STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675032	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Hill Healthcare Center	230 S Clark Rd Cedar Hill, TX 75104

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32227 Based on observation, interview, and record review, the facility failed to ensure residents were free from abuse and exploitation for 1 of 3 residents (Resident #1) reviewed for abuse, neglect, and exploitation. The facility failed to ensure Resident #1 was protected from sexual abuse by Resident #2. Resident #2 was found in Resident #1's bed lying to top of Resident #1, both nude from the waist down and Resident #2 was observed to have his hand on Resident #1's vaginal area as he swayed his hips side to side. On 11/04/24 at 5:00 PM, an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 11/05/24, the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. This failure could place residents at risk of sexually inappropriate behaviors from other residents. Findings included: Record review of Resident #1's quarterly MDS dated [DATE] reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included Alzheimer's disease, anxiety disorder, depression, bipolar disorder, and psychotic disorder. Resident #1 had a BIMS score of 0 meaning her cognition was severely impaired. The MDS further reflected Resident #1 ambulated independently and she resided in the secure unit. Record review of Resident #1's care plan revised on 07/24/24 reflected she resided on the secure unit due to elopement history at prior placement and care planned for impaired safety awareness and wandering into other's rooms and to get in their bed. Interventions included distract from wandering and offering pleasant diversions or structured activities. The care plan further reflected Resident #1 had a communication problem and staff needed to anticipate the resident's needs. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #2's quarterly MDS dated [DATE] reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included anxiety disorder, depression, schizophrenia, and suicidal ideations. Resident #2 had a BIMS score of 4, which indicated his cognition was severely impaired, he was usually understood by others and usually able to understand others. Per the MDS, Resident #2 ambulated independently and used a manual wheelchair for mobility. The MDS further reflected the resident had behavior problems related to paranoia, and was verbally and physically aggressive. Other behavior problems included taking clothes off down to brief in the hallway, shaking exit doors, becoming physical and verbal with staff, cursing and name calling. Interventions included to administer medications and analyze key times, places, circumstances, triggers, and what de-escalates behavior and document in the behavior tracking log. Record review of the facility's Provider Investigation Report dated 11/02/24 reflected during rounds Resident #2 was observed lying down with Resident #1 in her bed naked. Resident #1 was sent to the hospital for further evaluation and Resident #2 was put on one-on-one monitoring. Record review of the progress notes dated 11/02/24 documented by the Agency Nurse reflected the following: Rounds made on the hall this patient was noted lying naked on top of another patient in her room with his pants down. Her pants were also down and her brief was off and noted on the floor. This nurse immediately instructed patient to get up and exit room. Record review of Resident #2's progress notes dated 11/03/24 documented by LVN A reflected: 5:45am Remains on one-on-one till police took him away to their car Record review of the police report dated 11/03/24 reflected the following: .[Officer] then went to the offender's room and began to speak with him. The offender was hard of hearing and [Officer] had to type out messages for him to read to ask questions. When asked if he knew [Resident #1] he stated he did. When asked if he was in [Resident #1's] room, he stated he was. When asked why he was in [Resident #1's] room he advised because they were having sex. The offender advised he has had sex with her before and was invited into the room by the victim. He stated the victim never asked for sex today but invited him into the room, so he thought it was okay. [Resident #2] was ablet to tell [Officer] his name and birth date, what day of the week it was, and that he was currently in [City], showing that he was able to communicate and has his mental capacities. [Resident #2] was read his [NAME] Rights. When asked what the physical act of sex meant between him and [Resident #1] , [Resident #2] said my penis and her vagina. [Resident #2] said he did penetrate [Resident #2], did not wear a condom and did not ejaculate. [Resident #2] said he did not understand why he was being arrested because he did not hit [Resident #1] (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation on 11/04/24 at 10:28 AM revealed Resident #1 sitting in a chair in the common area of the locked unit. The locked unit was a long hall that was split up into two locked units, which were both co-ed with male and female residents. An attempt was made to interview Resident #1, but the resident did not respond nor did she make eye contact. The resident was asked simple basic yes/no questions, and the resident was not able to respond. A staff member, who was present, asked the resident if she wanted to color, and the resident did not make eye contact with the staff member. The resident was nodding her head to the music that was playing on the television. Resident #1 ambulated with no assistance and wandered through the secure unit hall. After wandering, she would sit back down in the chair in the common area. Interview with the Hospitality Aide on 11/04/24 at 10:30 AM revealed she worked with Resident #1 and #2 but was not working at the time of the incident. The Hospitality Aide said Resident #1 wandered through the halls and was totally dependent with care. Resident #1 was not able to communicate with others and at times may answer a simple yes/no question. The Hospitality Aide stated Resident #2 was independent with most all ADLs and was in his right mind meaning he could carry on conversations with others and make his own daily decisions. Interview on 11/04/24 at 11:28 PM with CNA B revealed Resident #1's dementia was very advanced. CNA B stated Resident #1 did not understand what was being said to her most of the time. When the resident was asked questions, she could not respond most of the time, and she mainly wandered the secure unit going in and out of other resident rooms looking for a bed to lie down on. CNA B said Resident #2 had some aggressive behaviors and could be very demanding but did not have any confusion CNA B stated Resident #2 was able to make all his needs known. Interview on 11/04/24 at 12:18 PM with CNA I revealed Resident #1 wandered the halls of the secure unit and at times would enter other resident rooms looking for a bed to lie on. The CNA said the resident was not able to hold or understand most conversations or commands. Resident #1 would at times say simple words like thank you and may or may not be able to answer yes/no questions. CNA I described Resident #2 as being more alert and oriented, independent with most all ADLs, and able to make his needs known. Resident #2 had moments where he displayed aggressive behaviors, mainly towards staff when things did not go his way or when he was not able to go outside and smoke. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 11/04/24 at 12:27 PM with LVN C revealed she was working the night of the incident between Resident #1 and #2, on 11/02/24. LVN C said the Agency Nurse who was working the other side of the secure unit, told her that during her rounds, around 9:00 PM, she noticed Resident #2 was not in his bed, so they began to look in every room and bathroom on the unit because it was not normal for the resident to wander. LVN C said she when she opened the door to Resident #1's room she found Resident #2 lying on top of Resident #1, and both residents were nude. Resident #1's brief was on the floor and appeared to have been ripped off. Resident #1 was seen moving his hips side to side and because he was hard of hearing, they had to tap on him to get his attention. At that time, LVN C noted Resident #2's hand was in between Resident #1's vaginal area. Resident #2 then ran out of the room appearing embarrassed but with a smirk. At that time, Resident #1 was assessed and there was no redness, discharge, or trauma noted to her vaginal area. While in his room, Resident #2 was asked to pull down his pants to see if there was any evidence of semen to know if he had actually penetrated Resident #1, but none was found. Resident #2 told the staff Resident #1 had asked him to her room; however, due to her severely impaired cognition, LVN C said she did not see that being possible as Resident #1 was not able to communicate. LVN C said while the Agency Nurse was asking him questions, she did hear Resident #2 say everyone needs a little sex sometimes. LVN C further stated she was not aware of any previous history of sexually inappropriate behaviors. Interview on 11/04/24 at 11:57 AM with the Agency Nurse revealed she was making room rounds around 9:00 PM when she noticed Resident #2 was not in his room, so she alerted LVN C and the aides. They began to look for Resident #2. The Agency Nurse stated she was behind LVN C when she opened the door to Resident #1's room. Upon opening the door, they saw Resident #2 lying on top of Resident #1, and both residents were nude from the waist down. Resident #1's brief was on the floor. When they got Resident #2's attention, he quickly got off Resident #1 and left her room. They immediately assessed Resident #1. Resident #1 she did not appear to look fearful, and they did not see any redness or trauma on her vaginal area. After Resident #1 was assessed, the Agency Nurse went to talk to the Resident #2 in his room. She also called the Administrator to let her know about the incident and while the Administrator was asking questions, the Agency Nurse was writing the questions down because Resident #2 was hard of hearing. Resident #2 was asked if he had sex with Resident #1, and Resident #2 said yes. He was asked if Resident #1 was his girlfriend, and Resident #2 said no. Resident #2 was asked why he had done what he did, and he responded with sometimes a man needs sex. Resident #2 said Resident #1 had invited him to her room. Resident #1 was sent to the hospital for further evaluation and Resident #2 was put on one-on-one monitoring. The Agency Nurse stated she had not previously worked with Resident #2, but staff told her sexually inappropriate behaviors were not part of his history. Interview on 11/04/24 at 12:53 PM with CNA D revealed she was alerted by the Agency Nurse that Resident #2 was not in his room during her rounds, so they began to check every room and bathroom. When opened the doot to Resident #1's room, they saw Resident #2 lying on top of Resident #1. CNA D stated both residents were nude from the waist down, and Resident #1's brief was on the floor. She stated Resident #2 was seen moving his hips side to side, while he was on top of Resident #1, and his left hand was on her vaginal area. Resident #2 was hard of hearing, so they had to tap on him to get his attention and he immediately left the room. The nurse assessed Resident #1, and the resident did not look frightened. When Resident #1's vaginal area was checked, there was no redness or trauma noted. CNA D said she had worked with Resident #2, and she was not aware of the resident having a history of sexually inappropriate behaviors. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 11/05/24 at 1:58 PM with LVN E revealed he worked the night of the incident, 11/02/24, and he got report from the Agency Nurse about what had occurred between Resident #1 and #2. Resident #2 was on one-on-one monitoring. LVN E said he asked Resident #2 what happened, and all the resident said was that Resident #1 had invited him to her room. LVN E said he had worked with both residents, and he did not believe Resident #1 was capable of making such a statement due to her severely impaired cognition. While working with Resident #2, he had never known the resident to have sexually inappropriate behaviors. LVN E said the police arrived during his shift, and they went to see Resident #1. After they left her room, they went to speak with Resident #2. LVN E stated he was not present during their interaction, but he was able to hear the resident tell the police he had been invited by Resident #2 to her room. He asked them if he had done anything wrong, and he was later taken by the police. Interview on 11/04/24 at 4:32 PM with the Social Worker revealed Resident #1 wandered the hall of the secure unit. She stated the resident was not able to answer yes or no questions due to her dementia. The Social Worker described Resident #2 as aggressive when it was time to smoke. She stated Resident #2 had a history of suicidal ideations, but she was not aware of Resident #2 having a history of sexually inappropriate behaviors. She further stated she had read about the incident between Resident #1 and #2 on 11/03/24, and she was asked to conduct safe surveys with the other residents on the secure unit today (11/04/24) as part of the investigation. The Social Worker said there were no other concerns identified during the safe surveys with the residents. Interview on 11/04/24 at 9:00 AM with the Administrator revealed she got a call from the Agency Nurse to let her know that during rounds they had found Resident #2 lying on top of Resident #1 and both residents were nude from the waist down. Resident #1 was assessed by the nursing staff and was sent to the hospital for further evaluation. She stated Resident #2 was put on one-on-one monitoring. The Administrator said she asked Resident #2 if he had sex with Resident #1, and Resident #2 responded, I think so. The Administrator asked him if Resident #1 had invited him to her room, and Resident #2 said yes she did. She stated Resident #2 told her he did not think he had done anything wrong. The staff were told to send Resident #1 to the hospital for further evaluation, and Resident #2 was later arrested by the police. The Administrator said Resident #1 was not alert and oriented, could not hold a conversation, and was always having to be redirected as she wandered in the secure unit. The Administrator stated Resident #2 did not have a history of having sexually inappropriate behaviors. The Administrator further stated Resident #2 had been placed in the locked unit because he had attempted to leave the facility in the past. Interview on 11/04/24 at 9:35 AM with the Hospital Sexual Assault Nurse Examiner revealed she had attempted to do a SANE exam on Resident #1 on 11/03/24 while the resident was at the hospital. She said the resident was responding to her name but was not making any sense. She stated Resident #1 had a sitter because she was trying to get out of bed. She said she was not able to do a swab or see if there was any trauma to her vaginal area because Resident #1 was not cooperative. Record review of the facility's Abuse, Neglect, and Misappropriation of Property policy, dated 2022, reflected: Subject: Prohibiting and preventing of Abuse, Neglect, Exploitation, and Misappropriation of Property (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	.The Health Care Center will ensure a safe environment for residents by prohibiting physical and mental abuse including involuntary seclusion, neglect, exploitation, and misappropriation of resident property. .Protection 1. All residents will be immediately protected from harm This was determined to be an IJ on 11/04/24 at 3:41 PM. The Administrator and the DON were notified. The Administrator was provided with the IJ template on 11/04/24 at 5:00 PM. The following Plan of Removal was submitted by the facility and was accepted on 11/05/24 at 11:03 AM and reflected the following: Plan of Removal: F600- Free from Abuse and Neglect Deficient practice: 1.The facility failed to ensure a resident had the right to be free from abuse when resident #1 sexually abused Resident #2. Procedures to address Deficient Practice: 1.) [Agency Nurse] Immediately separated the residents at around 9pm on 11/2/2024. 2.) [Agency Nurse] immediately completed head to toe assessment on identified female resident. 11/2/2024 3.) [Agency Nurse] was ordered by [Physician] to send identified female resident to the hospital for further evaluation. 11/2/24 4.) [Administrator] instructed Agency Nurse to place male resident that was observed in female residents' bed on 1:1 until alternate placement is found. 5.) Physicians and families were notified on 11/2/2024 by the (Administrator). 6.) City police department was notified by [Hospital] and male resident was arrested and taken to jail on 11/3/2024. 7.) All female residents that reside on the secure unit had a head-to-toe assessment completed by [LVN C]. No injuries or signs or symptoms of trauma observed. 11/2/24 8.) Directed re-in-service initiated on 11/2/2024, by the Administrator, with secured unit staff present at time of incident, on Abuse Prohibition Policy and Procedure. 9.) Safe Surveys were conducted by the [Social Service Director] on (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	11/4/2024. Actions to decrease risk of Occurrence/Re-Occurrence: 1.) Directed re-in-service, by the Administrator and Director of Nursing, with all staff, on Abuse Prohibition Policy and Procedure with emphasis on sexual abuse to be completed by 11/4/2024. 2.) Pre and post test will be completed for redemonstration of training by all staff prior to working assigned shift. Starting 11/5/24 3.) Administrator will be responsible for ensuring all staff are educated and complete a pre-and -post test to show understanding of the training. 4.) Administrator and Director of Nursing will complete random testing with staff weekly for four weeks and monthly for 3 months . 5.) All new hires will be educated by Director of Nursing, Administrator, on Facility's policy on Abuse and neglect. 6.) [Behavioral Health Services] will complete Comprehensive training for staff on recognizing signs of abuse, appropriate response protocols, reporting procedures, and de-escalation techniques by 11/5/2024. 7.) [Behavioral Health Services] /[Administrator] to complete Specific training for staff working with residents with cognitive impairments regarding potential triggers for aggressive behavior by 11/5/2024. 8.) Regular refreshers on abuse prevention policies and procedures to be completed during facility monthly employee meeting. 9.) Facility will separate the female resident from the male resident to avoid further interaction 11/5/2024. Resident Assessment and Monitoring: 10.) The charge nurses will weekly, quarterly, and as needed assess residents for potential risk factors, for abusive behavior, including cognitive decline, behavioral changes, and medical conditions and notify the physician of any changes. 11.) [MDS Nurse] to complete Individualized care plans for residents at risk, including strategies to manage potential aggressive behavior. Monitoring of the facility's Plan of Removal included the following: Record review of Resident #1's and other female resident's clinical records revealed the resident had been assessed by nursing after the incident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interviews on 11/05/24 from 11:03 AM to 3:47 PM with staff from various shifts to include the Social Worker, HR, BOM, Receptionist, Activity Assistant, Hospitality Aide, Restorative Aide, Activity Director, MDS Nurse, LVN A, CNA B, LVN C, CNA D, LVN E, CNA F, CNA G, [NAME] H, CNA I, Housekeeping J, [NAME] K, RN L, Laundry Aide M, CNA N, Housekeeping O, CNA P, CNA Q, OTA, OT, CNA R, CNA S, CNA T, RN U, RN V, LVN W, CNA X, CNA Y, CNA Z, CNA AA, and Housekeeping BB. All staff were able to identify: - the the different types of abuse; - definition of sexual abuse; - what to do if they observed two residents having sexual contact; - consensual and non-consensual sexual contact; and - what to do when residents wandered and entered other residents' rooms. Observation on 11/05/24 at 3:20 PM revealed the secure unit was split in two, separated by a secure door that required a code to open. The units were split into a male unit and a female unit. The Corporate Administrator and Corporate RN were informed the Immediate Jeopardy was removed on 11/05/24 at 4:03 PM. On 11/04/24 at 5:00 PM, an IJ was identified. While the IJ was removed on 11/05/24, the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal.