STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115525	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestview Health & Rehab Ctr	2800 Springdale Road Atlanta, GA 30315

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 - Few	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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on staff interviews, record review, and review of the facility's policy titled, Abuse, Neglect, and Exploitation Procedures, the facility failed to protect residents from resident to resident physical abuse for two of four sampled residents (R) (R5 and R4). Specifically, R5 was hit by R4. Findings include:Review of a facility policy titled Abuse, Neglect, and Exploitation Procedures with a revision date of 12/5/2025 revealed under Policy: It is the policy of the facility to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of residents property. Under Definition: Physical Abuse includes, but not limited to hitting, slapping, punching, biting, and kicking. It also includes controlling behavior through corporal punishment. Under Prevention of Abuse, Neglect, and Exploitation: .B. Identifying, correcting, and intervening in situations in which abuse , neglect, exploitation, and/or misappropriation of resident property is more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents care needs and behavioral symptoms.H. Assigning responsibility for the supervision of staff on all shifts for identifying inappropriate behaviors.1. Review of the electronic medical record (EMR) revealed R5 was admitted to the facility with diagnoses that included but not limited to unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood, unspecified, mild neurocognitive disorder due to known physiological condition with behavioral disturbance, unspecified injury of head, subsequent encounter.Review of R5's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/23/2025 revealed R5 had a Brief Interview for Mental Status (BIMS) score of 0 out of 15, which indicated the resident was severely cognitively impaired. It was recorded under section C (Cognitive Assessment) that R5 had Long and /short term memory problem. Review of Progress note dated 8/11/2025 at 15:42 pm (3:42 pm) revealed, Resident was in the day area, when another resident approached her and hit her.2. Review of the EMR revealed R4 was admitted to the facility with diagnoses that included but not limited to unspecified severe protein-calorie malnutrition, schizoaffective disorder, bipolar type, bipolar disorder, unspecified, adjustment disorder with mixed anxiety and depressed mood, anxiety disorder, unspecified, unspecified psychosis not due to a substance or known physiological condition, acute kidney failure, unspecified, acquired absence of right leg above knee, acquired absence of left leg above knee, and dysphagia.Review of R4's quarterly MDS with an ARD of 8/5/2025 revealed R4 had a BIMS score of 15, which indicated that resident had intact cognition.Review of a Progress note dated 8/11/2025 at 15:42 pm revealed Resident was in the day area, when another resident (R4) approached her and hit her.During an Interview on 8/20/2025 at 4:18 pm with Licensed Practical Nurse (LPN) BB regarding an incident that occurred between R4 and R5 on 8/11/2025, she revealed that R4 was visibly upset and crying, she stated R4 was taken to the day room where other residents were sitting. She revealed that R4 started screaming and yelling. She revealed that R5 was walking down the hall back and forth as she normally did and as she approached towards R4, R4 hit R5 and was verbally aggressive, calling R5 a curse word and to get away from her. She revealed that this was typical behavior for R4, especially when she didn't get her way.During an interview on 8/20/2025 at 4:36 pm with Certified Nursing Assistant (CNA) DD, she revealed that she witnessed an incident between R4 and R5 on 8/11/2025. She stated that R4 was upset about not getting ice-cream and pudding after lunch, which was provided to R4 by another staff. She stated that R4 started rolling down the hallway crying and having a tantrum. She stated that she took R4 to the TV room, which was by the nurse's station. She stated that R5 had dementia and was walking up and down the hall as she normally did. She went on to state that R5 was curious as she saw R4 crying. She stated R5 was confused because R4 was crying. She further stated that R4 was in a wheelchair crying and R5 went close to her wheelchair and that's when R4 hit R5, just one time, and then they were separated. She revealed that R4 called R5 a curse word.During an interview on 8/20/2025 at 5:02 pm with CNA CC, she revealed that she witnessed an incident between R4 and R5. She stated that R4 was upset because she couldn't go back to her room and was up and down the hall screaming and crying. She stated that she rolled R4 down to a chair in the dayroom and told R4 to be quiet because she was crying. She stated that R4 got in her wheelchair and started pushing stuff off the table. She further stated that when R5 was walking towards the table because R5 had a drink on that table, she stated that R4 was banging her hands and said to R5

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (continued on next page)

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and review of the facility policy titled, Abuse, Neglect, and Exploitation Policy and Procedures, the facility failed to protect residents from misappropriation of property for one resident (R) (R3) by not ensuring that R3's gold teeth were placed in a secure location. Findings include:Review of the facility policy titled Abuse, Neglect, and Exploitation Policy and Procedures dated and revised December 5,2022 revealed under Policy: it is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of residents property. Under Definitions: Misappropriation of Resident property means means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money, without the resident's consent. Under Policy Explanation and Compliance Guidelines: A. Prohibit and Prevent abuse, neglect, and exploitation of residents and misappropriation of resident property. 1. Prevention of Abuse, Neglect and Exploitation.G. Addressing features of the physical environment that may make abuse, neglect, exploitation, and misappropriation of resident property more likely to occur.Review of the electronic medical record (EMR) revealed R3 was admitted to the facility with diagnoses of but not limited to central cord syndrome at C4 level of cervical spinal cord, subsequent encounter, type iii occipital condyle fracture, left side, syncope and collapse, and adjustment disorder with mixed anxiety and depressed mood.Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed R3 had a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment.Review of a Progress note for R3 dated 5/6/2025 at 20:41 (8:41) pm revealed, Resident had fall with injuries when he went out for lunch with family. He had broken his teeth, abrasion noted on his face and right upper arm. First aid treatment rendered, neuro-checks started. MD notified, and resident (R3) was sent to name of hospital for evaluation. During an interview on 8/20/2025 at 11:06 am with Medical Social Worker (MSW) AA, she revealed that the facility Administrator offered R3 compensation for the missing gold grill for his teeth. She stated that the resident told her that the Administrator never came to talk to him and then later said the Administrator said that he would only compensate him $100.00. She stated that it was four grills that were missing. She stated that when she spoke to the Social Worker manager, she revealed that R3 declined $100.00. She stated that the facility never replaced R3's missing gold grills for his teeth.During an interview on 8/20/2025 at 10:31 am with Licensed Practical Nurse (LPN) II, she revealed that she was familiar with R3 missing his gold grill. She stated that on July 9, 2025, R3 stated that he was going to a dentist's appointment with a family member to get his gold tooth fixed. She stated that when R3 came back, he stated that he was not able to get his gold teeth fixed because he had to pay out of pocket and it was about $900.00. She stated that during discharge the facility did not replace R3's gold grill for his teeth.During an interview on 8/21/2025 at 11:08 am with LPN GG, she revealed that R3 came back from lunch with family and had an accident. She stated that when R3 came back to the facility he was bleeding and staff got him out of the car and sent him back to his room. She stated that R3 said that his gold grill for his teeth came out during the fall. She acknowledged R3 handed her over the gold grill teeth, and she wrapped the gold grill teeth in a paper towel and put in a clear plastic medication cup at R3's bedside. She stated that she was the one that sent R3 to the hospital with her supervisor LPN HH for a proper checkup. She stated that when R3 returned from the hospital, she told R3 that the teeth were at his bedside but R3 came back and stated that the gold grill was not there by the bedside. She further stated that R3 claimed that she threw the teeth away. She stated that she informed her supervisor, LPN HH. She stated that she had no idea what happened to the teeth and knew that she did not throw them away. She stated that she asked the housekeepers, and they all stated that they did not see or take the teeth. She stated that she was not sure of the housekeeper that was working in the hall on that day and not sure they were still here in the facility. She stated that they have different housekeepers every day. She stated that no one from social services came to inquire about the missing teeth. During an interview on 8/21/2025 at 11:24 am, LPN HH revealed that she did not see the gold grill that covered the teeth. She stated that the nurse told her that she had wrapped the teeth and obviously were not properly secured. She stated that she found out the next day that it was missing. She stated that the grill should have been secured properly. She stated that they didn't have a specific place to secure it, so it was placed at the bedside. She stated that they sent R3 out on two occasions for the fitting of the grill that she thought was replaced. She

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident family and staff interviews, and review of the facility policy titled, Transfer and Discharge (including AMA 'against medical advice'), the facility failed to provide a 30-day notice to three of seven sampled residents (R) (R3, R6, and R7) or their representatives before they were discharged from the facility. Findings include:Review of a facility policy titled Transfer and Discharge (including AMA) with original date of October 2017, Revised January 2024, revealed under Policy: It is the policy of the facility to permit each resident to remain in the facility, and not transfer or discharge for the resident from the facility, except in limited circumstances. Under Procedure: .4. The Facility's transfer/discharge notice will be provided to the resident and the resident's representative in a language and manner in which they can understand.5. Generally, the notice must be provided at least 30 days prior to a facility-initiated transfer or discharge of residents.1. Review of the electronic medical record (EMR) revealed R3 was admitted to the facility on [DATE] with diagnoses that included but not limited to central cord syndrome at C4 level of cervical spinal cord, subsequent encounter, burn of unspecified body region, syncope and collapse, and adjustment disorder with mixed anxiety and depressed mood.Review of R3's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/17/2025-Discharge Return Not Anticipated revealed R3 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident is not cognitively impaired. Review of a Progress Note dated 7/16/2025 at 23:10 (11:23 pm) revealed, A Resident observed on the floor in the bathroom sitting on buttock with head against the wall. The shower was running, and water was all over the floor. The resident stated that he slipped and fell on the floor. Head-to toe assessment done no visible injury noted, resident guarding left arm and complaint of pain to left arm at 9/10. Resident able to move all extremities without difficulty except left arm. Resident assisted off the floor into the w/c (wheelchair) with assist x2, neuro checks initiated and within normal limits. Tramadol 50 mg is given per prn (as needed) order. Resident being sent out to ED (emergency department) for eval (evaluation) and possible x-ray per resident request.Review of a Progress Note dated 7/17/2025 at 00:54 (12:54 am) revealed, Resident left facility via stretcher accompanied by 2 EMS (emergency medical services) attendants 2350 (11:50 pm). Resident alert and verbally responsive pain level remain at 9/10.Review of a Progress Note dated 7/17/2025 at 09:15 (9:15 am) revealed, Resident return from 'name of hospital' hospital approx. (approximately) 0915 s/p (status post) fall.Review of a Progress Note dated 7/17/2025 at 10:45 (10:45 am) revealed, Resident discharged from facility approx. 10:45. Transition to home. Resident alert and orient (oriented) x4, vitals stable, no distress/discomfort noted, ambulated self to 'name of car service'. Discharge instruction provided and reviewed with resident, Resident d/c (discharged) with personal belongings and medications. RP (responsible party) notified, 'name of physician staffing agency' notified, cp (care plan) updated.During a telephone interview on 8/20/2025 at 9:41 am with a Family member of R3, the family member stated that the facility discharged R3 without notice. He stated that the facility did not contact him about R3's discharge. He stated that the facility just dumped R3 at his house. He stated that R3 was not ready to be discharged . He stated that he did not receive a 30-day notice about the discharge regulation. He stated that R3 passed away on 8/2/2025 after being discharged on 7/17/2025.During an interview on 8/20/2025 at 10:31 am with Licensed Practical Nurse (LPN) II, she revealed that R3 was sent to 'name of hospital' on 7/17/2025 due to a fall during shower that morning and was discharged on 7/17/2025 when he returned from 'name of hospital' that same day.During an interview on 8/20/2025 at 11:06 am with Medical Social Worker (MSW) AA, she revealed that from the day of admission that R3 always wanted to go back to the community. When asked how much notice the residents were getting, she revealed that it just depended on the situation, that R3's locations changed but was always back to the community. She revealed that R3 was discharged to his uncle's home. She stated that the facility did not give a 30-day discharge notice to residents. She stated that they only gave verbal notice starting from the day of admission.Review of the EMR for R3 revealed there was no 30-day notice provided to R3 or their representative. 2. Review of the EMR revealed R6 was admitted to the facility on [DATE] with diagnoses that included but not limited to encephalitis and encephalomyelitis, unspecified, nontraumatic intracerebral hemorrhage, unspecified, compression of brain, unspecified severe protein-calorie malnutrition, epilepsy, unspecified, not intractable, without status epilepticus, vascular dementia, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, adjustment disorder with mixed anxiety and depressed mood, schizoaffective

