

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  06/20/2024
NAME OF PROVIDER OR SUPPLIER  Rock Creek Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47612</p> <p>Based on observations, interviews, and record review the facility failed to treat each resident with respect and dignity and provide care in a manner that promoted maintenance or enhancement of his or her quality of life for 1 of 24 residents (Resident #50) reviewed for resident rights.</p> <p>The facility did not ensure CNA S treated residents with dignity and respect when feeding two residents at the same time during the lunch meal.</p> <p>This failure could place residents at an increased risk of embarrassment, isolation, and diminished quality of life.</p> <p>The findings included:</p> <p>Record review of the face sheet, dated 06/18/2024, revealed Resident # 50 was an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of Alzheimer's disease (disease that destroys memory and other important mental functions), spinal stenosis, lumbar region without neurogenic claudication (compression of the spinal nerves in the lumbar (lower) spine), dysphagia (swallow difficulties).</p> <p>Record review of the MDS assessment, dated 04/25/2024, revealed Resident #50 had a BIMS score of 00, which indicated severe cognitive impairment. The MDS did not address eating assistance.</p> <p>Record review of the comprehensive care plan, revised on 05/14/2024, revealed Resident #50 interventions required one person assist with eating.</p> <p>During an observation on 06/20/2024 at 12:30 p.m. CNA S was observed feeding Resident # 50 and another resident at the same time.</p> <p>During an interview on 06/20/2024 at 1: 10 p.m. Resident # 50's family member stated the staff always feeds another resident while feeding Resident #50. Resident # 50 family member state they feel Resident # 50 was rushed to eat because the facility does not have enough staff to feed the residents that need assistance.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/20/2024 at 1:45 p.m., CNA S stated she feeds to residents at the same time when they do not have enough staff. CNA S stated she tried to give each resident the attention they need. CNA S stated it was important to give the resident the time and attention they deserve while eating. CNA S stated the risk to the resident was they may not get enough food or feel bad about themselves.</p> <p>During an interview on 06/20/2024 at 3:16 p.m., the DON stated the CNAs feed two residents at a time for staff utilization. The DON stated the alternative was the residents who need assistance would have to wait longer for their meal. The DON state it was important to feed the residents before the food gets cold.</p> <p>During an interview on 06/20/2024 at 4:42 p.m., the Administrator stated it could be common for the CNAs to feed two residents at the same time. The Administrator stated the alternative would be the family could hire someone to assist with feeding. The Administrator stated this could negatively affect Resident #50 by making her not want to eat in the dining room.</p> <p>Record review of the facility's policy titled Resident Rights indicated The facility must treat each resident with respect and dignity and care for each resident in a manner and in a environment that promotes maintenance and enhancement of his or her quality of life .</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47006</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 1 of 24 residents (Resident #2) reviewed for reasonable accommodation of needs.</p> <p>The facility did not ensure Resident #2's call light was answered timely and within reach when leaving her room on 06/17/2024.</p> <p>This failure could place residents at risk for unmet needs and decreased quality of life.</p> <p>The findings included:</p> <p>Record review of the face sheet, dated 06/19/2024, revealed Resident #2 was an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of cerebrovascular disease (an umbrella term for conditions that impact the blood vessels in your brain), anxiety disorder (group of mental illnesses that cause constant fear and worry), flaccid hemiplegia affecting right dominant side (severe or complete loss of motor function on one side of the body), and obesity (condition characterized by abnormal or excessive fat accumulation).</p> <p>Record review of the quarterly MDS assessment, dated 05/16/2024, revealed Resident #2 had unclear speech and was usually understood by staff. The MDS revealed Resident #2 was usually able to understand others. The MDS revealed Resident #2 had a BIMS score of 14, which indicated no cognitive impairment. The MDS revealed Resident #2 had an impairment of one side to the upper extremities and lower extremities. The MDS revealed Resident #2 was dependent on staff assistance for toilet hygiene and transfers.</p> <p>Record review of the comprehensive care plan, revised on 10/24/2023, revealed Resident #2 had an ADL self-care performance deficit. The interventions included: Encourage resident to use bell to call for assistance.</p> <p>During an observation and interview on 06/17/2024 beginning at 3:24 PM, Resident #2 was sitting up in her wheelchair in her room beside her bed. Resident #2 had the call light on, but the call light was laying in the floor beside her chair. Resident #2 stated she wanted to lay down and needed to be changed. Resident #2 said when she pressed the call light it had fallen on the ground, and she was unable to reach over her wheelchair to get it. Resident #2 stated she was waiting for a staff member to answer her call light.</p> <p>During an observation on 06/17/2024 at 3:30 PM, CNA E went into Resident #2's room and turned out the call light. CNA E then walked out of Resident #2's room.</p> <p>During an observation on 06/17/2024 at 3:35 PM, Resident #2's call light remained on the ground beside her wheelchair.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 06/17/2024 beginning at 3:38 PM, Resident #2 wheeled herself outside her room into the hallway. Resident #2 said she was unable to get her call light off the ground. Resident #2 stated a staff member had come into her room and turned the call light off and had not returned yet. Resident #2 said staff members turned her call light off all the time and did not come back. Resident #2 stated she was tired of it. CNA E walked by Resident #2 sitting in the hallway and did not explain why she had not returned to her room.</p> <p>During an observation on 06/17/2024 at 3:43 PM, The DOR was walking by Resident #2 in the hallway. The DOR asked Resident #2 if she needed anything and Resident #2 stated she needed to be put down to bed and changed. Resident #2 explained she had already told a staff member what she needed, and that staff member had turned out her call light, walked out of her room, and had not returned. The DOR stated she would finish what she was doing and then return to help her. CNA E was standing at the nurses' station visible from 400 Hall.</p> <p>During an observation on 06/17/2024 beginning at 3:48 PM, The DOR walked into Resident #2's room with her supplies. She was followed by CNA E.</p> <p>During an interview on 06/20/2024 beginning at 3:07 PM, CNA E stated she had worked at the facility for approximately 6 months. CNA E said she normally worked Hall 4. CNA E stated she answered Resident #2's call light on 06/17/2024 and she had requested to have been changed and laid down. CNA E stated she had told another CNA who was assigned to Resident #2, but she told her Resident #2 was going to have to hang on as she was working her way down the hallway. CNA E stated she told the charge nurse but did not notify or explain the situation to Resident #2. CNA E said she did not realize Resident #2's call light was on the ground when she entered her room to answer the call light. CNA E stated she should have made sure the call light was in reach before she left the room. CNA E stated it was important to ensure the call light was left in reach so the residents could have used it.</p> <p>During an interview on 06/20/2024 beginning at 5:17 PM, the DON stated he expected facility staff to ensure a resident's call light was left within reach. The DON said all staff were responsible for ensuring call lights were left in reach. The DON said it was important to ensure call lights were left in reach so the residents could have called for help and assistance.</p> <p>During an interview on 06/20/2024 beginning at 5:49 PM, the Administrator stated she expected staff to ensure call lights were left within reach and answered timely. The Administrator stated all staff were responsible for ensuring call lights were left within reach. The Administrator stated it was important to ensure call lights were left within reach so the residents could have used them. The policy for call lights was requested but not provided upon exit of the facility.</p>		

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43047</b></p> <p>Based on interview and record review, the facility failed to ensure each resident was informed before, or at the time of admission, and periodically during the residents stay, of services available in the facility and of changes for those services, which included changes for services not covered under Medicare/Medicaid or by the facility's per diem rate for 1 of 3 residents (Resident #183) reviewed for Medicare/Medicaid coverage.</p> <p>The facility failed to ensure Resident #183 was given a SNF ABN when discharged from skilled services at the facility prior to covered days being exhausted.</p> <p>This failure could place residents at risk for not being aware of changes to provided services.</p> <p>Findings included:</p> <p>Record review of Resident #183's face sheet, dated 06/19/2024, indicated Resident #183 was a [AGE] year-old male, originally admitted to the facility on [DATE] with diagnoses which included hypokalemia (low potassium).</p> <p>Record review of admission MDS assessment, dated 04/25/2024, indicated Resident #183 sometimes made himself understood and sometimes understood others. The assessment indicated Resident #183's BIMS score was 3, which indicated his cognition was severely impaired. The assessment indicated Resident #183 was receiving speech, occupational and physical therapy.</p> <p>Record review of the SNF Beneficiary Protection Notification Review indicated Resident #183 was receiving Medicare Part A services starting on 04/19/2024 and the last covered day of Part A services was 05/09/2024, However, a SNF ABN was not completed which would have informed Resident #183 of the option to continue services at the risk of out of pocket.</p> <p>During an interview on 06/20/2024 at 9:00 a.m., MDS Coordinator A stated she was responsible for ensuring Resident #183 was issued a SNF ABN. MDS Coordinator A stated Resident #183 had 60 days remaining. MDS Coordinator A stated the form should have been issued if the resident had skilled benefit days remaining and was being discharged from Part A services and continued living in the facility. When asked why the form was not given, MDS Coordinator A stated, It got missed. MDS Coordinator A stated it was important to ensure residents received the form because it notified the family and resident that there was a possibility that they could be responsible for extra charges that the insurance would not cover. MDS Coordinator A stated there was a not a risk because his needs were met.</p> <p>During an interview on 06/20/2024 at 3:44 p.m., the Administrator stated the MDS Coordinators were responsible for ensuring the SNF ABN was completed. The Administrator stated the regional coordinator was responsible for monitoring and overseeing. The Administrator stated it was important for residents to receive the SNF ABN so they are aware of how many days they have left that the insurance will pay.</p> <p>(continued on next page)</p>

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's' policy effective 04/30/2018, titled Creative Solution in Healthcare Policy and Procedure SNF ABN, indicated, a SNF ABN must be given to the beneficiary in order to transfer financial liability for the item or service to the beneficiary .</p> <p>Record review of CMS guidelines Beneficiary Notice Guidelines, approved by CMS-10124-DENC December 31, 2011, indicated Scenario Part A stay will end because: SNF (Skilled Nursing Facility) determines the beneficiary no longer requires daily skilled services. Resident has days remaining in the benefit period. Resident will remain in the facility (custodial care) Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN) CMS-10055 (2018) and Notice of Medicare Non-Coverage (NOMNC) CMS-10123 (12/31/11)) to be completed .</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43047</p> <p>Based on interview and record review, the facility failed to promptly resolve grievances for 1 out of 24 residents (Resident #41) reviewed for grievances.</p> <p>The facility did not ensure a grievance was filled out and followed up on after Resident #41 reported her watch was missing on 06/06/2024.</p> <p>This deficient practice could place the residents at risk for decreased quality of life and feelings of neglect.</p> <p>The findings included:</p> <p>Record review of the face sheet, dated 06/20/2024, revealed Resident #41 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of fracture of lower end of right femur (right hip fracture) and unspecified kidney failure (one or both of your kidneys no longer work on their own).</p> <p>Record review of the admission MDS assessment, dated 03/22/2024, revealed Resident #41 had clear speech and was understood by staff. The MDS revealed Resident #41 was able to understand others. The MDS revealed Resident #41 had a BIMS score of 13, which indicated no cognitive impairment. The MDS revealed Resident #41 felt like it was somewhat important to take care of personal belongings.</p> <p>Record review of the comprehensive care plan, revised on 05/20/2024, revealed Resident #41 had no behaviors or cognitive decline.</p> <p>Record review of the Grievance/Complaint Log, dated June 2024, revealed no entry for Resident #41 on 06/06/2024.</p> <p>Record review of the resident grievance form, dated 06/06/2024, revealed Resident #41 had initiated a grievance on 06/06/2024 with the Social Worker. The details indicated Resident #41 was missing a watch. The form was not complete. The following sections were left blank on the form:</p> <ul style="list-style-type: none"> <li>*The individual assigned to take action;</li> <li>*The date to be resolved by;</li> <li>*The summary of the pertinent findings and conclusions;</li> <li>*The corrective action taken to prevent recurrence;</li> <li>*The date of notification and method of notification for the resolution</li> </ul> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/17/2024 beginning at 2:31 PM Resident #41 stated she had a watch that her children gave her for her birthday. Resident #41 stated she laid it on the bedside table and went to therapy. Resident #41 stated when she returned to her room it was gone. Resident #41 believed it could have fallen in the trashcan, but the facility staff were unable to find the watch. Resident #41 stated she had not heard any more about the incident since she first reported it approximately a few weeks ago.</p> <p>During an interview on 06/20/2024 beginning at 12:38 PM, the Social Worker stated she was responsible for completing the grievance reports. The Social Worker stated Resident #41 reported her missing watch and a grievance had been completed. The grievance report was requested.</p> <p>During an interview on 06/20/2024 beginning at 12:48 PM, the Social Worker stated when a resident reported a missing item, she would have gotten the description of the item and sent a telegram to all department heads. The Social Worker stated she would have completed a grievance. The Social Worker stated the goal was to have grievances resolved within 1 week. The Social Worker stated if the item was not found, she would have followed up with the Administrator. The Social Worker stated Resident #41 reported her missing watch to her on 06/06/2024. The Social Worker stated she filled out the grievance today when she was asked for it by the state surveyor. The Social Worker said it honestly, it slipped through the cracks. The Social Worker stated this failure could have made the resident feel like their rights were not taken into consideration.</p> <p>During an interview on 06/20/2024 beginning at 5:17 PM, the DON stated grievances were reported in different ways and were shared with department heads. The DON stated the person responsible for completing the grievance was dependent on what the grievance was about. The DON stated a grievance should have been addressed right away. The DON stated it was important to ensure grievance were documented and initiated to come up with a resolution and address concerns made by the residents.</p> <p>During an interview on 06/20/2024 beginning at 5:49 PM, the Administrator stated Resident #41's missing watch should have been reported to the appropriate department with a grievance form filled out. The Administrator stated the interdisciplinary team was responsible for ensuring grievance were monitored and followed up on. The Administrator stated it was important to ensure grievances were documented and followed up on to validate if the grievance was an issue.</p> <p>Record review of the grievances policy, revised 11/02/2016, revealed The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have .the grievance official of this facility is the administrator of their designee the grievance official will: oversee the grievance process, receive and track grievances to their conclusion, lead any necessary investigations by the facility . issue written grievance decisions to the resident all written grievances decisions will include: the date the grievance was received, the summary statement of the residents grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns, a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued.</p>		

