STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675809	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westridge Nursing and Rehabilitation	1241 Westridge Ave Lancaster, TX 75146

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** Based on observation, interview and record review the facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for one of six residents (Resident #1) reviewed for abuse. The facility failed to ensure Resident #1 had the right to be free from abuse when Resident #2 physically and allegedly sexually assaulted her on 06/18/25. An IJ was identified on 06/19/25. The IJ began on 06/18/25 and removed on 06/19/25. The facility took action to remove the IJ before the abbreviated survey began. While the IJ was removed on 06/19/25, the facility remained out of compliance at a scope of isolated and severity level of potential for more than minimal harm because all staff had not been trained on resident-to-resident abuse prevention. This failure could place residents at risk for abuse. Findings included: Record review of Resident #1's face sheet, dated 06/19/25, reflected Resident #1 was a [AGE] year-old female who originally admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #1's Quarterly MDS Assessment, dated 05/16/25, reflected a BIMs score was not calculated. Her active diagnoses included non-alzheimer's dementia (refers to any form of dementia other than Alzheimer's disease), anxiety disorder (characterized by excessive, persistent, and uncontrollable worry and fear about everyday situations), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and schizophrenia (a serious mental health condition that affects how people think, feel, and behave). Record review of Resident #1's Progress Notes reflected the following: (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- 06/18/25 at 7:35 PM, LVN A wrote: This nurse was summoned by assigned aide, upon walking towards resident this nurse noted redness to residents neck area '[NAME]/Love Bite' This nurse [sic] asked resident how she sustained those redness [sic]. Resident states 'He [sic] was sucking on my neck' Asked resident to show this nurse who was sucking on her neck and she pointed resident [sic] '[Resident #2's initials]'. Notified Administrator, DON, ADON. [sic] Also informed NP C with [Dr. E's] services and NP D with [Psych]. Order received to monitor and separate residents. Informed residents responsible party [Resident #1's RP]. - 06/18/25 at 8:23 PM, LVN A wrote: Called 911 Non-emergency service called to report the incident. - 06/18/25 at 8:43 PM, LVN A wrote: [City Name] Police here [Police Officer's Name] and this nurse informed him of situation. Police requested for both parties information which was given by this nurse. This nurse also gives her personal information to the cop, then escorted/assisted him to female resident room to question/investigate situation. This nurse informs resident that the police officer is her [sic] to question her about the redness on her neck. Per resident, and [sic] she states. 'He came into my room, in my bed before lunch and pulled up my dress touching down there, he played with my titties, he started to hold my neck down to kiss me and I called for help and he left. After dinner, watching [sic] television he choked my neck, wanting to kiss me I didn't let him, so he suck my neck [sic], He [sic] tried to touch me down there and I didn't let him. Resident also stated that male resident never took off his clothes only used his hands [sic], when asked by the police officer. Police report Service [sic] number [police report number] [Police officer's Name and badge number]. - 06/18/25 at 9:13 PM, LVN A wrote: Received order from [Dr. E/NP C] to transfer resident to [Hospital Name F], possible protocol for a rape kit test to be carried out if applicable. This nurse informs [sic] RP of transfer and she agreed to transfer. - 06/18/25 at 11:21 PM, LVN A wrote: Resident out of the facility to [Hospital Name G] per facility transport. - 06/19/25 at 9:00 AM, the DON wrote: Writer along with regional interviewed resident regarding incident from last night. Resident was asked what happened, resident stated 'he tried to kiss me, he tried to suck on my neck, he tried to choke me, he tried to screw me, he tried to pull my diaper to the side, she stated she fought him off by crossing legs [sic] and he left, When [sic] asked Resident [sic] cannot remember who it was, and stated 'I am okay and I am sleepy. [sic] - 06/19/25 at 12:08 PM, RN I wrote: Resident arrived back to facility @ 0900 with after care papers. Assisted resident into assigned bed .no pain reported by resident; resident stated 'No .I'm ok' when asked if she had any pain .bruises around neck; skin intact, no bleeding, reddish skin discoloration around neck .Hourly resident rounds by this nurse. - 06/19/25 at 12:22 PM, RN I wrote: Alterations in Skin Integrity. Note location of any noted areas. Enter measurements in box provided.: [sic] Bruise Bruise: Note location of any noted areas. Enter measurements in box provided.: [sic] Bruise 1 neck area, Bruise 2 right, lateral chin (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of a Trauma Informed Care Assessment for Resident #1, dated 06/19/25, reflected the following: Have you ever experienced, witnessed, learned about a physical assault? Other- 'I fought him'. Unable to determine context .Have you ever experienced, witnessed, learned about a sexual assault? Other- 'I don't want to have sex'. Unable to determine context .Did any of these events bother you? Yes .Comment on events resident was bothered by: Unable to determine context. When prompted with, 'How did that make you feel?' she stated 'Violated.' Record review of Resident #1's Hospital Records, dated 06/19/25, reflected: Patient is a [AGE] year-old female with a past medical history of schizophrenia and dementia who presents from her skilled nursing facility/nursing home for evaluation of endorsed sexual assault. History is somewhat limited secondary to patient's cognitive decline, endorses that a male resident in her nursing facility 'tried to kiss my neck', states 'he tried to kiss my titties', states 'he tried to force my legs open but I kept them crossed'. Patient is unable to confirm if sexual or vaginal or anal penetration occurred, does not endorse oral penetration. Per nursing home staff (transportation staff), nursing home staff has been notified, patient is kept in a secure memory unit, nursing staff is investigating alleged perpetrator for any other information regarding the case .Skin: Superficial bruising of anterior neck .has superficial abrasions over the anterior neck Observation and interview on 06/19/25 at 5:44 PM revealed Resident #1 lying down in her bed. Resident #1 had multiple red marks and purplish/reddish bruises, about the size of quarters, to the right and left sides of her neck. Resident #1 was asked what happened to her neck. Resident #1 replied, He sucked my neck and choked me. Resident #1 said this happened in the TV Room and in her room. Resident #1 said he held her down because he tried to kiss her and she would not let him. Resident #1 said earlier in the day he tried to push her on the bed, he lifted up her dress and touched her breasts, so she hollered out and yelled and then he left. Resident #1 said she had not seen this person at the facility anymore. Resident #1 said she felt safe and was not in any pain. Interview on the phone on 06/19/25 at 1:12 PM with Resident #1's RP revealed she received a call from a nurse at the facility who told her the resident had [NAME]-like bruises to her neck. Resident #1's RP said she was told the facility was going to file a police report and sent the resident to the hospital for further evaluation. Resident #1's RP said she saw the resident had a bruise on her chin towards the right side of her face, a few scratches on her neck, and hickeys on her collar bone and neck area. Resident #1's RP said she did not notice any changes to the resident's behavior when she saw her earlier in the day. Record review of Resident #2's face sheet, dated 06/19/25, reflected Resident #2 was a [AGE] year-old male who originally admitted to the facility on [DATE], readmitted on [DATE], and was discharged on 06/19/25. Record review of Resident #2's Quarterly MDS Assessment, dated 06/09/25, reflected a BIMS score was not calculated. Further review reflected he had no behaviors of any kind towards anyone. His active diagnoses included non-alzheimer's dementia (refers to any form of dementia other than Alzheimer's disease) and cerebellar stroke syndrome (occurs when there's a disruption of blood flow to the cerebellum at the back of the brain). (continued on next page)

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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 care plan, edited 06/13/25, reflected the following: Problem Start Date: 10/03/24, Category: Behavioral Symptoms, [Resident #2] display inappropriate sexual behavior toward another female resident. [Resident #2] has risk for inappropriate sexual behaviors towards others including staff, and fellow female residents .Approach: Encourage activity involvement to for [sic] pleasurable distractions. Please ensure activity is at level of understanding for the resident. New orders and medications adjustment review with changes. 15 minutes check for the next 24 hours and tele visit from Psych NP. Record review of Resident #2's progress notes reflected the following: - 10/03/24 - A Previous DON wrote: Charge nurse reported housekeeping witnessed resident grab a female resident and forcefully give her a kiss on the mouth. Residents were separated, resident was place on q 15 min checks, MD, psych NP and family were notified - 06/18/25 at 8:43 PM, LVN A wrote: This nurse was summoned by assigned aide, upon walking towards aide on hallway this nurse noted redness to [Resident #1], female residents neck area [NAME]/Love Bite. This nurse asked female resident [Resident #1's room number] how she sustained those redness [sic]. Resident states ' He [sic] was sucking on my neck' Pointing to this male resident. Female resident, [Resident #1's initials and room number] pointed at this male resident 3 times in the television room. After separating both parties, This [sic] nurse asked male resident of what happened between him and female resident but he denies every question and states, 'I don't know anything with both hands up in the air' [sic]. Notified Administrator, DON, ADON. Also informed [NP C] with [Dr. E's] services and [NP D] with [Pysch]. Call placed to [Resident #2's Main RP] Voice [sic] message left but spoke with [Resident #2's Alternate RP and phone number]. Order received to monitor this resident Q 15 minutes and separate both parties, This [sic] nurse moves resident from [Resident #2's original room number] to [Resident #2's new room number]. Head to assessment [sic] completed, noted redness to left lower lip skin intact but red. - 06/18/25 at 9:15 PM, LVN A wrote: [City Name Police] here, [Police officer's name] and this nurse informed him of situation. Police requested for residents information [sic] which was given by this nurse. This nurse also gives [sic] her personal information to the cop, then escorted/assisted him to male residents room [Resident #2's new room number]. The police officer questioned this resident regarding what happened earlier on but resident states 'Nothing happened' Police officer asked him if he was being inappropriate with a female resident? Resident states 'I don't know a female resident' Resident threw both hands in the air that he doesn't know anything and he don't' [sic] remember anything. Police officer asked him if he had breakfast, lunch or dinner he replies saying 'No I don't, no food here' This nurse reminds him that he requested for extra pasta today from this nurse during dinner and asked if he remembers that, resident states 'OKAY' [sic]. Resident unable to give any detail or account of situation that transpired. Per police officer, I could arrest him but due to his condition they won't keep him but advised he needs a male unit. Resident continues to be 1:1/Q 15 MINS Supervision [sic]. - 06/19/25 at 12:52 AM, LVN J wrote: Res remains in room with 1 on 1 assigned. Res in bed with eyes closed .No attempted to get OOB or leave room noted. No episodes of sexual inappropriateness, aggression or agitation noted. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- 06/19/25 at 10:41 AM, RN I wrote: No unusual behavior. Q15 monitoring checks in progress during this shift .surveillance program for wandering residents in progress .One on one sitter in room [Resident #2's new room number]. - 06/19/25 at 11:28 AM, the SW wrote: The social worker contacted [Resident #2's RP] didn't answer and the social worker left a message for her to call the facility back. - 06/19/25 at 11:31 AM, the SW wrote: The social worker fax [sic] the resident clinicals to [a different NF] . - 06/19/25 at 1:32 PM, the DON wrote: The social worker contacted another family member for the resident to inform [them] that due to the incident that happened on yesterday the resident will be transferred to a sister facility. The resident has been approved and gave the family member the name and address to the moving facility. - 06/19/25 at 1:34 PM, RN I wrote: Q15 surveillance checks ongoing during this shift. One on One [sic] sitter at all times during this shift. Instructed by Admin and DON [the DON] to pack up resident's belongings. No unusual behaviors .cooperative during this shift. Spent shift in assigned bed .Hourly rounds by this nurse. - 06/19/25 at 2:05 PM, RN I wrote: Resident discharged Observation and interview on 06/19/25 at 11:45 AM revealed Resident #2 was in his room lying in bed. The ADON was standing in his doorway a few feet away from him. Resident #2 said he was doing good today and felt safe in the facility. Resident #2 said he had never tried to touch or kiss anyone at the facility. Resident #2 said he did not have any of those desires and had never tried to hurt anyone. Attempted interview on 06/19/25 on the phone at 1:28 PM with Resident #2's Main RP was unsuccessful as she did not answer. Attempted interview on 06/19/25 on the phone at 1:29 PM with Resident #2's Alternate RP was unsuccessful as she did not answer. Interview on 06/19/25 at 2:12 PM with LVN J revealed she worked the 10:00 PM to 6:00 AM shift overnight and was told by the previous shift that around dinner time in the TV room, Residents #1 and #2 were together and Resident #1 was found to have hickeys on her neck. LVN J said she was told Resident #1 told staff Resident #2 had sucked on her neck and tried to touch her down there. LVN J said staff called the police and that was when Resident #1 told staff before lunch there was an incident where she hollered for help and Resident #2 left her room because he was trying to touch her down there and played with her titties. LVN J said she never noticed any physical or sexual behaviors from Resident #2 towards anyone at the facility before this, so she was surprised to hear about it. LVN J said Resident #2 was placed on one-to-one observations and staff sat with him overnight after it happened to keep eyes on him. LVN J said she was in-serviced and knew what to do in regards to: identifying/reporting/stopping sexual or physical behaviors from residents towards others, supervising residents at all times but especially in common areas, and what the types and signs of abuse were, who and when to report abuse. (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 06/19/25 at 2:22 PM with RN I revealed she was at the facility when Resident #1 came back from the hospital this morning and did a skin assessment on her. RN I said when she asked Resident #1 if she was in pain the resident reported she was not. RN I said she had not observed any changes to Resident #1's behaviors so far during this shift. RN I said the skin assessment she completed revealed redness around Resident #1's neck area and a purple-ish bruise to the right side of her lower cheek. RN I said Resident #1 did not have those bruises yesterday morning when she cared for her. RN I said she never observed or knew about Resident #2 having any physical or sexual behaviors towards anyone at the facility. RN I said Resident #2 mostly stayed in his bed in his room during her shift. RN I said she did not observe any interactions between Residents #1 and #2 during her shift yesterday (06/18/25). RN I said she did not believe Resident #2 went to Resident #1's room at all near lunch time because not only was she working and an aide working, but the ADON and Administrator were also present as well. RN I said she was in-serviced and knew what to do in regards to: identifying/reporting/stopping sexual or physical behaviors from residents towards others, supervising residents at all times but especially in common areas, and what the types and signs of abuse were , who and when to report abuse . Interview on 06/19/25 at 1:36 PM with CNA M revealed she worked on the unit yesterday (06/18/25) during the 6:00 AM to 2:00 PM shift. CNA B said she knew nothing about the situation involving Residents #1 and #2. CNA M said normally both residents laid in their own beds in their own rooms during her shift. CNA M said she did notice Resident #1 had bruises to her neck when she saw her today that were not there yesterday. CNA M said Resident #2 never showed any sexual or physical behaviors towards anyone, but if he had she would have immediately reported it to her nurse and stopped it. CNA M said she was in-serviced and knew what to do in regards to: identifying/reporting/stopping sexual or physical behaviors from residents towards others, supervising residents at all times but especially in common areas, and what the types and signs of abuse were, who and when to report abuse. Attempted interview on the phone on 06/19/25 at 2:39 PM with CNA K who worked with both Residents #1 and #2 was unsuccessful as she did not answer or call back. Attempted interview on the phone on 06/19/25 at 2:40 PM with LVN L who worked with both Residents #1 and #2 was unsuccessful as she did not answer or call back. Interview on 06/19/25 at 2:56 PM with CNA B revealed she was working the 2:00 PM to 10:00 PM shift yesterday (06/18/25). CNA B said she took a few residents out for their smoke break around 6:30 PM and came back inside at 6:45 PM. CNA B said she was going to start her next set of rounds on residents and saw Resident #1, Resident #2 and Resident #3 sitting in the TV room together. CNA B said she noticed Resident #1 had bruises and redness that looked like two hickeys, scratches, and other marks to her neck that were not there before during her shift, so she alerted LVN A. CNA B said LVN A came over and asked Resident #1 what happened. CNA B said Resident #1 told LVN A what happened and pointed to Resident #2 saying he sucked on [her] neck and choked her. CNA B said Resident #2 was just sitting in the TV room like nothing had happened. CNA B said LVN A called the police and they came to talk to both residents. CNA B said LVN A told her Resident #2 was put on every 15-minute checks and then someone came to sit in his room with him the rest of the night. CNA B said it was normal for Residents #1, #2 and #3 to all be in the TV room sitting together watching TV after dinner. CNA B said Resident #1 was sent to the hospital and Resident #2 stayed in his room the rest of the shift. CNA B said she was in-serviced and knew what to do in regards to: identifying/reporting/stopping sexual or physical behaviors from residents towards others, supervising residents at all times but especially in common areas, and what the types and signs of abuse were, who and when to report abuse. (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 06/19/25 at 3:17 PM with LVN A revealed she worked the 2:00 PM to 10:00 PM shift yesterday (06/18/25). LVN A said after dinner Resident #1 wanted to go to the TV room to watch TV like she normally did every evening. LVN A said she saw Resident #1 sitting there in the chair like she always had. LVN A said she started to make her rounds on the residents and noticed Resident #2's TV was not working for some reason and would not turn on, so she asked if he instead wanted to watch TV in the TV room which he did. LVN A said later on in the shift she heard CNA B asking for her near the TV room, so she went to the area and saw Resident #1's neck was red. LVN A said she asked Resident #1 what happened because her neck was not like that a few minutes ago. LVN A said Resident #1 pointed to Resident #2 and said he sucked on her neck. LVN A said she took Resident #1 to her room to further assess her and asked her again what happened. LVN A said she had also asked CNA B to take Resident #2 to his room, although his room was right next door to Resident #1 so they moved him across the hall to be able to watch him better and so he would be in an empty room. LVN A said she assessed Resident #1 further and asked her what happened but Resident #1 appeared to be ashamed and shut down, not talking. LVN A said she called the Administrator who was the Abuse Coordinator for the facility and then was told to call the police. LVN A said the police came to the facility and she went into the room with Resident #1 to talk to the police officer. LVN A said Resident #1 told them Resident #2 came to her room before lunch and tried to touch her by pulling up her dress and touched her titties and kissed her and choked her. LVN A said the police officer asked Resident #1 if she ever lost consciousness and the resident said yes, and she had also screamed for help but then Resident #2 got up and ran out of the room. LVN A said Resident #1 continued by saying after dinner and in the TV room, Resident #2 came again and tried to pull her dress up again but she crossed her legs and did not let him go down there but he played with her titties again and tried to kiss her, but she fought him off. LVN A said Resident #1 explained Resident #2 began to suck on her neck and she pushed him away. LVN A said during the skin assessment she completed earlier there were no additional findings of an assault, physical or sexual that she could see. LVN A said Resident #1's neck had 4 places where there were bruises that looked like hickeys on one side of her neck and small circles on the other that were consistent with someone holding a person down. LVN A said Resident #1's story matched the injuries she sustained, and she had no history of making up stories. LVN A said she was not told about anything that happened during the previous shift around lunch time and since she was not there, she was not sure what happened. LVN A said she only knew of one other situation involving Resident #2 kissing a different female resident which was a long time ago. LVN A said after that situation happened, Resident #2 was put on every 15-minute checks until the psych provider could see him. LVN A said since then, Resident #2 never gave any indication he would do something like that again. LVN A said she was in-serviced and knew what to do in regard to identifying, reporting, stopping sexual or physical behaviors from residents towards others, supervising residents at all times but especially in common areas, and what the types and signs of abuse were , who and when to report abuse. (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 06/19/25 at 3:44 PM with the ADON revealed yesterday (06/18/25) evening, after dinner, CNA B noticed some bruising to Resident #1's neck and alerted LVN A. The ADON said LVN A assessed Resident #1 and after explaining what happened to her, the nurse alerted the Abuse Coordinator who was the Administrator. The ADON said Resident #1 told LVN A Resident #2 put his hands on her neck and sucked on her neck and was inappropriate with her. The ADON said Resident #2 was placed on every 15-minute checks and once they secured a staff member they sat with him one-on-one until he discharged from the facility. The ADON said Resident #2 was discharged today (06/19/25). The ADON said Resident #1 was sent to the hospital for an evaluation, both residents' families were notified, and the MD was also notified. The ADON said she herself saw Resident #1's injuries when she came back from the hospital today and noticed there were red dime-sized marks on her neck that were not there before. The ADON said she was not sure if the injuries were the result of Resident #2 sucking or choking on Resident #1's neck. The ADON said Resident #2 was involved in another incident with a different resident last year in either September or October where he kissed a resident. The ADON said after that happened, Resident #2 was placed on every 15-minute checks until the psych provider could see him. The ADON said the facility took the same approach with the situation that happened with Resident #1, except he was also placed on one-to-one until he discharged . The ADON said when she asked Resident #2 what happened, he could not recall anything but that was normal for him. The ADON said she did not have the opportunity to talk to Resident #1 about what happened. The ADON said the facility also in-serviced all staff regarding abuse/neglect, resident-to-resident altercations, and sexual behaviors. The ADON said she was on the unit yesterday (06/18/25) during the lunch meal service around 11:15 AM or 11:30 AM and never saw Resident #2 out of his room nor did she see Residents #1 and #2 together at any point. The ADON said Resident #2 was discharged to a sister facility that had an all-male secured unit and the family was agreeable to the move. (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 06/19/25 at 4:03 PM with the DON revealed she received a call yesterday from the Administrator saying LVN A reported CNA B went to get Resident #1 out of the TV room and noticed marks to her neck. The DON said LVN A asked Resident #1 who did that to her neck and the resident pointed to Resident #2. The DON said the staff on duty automatically separated the two residents and staff began arranging for Resident #2 to be placed on one-on-one. The DON said Resident #1 was sent to the hospital, but they could not conduct a rape kit because there was only evidence of a physical assault, not a sexual assault. The DON said Resident #1 told staff he grabbed her neck and touched her, he tried to kiss her on her neck, he sucked on her titties, he had tried to screw [her], he tried to pull her diaper to the side and get on top of her but the resident crossed her legs and he left out of the room. The DON said she asked Resident #1 what he looked like, and she said the man was white with grey hair and a beard which matched Resident #2's description. The DON said Resident #3 was also in the room, but he was not a reliable witness as he was not interviewable due to his condition. The DON said Resident #1's injuries were to both the right and left sides of her neck and on the front too. The DON said Resident #1's injuries looked like one