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and review of the facility's policy titled, Minimum Data set MDS Completion, the facility failed to complete accurate MDS assessments for three of seven sampled Residents (R1, R2, and R7). The deficient practice had the potential for R1, R2, and R7's care needs to go unmet.Findings include:Review of the facility's policy titled Minimum Data set MDS Completion dated October 2024, revised July 2025 revealed under Policy: It is the policy of this facility that residents are assessed, using a comprehensive assessment process in order to identify care needs and to develop an interdisciplinary care plan.1. Review of the electronic medical record (EMR) revealed R1 was admitted to the facility with diagnoses that included but not limited to dysarthria following unspecified cerebrovascular disease, and other secondary parkinsonism.Review of the most recent quarterly Minimum Data Set (MDS) dated [DATE] documented R1 had a Brief Interview for Mental Status (BIMS) of 15, which indicates R1 is not cognitively impaired.Review of a Progress Note dated 7/5/2025 at 22:09 (10:09 am) for R1 revealed, In response to roommate in 209A stating that resident threw soda at him, writer asked resident what happened, resident used communication board to inform writer that he asked roommate to turn off the heat when resident communicated that roommate stated he was going to kill him.Review of a Progress Note dated 8/5/2025 at 01:42 (1:42 am) for R1 revealed, Resident witnessed by CNA (certified nursing assistant) throwing a drink at his roommate, 'name of roommate'. The resident was upset that his roommate was adjusting the AC (air conditioning) unit. Resident reminded that it is not ok to throw objects at others and resident complied. Message left with the social worker. Resident is own RP (responsible party). Care plan updated. 'Name of physician agency' notified.Review of a Progress Note dated 8/5/2025 at 11:18 (am) for R1 revealed, SW (Social Worker) received a voicemail message from Night Shift nurse concerning resident's behavior of throwing water on his roommate. Resident has exhibited behavior before as being the aggressor and previously and roommate was transferred from the room. SW discussed with the resident how his behavior is inappropriate. SW informed resident that he has to alert nursing when he is in dispute with another resident. SW informed the resident that his behavior needs to change. The resident typed on his communication board that he would not do the behavior again and he would stop. SW discussed with resident that he would be transferred to another room/unit. SW previously discussed the matter with the Nursing Manager. Also, the Charge Nurse was informed that the resident would need to transfer to (room) A116.Review of Minimum Data Status (MDS) assessment for R1 dated 7/11/2025 revealed section E (Behavior) under E0200 under A and C indicated no behavior issues for R1. 2. Review of the EMR revealed R2 was admitted to the facility with diagnoses that included but not limited to major depressive disorder, single episode, unspecified, major depressive disorder, recurrent, moderate, vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, vascular dementia, unspecified severity, with other behavioral disturbance, and vascular dementia, moderate, with other behavioral disturbance. Review of a Progress Note dated 7/30/2025 at 18:24 (6:24 pm) for R2 revealed, Resident noted sitting in the hallway without clothing. Resident encouraged to cover up. Resident covered up and assisted to the room. Review of the MDS assessment dated [DATE] for R2 revealed in section E (Behavior) indicated no behavior issues.During an Interview on 8/21/2025 at 1:15 pm with Medical Social Worker (MSW) LL regarding R2 disrobing in the hallway on 7/30/2025 and was not coded on MDS section E (Behavior). She stated that she looked on MDS section E, next to the right icon and that's where she got the information for behavior entry. She stated that she relied on the EMR for the information. She acknowledged that the behavior of disrobing by R2 was not coded on section E of the MDS completed 8/1/2025, but it indicated no issues.3. Review of R7's EMR revealed R7 was admitted to the facility with diagnoses that included but not limited to unspecified severe protein-calorie malnutrition, local infection of the skin and subcutaneous tissue, unspecified, unspecified convulsions, pressure ulcer of foot drop, right foot, hypokalemia, alcohol abuse, uncomplicated, unspecified lack of coordination, and mild cognitive impairment of uncertain or unknown etiology.Review of R7's quarterly MDS assessment with an ARD of 7/29/2025 Discharge Return Not Anticipated revealed R7 had a BIMS score of 15, which indicated the resident is not cognitively impairedReview of a Progress Note dated 6/20/2025 at 17:23 (5:23 pm for R7 revealed, Pt (patient) admitted to facility from 'name of hospital' with Dx (diagnosis) of infected sacral decubitus ulcer, sacrum wound. Head to toe skin assessment completed with no complaints of pain or discomfort. Pt skin is expected color for ethnicity, warm and dry and