STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675418	A. Building B. Wing	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Manor at Seagoville	2416 Elizabeth LN Seagoville, TX 75159

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** 44786 Based on interview and record review, the facility failed to ensure that all alleged violations involving the reasonable suspicion of a crime were reported immediately to a law enforcement entity for its political subdivision, in accordance with State law, within two hours 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 1 (Resident #1) of 6 residents reviewed for abuse/neglect. The facility failed to report to the local law enforcement agency when the Administrator was notified by staff that Resident #1's family informed them Resident #1 stated he was sexually abused by a staff member on 03/23/25 and the report to law enforcement was not made until 03/25/25. This failure could place residents at risk for continued abuse due to unreported allegations of abuse. The findings included: Record review of Resident #1's face sheet dated 03/25/25, reflected an [AGE] year-old man, with an admitted [DATE]. Resident #1 had a diagnosis of Depression (feeling of sadness, loss of energy, and loss of interest), Insomnia (difficulty falling asleep) and Vascular Dementia (damage to blood vessels in the brain leading to changes in memory, behavior, and thinking). Record review of Resident #1's Comprehensive MDS dated [DATE], reflected Resident #1 had a BIMS score of 3, which indicated Resident #1 had sever cognitive impairment. The MDS reflected Resident #1 did not have any behaviors. Record review of Resident #1's Care Plan, with an effective date of 03/09/35, reflected Dementia as a problem and noted Resident #1 was disoriented when he received care from staff. Interventions for the problem were noted: While providing ADL care that may be misinterpreted for sexual acts, voice that you need to wipe or clean before performing the action. Record review of a physician's order dated 03/21/25, reflected an order for a foley catheter and noted it as needed. It also reflected may perform in/out for urine collection. (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an Incident Report dated 03/21/25 on Resident #1 reflected the following: Primary Injury Bleed from urethra Person in Charge- Account of Occurrence It was reported to this nurse that (resident name) was bleeding from the urethra (the hollow tube that lets urine, a waste product, leave the body). Resident was lying on his back in the bed. Resident stated he was in no pain and did not feel like he had to pee. (Resident name) had no bleeding from his urethra when this writer arrived at his room. Nurse reported she held pressure and was holding resident penis to assess for injury, none were noted. Detailed Location of Injury Bleeding from Urethra A. Witness Statement Nurse stated there was no bleeding until the catheter was being removed, when she saw blood, she stopped moving the catheter and the catheter was pushed out on its own. Signed by the DON Record review of a progress note dated 03/21/25 at 12:32 PM, documented by LVN A, reflected LVN A was called in to Resident #1's room regarding the catheter, that Resident #1 wanted the catheter out and stated he would pull it out if they did not get it out. LVN A then removed the catheter, there was a little bleeding, but resident stated he was not in pain. After the catheter was removed, his clothes and brief were changed, and Resident #1 asked to go to the dining area to eat lunch. Record review of a progress dated 03/21/25 at 15:30 (3:30 PM), documented by LVN A, reflected Resident #1 was sent out to the hospital due to bleeding. It was noted blood was present on the front of Resident #1's pants. The progress note stated the following: I was called to the room by charge nurse who was attempting to collect a UA sample from (Resident #1). When I entered the room, I noted that (Resident #1) was laying in the bed and the catheter was in place. (Resident #1) stated you better take this out of me before I snatch it out. In an observation and interview on 03/25/25 at 9:00 AM, Resident #1 was observed laying in the hospital bed awake. Resident #1 did not speak to Surveyor. Resident #1 was covered from his waist down with a sheet. There were no visible marks or bruises. Family Member #1 stated Resident #1 was doing well. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/25/25 at 1:28 PM, with the Administrator and the DON, the DON stated Resident #1 was at the facility for short term care and did not admit to the facility with a catheter. The DON stated Resident #1's doctor ordered and in and out catheter to ensure his antibiotics were working well. The DON stated Resident #1's charge nurse was LVN B. The DON stated last Friday, 03/21/25, Resident #1 received the catheter, but the staff had trouble getting a sample, as well as the Resident #1 wanted the catheter out. The DON stated there was bleeding when it was removed. The DON stated Resident #1 went to the hospital later that day and was discharged that same night, around 3:00 AM, back to the facility, still with a catheter. The DON stated the facility sent Resident #1, back out to the hospital due to bleeding, but it was more of an emergency, so he was sent to the closest hospital. She stated he has not returned from the hospital yet. The Administrator stated that after midnight on Sunday 03/23/25, Resident #1's Family Member told a staff member at the facility about the sexual abuse allegations. The Administrator stated the staff member then alerted her and she told the DON. The Administrator stated she also informed her corporate office. The Administrator stated she did not contact the local authorities. The Administrator stated she immediately started her own investigation, reported it to the state, and completed safe surveys. The Administrator stated no other residents voiced concern for abuse or neglect. The Administrator stated she did not find any evidence to support the allegations. The Administrator stated in-services were started on abuse/neglect, catheter care, emergencies, following orders, and reporting of abuse/neglect. The Administrator stated LVN B was suspended pending the investigation. The Administrator stated they did not call the police, because Resident #1 was not at the facility, but in the hospital. In an interview on 03/25/25 at 2:24 PM, Resident #1's Family Member #2 stated they received a call from the facility last Friday, 03/21/25 around 7:00 PM, and stated Resident #1 had to be sent to the hospital due to bleeding from his penis. Family Member #2 stated the facility stated it wad due to an issue with a catheter. Family Member #2 stated they later spoke with Resident #1, and Resident #1 told them a tall black man pulled his penis out and started sucking it. Family Member #2 stated Resident #1 told them he had to start hitting that man in the head to stop him and that the man bit him on the penis. Family Member #2 stated Resident #1 stated the staff tried to shove something up his penis. Family Member #2 stated she told the DON on 03/23/25 about what Resident #1 stated, and Family Member #2 stated the DON said that Resident #1 was always confused when she spoke with him. Family Member #2 stated the DON stated she would complete a report. In an interview on 03/26/25 at 10:00 AM, the Administrator stated she completed a police report yesterday and the police report number was provided. In an interview on 03/26/25 at 10:26 AM, the Police Detective stated he received the report that was filed yesterday, 03/25/25, by the facility, and was assigned to investigate. He stated he would provide an update next week. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/26/25 at 11:54 AM, LVN B stated he had regular interaction with Resident #1. He stated they were both familiar with each other. He stated he had never had any issues like this before last week. LVN B stated he was the initial nurse who tried to place the catheter. He stated Resident #1 did not already have a catheter, but the doctor ordered one for a UA. LVN B stated Resident #1 had an elevated white blood cell count. LVN B stated there was no resistance when he placed the catheter. He stated there was a little bleeding so, he called LVN A into the resident's room. He stated for the rest of his shift, the resident did not bleed, but he was called later and told he started to bleed again. LVN B stated he was calling Sunday night and informed about the sexual abuse allegations. LVN B stated he was trained by the facility on abuse and neglect. He stated the abuse coordinator was the Administrator. LVN B stated he had never abused or neglected any resident. LVN B stated he did not sexually abuse Resident #1. LVN B stated he had never been accused of any type of abuse. LVN B stated he was comfortable working at the facility but was now scared to change or resident or type of care like that. LVN B stated he was worried about being accused of something he did not do again. In an interview on 03/26/25 at 1:07 PM, the Administrator stated she understood she was to call the police if there was a reasonable cause. The Administrator stated she felt there was no risk of not contacting the police initially. The Administrator stated it depended on the situation or if she was able to substantiate the allegations. She stated she was not able to substantiate or find any evidence to confirm the allegations. She stated Resident #1 was no longer at the facility and was already scheduled to discharge the weekend of the incident before he went to the hospital. Record review of the facility's policy, titled, Abuse Protocol, dated 04/2019, reflected the following: 10. The Abuse Prevention Coordinator will: a. Immediately (within 2 hours) report to The Department of Aging and Disability Services (DADS) and other appropriate authorities incidents of Patient Abuse as required under applicable regulations and regulatory guidance. Report events that cause reasonable suspicion of serious bodily injury immediately (within 2 hours) after forming the suspicion