STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676004	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Hills Nursing & Rehabilitation	201 E Thompson St Decatur, TX 76234

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 - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**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 three of six residents (Residents #1, #3 and #2) reviewed for abuse.1. The facility failed to ensure Resident #3 did not kiss Resident #1 without her consent on 05/23/25.2. The facility failed to ensure LVN G did not yell at Resident #2. These failures could place residents at risk for injury or psychosocial harm. Findings included:1. Record review of Resident #1's admission Record, dated 07/17/25, reflected a [AGE] year-old female who admitted to the facility on [DATE].Record review of Resident #1's Quarterly MDS Assessment, dated 07/01/25, reflected she had a BIMS score of 06, which indicated moderate cognitive impairment. Her active diagnoses included non-Alzheimer's dementia (the loss of memory and other intellectual functions severe enough to cause problems in one's abilities to perform daily activities), anxiety disorder (a mental health condition characterized by excessive fear or anxiety that interferes with daily activities), and depression (a mood disorder that causes persistent feelings of sadness and loss of interest).Record review of Resident #1's care plan reflected the following: Focus: Resident has a history of attention seeking behaviors from the opposite sex.Interventions: Monitor resident for behaviors and report immediately. Date initiated: 05/23/25. Record review of Resident #1's Progress Notes reflected the following:- 05/23/25 at 11:57 AM, the DON made the following entry: Resident sitting on sofa in lobby with another resident behind her. Male resident was kissing all over resident's face and resident was holding her head down while male resident was attempting to raise resident's face by placing his hand underher [sic] chin. Resident states she told male resident to stop but he wouldn't. When male resident saw staff he immediately stopped and walked away from resident.- 05/23/25 at 12:30 PM, the SW made the following entry: This social worker asked resident to come to the social service office to discuss staff report of sexual assault with police officers. The social worker explained to the resident why the police were called and reassured her that she was not in trouble. Resident requested social worker stay in the room while the officers asked her questions. The resident struggled to discuss today's events and referenced an event that occurred last week in which another resident was trying to kiss her, but she told him to stop, at which point he did. Resident was tearful but emotionally stable while answering questions. After the officers were done social worker privately asked the resident if she had any more questions or if she needed anything and she said no. Social Worker returned resident to the dining room to finish her lunch. Record review of Resident #1's Trauma Informed PRN Assessment, dated 05/23/25, reflected she did not have any concerns related to the trauma she may have endured. Record review of Resident #3's admission Record, dated 07/17/25, reflected a [AGE] year-old male who was admitted to the facility on [DATE].Record review of Resident #3's MDS Assessment, dated 05/23/25, reflected he had a BIMS score of 15, which indicated no cognitive impairment. It noted he had physical behavior towards others in the last 1 to 3 days. His active diagnoses included epilepsy (a neurological condition characterized by recurrent, unprovoked seizures caused by abnormal electrical activity in the brain) and transient cerebral ischemic attack (a stroke, which happens when something prevents your brain from getting enough blood flow).Record review of Resident #3's care plan reflected the following: Focus: Resident will be observed by staff for 1:1 monitoring. Interventions: Resident will be observed by staff at all times during 1:1 monitoring. Date Initiated: 05/23/25. Focus: Behavior: Sexually inappropriate AEB: Making unwanted advances towards other residents. Interventions: Evaluate the resident's ability to understand behavior and the consequences of that behavior. Explain to resident the acceptable expressions of sexuality based on the cognitive evaluation. Listen/talk to the resident- see if they will tell you why they do the behavior. Psychiatric Services consult as needed. Reinforce with staff that clear, firm limits are healthy and required when resident makes inappropriate gestures or statements. Report incidents of inappropriate sexual behavior to charge nurse. If other resident's are involved, immediately intervene to protect the safety of all residents involved. Staff to be inserviced [sic] on behavioral approaches designed to effectively manage unacceptable sexual advances (avoid self disclosing personal information).Record review of Resident #3's Progress Notes reflected the following:-RN F on 05/23/25 at 11:57 AM wrote: Staff reports coming into building from lunch, witness this resident standing behind couch reaching for another resident who was sitting on couch and kissing on her face. This resident was attempting to lift other resident's head up by the chin to kiss her on the lips. When this resident noticed staff member he stopped and walked away from female resident. Female resident removed from area, one