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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676235	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain grooming and personal hygiene were provided for 1 of 5 (Resident #1) residents reviewed for ADLs. The facility failed to ensure Resident #1 received his scheduled showers in February 2026. These failures could place residents at risk of not receiving services/care, decreased hygiene and decreased quality of life.Findings Include: 1. Record review of the face sheet dated 3/5/36 indicated Resident #1 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including vascular dementia (progressive decline in thinking, memory, and behavior caused by impaired blood flow to the brain), hypertension (elevated blood pressure), major depressive disorder ((a serious, common mood disorder characterized by persistent sadness, loss of interest in activities, and fatigue), and chronic kidney disease stage 3 (kidney disease with mild to moderate damage and kidneys are less able to filter water and flood out of your blood). Record review of the MDS dated [DATE] indicated Resident #1 was understood by others and understood others. The MDS indicated Resident #1 had a BIMS score of 13 and was cognitively intact. The MDS indicated Resident #1 did not reject care. The MDS indicated Resident #1 required supervision or touching assistance with bathing. Record review of the care plan last revised on 2/26/26 indicated Resident #1 had an ADL self-care performance deficit with interventions including supervise as needed with bathing.Record review of Resident #1's Documentation Survey Reports dated February 2026 indicated Resident #1 was scheduled for showers Mondays, Wednesdays, and Fridays. The Documentation Survey Report indicated:Resident #1 was scheduled for 12 showers/baths and did not receive 7 of her scheduled showers.Resident #1 did not receive a shower on 2/9/26, 2/11/26, 2/13/26, 2/16/25, 2/20/26, 2/23/26, 2/25/26, and 2/27/26.Scheduled Bathing was not applicable on 2/4/26 and 2/6/26. Record review of Resident #1's EMR indicated there were no shower refusal sheets for February 2026. During an interview on 3/5/26 at 8:50 a.m. Resident #1 said she really did not remember if she had not gotten showers over the past 2 months. Resident #1 did not get her shower on 3/4/26 because she was not feeling good and chose not to take it. Resident #1 said staff do not come to get her for showers. Resident #1 said if she wanted a shower, she had to pursue it getting done. Resident #1 said she did not refuse showers. Resident #1 said when she did not get her scheduled showers, she felt yucky. During an interview on 3/5/26 at 12:39 p.m. CNA A said she worked as a shower aide in the facility Monday through Friday on the 6:00 a.m.- 2:00 p.m. shift. CNA A said if there were a blank space on the Documentation Survey Report for a scheduled shower it would indicate the shower was not done. CNA A said she did not know what it meant if the Documentation Survey Report indicated a shower was not applicable. CNA A said residents received their showers every other day. CNA A said Resident #1 would refuse her showers at times due to not wanting to get up. CNA A said if a resident refused a shower she completed and turned in a shower refusal sheet. CNA A said refusals of showers should also be documented in the Documentation Survey Report. CNA A said the importance of the residents receiving their scheduled showers was for hygiene, wound care, and to prevent a decline in health. During an interview on 3/5/26 at 12:45 p.m. the DON said the facility did have shower refusal sheets. The DON said she had (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

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	03/05/2026

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	checked the refusal sheets that had not been uploaded into the EMR and that Resident #1 did not have any refusal sheets that had not been uploaded into the EMR. During an interview on 3/5/26 at 2:03 p.m. the DON said if there was a blank on the Documentation Survey Report where a shower/bath was scheduled it indicated the shower was not done. The DON said she was not sure what not applicable meant in the Documentation Survey Report where a shower/bath was scheduled but assumed it was documented not applicable because the shower/bath was not done. The DON said she expected residents to receive their showers 3 times a week. The DON said she expected shower/bath refusals to be documented in the progress notes if a resident refused their shower/bath more than 2 times in one week. The DON said the importance of residents receiving their scheduled showers was cleanliness, hygiene, and to make the residents feel better. Record review of the facility's undated Bath, Tub/Shower policy indicated, Bathing by tub bath or shower is done to remove soil, dead epithelial cells (a thin, continuous, protective layer of cells), microorganisms (tiny, often single-celled organisms-including bacteria, viruses, and fungi), and body odor to promote comfort, cleanliness, circulation, and relaxation.The aging skin becomes dry, wrinkled, thinner, and blemished with various aging spots over time and is easily affected by environmental temperatures and humidity sun exposure soaps, and clothing fabrics. The frequency and type of bath or shower is preferred and necessary for some, the aging skin can be maintained by bathing every two days or with partial bathing as needed.

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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. Based on observation, interview, and record review, the facility failed to 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 infections for 1 of 3 staff (Treatment Nurse) and 1 of 7 residents (Resident #2) observed for infection control. The facility failed to ensure the Treatment Nurse wore a gown when providing wound care to Resident #2. This failure could place residents and staff at risk for MDROs, cross-contamination, spread of infection and could potentially affect all others in the building.Findings Include: 1. During an observation on 3/3/26 at 1:32 p.m. the Treatment Nurse performed wound care on Resident #2. EBP signage and PPE observed outside Resident #2's room with a sign in red that indicated personal care gown and gloves. The Treatment Nurse knocked on Resident #2's door before entering room. The Treatment Nurse assessed Resident #2's pain prior to performing wound care. The Treatment Nurse washed her hands and put on clean gloves. The Treatment Nurse did not put on a gown. Treatment Nurse removed the dressing to Resident #2's back, removed gloves, performed hand hygiene, and put on clean gloves. The Treatment Nurse cleansed the wound per physician orders, removed gloves, performed hand hygiene, put on clean gloves. The Treatment Nurse applied calcium alginate with silver (a highly absorbent, antimicrobial, and comfortable wound dressing designed for moderate to heavy, infected or colonized (contains multiple bacteria on the surface without causing an active immune response, clinical symptoms, or delayed healing)) and foam, boarded dressing (an absorbent, self-adherent wound dressing with a surrounding adhesive edge) to the wound, removed gloves, performed hand hygiene, and put on clean gloves. Treatment Nurse disposed of all supplies and dirty dressing in biohazard bag, removed gloves, washed hands, and exited the Resident #2's room. During an interview on 3/3/26 at 2:10 p.m. the Treatment Nurse said EBP stood for enhanced barrier precautions and included wearing a gown and gloves when providing care. The Treatment Nurse said gown and gloves should be worn when providing wound care to an open wound and when providing urinary catheter (a flexible tube inserted into the bladder to drain urine when a person cannot urinate naturally) or colostomy (a surgical procedure that creates an opening in the abdomen, connecting the colon to the outside of the body to divert waste into a pouch) care. The Treatment Nurse said she forgot to put on a gown prior to performing wound care because she was concerned with Resident #2's pain and was not paying attention. The Treatment Nurse said she usually wears a gown and gloves when performing wound care. The Treatment Nurse said the importance of EBP was to prevent cross contamination, to prevent spread of bacteria, and for infection control. During an interview on 3/5/26 at 1:52 p.m. the DON said when a resident was on EBP she expected staff to wear a gown, gloves, and mask or face shield (if necessary to protect the face from bodily fluids) when providing direct care to protect the residents from cross contamination. The DON said EBP was necessary for residents with open wounds, urinary catheters, PICC lines (a long, thin, flexible tube inserted into a large upper arm vein and thread toward the heart for long-term intravenous access), and PEG tubes (a flexible feeding tube inserted through the abdomen into the stomach using an endoscope to provide long-term nutrition, hydration, or medication to residents with swallowing difficulties or severe nutritional deficits). Record review of the facility's undated Enhanced Barrier Precautions indicated, Multidrug-resistant organism (MDRO) transmission is common in long-term care (LTC) facilities. Many residents in nursing homes are at increased risk of becoming colonized and developing infections with MDRO's. Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and glove use during high contact resident care activities. EBP are used in conjunction with standard precautions and expand the use of PPE to donning (putting on) of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing.