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	03/01/2026

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 - 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 observations, record review, interviews, and facility policy review, the facility failed to ensure adequate action was taken to prevent abuse for seven of 25 residents (R) reviewed for abuse related to (1) allegations of sexual abuse to R9 and R20 by R10; (2) an allegation of sexual abuse to R8 by R7; (3) an allegation of physically abusive to R23 by R22; (4) an allegation of abuse to R2 by R3; (5) an allegation of abuse to R5 by R4; (6) an allegation of abuse to R1 by nurse aide (NA) 51. The facility's failure to ensure no further abuse was perpetrated created the potential for residents to be, or to continue to be, abused, leading to serious physical and/or psychological harm for each resident.On 2/26/2026, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause serious injury, harm, impairment, or death to residents.On 2/26/2026 at 5:30 pm, the Administrator was notified that Immediate Jeopardy (IJ) was identified to have existed on 10/19/2025, when R9 made an allegation that a male resident, R10, sexually abused her by touching her in between her legs on that date.An Acceptable Removal Plan was received on 3/1/2026. Based on observation, record review, a review of facility policies as outlined in the Removal Plan, and staff interviews, it was validated that the corrective plans and the immediacy of the deficient practice were removed on 3/1/2026. The facility remained out of compliance while the facility continued management-level staff oversight, as well as continuing to develop and implement a Plan of Correction (POC). This oversight process includes monitoring residents and investigating/preventing abuse.Findings included:1. a. A review of R10's admission Record located in the electronic medical record (EMR) indicated the resident was admitted to the facility on [DATE]. The document indicated the resident's diagnoses included heart failure, pituitary acromegaly, gigantism, and neurosyphilis. A review of R10's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 1/22/2026 indicated a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated R10 had intact cognition. A review of R10's care plan, most recently updated 5/29/2024, indicated the resident had the potential to be verbally aggressive and sexually (abusive) to staff. The care plan indicated R10 was moved to another unit on 5/29/2024 due to allegations of abuse. Interventions included administering medications as ordered, analyzing key times, places, triggers, and what de-escalates the behavior, assessing the resident's understanding of the situation, allowing the resident time to express themselves and feelings toward the situation, and monitoring and documenting observed behavior and attempted interventions. There was nothing in R10's care plan to address the facility's plan or implemented interventions put into place for R20 to prevent potential further abuse of residents after either of the allegations of sexual abuse by R9 or R20. A review of R10's comprehensive record revealed nothing to indicate specific behavioral monitoring or (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	implemented interventions related to/in response to allegations of sexual abuse by R10, R9, or R20. A review of R10's Progress Notes, dated 4/10/2025, indicated, Resident transferred from B-2 to B-1 with all his belongings and medications. Report given from B-2 to nurse and resident adjusting well to new surroundings in stable condition. Resident RP [representative], TCPA [physician electronic notification system] notified, and CP [care plan] updated. The progress note did not address the reason for R10's transfer to a different unit. A review of R10's Progress Notes, dated 10/19/2025, indicated, Resident was transferred to unit C106 due to allegations made by another resident. Situation reported to the house manager, and appropriate actions were taken to ensure safety. Resident remained calm and cooperative during the transfer. RP made aware, TCPA notified CP updated. Attempts were made to interview R10 on 2/25/2026 at 12:00 pm and again on 2/26/2026 at 10:30 am. R10 declined an interview, other than to state that things were generally going fine at the facility. During observations of R10 on 2/25/2026 at 12:00 pm and 2/26/2026 at 10:30 am and 2:30 pm, it was revealed that the resident was not being monitored by any staff member, and the resident was able to freely move about the unit (a coed unit) in his wheelchair without restriction of any kind. b. A review of R9's admission Record indicated the resident was admitted to the facility on [DATE]. The document indicated the resident's diagnoses included a history of stroke. A review of R9's quarterly MDS assessment with an ARD of 12/3/2025 indicated a BIMS score of 13 out of 15, which indicated R9 had intact cognition. A review of R9's Behaviors Care Plan, most recently updated 12/3/2025, indicated the resident was involved in a report resident-to-resident altercation on 10/5/2025, was involved in an alleged inappropriate interaction reported from another resident on 10/19/2025, and was the receiver of resident-to-resident aggression on 12/3/2025. The care plan indicated interventions such as 10/19/2025 accused resident removed to another unit for safety measures, 10/5/2025 assessed resident for signs of injury, and 12/3/2025, resident removed from harm's way and placed into her room. Skin and pain assessed, and MD [Medical Doctor] notified. A review of R9's Progress Notes, dated 10/5/2025, indicated that the resident reported to the writer that another resident punched her while they were sitting and eating breakfast; no bruise, redness, or discomfort was noted. The other resident was observed in the hallway, denied the incident, and appeared calm with no signs of aggression. Incident reported to the manager for appropriate action. Both residents monitored; no further concerns noted at this time. Resident is her own RP, TCPA notified, CP updated. A review of R9's Progress Notes, dated 10/19/2025, indicated that the resident approached the writer tearful and emotional, stating that two days ago another resident rubbed her leg while she was wearing leggings. She reported that she shared the incident with another resident. The accused resident reportedly found out and confronted her during church service in an agitated manner. The writer immediately reported the situation to the house manager. Upon arrival, the house manager brought both residents to a private area to discuss and assess the situation. The reporting resident's account remained consistent with her initial statement to the writer. She also stated the accused resident rubbed his hand through her hair, but denied that his hand went beyond her legs. She (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	explained that she confided in the other resident because she felt safe speaking with him. The accused resident was interviewed by management. He stated that the reporting resident came to his room and that he gave her one dollar yesterday and another today. He denied rubbing her leg but was hesitant when asked if camera footage would confirm his version of events. He did, however, admit to rubbing his hand through the resident's hair. The accused resident was removed from the unit for safety and further investigation. A review of R9's Progress Notes, dated 12/3/2025, indicated that the resident informed the nurse that she was having a verbal disagreement with another resident while sitting in the dayroom, and the resident threw items at her, hitting her. Resident removed from dayroom and skin assessed with no visible injuries and denies pain at this time. A review of R9's comprehensive record revealed nothing to indicate R9 was physically assessed immediately after the allegation of inappropriate sexual contact on 10/19/2025 or that a psychosocial assessment of R9 was performed immediately after any of the above-referenced incidents to ensure there were no physical or psychosocial injuries to the resident as a result of the incidents. A review of the facility's investigation, provided by the facility, related to R9's 10/19/2025 allegation of sexual abuse by R10 revealed an incomplete investigation related to the alleged sexual abuse. The facility did not substantiate sexual abuse of R9 by R10 based on the incomplete investigation. During an interview conducted with R9 on 2/25/2026 at 3:50 pm, she confirmed her 10/19/2025 report of sexual abuse by R10 and stated, I was sitting in front of the TV and he walked by me in the wheelchair and he rubbed his hand like this on my leg (showing the surveyor caressing of her leg up the inside of her thigh) and then was touching my hair and moving fingers down here (on her thigh). It didn't feel right. It gives me chills to think about it. It brings back bad memories. I reported to the staff (the Administrator), and he got [R10] off the unit. They moved him somewhere else. Now I see him in the hallway, and I try to be nice to him, but he still creeps me out and makes comments (sexual and otherwise) to me that are not appropriate, but I try to ignore him. c. A review of R20's admission Record indicated the resident was admitted to the facility on [DATE] and discharged on 7/25/2025. The document indicated the resident's diagnoses included heart failure, schizophrenia, and vascular dementia. A review of R20's quarterly MDS assessment with an ARD of 4/2/2025 indicated a BIMS score of 15 out of 15, which indicated R20 had intact cognition. A review of R20's care plan, most recently updated 3/30/2025, indicated the resident reported she was touched inappropriately by another resident (R10). Interventions included sending to the emergency room for evaluation. There was nothing in the care plan to indicate ongoing interventions to prevent further abuse of R20 by R10 after the 3/30/2025 report of alleged sexual abuse. A review of R20's Progress Notes dated 3/30/2025 at 4:10 pm indicated, Resident returned from church downstairs. Upon return, the resident noted sitting in the day area in the presence of staff. After lunch, the resident heard repeating, He raped me. He raped me. When asked who, the resident states [R10]. Management was notified immediately. The manager arrived at the unit. Resident assisted to the private area. Upon speaking with the manager and this nurse, the resident does not mention any resident's name. Resident states that staff touch her private part when they are cleaning her. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of R20's Progress Notes, dated 3/30/2025 at 5:46 pm, indicated Resident out of facility to [Hospital] for evaluation via EMS [Emergency Medical Services]. Transported via stretcher. The resident is clean and dry. Escort at side. No c/o [complaint of] pain or discomfort. Attempted to notify resident RP without success. A review of R20's Progress Notes, dated 3/30/2025 at 8:48 pm, indicated, Resident is currently at [Hospital]. This writer spoke with the Patient Advocate. The advocate stated that when she tried to speak to the resident about the incident, [R20] became agitated and requested something to eat. Once, after getting a sandwich, the MD was able to speak with [R20], and she refused to be examined. [R20] told the MD that she was ready to go back to [Facility]. The MD was able to reach RP. Discharge back to [Facility] is in progress. A review of R20's Progress Notes, dated 3/31/2025 at 9:02 am, indicated, Patient returned to unit via stretcher, unable to perform rape kit by Hospital staff, resident very uncooperative and refused to allow staff to touch her, patient was accompanied by a CNA [Certified Nursing Assistant] to hospital visit, RP made aware. A review of the facility's investigation, provided by the facility, related to R20's 3/30/2025 allegation of sexual abuse by R10 revealed an incomplete investigation related to the alleged sexual abuse. The facility did not substantiate sexual abuse of R20 by R10 based on the incomplete investigation. Cross-reference F610 (Investigation of Abuse) for related findings. 2. a. A review of R7's admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including paranoid schizophrenia and vascular dementia. A review of R7's quarterly MDS assessment with an ARD of 2/16/2026 indicated a BIMS score of 14 out of 15, which indicated the resident was cognitively intact. A review of R7's comprehensive care plan, most recently dated 2/27/2026, indicated nothing related to the resident's recent history of potential sexual abuse of another resident (R8) or any plan/interventions to prevent residents in the facility from experiencing potential further sexual abuse by R7. A review of R7's Progress Notes, dated 11/16/2025 at 10:56 pm, indicated At approximately 2130 [9:30 pm], the CNA was heard screaming from the hallway. Upon looking down the hall, I noted her standing outside of [R8's room]. She said, 'Come here now.' Upon getting to [R8's room], [R8] was noted lying in bed with his penis out of the brief. The CNA stated that she noted the room door closed, but it is not usually closed, so she opened the door and noted [R7] bent over [R8]'s bed with his penis in his mouth, moving in an up and down motion. The CNA states that the resident [R7] stopped once he heard her scream. She then immediately asked him to leave the room . A review of R7's Progress Notes, dated 11/19/2025, indicated, SW [Social Worker] met with resident on Monday, (11/17/2025), concerning a recent reported sexual encounter resident allegedly had with his roommate. The resident stated that he was repeatedly asked (sic) by another resident to perform a sexual act. The resident stated he refused in the past but decided to do what his roommate asked. SW asked the resident if he felt he needed to discuss the matter with a psychiatrist or a counselor. The resident denies needing to talk with anyone. He informed SW that he is okay but would let SW know if he needed any resources. SW will continue to follow the resident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of R7's comprehensive progress notes revealed no further documentation related to the 11/16/2025 incident. Comprehensive review of R7's record revealed nothing to indicate that an attempt to assess R7's psychosocial well-being was conducted until 11/19/2025 (three days after the incident) or that R7 had ever been physically assessed related to the incident to rule out physical and/or psychosocial harm related to the incident. During observations on 2/24/2026 at 11:45 am, R7 was lying in his bed with the door to the hallway open. R7 was uncovered and naked from the waist down, with his penis in full view from the doorway. R7 