STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676036	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Ridge Nursing & Rehabilitation Center	700 E Vista Ridge Mall Dr Lewisville, TX 75067

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement written policies and procedures that prohibit and prevent abuse and neglect for 1 of 5 residents (Resident #5) reviewed for reporting according to the facility policy.The facility failed to follow the facility's policy to report allegation of abuse when Resident #5 made an outcry to the Psychologist regarding sexual abuse from her FM on 3/24/26.This failure could place residents in the facility at risk of abuse and lack of timely reporting of incidents.Record review of Resident #5's Quarterly MDS, dated [DATE], revealed a BIMS score of 10, which meant she had moderate cognitive impairment. Resident #5 had unclear speech, sometimes made herself understood and usually understood others. Resident #5 needed substantial/maximal assistance for oral hygiene, toileting hygiene, showering, upper body dressing, and personal hygiene. Resident #5 needed substantial assistance to roll left and right and to sit to lying.Record review of Resident #5's Care Plan, dated 3/25/26, revealed she had voiced some concern regarding the conduct of her (FM) towards her to the staff when he visits her. The care plan stated interventions were to have the FM visits to be supervised in common areas during the daytime when administration is present and police were notified. Resident #5's care plan revealed the following care areas:- ADL deficit- Severe Mental Illness; took antidepressant and anti-anxiety medications- Communications problems - Aphasia- Fall risk- Mood and psychosocial problems; had APS and psychological services involved.Record Review of TULIP showed no incident report regarding the incident was reported.Interview on 4/9/26 at 2:45 p.m., the Admin stated the Psychologist reported to her that Resident #5 told him the FM was touching her inappropriately sexually. She stated calling the state regarding allegations of abuse or neglect was her job. The Admin stated she did not report this to the state because Resident #5 said the FM always did this and he thought it was funny. She stated Resident #5 did not tell her it was without consent and that was why she did not report it to the state as she did not think it was abuse.Interview on 4/9/26 at 3:48 p.m., the Admin stated she did do an investigation, but she did not think it was abuse so she did not report it or turn the investigation into the state. Record review of the facility's Abuse Prevention Program, dated 2001, revealed under Policy Interpretation and Implementation 6. Investigate and report any allegations of abuse within timeframes as required by federal requirements.Policy StatementAll reports of resident abuse.shall be promptly reported to local, state, and federal agencies and thoroughly investigated by facility management. Findings of abuse investigations will also be reported.Reporting1. All alleged violations involving abuse.will be reported by the facility Administrator, or his/her designee, to the following persons or agencies; a. the State licensing/certification agency responsible for surveying/licensing the facility.2. An alleged violation of abuse.will be reported immediately, but not later than:a. Two (2) hours if the alleged violation involves abuse.4. The Administrator, or his/her designee, will provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within five (5) working days of the occurrence of the incident.

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 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** Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury to other officials (including the State Survey Agency where state law provided for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 1 out of 5 residents (Resident #5) reviewed for abuse or neglect.The facility failed to report an allegation of abuse to the State Survey Agency (HHSC) after they learned Resident #5 had made an allegation of sexual abuse against her FM on 3/24/26. These failures could place residents at risk of abuse, allegations of abuse not being reported immediately, and could result in physical and psychological harm. Record review of Resident #5's face sheet revealed a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnosis included: Aphasia (a communication disorder resulting from damage to brain areas responsible for language) following Cerebral Infarction (stroke), Dysphagia (a language disorder characterized by partial impairment of comprehension or expression of spoken words) following Cerebral Infarction, Major Depressive Disorder (mental health condition characterized by a persistent, intense and often disabling low mood and feeling of worthlessness) and Generalized Anxiety Disorder (a mental health condition characterized by persistent, excessive and uncontrollable worry about everyday things).Record review of Resident #5's Quarterly MDS, dated [DATE], revealed a BIMS score of 10, which meant she had moderate cognitive impairment. Resident #5 had unclear speech, sometimes made herself understood and usually understood others. Resident #5 needed substantial/maximal assistance for oral hygiene, toileting hygiene, showering, upper body dressing, and personal hygiene. Resident #5 needed substantial assistance to roll left and right and to sit to lying. Record review of Resident #5's Care Plan, dated 3/25/26, revealed she had voiced some concern regarding the conduct of her (FM) towards her to the staff when he visits her. The care plan stated interventions were to have the FM visits to be supervised in common areas during the daytime when administration is present and police were notified. Resident #5's care plan revealed the following care areas: ADL deficitSevere Mental Illness; took antidepressant and anti-anxiety medicationsCommunications problems - Aphasia Fall riskMood and psychosocial problems; had APS and psychological services involved. Record review of the Police Report revealed on 3/24/26, Resident #5 told the Psychologist the FM had been touching her vaginal area. The police report revealed she stated the FM would put his hand underneath her clothing causing direct contact with her vaginal area without her consent. The police report revealed Resident #5 stated she did not want to pursue criminal charges, and she still wanted the FM to visit her. The police report revealed facility staff advised all further visits from the FM would be supervised.Record review of Resident #5's Progress notes, on 3/25/26 at 1:08 p.m. by the SW, revealed Resident (#5) reported inappropriate behaviors in regard to (the FM) to the Psychologist. The Psychologist reached out to SW and SW met with resident to clarify concerns. APS was notified and the PD was called.Resident stated that she did not want charges pressed against (the FM) but wanted supervised visitations when he came. SW notified DON, Admin, and charge nurse. SW and DON will meet with partner (the FM) to discuss new visitation parameters.Record Review of TULIP showed no incident report regarding the incident was reported. Interview on 4/9/26 at 11:08 a.m., the RN stated Resident #5 had to have visits with the FM in the common area and they had to be supervised. The RN stated Resident #5 told the Psychologist the FM had touched her inappropriately. The RN stated she had not seen anything herself.Interview on 4/9/26 at 11:46 a.m., the SW stated about two weeks ago, around 3/23/26, Resident #5 reported to the Psychologist that the FM was touching her inappropriately. The SW stated she talked to Resident #5, and she did not want anything reported to the police. She stated Resident #5 stated the (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	inappropriate/intimate touching had taken place since she admitted to the facility but she did not want to tell anyone. The SW stated the FM was only able to visit Monday - Friday between 9 a.m. and 5 p.m. when leadership was in the facility. The SW stated Resident #5 told the police she did not want to press charges but wanted him to be able to visit with supervision. She stated the police told the FM if there were any more incidents, a no trespass order would be put in place. Interview on 4/9/26 at 12:42 p.m., the Psychologist stated Resident #5 had told him the FM was touching her inappropriately. He stated he was not sure of the exact date at that time but stated he let the SW at the facility, the police and APS know the same day. The Psychologist stated to his knowledge, the facility was having supervised visits between Resident #5 and the FM. Interview on 4/9/26 at 1:59 p.m., the ADON stated she heard there were allegations Resident #5's FM was touching her inappropriately. The ADON stated the allegations should have been called into the state by the Admin and anytime there were allegations of abuse or neglect. Interview on 4/9/26 at 2:22 p.m., the DON stated she received a call from the SW regarding the allegations of sexual abuse Resident #5 told to the Psychologist. The facility made sure Resident #5 was safe. She stated the police and APS were called. She stated the FM was on supervised visitation as Resident #5 still wanted him to visit. The DON stated Resident #5 never reported anything to her. The DON stated the Admin was responsible for reporting allegations of abuse and neglect to the state and this should have been reported. Interview on 4/9/26 at 2:45 p.m., the Admin stated the Psychologist reported to her that Resident #5 told him the FM was touching her inappropriately. She stated the police and APS were called. The Admin stated she talked to Resident #5, and she told her she did not want to press charges, did not want the police called and still wanted the FM to visit. The Admin stated the facility put supervised visitation between Resident #5 and the FM. She stated the visitation could only occur Monday - Friday from 9 a.m. - 5 p.m. in the common area when management was in the building. The Admin stated Resident #5 told her she felt safe and did not want to be supervised. She stated calling the state regarding allegations of abuse or neglect was her job. The Admin stated she did not report this to the state because Resident #5 said the FM always did this and he thought it was funny. She stated Resident #5 did not tell her it was without consent and that was why she did not report it to the state as she did not think it was abuse. Interview on 4/9/26 at 3:48 p.m., with the Admin stated she did do an investigation, but she did not think it was abuse so she did not report it. Record review of the facility's Abuse Prevention Program, dated 2001, revealed under Policy Interpretation and Implementation 1. Protect our residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual .6. Investigate and report any allegations of abuse within timeframes as required by federal requirements.Policy StatementAll reports of resident abuse.shall be promptly reported to local, state, and federal agencies and thoroughly investigated by facility management. Findings of abuse investigations will also be reported.Reporting 1. All alleged violations involving abuse.will be reported by the facility Administrator, or his/her designee, to the following persons or agencies; a. the State licensing/certification agency responsible for surveying/licensing the facility.2. An alleged violation of abuse.will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse.b. Twenty-four (24) hours if the alleged violation does not involve abuse and has not resulted in serious bodily injury. 4. The Administrator, or his/her designee, will provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within five (5) working days of the occurrence of the incident.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report the results of all investigations to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident.The facility failed to submit a completed investigation regarding the allegation sexual abuse of Resident #5 by her FM to the State Survey Agency.This failure placed residents at risk of further abuse and a lack of oversight by the State Survey Agency.Record review of Resident #5's face sheet revealed a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnosis included: Aphasia (a communication disorder resulting from damage to brain areas responsible for language) following Cerebral Infarction (stroke), Dysphagia (a language disorder characterized by partial impairment of comprehension or expression of spoken words) following Cerebral Infarction, Major Depressive Disorder (mental health condition characterized by a persistent, intense and often disabling low mood and feeling of worthlessness) and Generalized Anxiety Disorder (a mental health condition characterized by persistent, excessive and uncontrollable worry about everyday things).Record review of Resident #5's Quarterly MDS, dated [DATE], revealed a BIMS score of 10, which meant she had moderate cognitive impairment. Resident #5 had unclear speech, sometimes made herself understood and usually understood others. Resident #5 needed substantial/maximal assistance for oral hygiene, toileting hygiene, showering, upper body dressing, and personal hygiene. Resident #5 needed substantial assistance to roll left and right and to sit to lying.Record review of Resident #5's Care Plan, dated 3/25/26, revealed she had voiced some concern regarding the conduct of her (FM) towards her to the staff when he visits her. The care plan stated interventions were to have the FM visits to be supervised in common areas during the daytime when administration is present and police were notified. Resident #5's care plan revealed the following care areas:- ADL deficit- Severe Mental Illness; took antidepressant and anti-anxiety medications- Communications problems - Aphasia- Fall risk- Mood and psychosocial problems; had APS and psychological services involved.Record review of the Police Report revealed on 3/24/26, Resident #5 told the Psychologist the FM had been touching her vaginal area. The police report revealed she stated the FM would put his hand underneath her clothing causing direct contact with her vaginal area without her consent. The police report revealed Resident #5 stated she did not want to pursue criminal charges, and she still wanted the FM to visit her. The police report revealed facility staff advised all further visits from the FM would be supervised.Record review of Resident #5's Progress notes, on 3/25/26 at 1:08 p.m. by the SW, revealed Resident (#5) reported inappropriate behaviors in regard to (the FM) to the Psychologist. The Psychologist reached out to SW and SW met with resident to clarify concerns. APS was notified and the PD was called.Resident stated that she did not want charges pressed against (the FM) but wanted supervised visitations when he came. SW notified DON, Admin, and charge nurse. SW and DON will meet with partner (the FM) to discuss new visitation parameters.Record Review of the facility's Investigation, undated revealed the Admin was notified by the SW the allegations of inappropriate behavior by Resident #5's FM. The Admin had the police and APS contacted. The Admin interviewed Resident #5, and she stated he did not want to be supervised with the FM. The Admin and Resident #5 agreed that the FM would have supervised visitation, Monday - Friday from 9 a.m. - 5 p.m. when management was in the building.Record Review of TULIP showed no incident report regarding the incident was reported.Interview on 4/9/26 at 11:08 a.m., the RN stated Resident #5 had to have visits with the FM in the common area and they had to be supervised. The RN stated Resident #5 told the Psychologist the FM had touched her inappropriately. The RN stated she had not seen anything herself.Interview on 4/9/26 at 11:46 a.m., the SW stated about two weeks ago, around 3/23/26, Resident #5 reported to the Psychologist that the FM was touching her inappropriately. The SW stated she talked to Resident #5, and she did not want anything reported to the police. She stated Resident #5 stated the inappropriate/intimate touching had taken (continued on next page)

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