STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676442	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rollingbrook Rehabilitation and Healthcare Center	750 Rollingbrook Dr Baytown, TX 77521

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure all Pre-admission Screening and Resident Review (PASRR) Level 1 residents with mental illness were provided with an accurate PASSR Level 1 screening for 1 (Resident # 11) of 2 residents reviewed for PASSR screening. Resident #11 did not have an accurate and updated PASRR Level 1 screening reflecting a diagnosis of mental illness. This failure could place residents with mental illness at risk of not receiving a PASSR Evaluation for individualized care or special services to meet their needsRecord review of Resident #11's admission record dated 3/26/2026 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that include Unspecified dementia (refers to cases where the specific type of dementia cannot be clearly identified despite the presence of cognitive decline and memory loss), PTSD (a mental health condition that's caused by an extremely stressful or terrifying event either being part of it or witnessing it), Polyneuropathy (a nerve disease caused by damage to many nerves), Mood Disorder due to a known physiological condition with manic features (characterized by mood disturbances stemming directly from identifiable physical health issues), and Cognitive Communication Deficit (condition where a person's ability to communicate effectively is compromised by an underlying impairment in mental processes, rather than a primary problem with language or speech).Further record review of Resident #11's admission record revealed the diagnosis of PTSD was present on admission. Resident #11's diagnosis of unspecified dementia was created on 3/5/2026 and listed on Resident #11's primary diagnosis.Record review of Resident #11's Quarterly MDS signed as completed on 3/25/2026 revealed he had a BIMS score of 8 indicating moderate cognitive impairment. Section I of Resident #11's Quarterly MDS dated [DATE] was checked yes for having Non-Alzheimer's Dementia and PTSD. Record review of Resident #11's current Comprehensive Care Plan created and initiated on 12/25/2025 did not reflect a focus, goal, nor interventions that addressed Resident #11's diagnoses of Dementia nor PTSD.Record review of Resident #11's PASSR Level 1 screening dated 12/6/2025 Section C 9099 titled PASSR Screening revealed Resident #11 did not have a primary diagnosis of dementia, mental illness, intellectual disability, or a developmental disability. Observation of Resident #11 on 3/24/2026 at 9:08 AM showed him seated in a wheelchair outside of his room in a common area. He was dressed appropriately and appeared clean and well groomed. He stated he didn't like his room because it was too small. He attempted to speak about a subject but stopped and placed his hand on his forehead and remained quiet afterwards. During an interview on 3/25/2026 at 3:03 pm with the MDS nurse, she stated that Resident #11 did not have a diagnosis of dementia on admission. The MDS nurse stated that Resident #11 did have a diagnosis of PTSD on admission. When asked what the proper protocols for residents with PTSD were, the MDS nurse stated they were supposed to have a Level 2 PASSR evaluation. The MDS nurse stated that Resident #11 should have had a PASSR Level 2 completed. The MDS nurse stated she will complete a 1012 Correction for PASSR for Resident #11. When asked what the risks were for residents with PTSD who did not receive a properly completed PASSR 1, the MDS nurse stated that there would be lack of care and residents would not be able to access all their benefits. During an interview with the (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676442	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rollingbrook Rehabilitation and Healthcare Center	750 Rollingbrook Dr Baytown, TX 77521

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON on 3/26/2026 at 12:00 pm, she stated that she was not involved nor responsible with PASRR screenings or PASRR Level 2 evaluations. The DON stated her extent with PASSR positive residents focuses on nursing management. During an interview with the Administrator on 3/26/2026 at 12:23 pm, she stated that she was not involved in MDS assessments, and that they were handled by the MDS Nurse and Regional MDS consultant. During an interview with the Regional MDS consultant on 3/26/2026 at 1:58 pm, she stated that Resident #11 should have had the answer of yes in section C for Dementia. When asked what should have been done for Resident #11 since the PASRR Level 1 screening was incorrect, the Regional MDS consultant stated that the facility should have completed a 1012 correction or reached out to the entity who completed the PASRR Level 1 for a correction. When asked what the risks were to the residents if their PASRR Level 1 was incorrect, the Regional MDS consultant stated that residents could miss out on services that were beneficial.Record review of the facility policy titled Resident Assessment- Coordination with the PASRR program implemented February 2023 and revised in January 2026 reads in part. If a resident is admitted without a documented diagnosis of serious mental illness (MI), intellectual disability (ID), or related condition, and such diagnosis is identified after admission, the facility will initiate the PASARR referral process upon identification.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676442	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rollingbrook Rehabilitation and Healthcare Center	750 Rollingbrook Dr Baytown, TX 77521

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 (Resident #10) of 4 residents observed for medication administration. LVN A failed to keep Resident #10 in a safe and sanitary environment by attempting to administer insulin to him with the incorrect insulin pen. This failure could place residents at risk of adverse reactions and exposure and/or possible transmission of communicable diseases and infections. Record review of Resident #10's admission record dated 3/26/2026 revealed a [AGE] year-old male admitted to the facility originally on 9/23/2022 and readmitted on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disorder (a group of lung diseases that cause airflow blockage and breathing related problems), Type 2 Diabetes Mellitus (a chronic disease that is characterized by high levels of sugar in the blood), and Aphasia (primarily a language disorder that affects an individual's ability to communicate effectively and lead to difficulties in speaking, understanding, reading, and writing). Record review of Resident #10's quarterly MDS assessment dated [DATE] revealed that Resident #10 had a BIMS score of 15 which indicated a intact cognitive response.Record review of Resident #10's physician order summary revealed an order with a start date of 10/15/2025 for of Insulin Glargine Subcutaneous Solution Pen-injector 100 units/ml with directions to inject 30 units subcutaneously in the morning for DM related to Type 2 Diabetes Mellitus. Observation of LVN A on 3/25/2026 at approximately 8:12 am revealed her standing outside of Resident #10's room. LVN A agreed to be observed while she administered insulin to Resident #10. LVN A was observed grabbed an Insulin Glargine (Lantus) pen and showed surveyor the number of units that was going to be administered to Resident #10. Observation of LVN A on 3/25/2026 at 8:15 am revealed LVN A entered the room of Resident #10 with an Insulin Glargine (Lantus) pen in hand, an alcohol wipe, and gloves. LVN A approached Resident #10 and proceeded to wipe an area on Resident #10's upper left abdomen and was stopped by surveyor and requested to step outside Resident #10's room. During an interview on 3/25/2026 at approximately 8:16 am, LVN A was asked to read the name of the label that was attached to the Insulin Glargine (Lantus) pen she held and was going to administer to Resident #10. LVN stated oh, it belongs to another resident. LVN A stated she did not have Resident #10's insulin pen in her medication cart. LVN A stated she didn't read the label. LVN stated that she had the correct medication and the correct number of units. LVN A stated that she saw Lantus and thought it belonged to Resident #10. When asked if she had been trained in medication administration, LVN A stated she had. LVN A stated that she received refresher training for medication administration and other topics every month. LVN A stated that the risk of administering the incorrect insulin pen to the wrong resident included the risk of infection. During an interview with the DON on 3/26/2026 at 3:03 pm, she stated that insulin training for nurses was conducted annually and she was in the process of getting all nurses on the same training schedule. The DON stated that nurses perform training for medication administration quarterly, and random medication administration audits were also conducted. The DON stated that based on audit findings, training was conducted more frequently if necessary. The DON stated the risk involved of administering the wrong insulin pen to a resident, despite if it was the ordered insulin and correct number units, could result in an adverse effect to the resident and increased the risk of infection to the resident. Record review of facility policy titled Infection Prevention and Control Program date implemented 5/2023 and revised on 1/2024, reads in part. all staff shall demonstrate competence in relevant infection control practices. direct care staff shall demonstrate competence in resident care procedures established by our facility. Record review of facility policy titled Medication Administration date implemented 12/2020 and revised on 1/2025, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676442	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rollingbrook Rehabilitation and Healthcare Center	750 Rollingbrook Dr Baytown, TX 77521

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reads in part.10. Ensure that the six rights of medication administration are followed: a. Right Resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676442	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rollingbrook Rehabilitation and Healthcare Center	750 Rollingbrook Dr Baytown, TX 77521

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to establish and 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 (Resident #100) of 1 resident reviewed for infection control. LVN A failed to follow EBP prior to administering medications to Resident #100 through a gastrostomy tube (also called a g-tube).This failure could place residents at risk of exposure and/or possible transmission of communicable diseases and infections. Record review of Resident #100's admission record dated 3/26/2026 revealed a [AGE] year old female admitted to the facility on [DATE] with diagnoses that included gastrostomy status (presence of a gastrostomy tube), dysphagia (difficulty swallowing), and cognitive communication deficit (condition where a person's ability to communicate effectively is compromised by an underlying impairment in mental processes, rather than a primary problem with language or speech). Record review of Resident #100's baseline care plan with an effective date of 3/21/2026 revealed in section D - disease/illness management, Resident #100 has a gastronomy tube. Resident #100 did not have a completed MDS assessment. Record review on 3/26/2026 at 8:28 am of Resident #100's medication admission physician orders dated 3/20/2026 revealed all medications were listed with an administration route of via G-tube. Resident #100 had a physician order of EBP Record review on 3/26/2026 at 2:47 pm of Resident #100's physician order revealed that Resident #100 had an order of EBP.Record review of Resident #100's admission nursing progress dated 3/20/2026 at 6:59 pm written by LVN A reads in part. denies pain., G-tube in place. Meds is to be administered via G-tube due to block esophageal from a previous surgery. An observation on 3/25/2026 at 8:40 am revealed LVN A entered Resident #100's room with medication, supplies, and gloves. LVN A closed Resident #100's door, donned gloves, and proceeded to have Resident #100 lift her shirt and exposed the G-tube. LVN A leaned forward and grabbed Resident #100's G-tube. The surveyor immediately asked LVN A to step outside of Resident #100's room. When asked if there were any precautions that should be taken while using Resident #100's G-tube, LVN A did not answer. LVN A was asked to read the EBP sign that was posted across the hall on another resident's door. LVN A stated, Oh, I need to gown up. She wasn't a g-tube when I left. Observation of Resident #100's door did not reveal the presence of any PPE supplies nor a sign that indicated EBP were in place for Resident #100. During an interview with LVN A on 3/25/2026 at 9:30 am, she stated that she received weekly training from the DON on different topics. LVN A stated she had been trained in the different types of precautions which included EBP. When asked why she didn't utilize EBP when she entered Resident #100's room to administer medications via Resident #100's G-tube, LVN stated I just forgot. LVN A stated that Resident #100 was new to the facility. LVN A stated the risk of not adhering to EBP when required includes the risk of infection and lack of protection for both the residents and staff.During an interview with the DON on 3/26/2026 at 3:03 pm, she stated that she was the infection preventionist. The DON stated training on different types of precautions were given monthly and quarterly, and every time an incident occurred. The DON stated Resident #100 should have been on EBP. The DON stated that there were EBP signs in the supply room for new admissions, and that any nurse can initiate EBP for a resident. When asked what the risk were of staff not adhering to EBP when required, the DON stated that it could lead to infection, decreased cleanliness, and decreased the protection for the resident and the staff member. During an interview with the Administrator on 3/26/2026 at 12:23 pm, she stated that EBP staff training were conducted by the DON who was also the Infection Preventionist. Record review of facility policy titled Enhanced Barrier Precautions date implemented April 2024, reads in part.an order for EBP will be obtained for residents with any of the following: indwelling medical devices ex. Feeding tubes. This policy also reads in part. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities .#4. High-contact resident activities include.device care or use: feeding tubes.