STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676235	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rock Creek Health and Rehabilitation	1414 College Street Sulphur Springs, TX 75482

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44637 Based on interview and record review, the facility failed to develop and implement a baseline care plan within 48 hours of admission that included the instructions needed to provide effective and person-centered care of the resident that meets professional standards of quality care for 2 of 7 residents (Resident #1 and Resident #2) reviewed for baseline care plans. The facility failed to ensure Resident #1 had a baseline care plan completed within 48 hours of her admission on 8/26/24 that included the minimum healthcare information necessary to properly care for her including initial goals based on admission orders, physician orders, dietary orders, therapy services, and social services. The facility failed to ensure Resident #2 had a baseline care plan completed within 48 hours of her admission on 8/30/34. This failure could place newly admitted residents at risk of receiving inadequate care and services. Findings included: 1. Record review of the face sheet dated 9/5/24 indicated Resident #1 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including lung cancer, cancerous neuroendocrine (certain cells that release hormones into the blood in response to stimulation of the nervous system) tumors, alcoholic cirrhosis of the liver (a late stage of alcohol-related liver disease that occurs when the liver is permanently damaged), COPD, and diabetes. Record review of the entry MDS dated [DATE] indicated Resident #1 admitted to the facility from home on 8/26/24. Record review of Resident #1's medical records indicated there was not a baseline care plan. Record review of the comprehensive care plan revised on 8/30/24 indicated Resident #1 had little or no activity involvement related to the resident wishing not to participate initiated on 8/27/24. The care plan indicated all other focuses for Resident #1 were not initiated until 8/30/24. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Baseline Care Plan Acknowledgement dated 8/29/24 indicated Resident #1 and her representative had been provided a copy of the baseline care plan. During an interview on 9/4/24 at 4:22 p.m. the Administrator said Resident #1's care plan that was initiated on 8/27/24 was only for activities and it must have been missed to initiate the rest of the care plan within 48 hours. 2. Record review of the face sheet dated 9/5/24 indicated Resident #2 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses including heart failure (a chronic condition in which the heart does not pump blood as well as it should), chronic pain, hypertension (elevated blood pressure), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), need for personal assistance, muscle weakness, and reduced mobility. Record review of the entry MDS dated [DATE] indicated Resident #2 admitted to the facility from a short-term general hospital on 8/266/24. Record review of Resident #1's medical records indicated there was not a baseline care plan. Record review of the comprehensive care plan revised on 9/3/24 indicated Resident #2 focuses were initiated until 9/3/24. Record review of the Baseline Care Plan Acknowledgement dated 8/31/24 indicated Resident #2 had been provided a copy of the baseline care plan. During an interview on 9/4/24 at 1:30 p.m. the ADON said she was the one who reviewed the charge nurse's assessments after a resident was admitted and initiated the care plan. The ADON said she would print the baseline care plan and take it to the resident/resident's family. The ADON said after she printed the baseline care plan and provided it to the resident/resident's family the MDS coordinator was responsible for the comprehensive care plan. The ADON said she did not know how to retrieve the initial care plan she printed off after it was edited by the MDS coordinator. During an interview on 9/4/24 at 4:20 p.m. the ADON said the only care plans the facility had for Resident #1 and Resident #2 were the comprehensive care plans. The ADON said the comprehensive care plans were completed at the facility instead of baseline care plans. The ADON said the care plan initiation date was the date the care plan was completed. During an interview on 9/5/24 at 10:12 a.m. RN A said the DON and ADON had been responsible for completing baseline care plans prior to 9/4/24. RN A said the importance of baseline care plans was to inform staff how to care for a resident and meet their needs. During an interview on 9/5/24 at 12:28 p.m. LVN C said the charge nurse, or any nurse was responsible for the baseline care plan. LVN C said the baseline care plan should be completed on admission however there were times it was carried over to the next shift. LVN C said the importance of the baseline care plan was to let the entire team know the plan of care, how to care for the resident, and be able to recognize progress or decline in a resident. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/5/24 at 12:55 p.m. the DON said the admitting nurse was responsible for completing the baseline care plan. The DON said the baseline care plan should be completed within 48 hours of a resident admitting to the facility. The DON said the nursing administration reviewed new admission to ensure baseline care plans were completed. The DON said the importance of a baseline care plan was so the residents and their families were aware of the goals and treatments the facility had. Record review of the facility's undated Base Line Care Plans policy indicated, Completion and implementation of the baseline care plan within 48 hours of a resident's admission is intended to promote continuity of care and communication among nursing home staff, increase resident safety, and safeguard against adverse events that are most likely to occur right after admission; and to ensure the resident and representative, if applicable, are informed of the initial plan for care and services by receiving a written summary of the baseline care plan. The facility will develop and implement a baseline care plan for each resident that includes the instruction needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan will-Be developed within 48 hours of a resident's admission. Include the minimum healthcare information necessary to care for a resident including, but not limited to-Initial goals based on admission orders; Physician orders; Dietary orders; Therapy services; Social services; and PASARR recommendation, if applicable. The baseline care plan will reflect the resident's stated goals and objectives, and include interventions that address his or her current needs .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44637 Based on observation, interview and record review the facility failed to provide pharmaceutical services, including the accurate acquiring, administering and receipt of all drugs and biologicals, to meet the needs of 1 of 3 (Resident #1) residents reviewed for pharmacy services. The facility failed to ensure Resident #1 was administered her fentanyl (medication used to treat severe pain) transdermal patch (patch that attaches to the skin and contains medication) every 72 hours as ordered. This failure could place residents who receive medications at risk of not receiving the intended therapeutic benefit of the medications. Findings Include: 1. Record review of the face sheet dated 9/5/24 indicated Resident #1 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including lung cancer, cancerous neuroendocrine (certain cells that release hormones into the blood in response to stimulation of the nervous system) tumors, alcoholic cirrhosis of the liver (a late stage of alcohol-related liver disease that occurs when the liver is permanently damaged), COPD, and diabetes. Record review of the narcotic count sheet for Resident #1's fentanyl transdermal patches indicated she was administered her fentanyl patch on 8/27/24, 8/29/24, and 8/30/24. Record review of the MAR dated August 2024 indicated Resident #1 had a 25MCG/HR fentanyl patch applied on 8/27/24. The MAR indicate Resident #1 had her fentanyl patch removed and another patch placed on 8/30/24. Record review of the entry MDS dated [DATE] indicated Resident #1 admitted to the facility from home on 8/266/24. Record review of the care plan revised on 8/30/24 indicated Resident #1 had the potential for uncontrolled pain. The care plan indicated Resident #1 was on pain medication with interventions including administer medication as ordered. Record review of the order recap report (report that recaps medications the residents have been ordered and then the order completed or discontinued) dated 9/5/24 indicated Resident #1 had an order for a fentanyl transdermal patch 72 hours 25 MCG/HR (Fentanyl) Apply 1 patch transdermally every 72 hours for pain and remove per schedule starting 8/27/24 and was changed on 9/1/24 to fentanyl transdermal patch 72 hours 25 MCG/HR (Fentanyl) Apply 2 patches transdermally every 72 hours for pain and remove per schedule. During an observation and interview on 9/4/24 at 3:00 p.m. Resident #1 was lethargic and had a difficult time answering the surveyor's questions. Resident #1 said she did not remember her Fentanyl patch ever being changed too early. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/4/24 at 3:24 p.m. MA B said she administered Resident #1's fentanyl patch on 8/29/24 because that was how the MAR read. MA B said she administered Resident #1's fentanyl patch again on 8/30/24 because that was how the MAR read. MA B said she did not compare the MAR to the directions on the controlled drug record because the directions on the controlled drug record were not always correct. MA B said she did not question when the controlled drug record did not match the MAR because she was not a nurse. MA B said she did notice that the order was for 72 hours and it had been less than 72 hours each time she applied Resident #1's fentanyl patch but did not question it because the orders kept changing. During an interview on 9/5/24 at 10:08 a.m. the Hospice Nurse said the family did not want Resident #1 interviewed by anyone including the surveyor due to where she was in her disease process. The Hospice Nurse said Resident #1 being administered a fentanyl patch at 48 hours and then again at 24 hours instead of the ordered 72 hours would not have had any adverse effect on Resident #1 due to her increased pain, anxiety, history of drug abuse, and higher drug tolerance. During an interview on 9/5/24 at 10:12 a.m. RN A said it could be determined whether a medication had been administered or not by referring to the MAR. RN A said if a medication was not documented it was given in the MAR it was not given. RN A said the importance of documenting medication administration in the MAR was to be able to know whether a medication was given and know how to monitor a resident appropriately for adverse reactions. RN A was able to name the 5 rights of medication administration (right person, right time, right medication, right dose, and right route). During an interview on 9/5/24 at 12:28 p.m. LVN C said reviewing the MAR was the way to determine if a medication had been administered or not. LVN C said if a medication was not documented in some way on the MAR, it indicated the medication was not given. LVN C said the importance of ensuring medication administration was documented on the MAR was for staff to be able to know whether a resident received their medication. LVN C was able to name the 5 rights of medication administration. During an interview on 9/5/24 at 12:55 p.m. the DON said he expected staff to ensure they were administering the right medication to the right resident, at the right time. The DON said he expected medication administration to be documented accurately. The DON said to determine whether a medication had been given the MAR could be reviewed. The DON said if medication administration was not documented in the MAR there should be a progress note entered documenting the administration. The DON said he expected nurses and MAs to follow the 5 rights of medication administration. The DON said if an MA noted a discrepancy in the MAR, the times, or on the narcotic count sheet he expected them to go to the charge nurse with this information prior to administering the medication. Record review of the facility's Medication Administration Procedures policy revised on 10/25/17 indicated, All medications are administered by licensed medical and nursing personnel .After the resident ahs been identified, administer the medication and immediately chart doses administered on the medication administration record. it is recommended that the medication be charted immediately after administration, but if the facility permits, the medication may be charted immediately before administration .Defining the schedules for administering medications to: Maximize the effectiveness (optimal therapeutic effect) of the medication; Prevent the potential significant medication interactions such as medication-medication or medication-food interactions; and Honor resident choices and activities, as much as possible, or consistent with the person-centered comprehensive care plan .All current medication and dosage schedules are to be listed on the resident's current medication administration record .