Comprehensive Care Plans and Care Plan Timing and Revision. Quality Assurance:The facility will audit care plans monthly to ensure accuracy, completeness, and compliance with state and federal regulations.		

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 06/03/2026
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)		
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents received and the facility provided food and drink that was palatable, attractive, and at a safe and appetizing temperature for two of five residents (Residents #79 and #19) reviewed for dietary services. The facility failed to ensure the staff served hot meals to the residents, on 06/03/2026. This failure could place residents who received meals from the food cart at risk for diminished or altered nutritional status and potential weight loss. Findings included: A record review of Resident #79's, undated, face sheet revealed a [AGE] year-old female who was admitted to the facility originally 03/08/2024 and readmitted on [DATE]. Resident #79 had diagnoses which included major depressive disorder (persistent sadness, hopelessness, and loss of interest in activities), hypokalemia (low potassium), and muscle wasting and atrophy (loss or thinning of muscles). A record review of Resident #79's quarterly MDS, dated [DATE], revealed a BIMS of 12, which indicated the resident was moderate cognitively impaired. Resident #79 was at risk of malnutrition. Record review of Resident #19's face sheet, dated 06/01/2026, reflected a [AGE] year-old male, initially admitted [DATE] and readmitted [DATE], with the following diagnoses: hemiplegia and hemiparesis following unspecified cerebrovascular disease (loss of movement or paralysis on one side of body ,muscle weakness) major depressive disorder, single episode, unspecified (a serious mental health condition characterized by intense feelings of sadness, worthlessness, and loss of interest in activities, lasting at least 2 weeks), insomnia (a common sleep disorder characterized by persistent difficulty falling asleep, staying asleep, or waking up too early and struggling to return to sleep, resulting in poor sleep quality and significant daytime impairment), post-traumatic stress disorder(a mental health condition that some people develop after they experience a terrifying event)and suicidal ideation (recurring thoughts of ending one's life).Record review of Resident #19's Annual MDS Assessment, dated 02/05/26, reflected Resident #19 to have a BIMS score of 14, indicating his cognition was intact. During an observation/interview conducted 06/01/2026 at 10:44 AM, revealed Resident #79 was sitting in her bed. She stated the food was not that good, but it's OK. Resident #79 reported a concern regarding breakfast service on the morning of the interview. She stated that breakfast did not arrive until around 9:15 AM and the breakfast was not hot and that it was hardly ever hot. In an interview conducted on 06/02/2026 at 11:20 AM, a request was made to the DTM to provide a sample tray with regular texture meal items, same portions and resident set up. It was also requested that the sample tray would be the last tray served on Hall 300. In an interview conducted on 06/02/2026 at 3:02 PM, a request was made to the DTM to provide a sample breakfast tray on 06/03/2026 since the lunch test tray never arrived. The DTM stated the tray went out but the CNA did not know what to do with the tray. She apologized and said she would see that a breakfast tray was served the next day. Observation conducted 06/03/2026 at 8:55 AM, test tray was received and temperature of the food items were: 2 sausage links = 94.3 degrees Fahrenheit Scrambled eggs = 91.6 degrees Fahrenheit Pancake = was cool to touch In an observation/interview conducted 06/03/2026 at 9:10 AM, Resident #79 was sitting in her room with breakfast tray in front of her. She had only eaten a piece of the pancake and stated she was done eating. Resident #79 stated, The food was cold and not inspiring. Resident #79 stated the coffee was good and hot, but the rest of the food was cold. In an interview conducted 06/03/2026 at 9:15 AM, Resident #64 stated her food was not hot, but it was warm. She stated it was okay, but I won't complain. The coffee was good and hot. In an observation/interview conducted 06/03/2026 at 9:17 AM, Resident #19 was observed to not have (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Rockdale Estates & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 W Highway 79 Rockdale, TX 76567	
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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	eaten his eggs. Resident #19 stated the food was cold but edible. In an interview conducted 06/03/2026 at 1:47 PM, with the DTM, she stated some residents complained that their food as cold upon receipt. She stated the facility had attempted to address the issue. The DTM stated at one time, CNAs delivered trays directly to each of their assigned hallway immediately after meal preparation; however, currently, room trays for the 200, 300, and 400 halls were placed together on one cart for delivery. The DTM stated the facility previously ordered and tried a different plate to maintain food temperature, but the alternative plates did not improve the temperature of the food and caused sweating. She stated the plates received were not pellet plates (hold heat to keep food hot) and believed there may have been miscommunication on the type. The DTM further stated that she had requested different carts designed to better maintain food temperatures, but the facility had not yet purchased them. The DTM stated the potential harm associated with residents receiving cold food was that it would allow bacteria to grow and it increased the risk of foodborne illnesses. In an interview conducted 06/03/2026 at 2:17 PM, the Administrator stated there had not been any concerns reported to him lately regarding cold food. The ADM stated he ate meals from the kitchen himself, and the food temperature had been fine. He stated that cold food could lead to a resident not wanting to eat which could result in weight loss. Record review of the facility's, undated, policy, Food Temperature Control Policy, revealed: Purpose: To ensure safe food handling practices by maintaining proper food temperatures to prevent foodborne illness. Policy: All food must be stored, prepared, and served at safe temperatures in accordance with regulatory standards. Procedure: 3. Holding and Serving: Hot foods must remain above 135 F during service. Cold foods must remain below 41 F. Temperatures must be checked before service.		