was observed to reside in a private room without a roommate, and there were no staff or residents observed in the hallway or the general area of R7's room. R7 did not reply to the surveyor when the surveyor attempted to interview him. During an observation on 2/25/2026 at 11:25 am, R7 was lying in his bed in his room. R7 was covered by a blanket. R7 appeared to be confused at the time of the observation and was not able to be interviewed. During an observation on 2/27/2026 at 9:30 am, R7 was lying in his bed, sleeping. The resident was covered with a blanket. The surveyor had no observations of R7 outside of his room/bed throughout the investigation. During an interview with NA34 on 2/27/2026 at 9:35 am, she confirmed R7 did not have a roommate, rarely left his room, and was only able to move about the unit with total/extensive assistance from staff. She stated there had not been any recent concerns related to the resident. b. A review of R8's admission Record dated 2/27/2026 indicated the resident was admitted to the facility on [DATE] with diagnoses including paranoid schizophrenia, vascular dementia, and a history of head injury with loss of consciousness. A review of R8's quarterly MDS assessment with an ARD of 12/31/2025 indicated a BIMS score of 15 out of 15, which indicated R8 was cognitively intact. A review of R8's comprehensive care plan, most recently dated 1/2/2026, indicated nothing related to the resident's recent history of potential sexual abuse by another resident (R7) or any plan/interventions to prevent the resident from experiencing potential further sexual abuse by R7. A review of R8's Progress Notes, dated 11/16/2025 at 10:13 pm, indicated, At approximately 2130 [9:30 pm], the CNA was heard screaming from the hallway. Upon looking down the hall, I noted her standing outside of the room . she said 'Come here now. Upon getting to the resident's room, [R8] was noted lying in bed with his penis out of the brief. The CNA stated that she noted the room door closed, but it is not usually closed, so she opened the door and noted [R7] bent over [R7]'s bed with his penis in his mouth, moving in an up and down motion. The CNA states that [R7] stopped once he heard her scream. She then immediately asked him to leave the room. [R7] came up to the nurse's station and was noted spitting in the trash can in the sitting area. A review of R8's Progress Notes, dated 11/19/2025, indicated, SW met with the resident to discuss a recent report that the resident and his roommate were allegedly found by a staff person attempting a sexual encounter. Resident informed SW that he woke up to find his roommate had removed his private part from his brief. He stated that he was unaware until the staff entered the room. The resident stated he was fearful at the time when he woke up to the situation. The resident asked if he (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	felt safe. SW also asked if it would be helpful for SW to do a PSY [psychiatric] referral for the Psychiatrist and/or counseling. Resident stated he felt [sic] safe and that he did not need to speak with a psychiatrist and/or counselor. SW encouraged the resident to alert SW if he changed his mind or needed anything else. The resident asked SW if the day shift was aware of the situation between him and his former roommate. SW stated she was not aware if the day shift knew. SW explained that SW knew what occurred due to being his assigned SW. SW will continue to follow up with the resident. A review of R8's comprehensive progress notes revealed no further documentation related to the 11/16/2025 incident. Comprehensive review of R8's record revealed nothing to indicate that an attempt to assess R8's psychosocial well-being was conducted until 11/19/2025 (three days after the incident) or that R8 had ever been physically assessed related to the incident to rule out physical and/or psychosocial harm related to the incident. A review of the facility's investigation, provided by the facility, related to the 11/16/2025 allegation of sexual abuse of R8 by R7, revealed an incomplete investigation related to the alleged sexual abuse. The facility did not substantiate sexual abuse of R7 by R8 based on the incomplete investigation. Cross-reference F610 (Investigation of Abuse) for related findings. During an observation and interview on 2/24/2026 at 11:55 am, R8 was in bed in his room. The resident had difficulty responding to the surveyor's questions due to difficulty communicating verbally. However, the resident acknowledged he was okay by giving a thumbs up during the interview/observation. During an observation on 2/25/2026 at 11:40 am, R8 was observed sleeping in his bed. During an observation on 2/27/2026 at 9:40 am, R8 was observed lying in his bed. R8 was not observed out of his room/bed at any time during the investigation and was residing in a room on a different unit than R7. 3. a. A review of R22's admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including vascular dementia and a history of breast cancer. A review of R22's quarterly MDS assessment with an ARD of 1/7/2026 indicated a BIMS score of zero out of 15, which indicated R22 was severely cognitively impaired. A review of R22's care plan, most recently updated 1/20/2026, indicated the resident sometimes demonstrated behaviors. The care plan specifically indicated a behavior, dated 9/29/2025, during which the resident attempted to hit a staff member, and when she was not successful with this, she hit a resident instead. Interventions included administering medications as ordered, monitoring behaviors, and attempting to determine underlying causes. The care plan indicated the resident was placed on 1:1 care related to the 9/29/2025 incident. The care plan did not address the 12/20/2025 incident of alleged physical abuse. A review of R22's Progress Notes dated 12/20/2025 indicated, Writer was attempting to give the resident her meds for the morning along with some juice. The resident stated she did not want it, so the writer took the medication and cup from the resident. Upon receiving the cup and medication, the (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	resident turned around and threw up her fist to hit the writer. The writer moved out of the way and tried to talk to the resident when she proceeded to walk over and hit another resident [R23] while saying I will hit him [sic] then. Resident did draw back her arm and slap [R23] in the face. b. A review of R23's admission Record indicated the resident was admitted to the facility on [DATE]. The document indicated the resident's diagnoses included type two diabetes and unspecified dementia. A review of R23's annual MDS assessment with an ARD of 12/19/2025 indicated a BIMS assessment could not be completed due to the resident's poor cognition. The assessment indicated R23 had both short and long-term memory problems. A review of R23's care plan, most recently updated 8/11/2025, revealed nothing related to a 12/20/2025 incident of physical abuse perpetrated on R23 by R22. A review of R23's Progress Notes, dated 12/20/2025 at 1:33 pm, indicated, Writer was attempting to give another resident [R22] their meds for the morning along with some juice. The other Resident stated she did not want it, so the writer took the medication and cup from the resident. Upon receiving the cup and medication, the resident [R22] turned around and threw up her fist to hit the writer. The writer moved out of the way and tried to talk to the resident when she proceeded to walk over and hit [R23] while saying I will hit him then. Resident did draw back her arm and slap [R22] in the face. A review of R23's Progress Notes dated 12/20/2025 at 2:23 pm indicated, Upon assessment, no injuries [to R23] noted, and situation was deescalated. A review of the facility's investigation dated 12/20/2025, provided by the facility related to the incident of physical abuse perpetrated on R23 by R22 on 12/20/2025, revealed an incomplete investigation. However, the allegation of physical abuse of R23 by R22 was substantiated. 