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	07/02/2025

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. (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 0636 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 interview, observation and record review, the facility failed to make a comprehensive assessment of each residents' needs, strengths, goals, life history, and preferences within 14 calendar days after admission for 1 of 5 residents (Resident #31) reviewed for accuracy of assessments. The facility failed to accurately complete Resident #31's Quarterly Minimum Data Set assessment on 6/3/25 by not accounting for the falls on 4/18/25, 5/8/25, 5/16/25, 5/17/25, 5/21/25, 5/22/25 which occurred prior to her re-admittance to the facility on 6/2/25. This failure could place residents at risk of not having their needs met. Findings included: Record review of a face sheet dated 7/2/25 indicated Resident #31 was a [AGE] year-old female admitted to the facility on [DATE] with a re-admission on [DATE]. Resident #31 had the following diagnoses: metabolic encephalopathy (condition in which brain dysfunction occurs resulting in altered mental state, confusion and changes in behavior), and Extrapyramidal Movement Disorder (a disorder characterized by involuntary movements, muscle stiffness and tremors). Record review of Resident #31's comprehensive Minimum Data Set assessment dated [DATE] section A0310 reflected it was a quarterly assessment. In section J1800 regarding falls indicated, Resident #31 had no falls since admission/entry or reentry. Record review of Resident #31's Care Plan dated 6/2/25 reflected . I am at risk for falls r/t confusionDate Initiated: 11/16/2022Revision on: 11/16/2023 My fall risk will be minimized.Date Initiated: 11/16/2022Revision on: 12/13/2023Target Date: 05/25/2025 Become familiar with my daily routine and attempt to anticipate and meet my needsdaily.Date Initiated: 11/16/2022Revision on: 11/21/2022CG Encourage me to stay in common areas to promote more supervision.Date Initiated: 11/16/2022CMCG Encourage my participation in activities that will increase strength and mobility.Date Initiated: 11/16/2022CMResident had an actual fall on 5/17with no injuries, 5/21/25 abrasion to left knee and redness to forehead, 5/22/25 Date Initiated: 05/17/2025Revision on: 05/23/202 Ms. [NAME] will not have anymajor injuries from falls throughreview dateDate Initiated: 05/17/2025Target Date: 05/25/2025 Redirect Ms. [NAME] to chair when she wants to sit downDate Initiated: 05/17/2025CG sent to ER for evaluation.Date Initiated: 05/22/2025CN Therapy referral for strength and mobility/balance post fall and as needed per MDorder.Date Initiated: 05/17/2025PT. Record review of the facility Accident/Incident Logs reflected the following falls for Resident #31:- 4/18/25 witnessed fall- 5/8/25 unwitnessed fall- 5/16/25 unwitnessed fall- 5/17/25 unwitnessed fall- 5/20/25 unwitnessed fall- 5/22/25 witnessed fall- 6/28/25 witnessed fall- 6/30/25 unwitnessed fall In an interview with CNA F on 7/1/25 at 11:40pm who stated Resident #31was a fall risk and the interventions they had in place for her were close supervision, provide non-slip socks and follow behind her when she was up and walking. She stated resident was hospitalized recently and believed it was due to a fall she had. In an interview with LVN G on 7/1/25 at 11:59am who stated Resident #31 was a fall risk and should be checked on hourly to prevent falls. Resident #31's bed should always be in the lowest position. In an interview with RN H on 7/1/25 at 3:02pm who stated when Resident #31 came from the hospital she was a fall risk. Staff would ensure her bed was in the lowest position and make sure her call light was in reach. Observation of Resident #31 in bed on 7/2/25 at 12:07pm revealed resident was asleep with her bed in the lowest position. She had non-slip socks on, and the call light was within reach for her. In an interview with Minimum Data Set Coordinator on 7/2/25 at 11:23am revealed she had completed Resident #31's Quarterly Minimum Data Set Assessment on 6/3/25. She was responsible for accurately completing all sections of the Minimum Data Set assessment except for sections B, C, D, and E. She used the documentation from Certified Nurses Aids and nurses to complete the sections on the Minimum Data Set. She stated if a resident had a fall since the last Minimum Data Set she would mark the fall on section J. She reviewed Resident #31's Minimum Data Set, dated [DATE] and noted there were no falls marked for her. She stated Resident #31 was discharged from the facility on 5/22/25 and re-admitted on [DATE]. When she completed Resident #31's Minimum Data Set assessment on 6/3/25 she looked at what had changed from resident's last Minimum Data Set on 5/22/25 and updated it. The Minimum Data Set Nurse Coordinator noted resident had a fall on 5/22/25 which led to her hospitalization and therefore should have included that fall in her updated Minimum Data Set on 6/3/25. She stated she should have noted on the 6/3/25 Minimum Data Set Assessment any falls that resident had after 4/6/25. She stated she must have overlooked the information related to the residents falls when completing the Minimum Data Set assessment on 6/3/25. She stated she did not know if there would be a risk to the resident of not having an accurate Minimum Data Set since there were no injuries during her last fall. She did not think the failure

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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F 0656 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 observation, interview, and record review, the facility failed to develop and implement a person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 2 of 6 residents (Resident#8, and Resident#63) reviewed for comprehensive care plans in that: The facility failed to develop and implement a comprehensive person-centered care plan to address Resident #8's, and Resident#63's ADLs on the care plan revision dated 04/02/25. These deficient practices could place residents at risk of not receiving appropriate treatment and services. The findings included: Record review of Resident #8's Quarterly MDS assessment dated [DATE] reflected Resident #8 was an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included Diabetes Mellitus, Non-Alzheimer's Dementia, and Muscles weakness (generalized). Resident #8 had a BIMS score of 09 which indicated Resident #8's cognition was moderately impaired. Further review reflected Resident #8 had a code of 4 (Supervision or touching assistance - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) for eating and oral hygiene, and code 1 (Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) for C. Toileting hygiene. E. Shower/bathe self. F. Upper body dressing. G. Lower body dressing. H. Putting on/taking off footwear. I. Personal hygiene. Review of Resident #8's Comprehensive Care Plan, dated 04/02/25, revealed the care plan did not identify the resident's ADLs interventions. An observation and interview on 06/30/25 at 10:31 AM revealed Resident#8 was lying in bed. The nails on both hands were approximately 0.8 centimeter in length extending from the tip of her fingers. Resident #8 stated she did not like her long nails; she wanted them trimmed, and could not do it herself, and the staff did not want to trim them for her. Resident #8 uncovered her feet, and stated she wanted her toenails trimmed, and the staff did not want to trim them for her. Record review of Resident #63's admission MDS assessment dated [DATE] reflected Resident #63 was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included spinal stenosis-cervical region, congestive heart failure, Morbid (Severe) obesity due to excess calories, and osteoarthritis of knee. Resident #63 had a BIMS score of 15 which indicated Resident #63's cognition was intact. Further review reflected Resident #63 had a code of 5 (Setup or clean-up assistance - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.) for eating and oral hygiene, and code 1 (Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) for C. Toileting hygiene. E. Shower/bathe self. F. Upper body dressing. G. Lower body dressing. H. Putting on/taking off footwear. I. Personal hygiene. Review of Resident #64's Comprehensive Care Plan, dated 05/26/25, revealed the care plan did not identify the resident's ADLs interventions. An observation and interview on 06/30/25 at 11:37 AM revealed Resident#63 was up in wheelchair in her room. Resident#63 stated her understanding on admission was that she will get therapy to regain strength in her legs and hands, and she only got therapy for her hands, and have a better strength in her hands, and not on her legs. Interview on 07/02/25 at 11:15 AM OT Aide covering for the therapy department, she stated Resident#63 was admitted to facility on a long-term service and not skilled service. She stated the administration paid for the Resident to receivd five days of skilled services from 05/13/25 to 05/19/25. She stated the therapy department was only able to work on the Resident#63 upper extremities, and not on her lower extremities, because she was not able to come to the physical therapy room due to her refusal or the staff did not get her up in wheelchair. She stated the therapy department staff were able to get Resident#63 up out of wheelchair on Monday, Wednesday and Friday schedule, for lunch starting on 5/13/2025 to 5/19/2025 for the five days that were paid for by the facility. Follow up interview on 07/02/25 at 11:19 AM Resident#63 stated nobody talked to her about physical therapy in the morning. She stated the facility schedule her for showers MWF on the afternoon according to the position of her bed in the room (Bed B vs. Bed A). She stated, she asked to be accommodated for morning schedule shower and they refused. She stated the shower time was open all afternoon, and she never know the shower time exactly. Resident#63 stated it will be hard for her to be up in the wheelchair all day. She further stated on her shower schedule days, she got up in the wheelchair before lunch and go to bed after shower. Interview on 07/02/25

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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F 0677 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 observation, interview, and record review, the facility failed to provide the necessary services for residents who are unable to carry out activities of daily living to maintain good grooming and personal hygiene for 2 (Resident #8 and Resident #80) of 12 residents reviewed for ADLs. The facility failed on 06/30/2025 to ensure the following:1. Resident #8 had her fingernails trimmed.2. Resident #80 had fingernails trimmed and cleaned. This failure could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections, and a decreased quality of life. Findings included:1. Record review of Resident #8's Quarterly MDS assessment dated [DATE] reflected Resident #8 was an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included Diabetes Mellitus, Non-Alzheimer's Dementia, and Muscles weakness (generalized). Resident #8 had a BIMS score of 09 which indicated Resident #8's cognition was moderately impaired. Resident #8 was dependent on the staff with personal hygiene. Review of Resident #8's Comprehensive Care Plan, dated 04/02/25, reflected the following: Problem: [Resident #8] has impaired cognitive r/t Dementia. Goal: [Resident #8] will be able to communicate basic needs on a daily basis through the review date. Intervention. Monitor/document/report.expressing self. Further review of care plan revealed Resident#8 had not been care planed for ADLS, and no documentation of her been resistive to care. An observation and interview on 06/30/25 at 10:31 AM with Resident#8 revealed she was lying in bed. The nails on both hands were approximately 0.8 centimeter in length extending from the tip of her fingers. Resident #8 stated she did not like her long nails; she wanted them trimmed, and could not do it herself, and the staff did not want to trim them for her. 2. Record Review of Resident#80's Quarterly MDS assessment dated [DATE] reflected Resident #80 was an [AGE] year-old male admitted to the facility with initial admission date of 02/24/2025. His relevant diagnoses included Heart failure (heart cannot pump adequate blood to meet body needs), Diabetes mellitus (high blood glucose), Cerebrovascular accident (disruption to blood flow to brain), Hyperlipidemia (high blood lipid levels), Renal insufficiency (kidney functioning at severely reduced capacity), Hypertension (high blood pressure). Resident #80's BIMS score was 8, which indicated his cognition was moderately impaired. The MDS assessment indicated Resident #80 was dependent on staff for all personal hygiene needs. Resident #80 was on hospice care. In an observation and interview on 6/30/25 at 12:08 PM with Resident #80 revealed Resident #80 had long, jagged fingernails. His fingernails on right hand were at least 0.75-1 inch in length extending from the tip of his fingers. The nails were discolored tan and had dark brown colored residue underside. Resident #80 stated he would like his fingernails trimmed and cleaned. He added he had asked the staff about trimming them some time ago, but he was not sure why it was not trimmed yet. In an interview on 06/30/25 at 12:23 PM with LVN D who stated she worked in the facility for last 2 years. She stated CNAs and Nurses were responsible for nail care. She added Resident #80 did not have any history of refusals and fingernails should be trimmed and cleaned. She added even if Residents were on hospice, nail care should be offered to all residents. She stated the risk of not cutting and cleaning nails was lapses in infection control and loss of quality of life. In an interview on 06/30/25 at 12:27 PM CNA E stated she had worked in the facility for last 10 months and was aware of Resident #80's care needs. She stated CNAs and LVNs were responsible for nail care. She added Resident #80 was on hospice and she had not recently offered nail care to the resident. She stated nail care should be done on shower days and as needed. She stated untrimmed , dirty nails could cause infection and injury. In an interview on 07/01/25 at 1:17 PM with the DON who she stated Resident#8 fingernail were long and needed to be trimmed. She added Resident#8 was alert and oriented X4 (person, place, time and event) and sometimes she could refuse. She added Resident#80 was on hospice and hospice aides take care of all ADLs for the resident. She also stated that Facility CNAs should be offering ADLs including nailcare for hospice residents on as needed basis and stated Resident #80 had long and dirty fingernails and should have been clipped and cleaned. DON stated her expectation was that nail care should be provided every shower day and as needed. She stated that both CNAs and Nurses were responsible for doing nail care on all residents; except Nurses were responsible for nailcare if resident had a diagnosis of diabetes. She stated Resident#8 was resistive to care. The DON stated residents who had long fingernails could scratch themself. Record Review of the facility policy titled Care of Fingernails/Toenails revised October 2010 reflected, The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections 1. Nail care includes daily cleaning and regular trimming

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. (continued on next page)

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F 0687 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 residents received proper treatment and care to maintain mobility and good foot health for 1 Resident (Resident #8) of 6 residents reviewed for foot care. The facility failed on 06/30/2025 and did not provide adequate foot care for Resident #8 who was also a diabetic and had a standing order for podiatric services. Resident #8's Toenails were chipped, thick, and long. This failure could put residents at risk for infection, impaired mobility, and poor foot health as well as a decline in their quality of life. Findings included: Record review of Resident #8's Quarterly MDS assessment dated [DATE] reflected Resident #8 was an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included Diabetes Mellitus, Non-Alzheimer's Dementia, and Muscles weakness (generalized). Resident #8 had a BIMS score of 09/15 which indicated Resident #8's cognition was moderately impaired. Further review revealed Resident #8 was dependent for personal hygiene. Review of Resident #8's Comprehensive Care Plan, dated 04/02/25, reflected the following: Problem: [Resident #8] has impaired cognitive r/t Dementia. Goal: [Resident #8] will be able to communicate basic needs on a daily basis through the review date. Intervention. Monitor/document/report.expressing self. Further review of care plan revealed Resident#8 had not been care planed for ADLS, and no documentation of Resident#8 been resistive to care. Record review 07/01/25 at 10:00 AM revealed since Resident#8 was diabetic, she had a standing order dated (01/15/25) for podiatric referral. Review of the podiatric referral list for the residents in the facility Date Range: 01/01/25-06/30/25 printed on 06/30/25 revealed Resident#8 was not included on the list. An observation and interview on 06/30/25 at 10:31 AM revealed Resident#8 was lying in bed. Resident #8 uncovered her feet, and stated she wanted her toenails trimmed, and the staff did not want to trim them for her. She further stated the other day someone came in and did her roommate toenails, and when she asked the person to do hers, the person replied that she was not on the list. Interview on 07/01/25 at 12:10 PM the Social Worker) revealed someone had to let her know that the resident needed a referralShe stated the facility audited the referral list and starting from the current census everyone was put on podiatric referral list. She stated Resident#8 had never been referred for podiatric care. In an interview on 07/01/25 at 1:17 PM with the DON who stated Resident#8 was alert and oriented X4 and sometimes she could refuse or be resistant to care. She stated toenails care was a part of grooming, and it was the responsibility of the nurses during their weekly assessment to check. The DON stated the CNAs also were responsible to let the nurses know if the resident's toenail needed trimming. The DON stated the staff should report to the social worker the residents in need of podiatric referral. The DON stated she had to check with the SW if Resident#8 was included in the referral list for Podiatric care. The DON stated did not see how toenails not been trimmed could be a risk to the Resident, and added may be if the Resident got hurt and it became a problem. Follow up interview with the DON on 07/02/25 at 1:20 PM who stated Resident#8 podiatric referral went to the SW and now she was on the list. When asked about the Doctor order for toenails referral since December 2024, and never been referred for podiatric care, she replied it was the responsibility of Resident#8 to ask the staff and SW for her toenails care. The DON stated the standing order for toenail care were there to respond to resident's needs, and Resident#8 did not express her needs for toenail care, and it was the responsibility of the SW to follow the Doctor order, do the referral and maybe it was an oversight. In an interview on 07/02/25 at 2:30 PM with the Administrator, she stated Resident#8 knew her needs and did not ask for toenail care. When reminded of the Resident BIMS score of 09/15, and having dementia, she stated Resident#8 did not have dementia and she was self-responsible for her care, and needs. The Administrator stated the standing Doctor orders for podiatric referral was as needed to be utilized when the needs were there, and since Resident#8 did not express her needs for toenails care, the facility did not have to do the referral. The administrator refused to answer the question about the risk for untrimmed toenails to the residents and stated did not see how a resident could get hurt from untrimmed toenails. Review of the facility policy titled Skin integrity- foot care date implemented 09/10/2024, with the revised date 05/23/2025 revealed It is the policy of this facility to ensure residents receive proper treatment and care within professional standards of practice and state scope of practice, as applicable, to maintain mobility and good foot health. This policy pertains to maintaining the skin integrity of the foot. Policy Explanation and Compliance Guidelines: 1. The facility will provide foot care and treatment in accordance with professional standards of practice, including the prevention of complications from the resident's medical conditions.b. If necessary, the facility will assist

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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 observations, interviews, 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. The facility failed to ensure food items were properly stored in the facility freezer on 06/30/25. These failures could affect residents who received their meals from the facility's kitchen, by placing them at risk for food-borne illness, and food contamination. Findings included: Observation on 6/30/25 at 9:48 AM in the facility freezer revealed frozen cinnamon rolls were left uncovered in an open brown box exposing them to frigid air. In an interview 07/01/25 12:44 PM with the Dietary Manager who stated that everyone including cooks, dietary aides and himself were responsible for covering, dating, and labeling all food items in the kitchen. He stated all foods should be appropriately covered and sealed. He stated he tossed away the cinnamon rolls that were left open inside the freezer. He added the risk to residents of improper food storage that included dating, labeling, and covering food items was possibility of food borne illness in residents and cross contamination of food. In an interview on 07/01/25 at 12:51 PM with [NAME] B who stated she was working in the facility for about 18 years. She stated that everyone in the kitchen including dietary aides, cooks, and managers were responsible for appropriate food storage. She stated all food items in the kitchen especially in the refrigerator and freezer should be tightly covered . She stated risk of not covering food appropriately can cause food borne illness in residents. In an interview on 07/01/25 at 12:56 PM with Dietary Aide C who revealed all food items in the kitchen should be covered appropriately and it was the responsibility of all kitchen staff. She added that the risk to residents of not appropriately covering food items was residents could get sick. Review of the facility's policy titled Food Storage revised June 1, 2019, reflected, . Policy: To ensure that all food served by the facility is. of good quality and safe for consumption, all food will be stored according to the state, federal and US Food Codes and HACCP guidelines. Review of the Food and Drug Administration Food Code, dated 2022, reflected, . Food Storage.(B) .refrigerated, ready-to eat time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety

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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 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 review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 1 (Resident #41) resident reviewed for infection control. The facility failed on 06/30/2025 when CNA A failed to change gloves and perform hand hygiene when she went from dirty to clean during incontinence care for Resident #41. This deficient practice could place residents and nursing staff at risk of transmission of communicable diseases and infections. Findings included: Review of Resident #41's quarterly MDS, dated [DATE], revealed that Resident #41 was a [AGE] year-old female admitted on [DATE], her diagnoses included type 2 diabetes mellitus, Cerebrovascular accident, and weakness. Resident #41 had a BIMS score of 09 which indicated Resident #41's cognition was moderately impaired. Further review revealed Resident #41 was always incontinent of bowel and bladder. Review of Resident #41's care plan, dated 4/28/25, revealed, Problem. The resident has an ADL self-careperformance deficit r/t Confusion. Goal. The resident will maintain current level of function through the review date. Intervention. TOILET USE: The resident requires assistance by (1) staff for toileting. In an observation on 06/30/25 at 10:30am, CNA A entered Resident #41's room to provide incontinent care for the Resident. CNA A performed hands hygiene upon entering the room, and put on clean gloves, from handful of gloves, she was carrying in her uniform pocket. CNA A uncovered Resident#41 and unfastened the brief. CNA A cleaned Resident#41 front area using two to three wipes at a time. Resident#41 had a pasty large bowel movement. CNA A gloves got soiled with feces, she cleaned them with wipes, and helped Resident#41 turn toward the wall. CNA A cleaned Resident#41 buttocks area using two to three wipes at time. CNA A put the dirty wipes in the brief, folded the brief, and dispose of it in a plastic bag at the foot of the bed. CNA A folded the under pad and push it under Resident#41. CNA A with the same gloves got the clean brief and put it on the Resident. CNA A helped the Resident#41 turn back, and to her left finished putting the brief on her and tapped it. CNA A Covered Resident#41, put the trash bag together, removed gloves, washed hands, and took the bag to the dirty linens room, and sanitized hands. In an interview on 06/30/ 25 at 10:45am, CNA A stated that she was supposed to change glove and perform hands hygiene when going from dirty to clean task during the residents' care. She stated was not supposed to carry the gloves in her pocket. She stated her pocket could be dirty. She stated the risk of not following proper hands hygiene, and gloves use was the spread of infection to staff and other residents. In an interview on 07/02/25 at 1:20 PM, the DON who stated the staff are not supposed to put the gloves in their pocket, and just grab what they needed at the time. DON stated the issue with putting the gloves in their pocket cross contamination. DON stated during the incontinent care, the staff was supposed to change gloves with hands hygiene going from dirty to clean task, and any time they take off the gloves. She stated the purpose of that was to prevent infection. She stated she usually provided hand hygiene in-services when a concern occurs with infection control. Review of facility's Perineal care policy, dated 05/01/25, revealed . 9. Remove Gloves and discard. Perform hand hygiene. 10.Re-apply new set of gloves. 11. Place appropriate incontinent product under resident. 13 Remove gloves and discard. Perform hand hygiene .

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	07/02/2025

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observations, interviews and record review, the facility failed to ensure residents toileting facilities were adequately equipped to allow residents to call for assistance for 5 Residents (Resident#13, Resident#16, Resident#57, Resident#63, and Resident#87) of 20 residents reviewed for residents' call systems. The facility failed on 06/30/2025 to ensure the call light system was accessible to a resident, lying on the floor in the shared residents' toilets located inside the residents' rooms when the call lights were missing the pull strings, for:. Resident#13. Resident#16 . Resident#57. Resident#63 . Resident#87 This failure could place residents in the facility at risk of being unable to have a means of directly contacting caregivers. Findings included: -Observation on 06/30/25 at 10:48 AM residents' toilet call light pull string was missing for Resident#13 and Resident#16. - -Observation on 06/30/25 at 11:30 AM residents' toilet call light pull string was missing for Resident#57 and Resident#87. -Observation on 06/30/25 at 11:37 AM resident's toilet call light pull string was missing for Resident#63 Interview and observation on 07/02/25 at 12:38 PM the Maintenance/Housekeeping Director who stated he looked at the call light outlets and stated the string were missing. The Maintenance/Housekeeping Director stated he did not know about the missing call lights strings, and he would fix them right away. The Maintenance/Housekeeping Director stated the risk to a resident was the resident could fall, not get help, and could cause someone to be lying there for hours. Interview on 07/02/25 at 1:20 PM the DON who stated call light string supposed to be replaced if it was missing, and it was supposed to be within the reach of the resident. DON stated missing call light strings was a safety concerns. Interview on 07/02/25 at 2:33 PM the Administrator who stated the call light string should be within resident reach, so they could call for help when they need it. She stated missing strings for the bathroom call lights could be a safety issue. Review of the facility policy titled Call Lights: Accessibility and Timely response, revised 05/01/25 revealed The purpose of this policy is to assure the facility is adequately equipped with a call light to allow residents to call for assistance. 5.Staff will ensure the call light is within reach of resident and secured, as needed. Findings included: -Observation on 06/30/25 at 10:48 AM residents' toilet call light pull string was missing for Resident#13 and Resident#16. - -Observation on 06/30/25 at 11:30 AM residents' toilet call light pull string was missing for Resident#57 and Resident#87. -Observation on 06/30/25 at 11:37 AM resident's toilet call light pull string was missing for Resident#63 Interview and observation on 07/02/25 at 12:38 PM the Maintenance/Housekeeping Director who stated he looked at the call light outlets and stated the string were missing. The Maintenance/Housekeeping Director stated he did not know about the missing call lights strings, and he would fix them right away. The Maintenance/Housekeeping Director stated the risk to a resident was the resident could fall, not get help, and could cause someone to be lying there for hours. Interview on 07/02/25 at 1:20 PM the DON who stated call light string supposed to be replaced if it was missing, and it was supposed to be within the reach of the resident. DON stated missing call light strings was a safety concerns. Interview on 07/02/25 at 2:33 PM the Administrator who stated the call light string should be within resident reach, so they could call for help when they need it. She stated missing strings for the bathroom call lights could be a safety issue. Review of the facility policy titled Call Lights: Accessibility and Timely response, revised 05/01/25 revealed The purpose of this policy is to assure the facility is adequately equipped with a call light to allow residents to call for assistance. 5.Staff will ensure the call light is within reach of resident and secured, as needed.