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	04/17/2026

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were free of any significant medication errors for 1 of 11 residents (Resident #1) reviewed for medication errors. The facility failed to ensure Resident #1's hospital discharge orders were implemented to include enoxaparin (a medication commonly known as Lovenox, an anticoagulant medication used to prevent and treat DVT (deep vein thrombosis, a serious condition where a blood clot forms in a deep vein, usually in the legs, causing pain, swelling and redness) and pulmonary embolism (a life-threatening condition that occurs when a blood clot blocks an artery of the lung) after surgery or in patients with limited mobility), cefuroxime (an antibiotic medication commonly known as Ceftin used to treat infections) and Vitamin D3 (a vitamin medication also known as cholecalciferol essential for strong bones, immune function and calcium absorption) daily after her readmission on [DATE]. The facility failed to obtain the discharge medication record and caused to resident to miss approximately five days of enoxaparin, cefuroxime, and Vitamin D3 after her hospitalization in which she received treatment for a tibia / fibula (lower leg bones) fracture that required surgical intervention. This failure was identified by the surveyor during investigation and had not been previously recognized by the facility. An Immediate Jeopardy (IJ) was identified on 04/17/2026 at 12:20 p.m. The IJ template was provided to the facility on [DATE] at 1:00 p.m. While the IJ was removed on 04/17/2026 at 3:13 p.m., the facility remained out of compliance at a potential for more than minimal harm and a severity of pattern due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. These failures could place residents who require medication administered by the facility at risk of not receiving their medications as ordered, illness, hospitalizations, exacerbation of their disease processes, and death. Findings included: Record review of Resident #1's EMR accessed 04/17/26, reflected Resident #1 re-admitted to this facility on 04/11/2026 after hospitalization due to a left tibia (shin bone) and fibula (a non-weight-bearing bone located on the outside of the lower leg) closed fracture with surgical intervention. Diagnoses included osteopenia (a condition of reduced bone mineral density that makes bones weaker than average), anemia (a shortage of healthy red blood cells, reducing oxygen delivery to the organs), atherosclerotic heart disease (a condition of plaque build-up that reduces blood flow to the heart), dementia (a progressive syndrome causing cognitive decline to include memory loss, poor judgment and communication issues), and Diabetes Type II (a chronic condition where the body resists insulin or fails to produce enough insulin causing high blood sugar). Record review of Resident #1's Quarterly MDS dated [DATE] revealed she was rarely understood and rarely understood others and was unable to complete the BIMS assessment. Staff assessment of Resident #1's cognitive skills revealed severe impairment. Further review of this MDS revealed Resident #1 had upper and lower extremity range of motion impairment, required a Geri-chair (a specialized reclining, wheeled medical chair for patients with limited mobility), required total assistance in eating, toileting, bathing, required maximum assistance in dressing, bed mobility, transfers. Record review of Resident #1's hospital documents titled Discharge Summary and dated 04/11/2026 indicated under the Medication List, that Resident #1 should start (writing in capital letters) taking these medications: Cefuroxime 500 MG tablet, take 1 tablet (500mg total) by mouth 2 (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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	(two) times daily for 5 daysEnoxaparin 40MG/).4ML syringe, Inject 0.4mLs (40 mg total) into the skin daily for 28 days. Start taking on: 04/12/2026Vitamin D3 1000 units caps, take 5000 Units by mouth daily. Start taking on: 04/12/2026. Record review of Resident #1's MAR dated 04/01/2026-04/30/2026 revealed resident was not started on enoxaparin/Lovenox 40MG/0.4ML daily, cefuroxime/Ceftin 500MG twice a day or Vitamin D3 5000 units daily as ordered in hospital discharge. During an observation and interview on 04/16/2026 at 10:28 a.m., Resident #1 was seated in a Geri-chair in a reclined position in the common area near the nurse's station and was clean, odor free and appropriately dressed. Resident was pleasantly confused and responses to direct questions were nonsensical. No signs of distress, pain or discomfort noted. Resident #1 was moved to a secluded location to allow for physical assessment of left lower leg surgical site and upper body for signs of bleeding, bruising, warmth, redness, tenderness or swelling to rule out concern for infection and / or deep vein thrombosis (DVT). No adverse findings were identified. Surgical site was clean, dry, intact and 1 healing bruise to left temple identified from a previous incident when resident hit her head. During an interview on 04/17/26 at 9:25 a.m., the Medical Records technician stated that she normally picks up records after the Monday-Friday clinical meeting to include hospital clinical records with discharge