4.a. A review of R2's EMR revealed an admission date of 8/28/2023 with diagnoses of respiratory failure and post-concussional syndrome. A review of R2's Quarterly MDS with an ARD of 12/4/2025 revealed a BIMS score of 11 out of 15, which indicated R2's cognition was moderately impaired. b. A review of R3's EMR revealed an admission date of 1/14/2025 with diagnoses of head injury, cognitive impairment, and mood disorder. A review of R3's Annual MDS assessment with an ARD of 1/15/2026 revealed a BIMS score of three out of 15, which indicated R3's cognition was severely impaired. A review of the facility's investigative file provided by the facility revealed that R2's family member (FM)1 reported to the Licensed Practical Nurse (LPN) Unit Manager on 1/12/2026 that R2 had told him that R3 comes into her room and touches her body. 5a. A review of R5's EMR revealed an admission date of 12/5/2024 with diagnoses of dementia with anxiety and behavioral disturbances. A review of R5's Quarterly MDS assessment with an ARD of 1/1/2026 revealed a BIMS score of 15 (continued on next page)

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	non-consensual sexual contact of any type with a resident; and Physical Abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking. It also includes controlling behavior through corporal punishment; and Prevention of Abuse, Neglect and Exploitation: The facility will implement policies and procedures to prevent all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves: 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 the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms; D. The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect; and Protection of Resident: The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after investigation. Examples include but are not limited to: A. Responding immediately to protect the alleged victim and integrity of the investigation; B. Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed; C. Room of staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator; E. Protection from retaliation; F. Providing emotional support and counseling to the resident during and after the investigation, as needed; G. Revision of the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and policy review, the facility failed to ensure psychotropic medications were not given before informed consent or risk versus benefits for three of eight residents (R) (R11, R12, and R13) reviewed for psychotropic medications. This failure had the potential for ordered psychotropic medications provided without evidence of informed consent, which included treatment goals, benefits vs risks, and adverse reactions to treatment. Findings included:1. A review of R11's admission Record located under the Profile tab of the electronic medical record (EMR) revealed she was admitted to the facility on [DATE] with diagnoses of dementia with behavioral disturbances and adjustment disorder with disturbance of emotions and conduct. A review of R11's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 12/3/2025 revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated R11 was moderately cognitively impaired. A review of R11's February 2026 Medication Administration Record (MAR) revealed that the resident was prescribed Depakote ER extended-release tablet 250 milligrams (mg) to be given once a day at bedtime for mood stabilization and episodic agitation. A review of R11's Miscellaneous documents revealed there was no signed consent or risk versus benefits for psychoactive medications.2. A review of R12's admission Record revealed she was admitted to the facility originally on 6/27/2024, then readmitted on [DATE]. R12 was admitted with diagnoses of schizoaffective disorder, bipolar type, bipolar disorder, adjustment disorder with mixed anxiety and depression, and psychosis.A review of R12's quarterly MDS assessment with an ARD of 2/5/2026 revealed a BIMS score of 15 out of 15, which indicated R12 had intact cognition. R12 was also documented as receiving antipsychotic, antianxiety, antidepressants, and anticonvulsant daily. A review of R12's February 2026 Clinical Physician Order revealed that the resident was prescribed the following psychoactive medication:-Klonopin 0.5 mg tab twice a day for anxiety.-Abilify 10 mg tab once a day for schizoaffective disorder, bipolar type.-Sertraline HCL [hydrochloride] 25 mg tab, give three tabs once a day for depression. -Quetiapine Fumarate 100 mg tab twice a day for bipolar disorder.A review of R12's Consent for use of Psychoactive Medication form revealed that the consent was signed and witnessed by facility social workers because the resident did not have any hands or arms. The resident gave permission for the psychoactive medication, but the consent form had no medication listed. The form required drug, dosage, frequency, targeted behavior, and potential side effects to be written. There was none listed for the four different medications the resident was on. 3. A review of R13's admission Record revealed she was admitted to the facility originally on 1/7/2011 and then readmitted on [DATE]. R11 was admitted with diagnoses of dementia with behavioral disturbances, personality disorder, major depressive disorder, and psychosis. A review of R13's quarterly MDS assessment with an ARD of 1/20/2026 revealed a BIMS score of zero out of 15, which indicated R13 was severely cognitively impaired. A review of R13's February 2026 Clinical Physician Orders revealed that the resident was prescribed Valproate Sodium Oral Solution 250 mg/5 milliliters (ml) to be given 2.5 ml twice a day for behaviors. A review of R13's Miscellaneous documents revealed there was no signed consent or risk versus benefits for psychoactive medications.During an interview on 2/27/2026 at 4:16 pm, the Director of Nursing (DON) indicated she was unable to locate signed psychoactive medication consents for R11, R12, and R13.A review of facility's policy titled Use of Psychotropic Medication(s), last revision date May 2025, indicated that prior to initiating or increasing psychotropic medication, the resident, family, and/or resident representative must be informed of the benefits, risks, and alternatives for the medication, including any black box warnings for antipsychotic medications, in advance of such initiation or increase. The facility will document that the resident or resident representative was informed in advance of the risks and benefits of the proposed care, the treatment alternatives or other options, and the preferred (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	option to accept or decline in a format the facility deems to use (e.g., written consent form, narrative note, etc.).

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy, record review, and resident, family, and staff interviews, the facility failed to complete a thorough investigation of allegations of abuse for 15 of 25 residents (R) (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R13, R20, R21, R22 and R23) reviewed for abuse. The facility's failure to ensure that thorough investigations of abuse were conducted created the potential for residents to be, or to continue to be, abused, leading to serious physical and/or psychological harm for each resident.On 2/26/2026, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause serious injury, harm, impairment, or death to residents.On 2/26/2026 at 5:30 pm, the Administrator was notified that Immediate Jeopardy (IJ) was identified to have existed on 10/19/2025, when R9 made an allegation that a male resident, R10, sexually abused her by touching her in between her legs on that date.An Acceptable Removal Plan was received on 3/1/2026. Based on observation, record review, a review of facility policies as outlined in the Removal Plan, and staff interviews, it was validated that the corrective plans and the immediacy of the deficient practice were removed on 3/1/2026. The facility remained out of compliance while the facility continued management-level staff oversight, as well as continuing to develop and implement a Plan of Correction (POC). This oversight process includes monitoring residents and investigating/preventing abuse.Findings included:1. a. A review of R9's admission Record, found in the Electronic Medical Record (EMR), indicated the resident was admitted to the facility on [DATE] with diagnoses that included a history of stroke. A review of R9's Progress Notes, dated 10/5/2025, indicated, Resident reported to writer that another resident punched her while they were sitting and eating breakfast, no bruise, redness, or discomfort noted. The other resident was observed in the hallway, denied the incident, and appeared calm with no signs of aggression. Incident reported to the manager for appropriate action. Both residents monitored; no further concerns noted at this time. Resident is her own RP [Representative], TCPA notified, CP [Care Plan] updated. A review of R21's admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included acquired absence of right leg above the knee and housing instability. A review of R21's Progress Notes, dated 10/5/2025, indicated, Reported by another resident that [R21] hit her on the rt [right] arm. [R21] denies this occurred. Reported that this was witnessed by another resident. [R21] agreed to relocate to A105-D. RP is resident and aware, TCPA aware, CP updated. A review of the facility's investigation related to the 10/5/2025 alleged physical abuse of R9 by R21 revealed an incomplete investigation. Although the local Police Department (PD) was notified of the incident, responded to the facility, and provided a case number for the incident, no follow-up was done on the part of the facility to obtain the investigation information from the PD. The investigation documentation did not include interviews with residents in the area/or who may have been exposed to R21 or had knowledge of the incident, and did not include any assessment (physical or psychosocial) of either resident involved in the incident. b. A review of R9's Progress Notes, dated 10/19/2025, indicated, Resident approached writer tearful and emotional, stating that two days ago another resident rubbed her leg while she was wearing leggings. She reported that she shared the incident with another resident. The accused resident reportedly found out and confronted her during church service in an agitated manner. The writer (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	immediately reported the situation to the house manager. Upon arrival, the house manager brought both residents to a private area to discuss and assess the situation. The reporting resident's account remained consistent with her initial statement to the writer. She also stated the accused resident rubbed his hand through her hair, but denied that his hand went beyond her legs. She explained that she confided in the other resident because she felt safe speaking with him. The accused resident was interviewed by management. He stated that the reporting resident came to his room and that he gave her one dollar yesterday and another today. He denied rubbing her leg but was hesitant when asked if camera footage would confirm his version of events. He did, however, admit to rubbing his hand through the resident's hair. The accused resident was removed from the unit for safety and further investigation. Situation escalated to the house manager for continued follow-up and documentation. Resident is her own RP, TCPA notified CP updated. A review of R10's admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included heart failure, pituitary acromegaly and gigantism, and neurosyphilis. A review of R10's Progress Notes, dated 10/19/2025, indicated, Resident was transferred to unit C106 due to allegations made by another resident. Situation reported to the house manager, and appropriate actions were taken to ensure safety. Resident remained calm and cooperative during the transfer. RP made aware, TCPA notified CP updated. A review of the facility's investigation related to the 10/19/2025 alleged sexual abuse of R9 by R10 revealed an incomplete investigation. Although the local PD was notified of the incident, responded to the facility, and provided a case number for the incident, no follow-up was done on the part of the facility to obtain the investigation information from the PD. The investigation did not include interviews with residents in the area/or who may have been exposed to R10 or had knowledge of the incident, and did not include any assessment (physical or psychosocial) of either resident involved in the incident. c. A review of R9's Progress Notes, dated 12/3/2025, indicated, Resident informed nurse that she was having a verbal disagreement with another resident while sitting in the dayroom, and the resident threw items at her, hitting her. Resident removed from dayroom and skin assessed with no visible injuries and denied pain at this time. Resident is her own RP, CP updated, and MD notified via TCPA communication. A review of R5's admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including obstructive hydrocephalus and bipolar disorder. A review of R5's Progress Notes, dated 12/3/2025, indicated, Resident arguing with another resident [R9] and stated that the resident hit her. The resident noted sitting on the opposite end of the room at the time that she stated the resident had hit her. When asked where she hit her, she stated, She really didn't hit me. I just said that. When asked why, she didn't respond. The resident that she was engaged in a verbal altercation with [R9] stated that she was hit with items she threw at her. The resident admitted to throwing things at her out of frustration. Residents were separated. Room changed to C2-207C. RP called VM [voice mail] full, CP updated, and MD notified via TCPA communication. A review of the facility's investigation related to the 12/3/2025 alleged physical abuse of R9 by R5 revealed an incomplete investigation. Although the local PD was notified of the incident, responded to the facility, and provided a case number for the incident, no follow-up was done on the part of the (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	facility to obtain the investigation information from the PD. The investigation documentation did not include interviews with residents in the area/or who may have been exposed to R5 or had knowledge of the incident, and did not include any evidence of a psychosocial assessment of either resident involved in the incident. 2. A review of R7's admission Record indicated the resident was admitted to the facility on [DATE]. The document indicated the resident's diagnoses included paranoid schizophrenia and vascular dementia. A review of R7's Progress Notes, dated 11/16/2025 at 10:56 pm, indicated At approximately 2130 [9:30 pm], the Certified Nursing Assistant (CNA) was heard screaming from the hallway. Upon looking down the hall, I noted her standing outside of [R8's room]. She said, 'Come here now.' Upon getting to [R8's room], [R8] was noted lying in bed with his penis out of the brief. The CNA stated that she noted the room door closed, but it is not usually closed, so she opened the door and noted [R7] bent over [R8]'s bed with his penis in his mouth, moving in an up and down motion. The CNA states that the resident [R7] stopped once he heard her scream. She then immediately asked him to leave the room . House manager, TCPA, RP notified, care plan updated. A review of R8's admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including paranoid schizophrenia, vascular dementia, and a history of head injury with loss of consciousness. A review of R8's Progress Notes, dated 11/16/2025 at 10:13 pm, indicated, At approximately 2130 [9:30 pm], the CNA was heard screaming from the hallway. Upon looking down the hall, I noted her standing outside of the room. she said, 'Come here now.' Upon getting to the resident's room, [R8] was noted lying in bed with his penis out of the brief. The CNA stated that she noted the room door closed, but it is not usually closed, so she opened the door and noted [R7] bent over [R7]'s bed with his penis in his mouth, moving in an up and down motion. The CNA states that [R7] stopped once he heard her scream. She then immediately asked him to leave the room. [R7] came up to the nurse's station and was noted spitting in the trash can in the sitting area. House manager notified, TCPA, RP notified, care plan updated. A review of the facility's investigation related to the 11/16/2025 alleged sexual abuse of R8 by R7 revealed an incomplete investigation. Although the local PD was notified of the incident, responded to the facility, and provided a case number for the incident, no follow-up was done on the part of the facility to obtain the investigation information from the PD. The investigation documentation did not include interviews with residents in the area/or who may have been exposed to R7, or had knowledge of the incident, and did not include any evidence of a timely physical or psychosocial assessment of either resident involved in the incident. 3. A review of R22's admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including vascular dementia and a history of breast cancer. A review of R22's Progress Notes, dated 12/20/2025, indicated, Writer was attempting to give the resident her meds for the morning along with some juice. The resident stated she did not want it, so the writer took the medication and cup from the resident. Upon receiving the cup and medication, the resident turned around and threw up her fist to hit the writer. The writer moved out of the way and tried to talk to the resident when she proceeded to walk over and hit another resident[R23] while saying I will hit him (sic) then. The resident drew back her arm and slapped [R23] in the face. RP (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	notified. TCPA notified. CP updated. A review of R23's admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including type 2 diabetes and unspecified dementia. A review of R23's Progress Notes, dated 12/20/2025 1:33 pm, indicated, Writer was attempting to give another resident [R22] their meds for the morning along with some juice. The other resident stated she did not want it, so the writer took the medication and cup from the resident. Upon receiving the cup and medication, R22 turned around and threw up her fist to hit the writer. The writer moved out of the way and tried to talk to the resident when she proceeded to walk over and hit [R23] while saying I will hit him then. The resident drew back her arm and slapped [R22] in the face. RP notified. TCPA notified. CP updated. TCPA notified. A review of the facility's investigation related to the 12/20/2025 alleged physical abuse of R23 by R22 revealed an incomplete investigation. Although the local PD was notified of the incident, responded to the facility, and provided a case number for the incident, no follow-up was done on the part of the facility to obtain the investigation information from the PD. The investigation documentation did not include interviews with residents in the area/or who may have been exposed to R22 or had knowledge of the incident, and did not include any evidence of a psychosocial assessment of either resident involved in the incident. 4. A review of R2's EMR revealed an admission date of 8/28/202 with diagnoses including respiratory failure and post-concussional syndrome. A review of R2's Quarterly Minimum Data Set (MDS) Assessment with an assessment reference date (ARD) of 12/4/2025 revealed R2's Brief Interview for Mental Status Score (BIMS) score was 11, which indicated moderate cognitive impairment. A review of R3's EMR revealed an admission date of 1/14/2025 with diagnoses including head injury, cognitive impairment, and mood disorder. A review of R3's Annual MDS Assessment with an ARD of 1/15/2026 revealed a BIMS score of three out of 15, indicating severe cognitive impairment. A review of the facility's Final Report of Resident-to-Resident Sexual Abuse revealed R2 being touched by R3 on the thigh while she was in her room and in her bed. When R2 and R3 were interviewed, both R2 and R3 could not recall the situation and denied that R3 was in R2's room and touched R2's body. The facility failed to complete a thorough investigation, including statements from other residents potentially affected and staff who may have been present. The facility determined that since R2 and R3 did not recall the sexual abuse, and there was no other information collected, the sexual abuse was unsubstantiated. 5. A review of R5's EMR revealed an admission date of 12/5/2024 with diagnoses, which included dementia with anxiety and behavioral disturbances. A review of R5's Quarterly MDS Assessment with an ARD of 1/1/2026 revealed a BIMS score of 15 out of 15, indicating R5 is cognitively intact. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of R4's EMR revealed an admission date of 6/24/2024 with diagnoses including dementia, anxiety, and behavioral symptoms. A review of R4's Quarterly MDS assessment with ARD of 12/4/2025 revealed R4's BIMS score was 99, as R4 was unable to participate in the assessment due to her cognition. A review of the facility's Grievance/Complaint documentation and investigative Final Report of Resident-to-Resident abuse, which documented Licensed Practical Nurse (LPN)26 heard R5 called out and saw R4 pinching R5's breast. The facility investigated the allegation, spoke with the involved residents, other residents, and staff. The facility determined that resident-to-resident abuse occurred. Preventative measures include staff continuing education on resident-to-resident abuse and redirecting R4 if she attempts to touch another resident. The facility failed to complete a thorough investigation, including statements from other residents potentially affected and staff who may have been present. 6. A review of R1's EMR revealed an admission date of 9/6/2018 with diagnoses including Alzheimer's disease, major depressive disorder, and behavioral disturbance. A review of R1's Annual MDS assessment with an ARD of 1/14/2026, the facility's undated final report stated that R1's BIMS score was seven out of 15, indicating severe cognitive impairment. A review of the facility's investigative report revealed Nurse Aide (NA)37 and NA51 were providing personal care for R1 on 12/28/2025. R1 was refusing care when NA51 asked R1 to go into the bathroom so R1 could be changed. R1 continued to refuse care when NA51 grabbed R1 by the sweater and shirt and jerked R1 from a seated position and attempted to force R1 into the bathroom. As NA51 swung R1 toward the bathroom, NA37 witnessed R1 hit his head on the doorframe and received a laceration to the head. LPN26 entered R1's room to see NA51 swinging R1 to the bathroom and hitting his head on the doorframe. LPN26 provided first aid to R1, and the physician was notified. R1 declined to go to the hospital for care. A review of the facility's initial decision was to terminate NA37 and NA51, but after additional interviews with NA37 and NA51. R1 was interviewed using a language line, and R1 denied being abused and stated that he fell and hit his head and was not abused. The facility determined they could not verify abuse despite the witness interviews and statements. 7. A review of R13's admission Record revealed he was admitted to the facility on [DATE]. R13 was hospitalized and had a re-admission on [DATE] with diagnoses of dementia with behavioral disturbance, personality disorder, major depression, psychosis, and anxiety. A review of R13's quarterly MDS assessment with an Assessment Reference Date (ARD) of 1/20/2026 revealed a BIMS score of zero out of 15, which indicated R13 was severely cognitively impaired. R13 provided extensive assistance to the dependent for all activities of daily living (ADL) care. A review of R13's Care Plan, dated 10/30/2025, revealed that R13 refused his medications, ADL care such as bathing and incontinent care, getting out of bed, showers, and weights. R13 also displayed inappropriate behaviors, such as violent physical threats towards staff providing care to him. He was verbally abusive, threatened to throw urine on the charge nurse, pulled a butter knife on the nurse, and threatened to slice the nurse. The resident was combative with staff and made threats to the (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	physician. The residents' goal was not to act inappropriately. Interventions included psych referral, administering medications, staff to be consistent, gentle, and firm when setting limits, notifying the family of behaviors, and praising appropriate behaviors. A review of grievance/complaint report, dated 10/7/2025, revealed that R13's family member had visited the resident on this date, and the resident reported an incident that took place with LPN6 and LPN26. He stated they tried to force a pill down his throat. He refused the pill and stated LPN6 hit him with the TV remote, leaving a huge knot on the lower side of the neck. A review of the abuse investigation, provided by the facility, dated 10/7/2025, revealed the file contained a state self-Report, which detailed the incident. Initial investigation revealed that LPN6 did not work with R13 on that day, and LPN26 had not worked at the facility for three years. Resident stated that the incident happened the day before (10/6/2025) to his niece and a month ago to the Administrator and risk manager. The report indicated that LPN6 was suspended pending investigation, and LPN26 had already left employment three years ago and had not returned. The investigation folder included initial and final reports to the State Survey Agency (SSA), timely progress notes, witness statements from staff, R13 and family member, skin assessments, care plans, MDS, police report, staff schedules, grievance form, and risk management final report. There were no interviews of other residents cared for by LPN6 in the file. During an interview with the Manager Quality/ Risk Manager on 2/25/2026 at 2:43 pm, she indicated that there were no interviews with other residents taken care of by LPN6. The Manager Quality/ Risk Manager also stated that R13 and the family member were interviewed together in the presence of herself and the Administrator. During an interview with the Administrator on 2/25/2026 at 1:30 pm, he stated that he was in R13's room with the risk manager when the resident and niece were interviewed about the allegation of abuse. The administrator stated that the resident would not listen and became very angry. During an interview with the Manager of