STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455904	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rowlett Health and Rehabilitation Center	9300 Lakeview Pkwy Rowlett, TX 75088

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for two (Resident #76 and Resident #79) of twenty-four residents reviewed for reasonable accommodation of needs. The facility failed to ensure the call light system in Resident #76's room was in a position that was accessible to the resident on 07/22/2025.The facility failed to ensure the call light system in Resident #79's room was in a position that was accessible to the resident on 07/22/2025.This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency.Findings included:Resident #76 Record review of Resident #76's Face Sheet, dated 07/23/2025, reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE]. Resident #76 had diagnoses which included Alzheimer's disease (loss of memory and cognitive ability that interferes with daily life) and unsteadiness on feet. Record review of Resident #76's Quarterly MDS (tool used to assess functional capabilities and health needs) Assessment, dated 06/03/2025, reflected severely impaired cognition with a BIMS (tool used to assess cognition) score of 0. Section GG (functional abilities) indicated Resident #76 required assistance with self-care and mobility needs.Record review of Resident #76's Comprehensive Care Plan, dated 01/27/2025, reflected Resident #76 was at risk for falling related to impaired mobility and impaired cognition. One intervention was to keep the call light within reach and encourage the resident to use it to call for assistance as needed. During an interview and observation on 07/22/25 at 9:20 AM, Resident #76 was lying in bed awake. The bed was in the lowest position. The resident's recliner was to the right of Resident #76's bed. Resident #76's call light was on the floor on the opposite side of the recliner and not within the resident's reach. When asked if the resident used her call light, she stated no. Resident #76 was unable to answer further questions because of her cognitive status. During an interview on 07/22/2025 at 9:27 AM, CNA C stated Resident #76's call light should have been placed within reach. She stated it was important for residents to have their call light in reach in case they needed something. She stated whether or not a resident used their call light, they should always be able to reach the call light. She stated a resident might try to get up without assistance and fall. During an interview on 07/24/2025 at 11:42 AM, LVN A stated the call light should have been in reach. He stated it was important for all residents to have their call light in reach because that was how staff knew when a resident needed help.Resident #79Record review of Resident #79's Face Sheet, dated 07/23/2025, reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE]. Resident #79 had diagnoses which included hemiplegia (one-sided paralysis or weakness) following a stroke (blood flow to the brain is blocked), cognitive communication deficit, and the need for assistance with personal care. Record review of Resident #79's Quarterly MDS Assessment, dated 07/12/2025, reflected severely impaired cognition with a BIMS score of 0. Section GG indicated Resident #79 was dependent on staff for self-care needs and mobility needs.Record review of Resident #79's Comprehensive Care Plan, dated 01/15/2025, reflected Resident #79 was at risk for falling related to reduced mobility and a stroke with hemiplegia. During an observation on 07/22/25 at 9:40 AM, Resident #79 was lying in bed asleep. The bed was in the lowest position. Resident #79's call light was on the floor behind the roommate's bed. The call light was not within the resident's reach. During an interview on 07/22/2025 at 9:51 AM, CNA D stated all residents should have their call light within reach. He stated Resident #79 did not use the call light but it should have been where she could reach it. He stated it was important for the call light to be within reach in case the resident had an emergency or needed assistance. During an interview on 07/22/2025 at 11:52 AM, the ADON stated her expectation was for all residents to have their call light within reach. She stated Resident #76 and Resident #79 should have had their call lights in reach. She stated it was important for residents to have their call light to reach staff for assistance. She stated a potential risk of not having the call light within reach was a resident would be unable to call for assistance. During an interview on 07/24/2025 at 11:35 AM, the DON stated Resident #76 and Resident #79 should have had their call lights within reach. She stated some residents had dementia and may throw their call light. She stated it did not matter if a resident used their call light or not, all residents should be able to reach their call light. She stated it was important for residents to be able to reach staff when they needed something. During an interview on 07/24/2025 at 2:00 PM, the Administrator stated it was important for the residents to have their call lights within reasonable reach and this should be checked on every round. He

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents had the right to a safe, clean, comfortable, and homelike environment including but not limited to receiving treatment and supports for daily living safely for 10 of 15 resident rooms on the 500 hall (Resident rooms #1, #2, #3, #4, #5, #6, #7, #8, #9 and #10), and residents eating in the dining room, reviewed for environment.Based on observation, interview and record review the facility failed to ensure residents had the right to a safe, clean, comfortable, and homelike environment including but not limited to receiving treatment and supports for daily living safely for 10 of 15 resident rooms on the 500 hall (Resident rooms #1, #2, #3, #4, #5, #6, #7, #8, #9 and #10), and residents eating in the dining room, reviewed for environment. 1. The facility failed to ensure Resident rooms #1, #2, #3, #4, #5, #6, #7, #8, #9 and #10, were thoroughly cleaned and sanitized. 2. The facility failed to ensure the serving table in the dining room was thoroughly cleaned and sanitized. These deficient practices could place residents at risk of living in an unclean and unsanitary environment which could lead to a decreased quality of life. Findings include: An observation on 07/22/25 at 9:21 AM in the facility's main dining room revealed a large white serving table, which was used for drinks and condiments. The table had black and brownish stains along the front and side panel of the table and also on the bottom portion of the table. An observation on 07/22/25 at 11:04 AM of resident room [ROOM NUMBER] reflected the air condition vents had dark dirt stains on and between the vents. The shower floor in the bathroom had white and brown stains on it. The corners and edges of the bathroom floor had dirt build up in the corners and behind the toilet. An observation on 07/22/25 at 11:08 AM of resident room [ROOM NUMBER] reflected the air condition vents had dark stains on and between the vents. The shower floor in the bathroom had white and brown stains on it. The corners and edges of the bathroom floor had dirt build up in the corners and behind the toilet. A wastebasket in the bathroom had no trash bag and the inside bottom of the wastebasket had brownish stains and dried up dirt in it. An observation on 07/22/25 at 11:12 AM of resident room [ROOM NUMBER] reflected the air condition vents had dark stains on and between the vents. The corners of the room floor had white dirt particles and dirt build up. An observation on 07/22/25 at 11:16 AM of resident room [ROOM NUMBER] reflected the air condition vents had dark stains on and between the vents. The corners and edges of the bathroom floor had dirt build up in the corners and behind the toilet. A nightstand in the room had dirt and dust particles on top of it. A chest of drawers in the room had thick dust on top of it and a dirty shoe was sitting on top of it. A wastebasket in the bathroom had no trash bag and the inside bottom of the wastebasket had brownish stains and dried up dirt in it. An observation on 07/22/25 at 11:22 AM of resident room [ROOM NUMBER] reflected the air condition vents had [NAME] stains on and between the vents. The bathroom shower floor had rust stains from a shower chair in the shower. The bathroom floor had brown stains along the corners of the floor and behind the toilet. An observation on 07/22/25 at 11:29 AM of resident room [ROOM NUMBER] reflected the air condition unit filters had dust in them. The air condition vents had dark stains on and between the vents. An observation on 07/22/25 at 11:33 AM of resident room [ROOM NUMBER] reflected the air condition unit filter had dust in it. The air condition vents had dark stains on and between the vents. There was a roll of tissue paper lodged between the bathroom lights. An observation on 07/22/25 at 11:37 AM of resident room [ROOM NUMBER] reflected a privacy curtain with large brownish stains on both sides of the curtain. The bathroom floor had brown stains along the corners of the floor and behind the toilet. An observation on 07/22/25 at 11:41 AM of resident room [ROOM NUMBER] reflected the air condition unit filters had dust in them. The air condition vents had dark stains in them. An observation on 07/22/25 at 11:43 AM of resident room [ROOM NUMBER] reflected the air condition vents had dark stains in them. The cover of the air condition unit was slightly separated from the unit. The bathroom shower floor had yellow and black stains along the edges of the floor. The tile on the bathroom shower wall had dried up cement plastered all over the bottom of the wall and along a corner of the wall. The bathroom floor had brown stains along the corners of the floor and behind the toilet. In an interview on 07/24/25 at 8:52 AM, Housekeeping D stated she had been at the facility for 3 years. She stated she cleaned the 500 hall rooms. She stated she was responsible for cleaning the room floors, the air condition units, the air filters, wiping down the furniture, the bathrooms floors, toilets, showers, and she took down the privacy curtains to wash them. She stated she had the curtains cleaned when she saw they were dirty or had a smell and every two weeks. She stated they did not have a checklist to use when cleaning the room. She stated the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure that residents, who needed respiratory care, were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for two (Resident #1 and Resident #63) of six residents reviewed for respiratory care.The facility failed to ensure Resident #1's yankauer suction tip (device used to suction fluids and secretions from the oral cavity) was stored in a bag when not in use on 07/22/2025. The facility failed to ensure Resident 63's oxygen tubing was properly stored in a bag when not in use on 07/22/2025.This failure could place the residents at risk for respiratory infection and not having their respiratory needs met. Findings included: Resident #1Review of Resident #1's Face Sheet, dated 07/24/2025, reflected the resident was a [AGE] year-old male who originally admitted to the facility on [DATE]. Resident #1 had diagnoses which included cerebral infarction (blood flow to the brain if blocked), dysphagia (difficulty swallowing), and hemiplegia (one-sided paralysis or weakness). Record review of Resident #1's Physician Orders, dated 08/18/2024 reflected oral suction as need for increased secretions. Record review of Resident #1's Quarterly MDS Assessment, dated 04/25/2025, reflected a BIMS test was not conducted because the resident was rarely/never understood. The MDS Assessment indicated Resident #1 was moderately impaired in the area of cognitive skills for daily decision making. Section O (special treatments, procedures, and programs) reflected Resident #1 received hospice services. Record review of Resident #1's Comprehensive Care Plan, dated 06/16/2025, reflected Resident #1 was admitted to hospice services, per family request, related to cerebral infarction. Interventions included to work cooperatively with hospice to ensure resident's physical needs were met, symptoms controlled, and maximum comfort was provided for the resident An observation on 07/22/2025 at 10:10 AM revealed Resident #1 lying in bed asleep. A machined used to suction oral secretions was on Resident #1's nightstand. Suction tubing was connected to the machine and the yankaeur suction tip was lying on the nightstand behind the suction machine. It was not stored in a bag. During an interview on 07/22/2025 at 10:15 AM, LVN B stated the suction tip should have been covered. He stated it had not been used for a long time because Resident #1 was not having a lot of secretions. He stated it was kept there in case it was needed. He stated if someone touched it or sneezed on it, it would contaminate the suction tip and put Resident #1 at risk for getting an infection. During an interview on 07/24/2025 at 11:35 AM, the DON stated the yankauer suction tip in Resident #1's room should have been stored in a bag. She stated if it were not frequently used, staff could have placed a new sealed yankauer suction tip next to the machine in case it was needed. She stated the risk was contamination and it placed the resident at risk for infection. She stated she had already in-serviced staff about it Resident #63Record review of Resident #63's Face Sheet, dated 07/24/2025, reflected the resident was an [AGE] year-old female who admitted to the facility on [DATE]. Resident #63 had diagnoses which included COPD (disease of lung and airway that affects breathing), hypertension (high blood pressure), acute respiratory failure (life threatening condition where there is not enough oxygen in the blood), and difficulty in walking. Record review of Resident #63's Quarterly MDS Assessment, dated 07/22/2025, reflected intact cognition with a BIMS score of 15. Section I (active diagnoses) reflected Resident #63 was treated for COPD and acute respiratory failure. Record review of Resident #63's Physician's Orders, dated 07/17/2025, reflected an order for oxygen at 3 liters continuous via nasal cannula every shift related to acute respiratory failure.Record review of Resident #63's Comprehensive Care Plan, dated 07/18/2025, reflected Resident #63 had altered respiratory status/difficulty breathing related to acute on chronic respiratory (worsening of a chronic condition) respiratory failure. Interventions included to provide oxygen as ordered, monitor for signs and symptoms of respiratory distress, and report to medical doctor as needed.During an observation and interview on 07/22/2025 at 11:20 AM, Resident #63 was sitting up in bed. Resident was receiving oxygen via a nasal cannula and the oxygen concentrator was set at 3 liters. The wheelchair was next to Resident #63's bed and had a portable oxygen tank on the back of the wheelchair. The oxygen tubing was connected to the concentrator and was looped over the top of the oxygen concentrator. It was not bagged. Resident #63 stated she did not know it if was supposed to be bagged but she had no concerns with her care. During an interview on 07/22/2025 at 11:28 AM, LVN B stated the tubing on the wheelchair should have been stored in a bag since the resident was not using it. He stated it was important to keep the oxygen tubing covered to prevent contamination and the risk for infection

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 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 for the facility's only kitchen, reviewed for food and nutrition services. 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 for the facility's only kitchen, reviewed for food and nutrition services. 1. The facility failed to place a cover on top of the tea dispenser to avoid air borne contaminants. 2. The facility failed to ensure food in the freezer and dry storage area was labeled and dated when stored. 3. The facility failed to ensure expired food in the refrigerator and dry storage area was discarded. 4. The facility failed to ensure the ice machine and ice scoop holder were thoroughly cleaned. These failures could place residents at risk for cross contamination and food-borne illnesses. Findings include: Observations on 07/22/25 from 9:07 AM to 9:20 AM in the facility's only kitchen revealed: One zip lock bag of frozen chicken nuggets, located in the freezer, was not labeled with the date stored. One large container of honey mustard dressing, located in the refrigerator, had a disposal date of 6/17/25, and was not discarded. Packages of hot dog buns, hamburger buns, and white bread, located in the dry storage area, were not labeled with the date stored. One large tea dispenser, located in the kitchen area, had tea in it, but it did not have a lid placed on the top of the dispenser to avoid air-borne contaminants. An ice machine, located in the kitchen had stains and dirt particles along the door openings and the inside of the door. The ice machine scoop holder, hanging on the wall, had brown dirt particles on the inside bottom of the holder. In an interview and observation on 07/22/25 at 9:20 AM, the Dietary Manager was shown the concerns observed in the kitchen and she stated the tea was just recently prepared and should have been covered once it was done. She stated she was responsible for ensuring food was labeled and dated and ensuring food was discarded once it expired but the items mentioned were overlooked. She stated the ice machine was cleaned at least once a week by the night team, and they should have also cleaned the ice scoop holder. She stated not addressing the areas mentioned could result in residents getting sick. In an interview on 07/24/25 at 11:22 AM, the Administrator stated he was briefed by the Dietary Manager of some of the concerns observed in the kitchen. He was shown pictures of the concerns observed in the kitchen. He stated he was a little surprised to hear of some of the findings because the Dietary Manager stayed on top of labeling, dating, discarding of expired food, and cleaning kitchen equipment. He stated his expectation was for the kitchen to follow state guidelines. He stated not meeting these expectations could be harmful to the residents' health. Record review of the facility's policy on Dietary Services/ Food Storage (08/2007), revealed It is the policy of this facility that food storage areas shall be maintained in a clean, safe, and sanitary manner. All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks, and chipped areas. Ice which is used in connection with food or drink shall be from a sanitary source and shall be handled and dispensed in a sanitary manner. Record review of the U.S. Food and Drug Administration (FDA) Code (2022) revealed, Food shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based observations, interviews, 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 one (Resident #78) of six residents observed for infection control. The facility failed to ensure that CNA E changed gloves and performed hand hygiene, did not carry gloves in her pocket, and did not blow on her hands to dry the hand sanitizer, while providing incontinent care to Resident #78 on 07/22/2025.These failures could place the residents at risk of cross-contamination and development of infections.Findings included:Resident #78Review of Resident #78's Face Sheet, dated 07/23/2025, reflected the resident was a [AGE] year-old female who originally admitted to the facility on [DATE]. Resident #78 had diagnoses which included dementia (decline in cognitive function) and the need for assistance with personal care Record review of Resident #78's Quarterly MDS Assessment, dated 06/11/2025, reflected severely impaired cognition with a BIMS score of 0. Section H (bowel and bladder) indicated Resident #78 was always incontinent of bowel and bladder. Record review of Resident #78's Comprehensive Care Plan, dated 06/30/2025, reflected Resident #78 was at risk for pressure ulcer related to incontinence of bowel and bladder. One intervention was to immediately notify nurse of any new area of skin breakdown noted during bath or daily care. An observation and interview on 07/22/2025 at 2:40 PM revealed CNA E preparing to provide incontinence care to Resident #78. CNA E explained to Resident #78 what she was going to do and pulled the curtain for privacy. CNA E had incontinence care items placed on the bedside table. CNA E used hand sanitizer, removed two gloves from the pocket of her scrub top and put the gloves on her hands. CNA E pulled down the front of Resident #78's brief and used a single wipe for each pass to clean the resident. CNA E did not change gloves and use hand sanitizer. CNA E assisted Resident #78 to turn to her left side and took Resident #78's right hand, with the hand used to clean the resident, and placed the resident's right hand on the side rail of the bed. CNA E cleaned Resident #78's bottom. She removed her gloves and used hand sanitizer. CNA E pulled gloves from the pocket of her scrub top, softly blew on her hands to dry the sanitizer, and put on the clean gloves. CNA E secured the tabs on the resident's brief and pulled up the blanket to cover the resident. CNA E washed her hands in Resident #78's restroom before exiting the room. CNA E stated she had been a CNA since 1986, and started the prior week at the facility, working on an as needed basis. CNA E stated she should have removed her gloves and used hand sanitizer after cleaning Resident #78. CNA E stated she should not have blown on her hands to dry the hand sanitizer. CNA E stated she should not carry gloves in her pockets because they can get contaminated. CNA E stated she received training when she started working at the facility on resident care. CNA E stated it was important to prevent residents from getting an infection.During an interview on 07/24/2025 at 11:35 AM, the DON stated she had in-serviced staff related to incontinence care, hand washing, and not putting gloves in their pockets. She stated it was important to prevent contamination and infection. During an interview on 07/24/2025 at 11:50 AM, LVN A stated CNA E should have followed infection control measures when providing incontinence care for Resident #78. He stated staff were frequently in-serviced about incontinence care. LVN A stated sometimes PRN staff forgot routine hygiene practices. He stated as a nurse, when he observed CNAs not following proper procedures, it was a teaching moment for him. LVN A stated it was important to follow measures to prevent contamination and the spread of infection. Review of the facility's policy, Policy/Procedure - Nursing Clinical: Incontinent Care, revised 05/2007, reflected It is the policy of this facility to provide the necessary supplies, education, and oversight to ensure healthcare workers perform hand hygiene based on accepted standards. All personnel shall follow the handwashing/hand hygiene procedure to help prevent the spread of infections to other personnel, residents, and visitors.