STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676235	A. Building B. Wing	12/13/2024

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44637 Based on observation, interview, and record review the facility failed to ensure that the resident environment remained free of accident hazards to prevent injuries for 1 of 6 residents (Resident #1) reviewed for accident hazards. The facility failed to ensure CNA A properly transferred Resident #1 via mechanical lift (a device designed to help caregivers transfer patients) on 12/11/224 resulting in Resident #1 having a significant laceration to her scalp with exposure to underlying skull. The noncompliance was identified as PNC. The IJ began on 12/11/24 and ended on 12/11/24. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk for injury and death. Findings include: 1. Record review of the face sheet dated 12/13/24 indicated Resident #1 was an [AGE] year-old female, admitted to the facility on [DATE] with diagnoses including Alzheimer's, dementia, dysphagia (difficulty swallowing foods or liquids), and psychotic disorder (a mental disorder characterized by a disconnection from reality). Record review of the MDS dated [DATE] indicated Resident #1 rarely/never understood others and was rarely/never understood by others. The MDS indicated Resident #1 did not have a BIMS score. The MDS indicated Resident #1 was dependent with dressing, personal hygiene, bathing, and transfers. Record review of the care plan dated revised on 11/20/24 indicated Resident #1 had an ADL self-care performance deficit with interventions including requires 2-staff participation with mechanical lift transfers. (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the Nurse's Progress note dated 12/11/24 at 6:00 a.m. indicated, CNA getting resident out of bed. had resident in [mechanical lift] and while she was fixing to put resident in Geri-chair (a large, padded chair designed to help people with limited mobility sit and stand comfortable) roommate got up to bathroom all upset because lights were turned on and people talking and wouldn't let her sleep and pushed Geri chair back out of the way when CNA turned to get Geri chair resident leaned over and fell out of [mechanical lift] sling hitting head on side table has laceration to top of head and hematoma to right side of head and hematoma to right index finger. while in room assessing resident roommate continued fussing and complaining to staff. Record review of the Fall assessment dated [DATE] indicated Resident #1 was a high risk for falls. The Fall Assessment indicated Resident #1 had not had any falls in the past three months and was not able to stand. Record review of the hospital records dated 12/11/24 indicated per EMS report, nursing facility staff were attempting to transfer Resident #1 and accidently dropped her. The hospital records indicated Resident #1 hit her head sustaining a significant laceration to her scalp with exposure of underlying skull. The hospital records indicated the laceration was elliptical shaped (an oval shape, similar to a stretched-out circle) and approximately 25 cm in diameter. The hospital records indicated the laceration was large to where underlying skull could be seen. The hospital records indicated there was no deformity or fracture of the skull. The hospital records indicated the laceration was repaired at bedside requiring 22 staples. During an interview on 12/13/24 at 9:18 a.m. the Administrator said CNA A was suspended pending investigation and would probably be termed. The Administrator said she was waiting to hear from corporate regarding their decision on whether to terminate CNA A. Record review of a CNA Proficiency Audit dated 10/1/24 indicated CNA A had been successfully checked off on CNA skills including Hoyer Lift (Mechanical Lift)-2 person assist. During an interview attempt on 12/13/24 at 9:20 a.m. CNA A's phone was not in working service. During an interview attempt and observations on 12/13/24 at 10:45 a.m. Resident #1 did not answer any questions from the surveyor or speak. Resident #1 was observed with a pressure dressing to her head dated 12/12/24. Record review of the facility's undated Hydraulic Lift policy indicated, The hydraulic lift is a mechanical device used to transfer a resident from and to the bed and chair. It is reserved for those who are paralyzed, or too weak to transfer without complete assistance. The number of staff to provide assistance with the transferred should be determined by the manufacturer recommendations. The resident will achieve safe transfer to bed or chair via a mechanical lift device. The caregiver will demonstrate safe and correct transfer of the resident to the bed or chair via the hydraulic lift . Record review of the Battery Operated Electric Total Lift Owner's Manual revised 10/13/20 did not indicated the recommended number of staff to provide assistance with a transfer. The Administrator was notified on 12/13/24 at 12:13 p.m. that a Past Non-Compliance Immediate Jeopardy situation was identified due to the above failure. The Administrator was provided the Immediate Jeopardy template on 12/3/24 at 12:17 p.m. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility had corrected the noncompliance by the following: Suspending CNA A pending investigation. In-servicing staff regarding KARDEX (a nursing filing system that enable nursing staff to write, organize, and easily reference key patient information that shapes their nursing care plan) use in the EMR and Hydraulic Lift Use. Staff checkoffs by the DOR regarding Mechanical Lift Transfers The surveyor confirmed the facility had corrected the non-compliance prior to survey starting by: Record review of the Employee Disciplinary Report dated 12/11/24 indicated CNA was placed on investigatory suspension pending investigation into allegations of a resident injury involving the employee. Staff interviewed (CNA A, CNA B. CNA C, CNA D, Treatment Nurse E, CNA F, LVN G, MA H) on 12/13/24 between 10:00 a.m. and 10:41 a.m. were able to answer all question regarding in-services including mechanical lift transfer should always be performed with 2 staff members, the sling date should be checked to ensure it is not 6 months old or older, the integrity of the sling should be checked, the lift should be checked to ensure it was in proper working order, the wheelchair or bed should be locked, and the lifts base should be opened to the widest possible position, and residents' transfer status should always be checked in the KARDEX prior to transfer. Record review indicated 37 out of 60 direct care staff had received Mechanical Lift Transfer Skills Checkoffs from 12/11/24-12/13/24. During an interview on 12/13/24 at 9:39 a.m. the Administrator said the facility had 100% of staff in-serviced regarding mechanical lift use and KARDEX use in the EMR. The Administrator said staff were required to receive mechanical lift training from the DOR prior to being able to work the floor. The Administrator said the mechanical lift training would be ongoing until all staff had been trained/checked-off. Record review of Resident #1's care plan indicated it was in process of being revised. Record review of the in-service sign-in sheets and the employee roster dated 12/11/24 indicated 100% of nursing staff had been in-serviced regarding mechanical lift use and KARDEX use in the EMR. During an observation on 12/13/24 at 10:20 a.m. CNA B and CNA C performed a mechanical lift transfer. CNA B and CNA C performed mechanical lift transfer with 2 staff members, checked the date of lift pad prior to transfer, ensured sling was in good working order, guided resident while in sling to prevent injury, ensured the base was set to widest position when lifting and lowering resident, ensured the wheelchair wheels were locked prior to lowering resident to chair.