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<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43047</b></p> <p>Based on interview and record review, the facility failed to ensure an encoded, accurate, and complete MDS discharge assessment was electronically completed and transmitted to the CMS System within 14 days after completion for 1 of 1 resident (Resident #48) reviewed for discharge MDS assessments.</p> <p>The facility did not ensure Resident #48's discharge MDS assessment was completed and transmitted within 14 days of completion.</p> <p>This deficient practice could place residents at risk of not having records completed and submitted in a timely manner as required.</p> <p>Findings included:</p> <p>Record review of Resident #48's face sheet dated, 06/19/2024, indicated Resident #48 was an [AGE] year-old female, admitted to the facility on [DATE] with a diagnosis which included COVID-19 (a virus that causes a respiratory disease).</p> <p>Record review of a discharge summary note dated 01/14/2024 indicated Resident #8 was discharged to the hospital.</p> <p>Record review of a CMS Submission report indicated Resident #48's discharge MDS assessment dated [DATE] was transmitted on 02/05/2024.</p> <p>During an interview on 06/20/2024 at 9:00 a.m., MDS Coordinator A stated the Regional Reimbursement Nurse was responsible for transmitting the assessment to CMS. MDS Coordinator A stated the discharge assessment should have been transmitted 14 days after completion. MDS Coordinator A stated the discharge assessment should have been transmitted by 1/29/2024. MDS Coordinator A stated the importance of ensuring MDS assessments were completed timely was to ensure that proper documentation was collected prior to discharge.</p> <p>During a telephone interview on 06/20/2024 at 9:34 a.m., the Regional Reimbursement Nurse stated she was responsible for transmitting the discharge assessment. The Regional Reimbursement Nurse stated the assessment should have been transmitted within 14 days. The Regional Reimbursement Nurse stated when the assessment should have been transmitted, she was out on PTO, and she transmitted the assessments as soon as she came back. The Regional Reimbursement Nurse stated it was important to ensure assessments were submitted timely so that we have accurate and timely assessment submitted according to the RAI.</p> <p>During an interview on 06/20/2024 at 3:44 p.m., the Administrator stated she expected the discharge assessments to be completed on time. The Administrator stated at that time period when the MDS should have been submitted the Regional Reimbursement Nurse was responsible for making sure the MDS assessments were completed on time. The Administrator stated it was important to ensure assessments were timely submitted to initiate the plan of care.</p> <p>(continued on next page)</p>		

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<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record Review of the CMS RAI Version 3.0 Manual, dated October 2023, indicated, in Chapter 2, page 2-39 09. Discharge Assessment-Return Not Anticipated (A0310F), Must be completed (item Z0500B) within 14 days after the discharge date (A2000 + 14 calendar days). The RAI Manual further revealed the discharge assessment-return not anticipated must be submitted within 14 days after the MDS completion date (Z0500B +14 calendar days)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47006</b></p> <p>Based on observation, interviews, and record review, the facility failed to develop or implement a comprehensive person-centered care plan to meet resident's medical, nursing, mental and psychosocial needs identified in the comprehensive assessment for 1 of 3 residents reviewed for care plans. (Resident #57)</p> <p>The facility did not ensure Resident #57's ADL care plan accurately reflected her current ADL status with transfers.</p> <p>This failure could place residents at risk of not having individual needs met and a decreased quality of life.</p> <p>The findings included:</p> <p>Record review of the face sheet, dated 06/20/2024, revealed Resident #57 was a [AGE] year-old female who initially admitted to the facility on [DATE] with diagnoses of metabolic encephalopathy (brain dysfunction caused by problems with your metabolism, such as low glucose or high toxins) and mild cognitive impairment (slight decline in mental abilities, like memory and reasoning, that doesn't interfere with daily life).</p> <p>Record review of the quarterly MDS assessment, dated 05/02/2024, revealed Resident #57 had clear speech and was understood by others. The MDS revealed Resident #57 was usually able to understand others. The MDS revealed Resident #57 had a BIMS score of 10, which indicated moderately impaired cognition. The MDS revealed Resident #57 required setup or clean-up assistance with transfers, which means helper sets up or cleans up; resident completes activity; helper assists only prior to or follow the activity.</p> <p>Record review of the comprehensive care plan, revised 01/12/2024, revealed Resident #57 required two staff assistance and the use of a Hoyer lift with transfers.</p> <p>Record review of the Kardex (part of the electronic monitoring system that CNAs use to determine level of assistance needed) form, dated 06/20/2024, revealed Resident #57 required staff x 1 assistance with transfers, resident required Hoyer lift for transfers, and required staff x 2 for assistance.</p> <p>Record review of transferring task documentation, dated 06/07/2024 to 06/20/2024, revealed Resident #57 required limited assistance to total dependence with transfers.</p> <p>Record review of the event nurses' note, dated 06/15/2024, revealed Resident #57 received a skin tear to her left forearm, which measured 3 cm x 0.5 cm x 0.1 cm. The nursing description of the event said CNA transferring resident to the wheelchair, bumped arm on the arm of wheelchair causing a skin tear.</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER  Rock Creek Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  1414 College Street Sulphur Springs, TX 75482	
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the notes section of the incident report for skin tear that occurred on 06/15/2024 revealed a progress note, dated 06/17/2024, which revealed Resident #57's care plan was reviewed.</p> <p>During an observation and interview on 06/17/2024 beginning at 11:28 AM, Resident #57 was sitting up in her wheelchair in her room. Resident #57 had bruising to bilateral upper arms. Resident #57 had steri strips to her left arm, near the elbow. Resident #57 said she did not bump it, but it happened in therapy. Resident #57 was unable to communicate effectively related to her cognitive status and confused conversation.</p> <p>During an interview on 06/20/2024 beginning at 12:46 PM, RN W stated CNA H was transferring Resident #57 when she sat down and bumped her arm on the chair. RN W stated CNA H was using a gait belt and lifted her to the wheelchair. RN W stated Resident #57 did not require 2 staff members or a Hoyer lift during transfers. RN W stated she believed Resident #57 fluctuated in the amount of help she required but most of the time only required one person assistance with transfers. RN W stated she was not provided in-service training on transfers after Resident #57's incident during a transfer. RN W stated it was important to ensure the care plan accurately reflected Resident #57's ADL status with transfers to ensure her safety and prevent injuries, such as skin tears.</p> <p>During an interview on 06/20/2024 beginning at 4:11 PM, CNA H stated has worked at the facility for approximately 4 weeks. CNA H stated she worked double weekends and was working when Resident #57 received a skin tear. CNA H stated she had transferred Resident #57 to a wheelchair to obtain a weight that was requested by the nurse. CNA H stated when Resident #57 sat down in the wheelchair she received a skin tear. CNA H stated Resident #57 did not require much assistance, so she was not required to use a gait belt. CNA H said Resident #57 did not require a Hoyer lift. CNA H stated most of the time Resident #57 was able to transfer herself to the wheelchair. CNA H stated she did not have access to the care plan that she was aware of. CNA H stated she learned how much assistance each resident required during orientation.</p> <p>During an interview on 06/20/2024 beginning at 4:40 PM, MDS Coordinator B stated the care plans were updated during the quarterly care plan meetings on schedule with the MDS assessments. MDS Coordinator B stated the care planning process was a group effort, but acute changes were usually documented by the nursing department. MDS Coordinator B stated the DON had a daily standard of care meeting where acute changes were reviewed. MDS Coordinator B stated Resident #57 fluctuated in the level of assistance she required during transfers. MDS Coordinator B stated Resident #57 did not use the Hoyer lift all the time. MDS Coordinator B stated the care plan did not accurately reflect the care Resident #57 received. MDS Coordinator B stated it was important to ensure the care plan accurately reflected Resident #57's transfer status to help the nursing staff perform the care and services Resident #57 required. MDS Coordinator B stated not knowing Resident #57's actual status could have placed her at risk for injury.</p> <p>During an interview on 06/20/2024 beginning at 5:17 PM, the DON stated Resident #57's level of assistance required with transfers fluctuated. The DON stated when Resident #57 first arrived at the facility, she was totally dependent on staff. The DON stated Resident #57 had rebounded and was very independent. The DON stated Resident #57 recently had another setback but was still making improvements. The DON stated Resident #57's care plan for ADLs did not accurately reflect the current level of assistance she required with transfers. The DON stated nursing staff was responsible for updating the care plan for ADLs. The DON stated Resident #57's care plan was just overlooked. The DON stated the nursing tasks were more important than the care plan, which were not utilized by all staff.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the comprehensive care plan policy, undated, revealed Residents' preferences and goals may change throughout their stay, so facilities should have ongoing discussions with the resident and resident representative .so that changes can be reflected in the comprehensive care plan .care plan will be reviewed after each MDS assessment, and revised back on changing goals, preferences and needs of the resident and in response to current interventions .</p>

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47612</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident with limited mobility received appropriate treatment and services to prevent further decrease in range of motion for 1 of 1 resident reviewed for mobility. (Resident #50)</p> <p>The facility did not provide interventions to prevent deterioration of Resident #50's range of motion in her right arm.</p> <p>This failure could place residents at risk for decrease in mobility, range of motion, and contribute to worsening of contractures.</p> <p>Findings included:</p> <p>Record review of the face sheet, dated 06/18/2024, revealed Resident # 50 was an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of Alzheimer's disease (disease that destroys memory and other important mental functions), spinal stenosis, lumbar region without neurogenic claudication (compression of the spinal nerves in the lumbar (lower) spine), dysphagia (swallow difficulties).</p> <p>Record review of the MDS assessment, dated 04/25/2024, revealed Resident #50 had a BIMS of 00, which indicated severe cognitive impairment. The MDS revealed Resident #50 was dependent with two persons assist. MDS did not address splint for right arm contractor.</p> <p>Record review of the order summary, dated 05/31/2024, revealed Resident #50 per therapy recommendation-Apply splint to right arm in AM and remove at PM starting date 01/17/2024.</p> <p>Record review of the comprehensive care plan, revised on 05/14/2024, revealed Resident #50 goal The resident's mobility will be improved/restored by use of (brace to right arm, therapy to apply in the am and nursing to remove in the evening Monday thru Friday).</p> <p>During an observation and interview on 06/17/2024 at 11:10 a.m., Resident #50 observed reclined in a chair and appears well groomed. Resident # 50's family member stated she should have a brace on her right arm for contracture. Brace was observed lying on counter under Resident# 50's TV.</p> <p>During an observation on 06/18/2024 at 8:30 a.m., Resident # 50's brace for right arm contracture was observed lying on counter under TV.</p> <p>During an observation on 06/19/2024 at 4:47 p.m., Resident # 50's brace for right arm contracture was observed lying on counter under TV.</p> <p>(continued on next page)</p>

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 06/20/2024 at 10:45 a.m., Resident #50 was sitting in TV room without brace on right arm. LVN R stated she assumed since Resident #50's arm was propped up the brace was on. LVN R stated it was her responsibility for ensuring the brace was on Resident # 50's right arm. LVN R stated it was important for the brace to be on to prevent the arm from being tugged, moved, and stays in place pre therapy recommendation. LVN R stated the risk to Resident # 50 was her arm may not heal properly.</p> <p>During an interview on 06/20/2024 at 10:45 a.m., the Director of Rehab stated the CNAs or nurses are responsible for applying the brace after Resident #50 was discharged from therapy. The Director of Rehab stated the brace should be applied to Resident #50's right arm when she was out of bed. The Director of Rehab stated it was important for Resident #50 to wear the brace to prevent contracture. The Director of Rehab stated the risk to Resident #50 if the brace was not applied her arm could contract more.</p> <p>During an interview on 06/20/2024 at 3:16 p.m., the DON stated therapy was responsible for allying the brace in the mornings. The DON stated he thought LVN R check off Resident #50 was wearing the brace before therapy applied it. The DON stated it was important for Resident # 50 to wear the brace to prevent further contractures. The DON stated the risk to Resident #50 could be pressure sores or worsening contracture. The DON stated he would change the order from therapy applying the brace in the morning to nursing applying the brace in the mornings so nursing would know to apply the brace.</p> <p>During an interview on 06/20/2024 at 4:42 p.m., the Administrator stated she expected thee staff to apply the brace to Resident #50 right arm per the orders. The Administrator stated it was important for Resident #50 to have the brace on to stabilize her arm. The Administrator stated the risk to the resident was worsening of the contracture. The Administrator stated she would monitor by check off.</p> <p>Record review of the facility's policy titled Immobilization Devices, Splints/Slings/Collars/Straps dated 2003, indicated Immobilization devices are splints slings cervical collars and clavicle straps that are applied to restrict movement, support and preserve the integrity of an injured arm, shoulder or neck. Splints are rigid devices that can be used to treat a bone fracture, dislocation, or to prevent further damage of [NAME], joints and muscle following injury or during acute phases of chronic disease such as arthritis. Splints are also used to treat contractures.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47612</p> <p>Based on observation, interview, and record review, the facility failed to ensure the resident remained as free of accident hazards as possible for 1 of 2 residents (Resident # 50) reviewed for accidents and hazards.</p> <p>The facility failed to ensure Resident #50 had a safe transfer when the CNA allowed Hoyer lift cradle to hit her above the right eye on 06/18/2024.</p> <p>These failures could place residents at risk for injury.</p> <p>The findings included:</p> <p>Record review of the face sheet, dated 06/18/2024, revealed Resident # 50 was an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of Alzheimer's disease (disease that destroys memory and other important mental functions), spinal stenosis, lumbar region without neurogenic claudication (compression of the spinal nerves in the lumbar (lower) spine), dysphagia (swallow difficulties).</p> <p>Record review of the MDS assessment, dated 04/25/2024, revealed Resident #50 had a BIMS score of 00, which indicated severe cognitive impairment. The MDS revealed Resident #50 was dependent with two persons assist with transfers.</p> <p>Record review of the comprehensive care plan, revised on 05/14/2024, revealed Resident #50 required two staff for Hoyer transfers.</p> <p>During an observation and interview on 06/17/2024 at 11:10 a.m., Resident #50 observed reclined in chair and appears well groomed. Resident # 50's family member stated Resident #50 had been hit in the head and face several times during Hoyer transfer.</p> <p>During an observation on 06/18/2024 at 8:30 a.m., CNA E And CNA Q was preparing to transferring Resident #50 from the chair to the bed when the cradle of the Hoyer lift hit Resident #50 above the right eye.</p> <p>During an interview on 06/18/2024 at 10:34 a.m., CNA Q stated she was trained upon hire to use the Hoyer lift. CNA Q stated she was responsible for transferring the resident safely. CNA Q stated it was important to protect the resident to prevent injury. CNA Q stated the harm to the resident could be mental issues, bruising, bleeding or could cause eye damage.</p> <p>During an interview on 06/18/2024 at 10:52 a.m., CNA E stated she was trained to use the Hoyer lift at a previous job. CNA E stated she was responsible for resident safety during the Hoyer lift transfer. CNA E stated it was important to put your hand in front of the residents face to protect them from being hit with the cradle of the Hoyer lift. CNA E stated the harm to the resident could be a black eye or a hurt nose.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/20/2024 at 1:58 p.m., ADON G stated the head CNA, herself and the DON were responsible for the CNA's. ADON G stated it was important to do Hoyer lift transfers correctly so accidents such as people getting hit or skin tears don't happen. ADON G stated the harm to the resident could be bumps or bruising.</p> <p>During an interview on 06/20/2024 at 3:16 p.m., the DON stated it was his responsibility to oversee the CNA's. The DON state the Hoyer lift was on a lose swivel and accidents do happen. The DON stated it was important for the CNAs to let the charge nurse or himself know if someone was injured with the Hoyer lift during transfers so the resident could be assessed. The DON stated the risk to the resident was skin tear or other injuries. The DON state he would try to get a different Hoyer lift.</p> <p>During an interview on 06/20/2024 at 4:42 p.m., the Administrator stated the responsibility of ensuring the CNAs are trained on the Hoyer lift transfer was the interdisciplinary between nurse management, treatment nurse and lead CNA. The Administrator stated it was important to use the Hoyer lift correctly to prevent injury. The Administrator stated the risk to the resident was my never want to get up. The Administrator stated she would monitor by check off.</p> <p>Record review of the facility's policy titled Hydraulic Lift indicated The resident will achieve safe transfer to bed or chair via a mechanical lift device.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47612</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 2 residents (Resident #69) reviewed for incontinence.</p> <p>The facility failed to ensure Resident #69 was provided proper incontinent care and catheter care.</p> <p>These failures could place residents at risk for urinary tract infections and a decreased quality of life.</p> <p>Findings Included:</p> <p>Record review of the face sheet, dated 06/18/2024, revealed Resident # 69 was an [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of acute cystitis with hematuria (blood cells in the urine, paraplegia, unspecified (paralysis that occurs in the lower half of the body), encephalopathy (damage or disease that affects the brain), pressure ulcer of sacral region, stage 4 ( the blood supply has been so severely cut off that the wound tunnels down through all layers of the skin and exposes bone).</p> <p>Record review of the MDS assessment, dated 04/25/2024, revealed Resident #69 had a BIMS score of 00, which indicated moderately cognitive impairment. The MDS revealed Resident #69 was always incontinent and had an indwelling catheter.</p> <p>Record review of the comprehensive care plan, revised on 06/4/2024, revealed Resident #69 was at risk for skin breakdown. The interventions included: incontinent care after each episode and apply moisture barrier. Resident # 69 has a indwelling catheter. The interventions included: catheter care provided.</p> <p>Record review of the order summary, revised on 06/4/2024, revealed Resident #69 foley catheter should be change as needed, revision date 05/29/2024 and to flush foley catheter with 60 ml sterile saline daily to prevent occlusion of catheter, start date 06/07/2024.</p> <p>During an interview on 06/18/2024 at 11:58 a.m., Resident #69's family member stated she had video of staff members not wearing PPE (personal protective equipment) while providing cares and not following guidelines for care.</p> <p>During an observation on 06/19/2024 at 9:00 a.m. of date stamped 05/08/2024 at 1:59 p.m., ring video with audio and visual revealed Resident #69 lying on left side in the bed. CNA D came into view on the video not following enhanced barrier and put on gloves, placed a clean brief under Resident#69, then turn Resident #69 to his back and clean the front groin area, then turned the resident back on to his left side and cleaned the buttock area, then removed solid items and applied clean brief. CNA D was not visualized changing gloves or performing hand hygiene during incontinent care. CNA N not following enhanced barrier precautions was seen in the video collecting solid items.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 06/19/2024 at 9:00 a.m. of date stamped 06/08/2024 at 9:58 a.m., ring video with audio and visual revealed Resident #69 lying on his back while LVN X not following enhanced barrier precautions (wearing gown and gloves to prevent infection) was performing catheter care when LVN X reached up to pull the curtain closed she was not wearing gloves.</p> <p>During an interview on 06/20/2024 at 2:41 p.m., CNA D stated she would have worn personal protective equipment during care. CNA D stated Resident #69 was completely incontinent, and she had to catch him when he wanted it done or he would refuse. CNA D stated during the video she was told that the incontinent care had already been previously completed but he still had bowel movement on him. CNA D stated you only have a short amount of time to complete incontinent care with the resident, and she did not bring extra supplies.</p> <p>During an interview on 06/20/2024 at 2:58 p.m., CNA N stated she had performed care on Resident # 69 several times and Resident # 69 can become combative. CNA N stated Resident # 69 likes her and she was able to calm him down. CNA N stated she feels Resident # 69 family member makes the situation worse. CNA N stated that was the first she had seen blood from the catheter.</p> <p>During an interview on 06/20/2024 at 3:16 p.m., the DON stated he expected staff to wear personal protective equipment during resident care. The DON stated he does not know why LVN X was not wearing personal protective equipment during resident care. The DON state it was important to wear the personal protective equipment during resident care to prevent infection. The DON stated he would make sure the staff was in serviced on enhanced barrier precautions and the appropriate personal protective equipment to wear during resident care.</p> <p>During an interview on 06/20/2024 at 4:42 p.m., the Administrator stated she expected staff to wear during resident care. The Administrator stated wear personal protective equipment was important for infection control. The Administrator stated the risk to the resident was infection.</p> <p>During an interview on 06/20/2024 at 4:51 p.m., LVN X stated she would have been wearing personal protective equipment during care. LVN X stated it was important to wear personal protective equipment during care to prevent cross contamination. LVN X stated the risk to Resident # 60 was infection.</p> <p>Record review of the facility's policy titled Perineal Care date 5/11/2022, indicated The procedure aims to maintain the resident dignity and self-worth and reduce embarrassment by providing cleanliness and comfort to the resident, preventing infections and skin irritation, and observing the resident's skin condition .</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47006</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure parenteral fluids were administered consistent with professional standards of practice and in accordance with physician orders for 1 of 1 (Resident #68) resident reviewed for intravenous fluids.</p> <p>The facility did not ensure LVN F followed the policy and procedure for Resident #68's PICC line (a long, thin tube that's inserted through a vein in your arm and passed through to the larger veins near your heart) when the patency was not assessed, and resistance was met during the 10 mL saline flush.</p> <p>This failure could place residents at risk for PICC line associated complications such as occlusion (blockage), thrombosis (blood clot), and infection.</p> <p>The findings included:</p> <p>Record review of the face sheet, dated 06/19/2024, revealed Resident #68 was a [AGE] year-old male who initially admitted to the facility on [DATE] with diagnosis of pneumonia (lung infection).</p> <p>Record review of the admission MDS assessment, dated 05/30/2024, revealed Resident #68 had clear speech and was understood by others. The MDS revealed Resident #68 was able to understand others. The MDS revealed Resident #68 had a BIMS score of 12, which indicated moderately impaired cognition. The MDS revealed Resident #68 received IV medications while a resident.</p> <p>Record review of the comprehensive care plan, revised 05/30/2024, revealed Resident #68 had IV access. The interventions included: administer IV medications as ordered, flush the ports/lines as ordered, and resident has PICC line IV access.</p> <p>Record review of the order summary report, dated 06/18/2024, revealed Resident #68 had the following orders:</p> <p>Flush IV line with 10 mL of normal saline before and after medication every shift, which started on 05/27/2024.</p> <p>Piperacillin Sod-Tazobactam Intravenous Solution (antibiotic) - Use 3.375 gram intravenously three times a day for pneumonia, which started on 05/30/2024.</p> <p>Record review of the MAR, dated June 2024, revealed Resident #68 received IV antibiotics at 7 AM, 1 PM, and 7 PM. The MAR further revealed Resident #68 received a 10 mL normal saline flush before and after medication.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Rock Creek Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  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.			
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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 06/18/2024 beginning at 1:02 PM, LVN F prepared Resident #68's 10 mL normal saline flush and attached it to the PICC line. LVN F did not check patency by drawing back on the syringe to check for blood. LVN F attempted to push the normal saline flush and met resistance. LVN F had to readjust Resident #68's arm, over approximately 5 minutes, and continued to meet resistance. LVN F was eventually able to flush the line. LVN F then proceeded to hang the IV medication and attached it to the PICC line. LVN F noticed the medication was not dripping so he had to adjust Resident #68's arm until the medication started dripping at a slow steady rate.</p> <p>During an interview on 06/18/2024 beginning at 1:38 PM, LVN F stated he noticed Resident #68's PICC line was not easily flushed earlier in the morning at 7 AM. LVN F stated Resident #68's PICC line had not been difficult to flush prior to that morning on 06/18/2024. LVN F said the protocol for PICC lines that were difficult to flush and had resistance was to notify the doctor. LVN F stated he had not notified the doctor. LVN F stated he was not allowed to draw blood through the PICC line, so he did not check the patency of the line by drawing back on the line for a blood return. LVN F stated he never checked for a blood return when using a PICC line. LVN F stated using the PICC line when resistance was noted could have indicated an occlusion. LVN F stated using a PICC line that was occluded could have caused a blood clot to break loose. LVN F stated he had received IV training, approximately in September of 2023. LVN F said he has worked with PICC lines before, but he did not work with often.</p> <p>During an interview on 06/18/2024 beginning at 1:47 PM, the DON stated IV competencies were completed on hire and annually. The DON stated he was unsure when the last in-service was completed but it had not been a full year since the last one. The DON stated the facility accepted patients with PICC lines, but the facility did not usually have a lot. The DON said Resident #68 admitted from the hospital with the PICC line in place. The DON said before a nurse attempted to flush a PICC line, blood should have been withdrawn to check patency. The DON said the PICC line should have been flushed with 10 mL of saline before and after use. The DON said the nurses were not supposed to use a PICC line if they met any resistance during the flush or medication administration. The DON stated LVN F should have stopped using the line and called the doctor if resistance was met. The DON said resistance during a flush could have indicated an occluded PICC line. The DON said using the PICC line with an occlusion could have caused a blood clot to break loose which could have caused a pulmonary embolism or CVA.</p> <p>During an interview on 06/18/2024 beginning at 3:30 PM the DON stated he checked on Resident #68's PICC line and it was flushing without issues and had a good blood return. The DON said he went ahead and notified the doctor with no new orders. The DON said the doctor said it was okay to continue to use the line. The DON stated he added to the IV flush order, which reminded the nurses to not use the line if resistance was met and to notify the doctor. The DON stated one-on-one training was completed with LVN F and other nursing staff members were in the process of completing in-service training on PICC lines.</p> <p>During an interview on 06/20/2024 beginning at 8:46 AM, the DON said the IV competencies included all forms of IV therapy including PICC lines. The DON stated the competencies were a hand on check off. The DON stated the training website recently updated their training, which included a training on IV lines. The DON stated LVN F completed the training on 06/18/2024.</p> <p>During an attempted interview on 06/20/2024 beginning at 4:06 PM to gather more information LVN F dropped the call and did not return the phone call upon exit of the facility.</p> <p>(continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/20/2024 beginning at 5:49 PM, the Administrator stated she expected the nursing staff to follow the policy regarding PICC lines. The Administrator stated nursing management was responsible for monitoring to ensure PICC line polices were followed. The Administrator stated it was important to ensure policies were followed for PICC lines to ensure residents were getting the medication appropriately through the IV.