side was where she was choked and the other was where she had been sucked on causing the hickeys. The DON said she was not sure if that was exactly what happened but that was what it sort of looked like. The DON said she always saw Resident #2 in his bed in his room and since she had only been there for about 4 months, she was not aware of the prior incident where he had kissed another resident months ago. The DON said she believed Resident #1 had her times mixed up as to when the lunch incident happened because the ADON, a housekeeper, and a therapist were there around the same time as the nurse and aide as well and none of the staff saw the residents interacting in any way. The DON said she thought the earlier incident happened before dinner, if it happened at all. The DON said Resident #2 had to be discharged because of the extent of him violating Resident #1's privacy and attacking her. The DON said the facility also in-serviced all staff regarding abuse/neglect, resident-to-resident altercations, and sexual behaviors. The DON said what Resident #2 did to Resident #1 was considered abuse. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675809	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westridge Nursing and Rehabilitation	1241 Westridge Ave Lancaster, TX 75146

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 06/19/25 at 4:43 PM with the Administrator revealed she was on her way home yesterday (06/18/25) when she got a call from LVN A saying CNA B came in from smoking the residents and started doing her rounds to get everyone cleaned up. The Administrator said CNA B took Resident #1 from the TV room and noticed she had bruising to her neck, so she called LVN A over to assess the resident. The Administrator said LVN A and CNA B took Resident #1 to the dining room and asked her what happened to which they were told Resident #2 sucked on her. The Administrator said Residents #1, #2 and #3 were in the TV room together which was normal for them to be in that room after dinner together as it's a common area. The Administrator said due to Resident #3's condition he was not able to be interviewed or recall anything that happened. The Administrator said after Resident #1 identified Resident #2 as the Alleged Perpetrator, the staff started him on every 15-minute checks while the ADON tried to find staff to sit with him one-on-one until he could be discharged . The Administrator said LVN A called the doctor to let them know what happened and sent Resident #1 to the hospital to be further evaluated. The Administrator said LVN A also called the police department, and an officer arrived at the facility. The Administrator said the police officer explained there was no signs of a sexual assault, only a physical assault. The Administrator said the hospital explained since there was no penetration they would not be able to complete a rape kit exam. The Administrator said Resident #1 returned to the facility this morning around 9 AM while the facility was working on transferring Resident #2 out of the facility. The Administrator said she was sent pictures by LVN A of Resident #1's injuries and saw it looked like she had hickeys on her neck. The Administrator said she believed Resident #1 had her times mixed up and the lunch incident did not happen at that time but might have happened before dinner instead. The Administrator said she was on the unit a lot yesterday (06/18/25) and never saw anything that seemed unusual between Residents #1 and #2. The Administrator said nothing else was reported to her about the 2:00 PM to 10:00 PM shift from yesterday. The Administrator said Resident #1 did not have a history of making up stories and Resident #2 did not have a history of any sexual or physical behaviors with anyone. The Administrator said there was only one incident where Resident #2 kissed another resident on the lips months ago which had already been reported and investigated. The Administrator said it was normal for the residents to be sitting in the TV area together and nothing had ever happened prior to this incident amongst any of them. The Administrator said the facility also in-serviced all staff regarding abuse/neglect, resident-to-resident altercations, and sexual behaviors. The Administrator said all residents had the right to be free from abuse, the facility was their home, and they deserved to be in a safe environment with quality of care and life. The Administrator said all staff were responsible for ensuring residents were free from abuse. The Administrator said if Resident #2's actions were intentional this situation would be considered a form of abuse. The Administrator said if residents were not free from abuse that could cause some type of harm to them either emotionally or physically. The Administrator said staff were constantly monitoring residents to ensure they were free from any abuse. The Administrator said all staff were trained to monitor residents at all times. Record review of resident safe surveys reflected 14 were completed with residents on 06/19/25 with no additional findings of any other abuse in the facility. Record review of an in-service, dated 06/19/25, reflected 35 staff were in-serviced regarding resident-to-resident altercations, sexual expression, and abuse and neglect. Record review of a post test completed by 35 staff reflected they understood the facility's policy and procedures regard[TRUNCATED]