documents and then proceeds to upload them to the EMR system. The Medical Records technician stated she uploaded all of the hospital discharge records that were provided, and the discharge medication list was not in the packet. During an interview on 04/17/26 at 10:19 a.m., ADON A stated that she was on duty when Resident #1 arrived via ambulance stretcher to the facility on [DATE]. ADON A stated that she was not provided with a discharge medication reconciliation form and proceeded to follow the discharge summary which did not identify any medication recommendations. ADON A stated she should have contacted the hospital to request a discharge medication list to complete the admission for Resident #1. The ADON stated that failure to follow the discharge instructions placed Resident #1 at risk for post-operative infection and development of a DVT. The ADON reviewed the facility process for admissions / readmissions was to review and verify the discharge medications with the accepting physician, complete data in-put into the EMR and order new medications as indicated. ADON A stated the admitting orders are reviewed the following day by herself, the other ADON or the DON for accuracy and completeness. The ADON could not say why Resident #1's medications were not reviewed post admission. During an interview on 04/17/2026 at 10:23 a.m., the Physician stated he was notified by the DON on 04/16/2026 (unknown time) that the hospital discharge instructions were not followed for Resident #1. The Physician stated that he provided orders for the facility to start the missed medications on 04/17/2026 and stated the risks for not receiving the ordered medications post-operative would be increased risk for infection and increased risk for development of a DVT The Physician stated that Resident #1 had been assessed since readmission with no adverse effects related to not receiving the medications. The Physician stated that he expects the admitting nurse to notify him of accurate physicians orders when a resident admits or readmits to the facility to ensure appropriate care and treatment. During an interview on 04/17/2026 at 10:53 a.m., RN B stated that when a new or readmission arrives to the facility, she reviews the discharge documents to include the discharge medication list. RN B stated that if the resident arrives to the facility without a discharge medication list, she would contact the hospital to have it faxed to the facility, verify orders with the accepting physicians and order new medications as indicated. RN B stated she did not complete the readmission for Resident #1 and only saw the discharge clinical records that were uploaded to the EMR. During an interview on 04/17/2026 at 10:56 a.m., RN C stated she reviews all new orders with the accepting physician and completes data input for any changes in the EMR. RN C stated if the resident arrives without a medication list, she will contact the hospital to have it faxed over. RN C stated she did not completed the readmission process for Resident #1 and she is not on her unit, so she would have had no need to review the clinical records. During an interview on 04/17/2026 at 10:58 a.m., ADON D stated that she reviews all hospital discharge documents to include discharge medication lists for all new and readmissions with (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	the physician to verify the orders. ADON D stated if a resident arrives to the facility without a discharge medication list, she will check in the EMR to see if it is uploaded or contact the discharging facility to request the record be faxed to the nursing facility. ADON D reviewed the admission process and provided demonstration of the process with a readmission who admitted on [DATE] to include review of the admission orders, verification that the orders were accurately processed in the EMR and that the orders were placed in the medical records box to be uploaded to the EMR. ADON D stated she did not complete the readmission for Resident #1 and began reviewing the clinical documents that were uploaded to the EMR on 4/16/26 after the DON had indicated that not all the orders were transcribed correctly. During an interview on 04/17/2026 at 11:00 a.m., the Administrator stated that she expected the nursing staff to be thorough in the documentation of all new admissions and readmissions and that the DON was ultimately responsible for this area. The Administrator acknowledged that failure to accurately review the medications could result in harm or injury to the resident. During an interview on 04/17/2026 at 3:15 p.m., the DON confirmed the admission process was to review the admitting orders the following day or on the following Monday if the admission occurred on a weekend. The DON could not say why Resident #1's admitting orders were not reviewed per facility protocol. The DON stated that not following discharge instructions placed this resident at risk for increased bleeding / bruising and/or DVT development as well as increased the risk for post-operative infection. Record review of the facility policy titled Admission/Readmission, undated, revealed Procedure: 2. Review the medical diagnoses and physician orders. Orders should include.orders for medications.as specified by the physician. This was determined to be an Immediate Jeopardy (IJ) pattern on 04/17/2026 at 12:20 p.m. The Administrator and Director of Nurses were notified and provided the IJ Template on 04/17/2026 at 1:00 p.m. and a Plan of Removal was requested. The facility's plan of removal was accepted on 04/17/2026 at 3:13 p.m. and included the following: Alleged Issues:The facility failed to ensure Resident #1 was free from significant medication errors when the facility failed to administer anticoagulant medication enoxaparin/Lovenox, antibiotic medication cefuroxime/Ceftin and vitamin supplement medication Vitamin D3 according to the hospital discharge instructions as ordered by the discharging physician. Plan of Removal: 1.Immediate Corrective ActionsThe physician was notified by the DON on 04/17/2026 of the Immediate Jeopardy. The physician gave verbal orders to start the medications that were indicated on the discharge instructions. The DON and Regional Compliance Nurse (RCN) reviewed admissions / readmissions for the 30 days prior to the incident for any other potentially affected residents with completion of 04/17/26. The DON indicated that per facility protocol, the DON/ADON or designee will review all admissions and readmissions for accurate and complete order entry. 2. EducationThe RCN provided 1:1 in-service to the Administrator, DON and ADON's on the following topics: Abuse & Neglect Policy - Failure to transcribe orders or administer medications could be considered NeglectNotification of change in condition policy - Notify Physician immediately of any missed or omitted medications and of the changes in resident condition related to these failures. Medication Reconciliation Policy - The Charge Nurse is responsible to reconcile medications with the physician on admission or readmission. Following physician's orders - The Charge Nurse is responsible to transcribe and initiate all orders for new admissions and readmissions. Nursing staff (22 of 22) were in-serviced on 04/17/2026 by the RCN / DON / ADON regarding the following topics: Abuse & Neglect Policy - Failure to transcribe orders or administer medications could be considered NeglectNotification of change in condition policy - Notify Physician immediately of any missed or omitted medications and of the changes in resident condition related to these failures. Medication Reconciliation Policy - The Charge Nurse is responsible to reconcile medications with the physician on admission or readmission and if no orders are received from the discharging facility, the Charge Nurse is required to contact the discharging facility to obtain orders or the accepting physician if unable to obtain discharge orders. Following physician's orders - The Charge Nurse is responsible to transcribe and initiate all orders for new admissions and readmissions. 3.MonitoringA Physician (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	orders / New admission/readmission monitoring form was initiated on 04/17/2026 at 11:00 a.m. Monitoring for compliance will continue for 6 weeks and be reviewed monthly in QAPI meeting for 90 days. The DON / ADON or designee will monitor each new admissions physicians orders daily Monday - Friday. A weekend supervisor or designee (the facility does not currently have a dedicated weekend supervisor) will monitor the physicians orders on Saturday and Sunday to ensure orders were transcribed correctly per discharge instructions. The Administrator will ensure the clinical meeting IDT members review the physician's orders for all new and readmissions at the clinical meeting Monday-Friday and review the effectiveness of this system at the monthly QAPI meeting. The RCN verified an off-schedule QAPI meeting was held with Performance Improvement Plan in place in conjunction with this Plan of Removal. The surveyor confirmed the POR had been implemented sufficiently to remove the IJ by: During an interview on 04/17/2026 at 10:23 a.m., the Physician confirmed that he had been notified by the DON of the medication error for Resident #1 as well as facility monitoring to ensure no other residents would be affected by similar errors. Record review of Resident #1's physicians orders on 4/17/26 at 1:18 p.m. revealed the attending physician had been contacted and orders were obtained to reconcile Resident #1's medications to reflect the hospital discharge medication list. Record review of Resident #1's April MAR reflected orders for enoxaparin 40MG/4ML was received 04/16/2026 and administered 04/17/2026, Ceftin 500 mg x 5 days BID with first dose administered 04/16/2026, and Vit D3 1000u daily with first dose administered 04/17/2026. Record review on 4/17/26 at 1:25 p.m. revealed that the facility held a QA meeting to review findings of significant medication error and provided surveyor with monitoring sheet implemented to ensure accurate review of medications transcribed for new admissions or readmissions for 6 weeks, then monthly review at QAPI meeting and to be available for the Administrator to review at daily clinical meetings and with spot check. Record review of Inservices completed 04/16/2026 at 1:30 p.m. revealed the RCN provided 1:1 training for the DON and the Administrator that addressed Abuse & Neglect Policy, notification of change in condition, medication reconciliation, and following physicians 'orders. Record review of Inservices completed 04/16/26-04/17/26 at 1:30 p.m. revealed the DON provided training for 9 of 9 administrative and floor nursing staff and that addressed Abuse & Neglect Policy, notification of change in condition, medication reconciliation, and following physicians' orders. Record review of Inservices completed 04/17/2026 at 2:25 p.m. revealed 18 of 18 nursing staff received the Inservice training via automated application (a program that sends the required trainings directly to a cell number or email as designated upon hire) beginning on 04/17/2026 at 8:18 a.m. and completed at 04/17/2026 at 2:15 p.m. to include Abuse & Neglect Policy, notification of change in condition policy, medication reconciliation policy, and following physicians orders. During an interview on 04/17/2026 at 1:19 p.m., ADON A revealed she had been provided training by the DON on the proper procedures to be followed for all new admissions and readmissions specifically related to medication reconciliation to include verifying the orders with the accepting physician, entering the orders in the EMR and ordering medications as needed. During an interview on 04/17/2026 at 1:24 p.m., RN B stated she had received training from the DON on the procedures for new admissions and readmissions, noting that this was a refresher for her as she was already aware of the steps to take to include review of the hospital clinical records, contacting the hospital if the resident arrived without a discharge medication listing, verifying the orders with the physician, entering the orders in the EMR and ordering the medications as needed. During an interview on 04/17/2026 at 1:28 p.m., RN C stated she had received additional training for new admissions and readmissions and understood the content of the training with no concerns. RN C stated she understood the importance of reviewing all clinical documentation provided by the discharging facility, to include the medication list and completing an accurate reconciliation of the medications by notifying the physician, clarifying orders and entering the information in the EMR. During an interview on 04/17/2026 at 1:30 p.m., ADON D stated she had received the training provided by the DON regarding new admissions and readmissions and she was very aware of the steps and processes to ensure accurate medication reconciliation to (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	include verifying the discharge medication orders with the physician or nurse practitioner, entering the orders in the EMR and ordering any new medications. ADON D stated that if a new medication is available from the pharmacy medications provided as house stock, she will administer the first dose and order the remaining doses. During an interview on 04/17/2026 at 1:35 p.m., LVN E and LVN F (MDS Nurses in shared office) confirmed they had received the training and understood the content. LVN E stated she does not usually have to do admissions, but understood it was vital to verify the discharge medications with the physician and notify the discharging facility if the list did not arrive with the resident. LVN F stated that once the medication list if verified with the physician, the nurse would need to enter the orders in the EMR and order the medications. During an interview on 04/17/2026 at 1:40 p.m., LVN G confirmed she had received training on admissions and readmissions regarding medication reconciliation and understood correct process to complete an admission to include reviewing the clinical records, contacting the physician to verify the orders, entering the orders in the EMR and ordering the medications. During an interview on 04/17/2026 at 1:44 p.m., LVN H confirmed she had received training on the admission process and understood content and procedures to be followed to include the importance of reviewing the clinical documents, specifically the medications and to review new orders with the physician. LVN H stated that if a resident arrived to the facility without a discharge medication list, she would notify the discharging facility to request a copy be faxed. During an interview on 04/17/26 at 1:50 p.m., LVN K confirmed she had attended the training and understood the correct processes to be followed when a new admission or readmission arrives to the facility. During an interview on 04/17/2026 at 2:00 p.m., the DON confirmed that she had completed an audit of the past 30 days of admissions and readmissions to ensure accurate medication reconciliation according to the discharge medication listing for 31 of 31 residents. Record review of the admission and Discharge report dated 04/16/2026 and reflecting admissions and readmissions from the period of 03/16/2026-04/16/2026 revealed a total of 31 admissions to include Resident #1. Record review of hospital discharge medication list for 11 of 11 residents admitted in this time period in comparison with the facility MAR for the identified admission date revealed no discrepancies in medication reconciliation with the exception of the identified Resident #1. The RCN, Director of Nurses and Administrator were informed that the Immediate Jeopardy was removed on 04/17/2026 at 3:13 p.m. The facility remained out of compliance at a potential for more than minimal harm with a scope identified as pattern due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems.