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	08/15/2025

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 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. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to provide adequate supervision for 1 (Resident#1) of 8 residents reviewed for supervision. The facility failed to ensure Resident #1 had adequate supervision on Saturday 07/19/25 for approximately 30 minutes. Resident#1 left out the front door and wheeled himself across 4 lanes (with two lanes that ran in the opposite direction) of traffic across the street to the gas station unsupervised. These failures could place residents' health and safety at risk. The non-compliance was identified as past non-compliance (PNC). The IJ began on 07/19/25 and ended on 07/31/25 the facility had corrected the non-compliance before the state's investigation began. Findings included: Record review of Resident#1's face sheet reflected, he was a [AGE] year old male who was originally admitted on [DATE] and readmitted on [DATE] and diagnosed with unspecified Dementia (diagnosis used when a person exhibits symptoms of dementia, but the specific type or cause cannot be determined), partial traumatic trans phalangeal amputation of right middle finger (traumatic injury that causes the partial loss of a finger at the level of the joint between the finger bone (phalanx) and the hand bone (metacarpal)), subsequent encounter, major depressive disorder, recurrent, Epileptic seizures related to external causes, not intractable without status Epilepticus (neurological events characterized by abnormal electrical activity in the brain), heart failure, unspecified, catatonic schizophrenia (brain doesn't manage muscle movement signals), mixed receptive-expressive language disorder (communication disorder), Rhabdomyolysis (Break down of muscle tissue), unspecified abnormalities of gait and mobility. Record review of Resident#1's MDS, dated [DATE] reflected his BIMS score was 06 which indicated severe cognitive impairment. Record review of Resident#1 care plan, undated reflected on 07/14/25 The resident has limited physical mobility r/t weakness and debility. Goals reflected, the resident will maintain current level of mobility Interventions reflected, the resident requires supervision to limited assistance by staff for locomotion using manual wheelchair. Support and assistance fluctuate r/t cognitive deficit, weakness. Record review of Resident#1's Elopement Risk Assessment, dated 06/18/25 reflected in part: 1. Mobility - propels, 2. Mental Stability- Alert oriented times 3 (patient is aware of their identity, location, and the current date), 4. History of elopement attempts - no attempts, 5. Behavior Modification- Behavior redirected.7. Diseases (Dementia, any type of mental illness)- non-present. 8. Summary of the elopement risk assessment- The resident is not at risk for elopement. Record review of Resident#1's progress notes dated, 07/16/25 to 08/15/25 reflected in part: Dated 07/16/25 reflected Per social worker resident been attempting to push the front door yesterday, at this time resident sitting at the front lobby at this time resident did not want to talk to this nurse .NP notified , Dated 07/17/25 Resident#1 test results reflected (Enterococcus faecalis (Gram-positive bacterium commonly found in the gastrointestinal tract): Positive, Pseudomonas aeruginosa (can cause infections in the blood, lungs, urinary tract, or other parts of the body after surgery.: Positive) and resistance to multiple antibiotics, Noted by RN C Dated 07/18/25 Resident#1's First dose of IV Vancomycin (glycopeptide antibiotic used primarily to treat serious bacterial infections, particularly those caused by Gram-positive bacteria) 1g administered via midline to the right upper arm for treatment of UTI . Noted by RN C Dated 07/19/25 reflected Approximately [1:00 pm] resident with others were taken out to the smoking zone. After the resident finished smoking, he was let inside by the CNA. The resident noted sitting across the nurse station for a few minutes, then wheeled himself on the hallway towards his room. Approximately [1:30 pm] the activity staff notified this nurse that the resident was outside in the front side of the building. This nurse rushed to the front of the building immediately and noted resident sitting on his wheelchair on the driveway with the maintenance Director standing behind him. Maintenance director stated that the resident was across the street. Resident Assisted back into the building. This nurse asked the resident where are you coming from? Resident replied, I don't know, I don't know, I don't know.shaking his head left to right Head to toe assessment completed no injuries noted, Vitals: BP126/60, P68, RR17 T97.7, o2 96% on room air. Resident denies pain at the moment and no s/s of distress noted. Administrator, [FNP] DON and Family notified.[FNP] gave new orders to house the resident in the secure unit. Resident transferred to the secure unit. Report given to the unit nurse . ADM and nurse followed up with resident regarding incident from earlier today. Resident was asked if he went across the street, resident smiled while shaking his head stated I went to the front because I'm a strong man. Resident stated he's fine and asked ADM not to worry .ADM called resident RP again to inform her of resident going outside of facility with no supervision. Resident RP stated