</p> <p>Record review of the licensed nurse proficiency audit, dated September 2023, revealed LVN F had been checked off and was satisfactory for IVN skills, which included initiating IV therapy, maintaining IV therapy, assessment, and proper documentation.</p> <p>Record review of the course completion history for infusion therapy: IV fluids; Management of IV devices, dated 06/18/2024, revealed LVN F completed the course.</p> <p>Record review of the Central Venous Catheters policy, undated, revealed 5. Blood Cannot Be Aspirated. If blood cannot be aspirated, the catheter may be kinked, clotted, or no longer in the venous system .The nurse will remove the injection caps and attempt to aspirate. If blood cannot be aspirated, infuse 10-20 mL of normal saline while assessing for swelling .Notify the physician if blood cannot be aspirated and interventions do not result in success .occlusion should be considered when it is difficult to infuse, flush, and/or aspirate the catheter. Partial obstruction manifests as resistance with flushing and/or absence of blood return with aspiration .the nurse will notify the physician immediately when occlusion of the line is suspected .</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>47006</p> <p>Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5 percent. There were 5 errors out of 26 opportunities, resulting in a 19.23 percent medication error rate for 2 of 5 residents reviewed for medication error. (Resident's #72 and #73)</p> <p>The facility did not ensure the following:</p> <ol style="list-style-type: none"> <li>1. Resident #72 was given Centrum Silver (Multiple Vitamins-Minerals) as ordered by the physician on 06/18/2024.</li> <li>2. Resident #72's losartan potassium (blood pressure medication) was not held for a diastolic blood pressure of 63, according to the ordered parameters of hold for diastolic blood pressure less than 90 on 06/18/2024.</li> <li>3. Resident #73's levetiracetam (anticonvulsant medication) and baclofen (muscle relaxer) were given late on 06/18/2024.</li> <li>4. Resident #73's nifedipine (blood pressure medication) was not held for a diastolic blood pressure of 84, according to the ordered parameters of hold for diastolic blood pressure less than 90 on 06/18/2024.</li> </ol> <p>These failures could place residents at risk for adverse reactions or ineffective dosage related to inaccurate drug administration.</p> <p>The findings included:</p> <ol style="list-style-type: none"> <li>1. During an observation on 06/18/2024 beginning at 8:02 AM, MA L obtained Resident #72's blood pressure. The blood pressure was 63 diastolic. MA L prepared Resident #72's medications for administration. MA L placed one tablet from a bottle of multivitamin into the medication cup. MA L placed one tablet from the card losartan potassium .hold for diastolic blood pressure less than 90 into the medication cup. MA L took Resident #72's medication into the room and he took them with a drink of water.</li> </ol> <p>Record review of the order summary report, dated 06/18/2024, revealed Resident #72 had the following orders:</p> <p>Centrum Silver Tablet (Multiple Vitamins-Minerals) - Give one tablet by mouth one time a day for vitamin supplement, which started on 03/04/2024.</p> <p>Losartan potassium oral tablet 100 mg - Give one tablet by mouth one time a day related to arrhythmias; Hold for diastolic blood pressure less than 90.</p> <p>Record review of the MAR, dated June 2024, revealed Resident #72 received centrum silver and losartan potassium daily.</p> <p>(continued on next page)</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. During an observation on 06/18/2024 beginning at 8:16 AM, MA K obtained Resident #73's blood pressure. The blood pressure was 84 diastolic. MA K prepared Resident #73's medication for administration. MA K placed one tablet from the care of levetiracetam (anticonvulsant medication) into the medication cup. MA K placed one tablet from the card nifedipine .hold for diastolic blood pressure less than 90 into the medication cup. MA K placed one tablet from the card baclofen into the medication cup. MA K took Resident #73's medication into the and she took them with a drink of water.</p> <p>Record review of the order summary report, dated 06/18/2024, revealed Resident #73 had the following orders:</p> <p>Baclofen 10 mg - give one tablet by mouth three times a day for muscle spasms, which started on 01/15/2024.</p> <p>Keppra (levetiracetam) 250 mg - give one tablet by mouth three times a day for seizures, which started on 06/15/2024.</p> <p>Nifedipine 30 mg - give one tablet by mouth one time a day .hold for diastolic blood pressure less than 90, which started on 02/02/2024.</p> <p>Record review of the MAR, dated June 2024, revealed Resident #73 received baclofen, Keppra, and nifedipine daily. The MAR further revealed baclofen and Keppra were scheduled for 7 AM.</p> <p>During an interview on 06/20/2024 beginning at 2:17 PM, MA K stated she had not realized Resident #73's blood pressure medication had a hold parameter for her diastolic blood pressure less than 90. MA K stated those were not the normal parameters and it should have been held for diastolic blood pressure less than 60. MA K stated if she had noticed a medication with a hold parameter outside of the normal, she should have notified the charge nurse so she could have clarified with the doctor. MA K stated Resident #73's Keppra and baclofen were scheduled for 7 AM. MA K stated you had an hour before and an hour after the scheduled time to administer the medication. MA K stated she administered Resident #73's medications late at times depending on what was going on at the facility. MA K stated it was important to ensure medication was given on time to ensure the residents received the effective dosages. MA K stated it was important to ensure medications were held according to the medication parameters to prevent adverse reactions. MA K stated given blood pressure medications outside the parameters could have caused the blood pressure to bottom out.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 06/20/2024 beginning at 2:21 PM, MA L stated she was unaware Resident #72's blood pressure medication had a hold parameter for his diastolic blood pressure less than 90. MA L stated those were not the normal parameters and it should have been held for a diastolic blood pressure less than 60. MA L stated she should have asked the nurse to clarify the orders with the doctor if the hold parameters were outside of the normal. MA L stated she had not notified the nurse because she was unaware of the parameters. MA L stated the order could have been changed and no one let her know. MA L stated most of the time if a resident has an order for centrum silver, they will administer the house stock or generic unless it was specifically said not to. MA L stated the order should have matched what was given. MA L stated she compared the card or bottle to the MAR during medication administration most of the time. MA L stated she had previous notified a charge nurse that the orders did not match but was unable to specify which charge nurse she had spoken to. MA L stated it was important to ensure medications were given according to the doctor's orders to prevent adverse reactions. MA L stated a blood pressure medication given outside the parameters could have caused Resident #72's blood pressure to drop.</p> <p>During an interview on 06/20/2024 beginning at 5:17 PM, the DON stated normal hold parameters for a diastolic blood pressure were less than 60 not less than 90. The DON stated those parameters for Resident #72 and Resident #73 were likely entered into the system incorrectly. The DON stated the medication aides were familiar with the parameters less than 60 they probably just overlooked it. The DON stated the doctor should have been notified to determine if the bottle of multivitamins could have been substituted with the bottle of Centrum Silver. The DON stated medications could have been given an hour before the scheduled time or an hour after the scheduled time. The DON stated he expected medications to have been given within the required timeframes. The DON stated it was important to administer medications how they were ordered by the physician because it could have affected absorption or the effectiveness of the medications. The DON stated not giving medications as prescribed by the doctor could have caused adverse effects.</p> <p>During an interview on 06/20/2024 beginning at 5:49 PM, the Administrator stated she expected the nursing staff to ensure the policy was followed for medication administration. The Administrator stated nursing management was responsible for monitoring to ensure medications were administered correctly. The Administrator stated it was important to ensure medications were administered per the doctors' orders to help with ailments the residents might have.</p> <p>Record review of the medication administration procedures policy, revised 10/25/2017, revealed .defining the schedules for administering medications to: maximize the effectiveness (optimal therapeutic effect) of the medication, prevent potential significant medication interactions such as medication-medication or medication-food interactions .the 10 rights of medication should always be adhered to: . right medication . right time .right assessment</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>47006</p> <p>Based on observation, interview, and record review the facility failed to ensure that residents were free of significant medication errors for 2 of 5 residents reviewed for medication administration. (Resident's #72 and #73)</p> <ol style="list-style-type: none"> <li>1. Resident #72's losartan potassium (blood pressure medication) was not held for a diastolic blood pressure of 63, according to the ordered parameters of hold for diastolic blood pressure less than 90 on 06/18/2024.</li> <li>2. Resident #73's levetiracetam (anticonvulsant medication) was given late on 06/18/2024.</li> <li>3. Resident #73's nifedipine (blood pressure medication) was not held for a diastolic blood pressure of 84, according to the ordered parameters of hold for diastolic blood pressure less than 90 on 06/18/2024.</li> </ol> <p>These failures could place the resident at risk of medical complications and not receiving the therapeutic effects of their medications.</p> <p>The findings included:</p> <ol style="list-style-type: none"> <li>1. During an observation on 06/18/2024 beginning at 8:02 AM, MA L obtained Resident #72's blood pressure. The blood pressure was 63 diastolic. MA L prepared Resident #72's medications for administration. MA L placed one tablet from the card losartan potassium .hold for diastolic blood pressure less than 90 into the medication cup. MA L took Resident #72's medication into the room and he took them with a drink of water.</li> </ol> <p>Record review of the order summary report, dated 06/18/2024, revealed Resident #72 had an order for Losartan potassium oral tablet 100 mg - Give one tablet by mouth one time a day related to arrhythmias; Hold for diastolic blood pressure less than 90.</p> <p>Record review of the MAR, dated June 2024, revealed Resident #72 received losartan potassium daily.</p> <ol style="list-style-type: none"> <li>2. During an observation on 06/18/2024 beginning at 8:16 AM, MA K obtained Resident #73's blood pressure. The blood pressure was 84 diastolic. MA K prepared Resident #73's medication for administration. MA K placed one tablet from the care of levetiracetam (anticonvulsant medication) into the medication cup. MA K placed one tablet from the card nifedipine .hold for diastolic blood pressure less than 90 into the medication cup. MA K took Resident #73's medication into the and she took them with a drink of water.</li> </ol> <p>Record review of the order summary report, dated 06/18/2024, revealed Resident #73 had the following orders:</p> <p>Keppra (levetiracetam) 250 mg - give one tablet by mouth three times a day for seizures, which started on 06/15/2024.</p> <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Nifedipine 30 mg - give one tablet by mouth one time a day .hold for diastolic blood pressure less than 90, which started on 02/02/2024.</p> <p>Record review of the MAR, dated June 2024, revealed Resident #73 received Keppra and nifedipine daily. The MAR further revealed the Keppra was scheduled for 7 AM.</p> <p>During an interview on 06/20/2024 beginning at 2:17 PM, MA K stated she had not realized Resident #73's blood pressure medication had a hold parameter for her diastolic blood pressure less than 90. MA K stated those were not the normal parameters and it should have been held for diastolic blood pressure less than 60. MA K stated if she had noticed a medication with a hold parameter outside of the normal, she should have notified the charge nurse so she could have clarified with the doctor. MA K stated Resident #73's Keppra was scheduled for 7 AM. MA K stated you had an hour before and an hour after the scheduled time to administer the medication. MA K stated she administered Resident #73's medications late at times depending on what was going on at the facility. MA K stated it was important to ensure medication was given on time to ensure the residents received the effective dosages. MA K stated it was important to ensure medications were held according to the medication parameters to prevent adverse reactions. MA K stated given blood pressure medications outside the parameters could have caused the blood pressure to bottom out.</p> <p>During an interview on 06/20/2024 beginning at 2:21 PM, MA L stated she was unaware Resident #72's blood pressure medication had a hold parameter for his diastolic blood pressure less than 90. MA L stated those were not the normal parameters and it should have been held for a diastolic blood pressure less than 60. MA L stated she should have asked the nurse to clarify the orders with the doctor if the hold parameters were outside of the normal. MA L stated she had not notified the nurse because she was unaware of the parameters. MA L stated the order could have been changed and no one let her know. MA L stated she compared the card or bottle to the MAR during medication administration most of the time. MA L stated it was important to ensure medications were given according to the doctor's orders to prevent adverse reactions. MA L stated a blood pressure medication given outside the parameters could have caused Resident #72's blood pressure to drop.</p> <p>During an interview on 06/20/2024 beginning at 5:17 PM, the DON stated normal hold parameters for a diastolic blood pressure were less than 60 not less than 90. The DON stated those parameters for Resident #72 and Resident #73 were likely entered into the system incorrectly. The DON stated the medication aids were familiar with the parameters less than 60 they probably just overlooked it. The DON stated medications could have been given an hour before the scheduled time or an hour after the scheduled time. The DON stated he expected medications to have been given within the required timeframes. The DON stated it was important to administer medications how they were ordered by the physician because it could have affected absorption or the effectiveness of the medications. The DON stated not giving medications as prescribed by the doctor could have caused adverse effects.</p> <p>During an interview on 06/20/2024 beginning at 5:49 PM, the Administrator stated she expected the nursing staff to ensure the policy was followed for medication administration. The Administrator stated nursing management was responsible for monitoring to ensure medications were administered correctly. The Administrator stated it was important to ensure medications were administered per the doctors' orders to help with ailments the residents might have.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the medication administration procedures policy, revised 10/25/2017, revealed .defining the schedules for administering medications to: maximize the effectiveness (optimal therapeutic effect) of the medication, prevent potential significant medication interactions such as medication-medication or medication-food interactions .the 10 rights of medication should always be adhered to: .right time .right assessment .</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43047</b></p> <p>Based on observations, interviews, and record review, the facility failed to ensure that all drugs and biologicals used in the facility were labeled in accordance with professional standards and were stored in a locked compartment and only accessible by authorized personnel for 2 of 24 residents (Residents #3 and #13) reviewed for medication storage.</p> <ol style="list-style-type: none"> <li>The facility did not ensure Resident #3's hydrocortisone cream (topical treatment for skin conditions) 1% was properly safe and secured.</li> <li>The facility did not ensure Resident #13's eye drops were properly safe and secured.</li> </ol> <p>This failure could place residents at risk for misuse of medication and overdose, adverse reactions of medications, and not receiving the therapeutic benefit of medications.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>Record review of the face sheet, dated 06/19/2024, indicated Resident #3 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included orthostatic hypotension (drop in blood pressure that occurs when moving from a laying down position to a standing position).</li> </ol> <p>Record review of the order summary report, dated 06/19/2024, indicated Resident #3 had an order, which started on 03/05/2024, for hydrocortisone cream 2.5%, apply to affected areas topically every 6 hours as needed for itching.</p> <p>Record review of the admission MDS assessment, dated 11/13/2023, indicated Resident #3 made herself understood and understood others. Resident #3 BIMS score was 13, which indicated her cognition was intact. Resident #3 had no behaviors or refusal of care.</p> <p>Record review of the comprehensive care plan, initiated on 12/05/2023, indicated Resident #3 had an ADL self-care performance deficit. The interventions included: assist x1 with personal hygiene as required.</p> <p>Record review of a self-medication program assessment of skills dated 06/20/2024 indicated Resident #3 was not able to self-administrate medications.</p> <p>During an observation and interview on 06/17/2024 at 11:03 a.m., Resident #3 was sitting in her wheelchair when surveyor observed a tube labeled hydrocortisone cream 1% on her nightstand in a caddy organizer. Resident #3 stated someone in the facility gave it to her. Resident #3 was unable to recall who that someone was. Resident #3 stated she used the medication for itching.</p> <p>During an observation on 06/18/2024 at 9:08 p.m., Resident #3 was lying in bed when surveyor observed a tube labeled hydrocortisone cream 1% on her nightstand in a caddy organizer.</p> <p>(continued on next page)</p>

