STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675081	A. Building B. Wing	09/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Acres Living and Rehabilitation Center	2525 Centerville Rd Dallas, TX 75228

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48235 Based on interviews and record review the facility failed to ensure all alleged violations involving abuse and neglect were reported immediately, but not later than 2 hours after the allegations were made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, for one (Resident #1) of nine residents reviewed for abuse and neglect. The Abuse Coordinator failed to report an allegation of sexual abuse involving Resident #1 to the State Agency immediately but no later than 2 hours on 09/05/2024. The Abuse Coordinator was notified on 09/05/24 at 8:25 AM about the allegation of sexual abuse. The Abuse Coordinator self-reported the allegation of sexual abuse to the State Agency on 09/05/24 at 2:25 PM. This failure could place residents at risk of abuse and neglect. Findings included: Review of Resident #1's Quarterly MDS assessment dated [DATE] revealed she was a [AGE] year-old female admitted to the facility on [DATE]. Resident # 1's diagnoses included: unspecified dementia (memory loss), muscle weakness (lack of muscle strength), and other abnormalities of gait and mobility. Resident #1 had a BIMS score of 02 indicating severe cognitive impairment. She required moderate assistance with personal hygiene and supervision with toilet transfers. Resident #1 was occasionally incontinent of bowel and bladder. Review of Resident #1's Comprehensive Care Plan dated 08/09/2024 reflected Resident #1 was at risk for altered respiratory status/difficulty in breathing and at risk for impaired cognitive function related to dementia. Review of the nursing note dated 09/05/24 at 8:25 am revealed LVN A notified the Abuse Coordinator/Administrator that Resident # 1 was being transferred to the hospital for an allegation of sexual abuse. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675081	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/07/2024
NAME OF PROVIDER OR SUPPLIER Golden Acres Living and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2525 Centerville Rd Dallas, TX 75228	

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Progress note record with an effective date of 09/05/2024 08:25 and created date of 09/05/2024 10:27, by LVN A revealed Resident #1's Family Member C was talking to LVN A. Resident #1 came to the dining room and said, someone raped me last night, resident #1 was crying, and she was visibly upset. Review of an email dated 09/05/24 at 2:25 PM from the Abuse Coordinator revealed he reported the allegation of sexual abuse to HHSC at 2:25 PM. Observation and interview on 09/07/2024 at 11:03 AM with Resident #1 revealed she could not remember the incident and could not provide any details of the alleged incident. Interview on 09/07/2024 at 09:58 AM, the forensic nurse revealed she saw Resident #1 at the local hospital to complete a SANE Examination (Forensic evidence collection process from sexual assault victims) on 09/05/2024. She stated Resident #1 reported to her that she was raped the previous night (09/04/2024). Interview on 09/07/2024 at 10:57 AM with Resident #1's Family Member B revealed Resident #1 told Family Member C on 09/05/2024 morning (exact time not known) that she was raped the previous night (09/04/24). The Family Member B stated the Family Member C immediately reported this to the charge nurse and took Resident #1 to the hospital for evaluation. Interview on 09/05/24 at 2:16 PM with the DON revealed on 09/05/24 around 9:30 AM, Resident #1 told Family Member C and LVN A that she was raped the previous night. The DON stated LVN A could not talk with the resident because the family member took the resident to the hospital for evaluation. Interview with the DON revealed the Administrator was the Abuse Coordinator. The DON stated the Administrator was responsible for reporting an allegation of abuse to the state agency within 2 hours of learning about the incident. Interview revealed the DON did not know if this allegation of sexual abuse was reported to the state agency within 2 hours. Interview on 09/05/2024 at 3:23 PM with the Social Services Assistant revealed she was attending the morning staff meeting on 09/05/24. The Social Services Assistant stated LVN A came to the meeting room and told the Administrator about Resident #1's sexual abuse allegation around 10 AM. Interview on 09/05/2024 at 03:36 PM with the Administrator revealed he was the Abuse Coordinator. He stated his expectation of the staff was to notify him of any concerns of abuse immediately. The Administrator stated he first learned about Resident #1's sexual abuse allegation around 10:30 AM from a staff member. He stated Resident #1's family took the resident to the hospital and returned to the facility around 3:30pm. The Administrator stated he then notified the local police. Interview revealed the local police came to the facility to talk with Resident # 1. The Administrator stated he followed the abuse reporting time as per the Long-Term Care Provider Letter Number PL 19-17, and it was supposed to be reported to the state within 2 hours. He stated he reported this allegation to the state sometime in the afternoon, he could not remember the exact time. The Administrator then provided the copy of the email reporting the incident to the state and it showed the incident was reported to the state on 09/05/2024 at 02:25 PM. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Telephone interview on 09/07/24 at 5:14 PM with LVN A revealed she was in the dining room when Family Member C asked her to reach out to the doctor to test the resident. Interview with LVN A revealed Resident #1 came to the dining room crying and said she was raped last night. LVN A stated she immediately called the Administrator's office, but he did not answer. LVN A then called the conference room but no one answered the phone. Interview revealed around 8:45 am she tried to call the Administrator's phone, but he did not answer. LVN A stated she went to look for the Administrator and found him in a meeting with other staff. Interview revealed she notified the Administrator about the allegation of sexual abuse made by Resident #1. Review of the facility policy, the Long-Term Care Provider Letter Number PL 19-17 dated 06/10/2019, reflected Abuse, neglect, exploitation, misappropriation of resident property and other incidents that a nursing facility must report to the health and human services commission. Abuse with or without serious bodily injury required to report immediately but not later than two hours after the incident occurs or is suspected.