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

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Record review of the face sheet dated 06/19/2024, indicated Resident #13 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included macular degeneration (eye disease that causes a gradual breakdown of cells to the part of the eye that controls the central vision).</p> <p>Record review of the order summary report, dated 06/19/2024, indicated did not indicate Resident #13 had an order for eye drops.</p> <p>Record review of the admission MDS assessment, dated 02/08/2024, indicated Resident #13 made herself understood and understood others. Resident #13 BIMS score was 15, which indicated her cognition was intact. Resident #13 had no behaviors or refusal of care.</p> <p>Record review of the comprehensive care plan, revised on 10/24/2023, indicated Resident #13 had impaired vision function. The interventions included: monitor/document/report to MD the following s/sx of acute eye problems: change in ability to perform ADLs, decline in mobility, sudden visual loss, pupils dilated, gray or milky, c/o halos around lights, double vision, tunnel vision, blurred or hazy vision.</p> <p>Record review of a self-medication program assessment of skills dated 06/20/2024 indicated Resident #13 was not able to self-administrate medications.</p> <p>During an observation and interview on 06/17/2024 at 11:11 a.m., Resident #13 was lying in bed when surveyor observed a bottle labeled equate dry eye relief on bedside table. Resident #13 stated she had macular degeneration in both eyes, and she instilled 2 drops into both eyes. Resident #13 stated she bought the medication herself.</p> <p>During an observation on 06/18/2024 at 9:09 a.m., Resident #13 was lying in bed when surveyor observed a bottle labeled equate dry eye relief on bedside table.</p> <p>During an observation, interview and record review on 06/20/2024 beginning at 9:42 a.m., LVN T observed the tube of hydrocortisone cream 1% on Resident #3's nightstand in a caddy organizer and observed a bottle that was labeled eye drops on Resident 13's bedside table. LVN T stated she did not know if they had an order to self-administrator. After reviewing their medical records, LVN T stated neither one of them had an order for the medications that was observed in their room. LVN T stated all staff were responsible for checking resident rooms to ensure safety. LVN T stated if a resident was able to self-administer an assessment must be completed and an order obtained prior to administration. LVN T stated it was important that medications were not left at bedside because others could ingest the medication or cause poison toxicity.</p> <p>(continued on next page)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/20/2024 at 3:11 p.m., the DON stated all staff were responsible for ensuring medications were storage appropriately. The DON stated ultimately the nurses were responsible for monitoring. The DON stated before a resident could keep medications at bedside a self-administer assessment must be completed. The DON stated if it was determined there are procedures that must be followed. The DON stated he monitored by routine checks to ensure compliance. The DON stated she had not noticed issues in the past with medications being stored at bedside. The DON stated if there an issue it was corrected immediately, and the physician was notified if an order was needed. The DON stated champion rounds were done every morning. The DON stated either MDS Coordinator A or B were responsible for rounds, but they had been out since 06/19/2024. The DON stated it was important to ensure medications were not let at bedside for resident safety and to ensure medications were administered properly.</p> <p>During an interview on 06/20/2024 at 3:44 p.m., the Administrator stated if the resident was not cognitive to administer medications, medication should not be stored at bedside. The Administrator stated all staff were responsible for monitoring to ensure medications were safely stored. The Administrator stated the nursing department were responsible for monitoring and overseeing. The Administrator stated it was important to ensure medications were not let at bedside so that it was administered properly.</p> <p>Record review of the facility's policy Recommended Medication Storage revised 07/2012 did not address medication storage.</p>		

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43047</b></p> <p>Based on interview and record review, the facility failed to ensure laboratory services were obtained to meet the needs of 2 of 24 residents (Residents #3 and #22) reviewed for laboratory services.</p> <p>The facility did not obtain a physician's ordered CBC (used to measure different parts and features of blood), CMP (test used to monitor the blood sugar levels, the balance of electrolytes and fluid as well as the health of kidneys and liver), lipids (levels of cholesterol and other fats in the blood), TSH (test used to measure hormone), T4 (test used to measure thyroxine in the blood) for Resident #3.</p> <p>The facility did not obtain a physician's ordered CBC (used to measure different parts and features of blood), CMP (test used to monitor the blood sugar levels, the balance of electrolytes and fluid as well as the health of kidneys and liver), lipids (levels of cholesterol and other fats in the blood), TSH (test used to measure hormone) for Resident #22.</p> <p>These failures could place residents at risk of not receiving lab services as ordered and not managing medications at a therapeutic level.</p> <p>Findings included:</p> <p>1. Record review of the face sheet, dated 06/19/2024, indicated Resident #3 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses which included hypothyroidism (underactive thyroid).</p> <p>Record review of the order summary report, dated 06/19/2024, indicated Resident #3 had an order, which was ordered on 11/29/2023, for CBC, CMP in January/April/July/</p> <p>October, Lipid panel, TSH, T4 in January/July.</p> <p>Record review of the admission MDS assessment, dated 11/13/2023, indicated Resident #3 made herself understood and understood others. Resident #3 BIMS score was 13, which indicated her cognition was intact. Resident #3 had no behaviors or refusal of care.</p> <p>Record review of the comprehensive care plan, initiated on 12/05/2023, indicated Resident #3 had hypothyroidism. The interventions included: obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated.</p> <p>Record review of Resident #3's electronic medical record indicated there was no results found for CBC, CMP, Lipids, TSH, and T4 for the month of January 2024 or April 2024.</p> <p>2. Record review of the face sheet, dated 06/19/2024, indicated Resident #22 was an [AGE] year-old female, admitted to the facility on [DATE] with diagnoses which included hypertension (high blood pressure).</p> <p>(continued on next page)</p>		

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the order summary report, dated 06/20/2024, indicated Resident #22 had an order, which was revised on 04/22/2024, for CBC, CMP in January/April/July/October and TSH, Lipid in January/July.</p> <p>Record review of the admission MDS assessment, dated 08/14/2023, indicated Resident #22 made herself understood and understood others. Resident #22 BIMS score was 15, which indicated her cognition was intact. Resident #22 had no behaviors or refusal of care.</p> <p>Record review of the comprehensive care plan, revised on 02/19/2024, indicated Resident #3 had the potential fluid deficit related to Lasix (diuretic use). The interventions included: obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated.</p> <p>Record review of Resident #22's electronic medical record revealed CBC, TSH, CMP and Lipid results obtained on 08/09/2023. There were no results found for the month of October 2023, January 2024 and April 2024.</p> <p>During an interview on 06/20/2024 at 1:39 p.m., ADON G stated prior to surveyor intervention the floor nurses were responsible for pulling the lab results daily. ADON G stated her, and the DON were responsible for putting orders in PCC and completing the lab requisition when the resident was admitted , or changes were needed. ADON G stated her, and the DON were responsible for monitoring and overseeing by reviewing the charts quarterly. ADON G stated there had been issues in the past with labs and an audit was completed back in April 2024. ADON G stated there were several residents who quarterly labs were not completed. ADON G stated after the audit was completed, she (ADON) went and wrote brand new lab requisition for everyone. ADON G stated honestly, she did not know how Resident #3, and #22 labs were missed. ADON G stated after speaking with the MD he would like the CBC and CMP every 3 months and the TSH and Lipid panel should have been discontinued after the last results because she was not those medications. ADON G stated the processed the facility currently have in placed for monitoring labs will be revamped to ensure admission or quarterly labs were not missed. ADON G stated this failure could potentially put residents at risk for toxicity of certain medications and worsening of health condition.</p> <p>During an interview on 06/20/2024 at 3:11 p.m., the DON stated an audit was completed back in April 2024 to ensure that everyone that needed a lab had an order. The DON stated what was not done was to ensure the lab was drawn 100%. The DON stated moving forward the ADON or designee will monitor lab system and ensure a complete lab audit of all residents was completed in timely manner. The DON stated the ADON, or designee would monitor the draw report on the website weekly to ensure all ordered labs were collected and results were reported to MD to review. The DON stated this failure could potentially be critical and life threatening.</p> <p>During an interview on 06/20/2024 at 3:44 p.m., the Administrator stated she expected labs to be drawn per scheduled. The Administrator stated the nursing management (DON/ADON) were responsible for monitoring and overseeing. The Administrator stated it was important to ensure labs were drawn as scheduled so residents get the medications that was needed.</p> <p>Record review of the facility's undated policy titled Physician's Orders indicated . to monitor and ensure the accuracy and completeness of the medication orders, treatment orders, and ADL order for each resident .</p> <p>(continued on next page)</p>		

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/20/2024 at 5:36 p.m., the Administrator stated there was not a policy and procedure regarding lab monitoring.</p>		

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<p>F 0803</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>30527</p> <p>Based on observation, interviews, and record review, the facility failed to ensure the meals served to residents met the nutritional needs of residents for 1 of 1 meal (the lunch meal), as evidenced by:</p> <p>The facility failed to ensure [NAME] F followed the recipe for pureeing the hamburger beef patties for the lunch meal on 06/18/2024.</p> <p>This failure could place residents at risk for weight loss, not having their nutritional needs met, and a decreased quality of life.</p> <p>Findings included:</p> <p>During record review of a facility menu titled Creative: Week 3 - dated 06/18/2024, indicated the pureed menu for the day was hamburger steak, baked potatoes, sauteed broccoli, honey kissed roll, margarine, sour cream, pistachio fluff, and iced tea.</p> <p>During an observation and interview on 06/18/2024 at 11:38 a.m., [NAME] U prepared the pureed meal for the residents. [NAME] U said she sometimes followed a recipe when she pureed food, but she did not have one that day. [NAME] U had 5 beef hamburger patties in the blender. [NAME] U said she had 6 residents who received pureed meals. [NAME] U said if the food in the blender became runny, she added a small amount of thickener. [NAME] U took the blender and emptied the mixture into a metal pan on the steam table. [NAME] U said she was aware the recipe had instructions on preparing pureed meals, but she did not have a copy of the recipe. [NAME] U said the Dietary Manager was unable to print the recipe because the computer was not working. The Dietary Manager did not provide [NAME] U with a copy of the recipe with the instructions to prepare the pureed meal. [NAME] U said she watched the consistency of the food until it looked to be the consistency of baby food. [NAME] U then placed the mixture in a pan on the serving line. [NAME] U said following the menu and recipe for meals was important to maintain the nutrient value of the food and to maintain resident weights.</p> <p>During an interview on 06/20/2024 at 02:15 p.m., the Dietary Manager said she normally printed off the menu and pureed recipes for the cooks to use daily. The Dietary Manager said she had not printed them off for the lunch menu on 06/18/2024 because the computer was not working properly. The Dietary Manager stated it was important to follow the menus and recipes, so residents received the correct amount of food, and the nutrient value of the food did not decrease.</p> <p>During an interview on 06/20/2024 at 03:52 p.m., the ADM stated she expected dietary staff to follow the menu and the recipes for pureed food. The ADM stated she expected the Dietary Manager to ensure recipes were printed for each meal. The ADM stated the importance of following the recipe was to ensure residents had the appropriate nutrients.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Record review of the Dietary Services policy, last revised on 2012 indicated, .Fundamental Information: A preplanned menu is provided to the facility, which has been planned or reviewed by a Registered Dietitian and includes meals that are adequate to meet the average resident's nutritional needs. The policy did not address following pureed recipes or preparing pureed meals.</p>

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47612</p> <p>Based on observation, interview and record review, the facility failed to ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs for 3 of 37 residents (Resident #54, # 41 and #76) reviewed for food form in that:</p> <ol style="list-style-type: none"> <li>1.The facility did not ensure Resident #54 had diet orders or received meals that addressed her potential for malnutrition.</li> <li>2. The facility did not ensure Resident #41 was given double protein portion as ordered by the physician.</li> <li>3. The facility did not ensure Resident #76 chicken parmesan was chopped as ordered by the physician.</li> </ol> <p>This failure could place residents at risk of not receiving food to meet their needs.</p> <p>Findings Included:</p> <p>1.Record review of the face sheet, dated 06/20/2024, revealed Resident # 54 was an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of major depressive disorder (a persistently low or depressed mood), hypothyroidism ( a common condition where the thyroid does not create or release enough thyroid hormone into your bloodstream), anxiety disorder ( a condition in which a person has excessive worry and feelings of fear, dread and uneasiness.</p> <p>Record review of the order summary report, dated 06/11/2024, revealed Resident #54 orders does not address her diet.</p> <p>Record review of the MDS assessment, dated 06/05/2024, revealed Resident #54 made herself understood and understood others. The assessment indicated Resident #54 BIMS score was 15, which indicated her cognition was intact. The assessment indicated Resident #54 had no behaviors or refusal of care. The assessment indicated Resident #54 did have a weight loss of 5%. The assessment did not address Resident #54's diet.</p> <p>Record review of the comprehensive care plan, revised on 06/13/2024, indicated Resident #54 had a potential for malnutrition. The interventions included: monitor resident's weight, offer diet as ordered by the physician and update food preferences as needed.</p> <p>During an observation on 06/17/2024 at 12:38 p.m., Resident #54 received a single serving of the entree which was pot roast.</p> <p>During an interview and observation on 06/17/2024 at 12:40 p.m., ADON O was asked by the surveyor if Resident #54 entree was considered a large portion. ADON stated, she was not sure she would have to check with the cook.</p> <p>(continued on next page)</p>		

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 06/20/2024 at 1:06 p.m., [NAME] P stated he did not work on 06/17/2024. [NAME] P stated Resident #54 should have gotten one-and a half piece of meat. [NAME] P stated it was the cook, Dietary Manager, and nursing staff responsibility to make sure the trays were correct before serving residents. [NAME] P stated this failure could potentially put residents at risk for weight loss.</p> <p>During an interview on 06/20/2024 at 1:26 p.m., the Dietary Manager stated she expected physician orders to be followed. The Dietary Manager stated Resident #54 should have received one and a half pieces of meat for a large portion of protein. The Dietary Manager stated if Resident #54 does not receive the correct portion it could put her at risk for weight loss. The Dietary Manager stated she would monitor as the staff fixed the residents plates.</p> <p>During an interview on 06/20/2024 at 3:16 p.m., the DON stated nurses were responsible for checking food trays prior to giving them out to residents. The DON stated it was important for Resident #54 to receive the ordered portion. The DON stated Resident #54 was on supplements for weight loss due to her disease process. The DON stated the risk to the resident was decrease in protein and weight loss.</p> <p>During an interview on 06/20/2024 at 4:42 p.m., the Administrator stated she expected dietary staff to follow the physician orders. the Administrator stated she expected the food trays to be checked and residents to receive the correct diet. The Administrator stated it was important for residents to receive the correct diet order because it contribute to their overall care and health. The Administrator stated the dietary and nursing were responsible for monitoring and overseeing.</p> <p>2. Record review of the face sheet, dated 06/19/2024, indicated Resident #41 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included unspecified fracture of lower end of right femur.</p> <p>Record review of the order summary report, dated 06/19/2024, indicated Resident #41 had an order, which started on 03/16/2024, for regular diet regular texture, regular consistency, double protein portions at every meal.</p> <p>Record review of the admission MDS assessment, dated 03/22/2024, indicated Resident #41 made herself understood and understood others. The assessment indicated Resident #41 BIMS score was 13, which indicated her cognition was intact. The assessment indicated Resident #41 had no behaviors or refusal of care. The assessment indicated Resident #41 did not have weight loss of 5%. The assessment did not address Resident #41's diet.</p> <p>Record review of the comprehensive care plan, revised on 05/28/2024, indicated Resident #41 had a potential for malnutrition. The interventions included: monitor resident's weight, offer diet as ordered by the physician and update food preferences as needed.</p> <p>During an observation on 06/17/2024 at 12:38 p.m., Resident #41 received a single serving of the entree which was pot roast.</p> <p>During an interview and observation on 06/17/2024 at 12:39 p.m., ADON O was asked by the surveyor if Resident #41 entree was considered double. ADON stated, no and took the tray back to the kitchen to request for another serving of protein.</p> <p>(continued on next page)</p>		

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. Record review of the face sheet, dated 06/19/2024, indicated Resident #76 was a [AGE] year-old female originally admitted to the facility on [DATE] with diagnoses which included malignant neoplasm (cancerous tumor) of unspecified part of unspecified bronchus (extension of the trachea).</p> <p>Record review of the order summary report, dated 06/19/2024, indicated Resident #76 had an order, which started on 02/26/2024, for regular diet regular texture, regular consistency, chopped meat.</p> <p>Record review of the admission MDS assessment, dated 02/08/2024, indicated Resident #76 made herself understood and understood others. The assessment indicated Resident #76 BIMS score was 15, which indicated her cognition was intact. The assessment indicated Resident #76 had no behaviors or refusal of care. The assessment indicated Resident #76 did not have weight loss of 5%. The assessment did not address Resident #76's diet.</p> <p>Record review of the comprehensive care plan, revised on 02/19/2024, indicated Resident #76 had a potential for malnutrition. The interventions included: monitor resident's weight, offer diet as ordered by the physician and update food preferences as needed.</p> <p>During an observation on 06/17/2024 at 12:35 p.m., Resident #76 received small, cubed pieces of chicken parmesan.</p> <p>During an interview and observation on 06/17/2024 at 12:36 p.m., ADON O was asked by the surveyor if Resident #76 entree was considered chopped. ADON stated, no, it's cubed and took the tray back to the kitchen to request for meat to be chopped.</p> <p>During an interview on 06/20/2024 at 1:06 p.m., [NAME] P stated he did not work on 06/17/2024 but the chicken should have been served chopped instead of cubed. [NAME] P stated when a meat was chopped it should be between cubed and mechanical. [NAME] P stated a knife was used to chop up the meat. [NAME] P stated Resident #41 should have gotten double serving instead of single. [NAME] P stated it was the cook, Dietary Manager and nursing staff responsibility to make sure the trays were correct. [NAME] P stated ultimately the nursing department were responsible for ensuring the trays were correct before serving a resident. [NAME] P stated this failure could potentially put residents at risk for choking and weight loss.</p> <p>During an interview on 06/20/2024 at 1:26 p.m., the Dietary Manager stated the cook should have chopped the meat with a knife prior to handing the tray to the nursing staff. The Dietary Manager stated Resident #41 should have gotten double portions. The Dietary Manager stated she expected physician orders to be followed. The Dietary Manager stated the cook, herself and the nursing department were responsible for checking the trays prior to serving the residents. The Dietary Manager stated usually when the cook started to fix the residents plate, she was there to monitor and oversee. The Dietary Manager stated every now and then she would catch a tray incorrect and have the staff to redo the tray. The Dietary Manager stated staff were verbally in-serviced immediately. The Dietary Manager stated this failure could put residents at risk for choking and weight loss.</p> <p>(continued on next page)</p>		

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 06/20/2024 at 3:11 p.m., the DON stated nurses were responsible for checking food trays prior to giving them out to residents. The DON stated #76 patty should have been cut up in smaller pieces. The DON stated it was chopped but not finely. The DON stated Resident #41 should have gotten double protein serving. The DON stated when he checked the trays on 06/17/2024 he thought they were correct. The DON stated, I can't catch everything. The DON stated this failure could put residents at risk for difficulty chewing/swallowing, decrease in protein and weight loss.</p> <p>During an interview on 06/19/2024 at 3:44 p.m., the Administrator stated she expected the food trays to be checked and residents to receive the correct diet. The Administrator stated it was important for residents to receive the correct diet order because it contribute to their overall care and health. The Administrator stated the dietary and nursing were responsible for monitoring and overseeing.</p> <p>Record review of the facility's undated policy titled Resident Menus indicated, we will strive to assure the resident's nutritional needs are provided based on the RDA. The standard menu will ensure nutritional adequacy of all diets, offer a variety of food in adequate amounts at each meal, and standardize food production . 5. The Dietary Service Manager and cooks are trained and responsible for the preparation and service of therapeutic diets as prescribed .</p> <p>Record review of the facility's undated policy titled Physician's Orders indicated . to monitor and ensure the accuracy and completeness of the medication orders, treatment orders, and ADL order for each resident .</p> <p>Record review of the facility's undated policy titled Diet Order/Diet Manual did not address chopped or double portions diet.</p> <p>43047</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>30527</p> <p>Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in the facility's only kitchen.</p> <p>The facility did not ensure:</p> <ol style="list-style-type: none"> <li>1. Sanitization buckets were at the appropriate sanitization level on 06/17/2024.</li> <li>2. DA V failed to wear a hair net while in the kitchen on 06/18/2024.</li> </ol> <p>These failures could place residents at risk of cross-contamination and foodborne illness.</p> <p>Findings included:</p> <p>During an observation and interview on 06/17/2024 at 10:10 a.m., the sanitation bucket was located on the bottom of the food preparation and serving area. The bucket was filled approximately 1/3 of the way with a brownish clear liquid and small debris floating on top. The test strip was performed and revealed no sanitizer was in the liquid inside the bucket. [NAME] U stated she had prepared the bucket earlier and the sanitation strip tested at 400. [NAME] U said the purpose of the sanitizer in the sanitation bucket testing at the appropriate level was to prevent the spread of bacteria.</p> <p>During an observation and interview on 06/18/2024 at 11:38 a.m., DA V entered the kitchen without a hair net. DA V stated he had always entered the kitchen without a hairnet to retrieve a hair net from the inside of the kitchen because the hairnets located at the kitchen's entryway did not contain his hair well enough. DA V stated the purpose of the hairnet was to prevent cross contamination and hair in the resident's food.</p> <p>During an interview on 06/20/2024 at 02:15 p.m., Dietary Manager said that she went behind the staff to ensure that the kitchen was being cleaned and everyone was doing the tasks as assigned. The Dietary Manager said she expected the dietary staff to check the sanitation levels in the sanitation buckets appropriately. The Dietary Manager said she expected all dietary staff to wear hair nets at all times. The Dietary Manager stated the purposes of appropriate sanitation levels and wearing hairnets was to prevent cross contamination and provide a sanitary cooking environment.</p> <p>During an interview on 06/20/2024 at 2:24 p.m., Administrator said she expected the Dietary Manager to check behind the staff to ensure that these tasks were completed efficiently. The Administrator said that she expected the kitchen to promote cleanliness and provide a healthy environment for the residents and prevent cross contamination.</p> <p>(continued on next page)</p>		

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F 0812  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	Record review of the Record review of the Dietary Services policy, last revised on 2012 indicated, .Infection Control: 8. Sanitation of food preparation surfaces A. All kitchenware and food contact surfaces will be cleaned and sanitized after each use. B. Fresh cloths and sanitizer will be used for cleaning all surfaces. Sanitizer will be minimum of 100 ppm chlorine or 25 ppm iodine or 150 - 440 ppm quaternary ammonia - tested using		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47006</b></p> <p>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 6 residents (Resident #68) reviewed for enhanced barrier precautions, 2 of 2 residents (Resident's #21 and #23) reviewed for respiratory care, 1 of 2 residents (Resident #69) reviewed for wound care, and 1 of 2 residents (Resident #2) reviewed for infection control practices with ADLs .</p> <ol style="list-style-type: none"> <li>The facility did not ensure LVN F wore enhanced barrier precautions while administering IV medications through Resident #68's PICC line.</li> <li>The facility did not ensure CNA C and CNA D did not contaminate clean linens with soiled linens while providing assistance with ADLs for Resident #2.</li> <li>The facility did not ensure Resident #21, and Resident #23 were tested for the flu or COVID-19 when they developed signs and symptoms.</li> <li>The facility failed to ensure Resident #69 was provided proper wound care.</li> </ol> <p>These failures could place residents and staff at risk for cross contamination and the spread of infection.</p> <p>The findings included:</p> <ol style="list-style-type: none"> <li>Record review of the face sheet, dated 06/19/2024, revealed Resident #68 was a [AGE] year-old male who initially admitted to the facility on [DATE] with diagnosis of pneumonia (lung infection).</li> </ol> <p>Record review of the admission MDS assessment, dated 05/30/2024, revealed Resident #68 had clear speech and was understood by others. The MDS revealed Resident #68 was able to understand others. The MDS revealed Resident #68 had a BIMS score of 12, which indicated moderately impaired cognition. The MDS revealed Resident #68 received IV medications while a resident.</p> <p>Record review of the comprehensive care plan, revised 05/30/2024, revealed Resident #68 had IV access and was on enhanced barrier precautions. The interventions included: gloves and gown should be donned if any of the following activities are to occur: linen change, resident hygiene, transfer, dressing, toileting/incontinent care, bed mobility, wound care, enteral feeding care, catheter care, trach care, bathing, or other high-contact activity.</p> <p>During an observation on 06/18/2024 beginning at 1:02 PM, LVN F prepared and administered medication through Resident #68's PICC line. LVN F did not wear a gown while he was performing care with the PICC line.</p> <p>During an attempted interview on 06/20/2024 beginning at 4:06 PM to gather more information LVN F dropped the call and did not return the phone call upon exit of the facility.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Record review of the face sheet, dated 06/19/2024, revealed Resident #2 was an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of cerebrovascular disease (an umbrella term for conditions that impact the blood vessels in your brain), anxiety disorder (group of mental illnesses that cause constant fear and worry), flaccid hemiplegia affecting right dominant side (severe or complete loss of motor function on one side of the body), and obesity (condition characterized by abnormal or excessive fat accumulation).</p> <p>Record review of the quarterly MDS assessment, dated 05/16/2024, revealed Resident #2 had unclear speech and was usually understood by staff. The MDS revealed Resident #2 was usually able to understand others. The MDS revealed Resident #2 had a BIMS score of 14, which indicated no cognitive impairment. The MDS revealed Resident #2 had an impairment of one side to the upper extremities and lower extremities. The MDS revealed Resident #2 was dependent on staff assistance for toilet hygiene and transfers.</p> <p>Record review of the comprehensive care plan, revised on 10/24/2023, revealed Resident #2 had an ADL self-care performance deficit and required staff assistance with transfers and toileting.</p> <p>During an observation on 06/17/2024 beginning at 10:46 AM, CNA C and CNA D provided incontinent care to Resident #2. After incontinent care was finished, CNA C left the soiled linen under Resident #2 and placed the clean mechanical lift pad, clean incontinent brief, and pulled up Resident #2's clean pants. CNA D rolled Resident #2 and finished pulling the clean linen to lay on top of the dirty linen. CNA C and CNA D then attached the Hoyer lift pad to the Hoyer lift and placed Resident #2 in her wheelchair.</p> <p>During an interview on 06/20/2024 beginning at 2:01 PM, CNA C stated she should have made sure the soiled linen was removed before the clean linen was placed on Resident #2. CNA C stated she did not normally place clean linen on top of dirty linen, but she was nervous. CNA C stated it was important to make sure the soiled linen was removed before clean linens were placed to prevent cross contamination and infections.</p> <p>During an interview on 06/20/2024 beginning at 2:41 PM, CNA D stated she should have made sure the soiled linen was removed before placing the clean linens on top during care with Resident #2. CNA D stated clean linen was not supposed to come into contact with soiled linen. CNA D stated it was important to ensure soiled linen was removed before clean linens were placed for infection control.</p> <p>3. Record review of the face sheet, dated 06/20/2024, revealed Resident #23 was an [AGE] year-old female who initially admitted to the facility on [DATE] with diagnosis of unspecified dementia without behaviors (group of symptoms affecting memory, thinking and social abilities that interferes with daily life) and developed a diagnosis of acute upper respiratory infection on 04/08/2024. The face sheet revealed Resident #23 resided on Hall 5.</p> <p>Record review of the quarterly MDS assessment, dated 03/25/2024, revealed Resident #23 had clear speech and was sometimes understood by others. The MDS revealed Resident #23 was sometimes able to understand others. The MDS revealed Resident #23 had a BIMS score of 13, which indicated no cognitive impairment. The MDS revealed Resident #23 had inattention and disorganized thinking. The MDS revealed Resident #23 had delusions. The MDS revealed Resident #23 had acute respiratory failure with hypoxia and a history of the flu.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the comprehensive care plan, initiated 12/28/2023, revealed Resident #23 declined the flu vaccination. The care plan further revealed Resident #23 had a respiratory infection on 04/06/2024. The care plan further revealed Resident #23 was at risk for signs and symptoms of COVID-19. The interventions included: observe for signs and symptoms of COVID-19, document and promptly report signs or symptoms of: fever, coughing, sneezing, sore throat, respiratory issues.</p> <p>Record review of the order recap report, dated 03/01/2024 to 06/20/2024, revealed Resident #23 had an order which started on 04/06/2024 for azithromycin (antibiotic) and a Medrol dose pack (steroids) for an upper respiratory infection. The order recap further revealed an x-ray was ordered for cough and congestion.</p> <p>Record review of the MAR, dated April 2024, revealed Resident #23 received azithromycin (antibiotic) and Medrol dose pack for an upper respiratory infection.</p> <p>Record review of the progress note, dated 04/06/2024, revealed Resident #23 was congested and had a cough with yellow sputum. The note further revealed Resident #23 was wheezing, and the doctor ordered medications and a chest x-ray.</p> <p>Record review of the SBAR (assessment used to notify the physician when a resident has a change of condition) assessment, accessed on 06/20/2024, revealed an SBAR assessment had not been completed on 04/06/2024, when Resident #23 developed a cough and congestion.</p> <p>Record review of the Respiratory Screen assessment, accessed on 06/20/2024, revealed a respiratory screen had not been completed on 04/06/2024, when Resident #23 developed a cough and congestion.</p> <p>Record review of the electronic health record, accessed on 06/20/2024, did not indicate any laboratory testing was performed on Resident #23 to include COVID-19 testing or influenza testing.</p> <p>4. Record review of the face sheet, dated 06/20/2024, revealed Resident #21 was a [AGE] year-old female who admitted to the facility on [DATE] with a diagnosis of pneumonitis due to inhalation of food and vomit (inflammation of lung tissue due to non-infectious causes, which results in cough without mucus or phlegm, shortness of breath and fatigue), fracture of right femur (right hip fracture), and acute postprocedural respiratory failure. The face sheet further revealed Resident #21 resided on Hall 5.</p> <p>Record review of the quarterly MDS assessment, dated 05/21/2024, revealed Resident #21 had clear speech and was understood by others. The MDS revealed Resident #21 was able to understand others. The MDS revealed Resident #21 had a BIMS score of 10, which indicated moderately impaired cognition. The MDS revealed Resident #21 had no behaviors or refusal of care.</p> <p>Record review of the comprehensive care plan, revised 02/23/2024, did not address Resident #21's history of acute upper respiratory infection.</p> <p>Record review of the order recap report dated 04/01/2024 - 06/20/2024, revealed Resident #21 had an order which started on 04/17/2024 for a chest x-ray for cough. The order recap report further revealed an order, which started on 04/18/2024 for azithromycin (antibiotic) and Medrol dose pack (steroids) for an upper respiratory infection.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the MAR, dated April 2024, revealed Resident #21 received azithromycin and Medrol dose pack for an upper respiratory infection.</p> <p>Record review of the progress notes dated 03/20/2024 - 04/20/2024, revealed no entries for 04/17/2024. The progress note dated 04/18/2024, revealed Resident #21's chest x-ray results were negative for pneumonia. The doctor was notified of Resident #21's continued symptoms of productive cough and congestion. The doctor ordered azithromycin and Medrol dose pack.</p> <p>Record review of the SBAR assessment, dated 04/17/2024, revealed Resident #21 had a respiratory change and suspected infection. The SBAR revealed Resident #21 had cold/flu like symptoms which included nasal congestion, dry cough, new or increased cough, and new or increased shortness of breath, which started on 04/16/2024. The SBAR suggested an x-ray and the doctor was notified on 04/17/2024.</p> <p>Record review of the respiratory infection nurses' note, dated 04/18/2024, revealed Resident #21 had nasal congestion and a sore throat.</p> <p>Record review of the respiratory infection nurses' note, dated 04/19/2024, revealed Resident #21 had nasal congestion, fatigue, fever, and cough.</p> <p>Record review of the electronic health record, accessed on 06/20/2024, did not indicate any laboratory testing was completed on Resident #21 to include COVID-19 or influenza testing.</p> <p>During an attempted interview on 06/20/2024 beginning at 4:06 PM to gather more information LVN F dropped the call and did not return the phone call upon exit of the facility.</p> <p>During an attempted interview on 06/20/2024 beginning at 3:14 PM to gather more information LVN M did not answer the telephone or return the call upon exit of the facility.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 06/20/2024 beginning at 4:21 PM, ADON G stated she believed enhanced barrier precautions were stupid and ridiculous and just another way for the government to earn money. ADON G stated enhanced barrier precautions were required for any residents with an indwelling device. ADON G stated LVN F should have worn enhanced barrier precautions while providing care to Resident #68's PICC line. ADON G stated the nursing staff has had training on enhanced barrier precautions. ADON G stated it was important for staff to ensure they wore enhanced barrier precautions while providing care to not transfer bacteria to the patients. ADON G stated it was important to protect the staff and other residents from the spread of infection. ADON G stated staff should not have placed clean linen on top of soiled linen. ADON G stated she monitored infection control practices during ADL care during checks off or random observations. ADON G stated she had observed staff putting clean linen on top of dirty linens a few times but had not recently. ADON G stated it was important to ensure infection control practices were followed during ADL care so there was no transfer of bacteria from bodily fluids. ADON G stated the signs and symptoms of COVID-19 were similar to other respiratory infections. ADON G stated the signs and symptoms were fever, cough, loss of taste/smell, body pains, and sore throat. ADON G stated if residents had signs or symptoms of COVID-19 or the flu, she would have contacted the doctor to let him decide if testing was required. ADON G stated the facility no longer tested for COVID-19. ADON G stated the facility almost always obtained a chest x-ray. ADON G stated flu testing should have been completed for residents with signs or symptoms of the flu, especially during flu season. ADON G stated Resident #21 and Resident #23 were not tested for COVID-19. ADON G stated Resident #21 might have been tested for the flu but did not believe Resident #23 was tested for the flu . ADON G stated it was the company policy related to the changes with the CDC to no longer automatically jump to COVID-19 testing when symptoms were present.</p> <p>During an interview on 06/20/2024 beginning at 5:15 PM, ADON G stated Resident #21 was not tested for the flu.</p> <p>During an interview on 06/20/2024 beginning at 5:17 PM, the DON stated enhanced barrier precautions should have been used while dealing with a PICC line. The DON stated he expected the nursing staff to utilize the enhanced barrier precautions. The DON stated he was responsible for monitoring to ensure staff were using the enhanced barrier precautions while providing care. The DON stated it was important to use the enhanced barrier precautions for high-risk residents to prevent the spread of multi-drug resistant organisms that could have caused infections. The DON stated he expected nursing staff to ensure infection control practices were followed while providing assistance with ADLs. The DON stated the CNAs, charge nurses, the DON were responsible for monitoring to ensure infection control practices were followed. The DON stated it was important to make sure clean linens were not placed on soiled linen for infection control. The DON stated CDC guidelines were what was followed by the facility for COVID-19 and flu testing. The DON stated the facility did not automatically perform COVID-19 testing when a resident had signs or symptoms. The DON stated an SBAR should have been completed for a change of condition and the doctor should have been notified. The DON stated Resident #21 and Resident #23 were not COVID-19 or flu tested . The DON stated looking back COVID and flu testing should have been performed to ensure respiratory infections did not spread .</p> <p>During an interview on 06/20/2024 beginning at 5:49 PM, the Administrator stated she expected the nursing staff to follow the policy regarding infection control practices. The Administrator stated nursing management and the IDT were responsible for monitoring to ensure infection control policies were followed. The Administrator stated it was important to ensure infection control policies were followed to reduce the spread of infections.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>47612</p> <p>5.Record review of the face sheet, dated 06/18/2024, revealed Resident # 69 was an [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of acute cystitis with hematuria (blood cells in the urine, paraplegia, unspecified (paralysis that occurs in the lower half of the body), encephalopathy (damage or disease that affects the brain), pressure ulcer of sacral region, stage 4 ( the blood supply has been so severely cut off that the wound tunnels down through all layers of the skin and exposes bone).</p> <p>Record review of the MDS assessment, dated 05/19/2024, revealed Resident #69 had a BIMS score of 00, which indicated moderately cognitive impairment. The MDS revealed Resident #69 was dependent with two persons assist. The MDS indicated Residents # 69 had a stage 4 pressure ulcer. The MDS indicated Residents # 69 had rejected care.</p> <p>Record review of the comprehensive care plan, revised on 06/4/2024, revealed Resident #69 was at risk for skin breakdown. The interventions revealed Resident #69 frequently refused wound care and the use of a wedge for offloading pressure to promote wound healing.</p> <p>Record review of the order summary, revised on 04/12/2024, revealed Resident #69 special instructions for enhanced barrier precautions, cleanse right Ischium with normal saline, apply calmoseptine to periwound, apply medihoney, apply alginate, cover with dry dressing, start date 05/29/2024.</p> <p>During an interview on 06/18/2024 at 11:58 a.m., Resident #69's family member stated Resident #69 was currently in the hospital with a bone infection in his hip that has no chance of recovery according to the hospital. Resident #69's family member stated the facility staff block his camera in the room when providing care and was unable to see. Resident # 69 family member stated his wound progressively became worse. Resident # 69 family member stated the wound care nurse quit the facility 2 months ago and the facility said the nurses could perform the wound care and she feels they have not been trained properly. Resident #69's family member stated the facilities wound care doctor said he would fire the resident if he went with another provider but ended up firing him anyway. Resident #69's family member stated she had to take him to an outside wound care provider and he was only seen a couple of times before this last time they sent him to ER. Resident #69's family member stated he developed another wound she did not even know about and was not notified of. Resident #69's family member stated she had video of staff members not wearing PPE (personal protective equipment) while providing cares and not following guidelines for performing wound care.</p> <p>During an observation on 06/19/2024 at 9:00 a.m. of date stamped 05/08/2024 at 1:59 p.m., ring video with audio and visual revealed Resident #69 lying left side in bed when ADON G came into view opens gauze package and place gauze into wound with gloved hand and then dressed wound.</p> <p>During an interview on 06/19/2024 at 9:25 a.m., ADON G stated she was the infection preventionist. ADON G stated she had done wound care on Resident #69 several times when he would allow it to be done. ADON G stated Resident #69 would refuse care daily. ADON G stated she would normally wear personal protective equipment when performing wound care and have her supplies on a cleaned bedside table. ADON G stated depending on the wound she would normally use a Q-tip to place the gauze in the wound. ADON G stated she should have been wearing personal protective equipment when performing wound care to prevent infection.</p> <p>(continued on next page)</p>		

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  06/20/2024
NAME OF PROVIDER OR SUPPLIER  Rock Creek Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 06/20/2024 at 3:16 p.m., the DON stated he expected staff to wear personal protective equipment during resident care. The DON stated he does not know why nursing staff was not wearing personal protective equipment during resident care. The DON sated Resident #69 was very difficult and the staff had to perform care quickly when Resident #69 allowed them to. The DON state it was important to wear the personal protective equipment during resident care to prevent infection. The DON stated he would make sure the staff was in serviced on enhanced barrier precautions and the appropriate personal protective equipment to wear during resident care.</p> <p>During an interview on 06/20/2024 at 4:42 p.m., the Administrator stated she expected staff to wear personal protective equipment during resident care The Administrator stated wear personal protective equipment was important for infection control. The Administrator stated the risk to the resident was infection.</p> <p>Record review of the enhanced barrier precautions policy, undated, revealed .enhanced barrier precautions are indicated for residents with any of the following: .wound and/or indwelling medical devices env if the resident is not known to be infected or colonized with a MDRO .indwelling medical device examples include central lines . The policy further indicated gloves and gown should have been worn for device care or use of a central line.</p> <p>Record review of the infection control plan: overview, undated, revealed personnel will handle, store, process and transport linens so as to prevent the spread of infection .the program will: perform surveillance and investigation to prevent, to the extent possible, the onset and the spread of infection .</p> <p>Record review of the procedure for data collection / reporting policy, undated, revealed the facility will use a system of surveillance designed to identify possible communicable disease or infections before they can spread to other persons in the facility .residents who present with signs/symptoms of infection will trigger an infection control entry into the log .the infection preventionist (IP) or designee will may request additional clinical verification of infection as needed for diagnosis by consulting with the attending physician . the IP will have the authority to request additional clinical verification if the patient's condition warrants .</p> <p>Record review of the Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 Pandemic, updated May 8, 2024, revealed anyone with even mild symptoms of COVID-19, regardless of vaccination status, should receive a viral test for SARS-CoV-2 as soon as possible .symptomatic individual identified - residents, regardless of vaccination status, with signs or symptoms must be tested .</p> <p>Record review of the facility's policy titled Infection Control date 5/11/2022, indicated, the facility will establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection</p>		