Quality/Risk Manager on 2/25/2026 at 4:25 pm, she stated she did most of the facility's abuse investigations. She confirmed the survey team had been provided with all of the facility's investigation material related to the above-referenced incidents of potential abuse. She confirmed the investigation information had never been obtained from the local PD for any of the investigations, stating, They know, and we know they do not investigate these things for residents in long-term care facilities and confirmed documentation to indicate physical and psychosocial assessments of the residents involved in the referenced incidents of potential abuse had not been done in a timely manner. She confirmed residents who may have been present during or who may have had knowledge of any of the incidents had not been interviewed as part of the investigations. During an interview with the Administrator on 2/26/2026 at 9:26 am, he confirmed he was the facility's Abuse Coordinator but stated he did not do most of the facility's abuse investigations. He stated he generally did a review of investigations done by the Manager of Quality/Risk Manager. The Administrator confirmed the investigations referenced above were not complete and stated he expected that investigations into allegations of abuse were to be thorough (including resident and staff interviews, notification of the local police department (PD), along with follow-up with the local PD for information related to their investigation, and timely physical and psychosocial assessment of residents involved in the allegations. (continued on next page)

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	115525	A. Building B. Wing	03/01/2026

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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the facility's Abuse, Neglect and Exploitation Policy dated most recently reviewed March 2025 read, in pertinent part, Investigation of Alleged Abuse, Neglect and Exploitation: A. [Licensed Practical Nurse] LPN reports of abuse, neglect or exploitation occur. B. Written procedures for investigations include: 1. Identifying staff responsible for the investigation; 2. Exercising caution in handling evidence that could be used in a criminal investigation (i.e., not tampering with or destroying evidence); 3. Investigating different types of alleged violations; 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, record review, and family and staff interviews, the facility failed to ensure appropriate social services assistance was provided for one of 25 sampled residents (R) (R18). The facility's failure to ensure the provision of social services assistance for R18 created the potential for this and other residents to experience harm related to having unmet psychosocial needs.Findings included: A review of R18's admission Record, found in the electronic medical record (EMR) under the Admissions Tab, indicated the resident was admitted to the facility on [DATE] with a diagnosis of quadriplegia and idiopathic hypotension.A review of R18's quarterly Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 12/22/2025, indicated a Brief Interview for Mental Status (BIMS) assessment score of 15 out of 15, which indicated the resident was cognitively intact. A review of R18's Care Planning Progress Notes, dated 7/9/2025, indicated, Care Plan meeting held with IDT (Interdisciplinary Team) and resident's RP (representative)/Mother via phone today. SW (Social Worker) informed the resident's mother that another attempt was made at completing the Social Security form for the resident to receive a Social Security Card with the assistance of Medical Records. The resident's end goal is to get a Georgia ID.A review of R18's Care Planning Progress Notes, dated 10/9/2025, indicated, Care Plan Meeting held with IDT and resident's RP/mother via phone today. No psychosocial concerns. SW discussed with the mother if she could assist with getting the resident's Social Security Card, due to two attempts, and the resident has not received the card.A review of R18's Application for a Social Security Card document, dated 11/10/2025, revealed that an application had been filled out for R18's social security card on that date.A review of R18's comprehensive record revealed nothing to indicate facility follow-up related to assistance with obtaining the resident's social security card and/or Georgia ID after the Application for a Social Security Card document was filled out on 11/10/2025.During an interview with R18 on 2/26/2026 at 9:24 am, he confirmed he never received his social security card or a Georgia ID and stated he would like to get those items. During an interview with R18's Mother/Representative (FM1) via phone on 2/27/2026 at 12:05 pm, she confirmed R18 had never received his social security card, and without the social security card, he was not able to obtain a Georgia ID. She stated the situation had been very stressful for R18 and herself. FM1 stated she lived out of state and had health problems of her own, and so was not able to assist R18 with obtaining his social security card, and was relying on assistance from facility staff to accomplish the task. She stated, I pray to God this gets rectified. During an interview with the Social Services Director (SSD) and Social Worker (SW1) on 2/27/2026 at 12:19 pm, SW1 confirmed there had not been any follow-up on the part of the facility related to R18's social security card and Georgia ID since 11/10/2025 (a period of more than three and one-half months). The SSD acknowledged the facility's delay in assisting R18 to obtain his social security card and confirmed it was the responsibility of social services staff to assist with such matters.A review of the facility's Social Services Policy, dated February 2026, revealed, in pertinent part, The facility, regardless of size, will provide medically-related social services to each resident, to assist in attaining or maintaining the resident's highest practicable physical, mental, and psychosocial well-being; and Services to meet the resident's needs may include: d. Making arrangements for obtaining items, such as adaptive equipment, clothing, and personal items. Making referrals and obtaining needed services from outside entities (e.g., talking books, absentee ballots, community wheelchair transportation.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on record review, policy review, and staff and resident interviews, the facility's administration failed to implement the abuse policies and procedures for 15 of 25 sampled residents (R) (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R13, R20, R21, R22, and R23) reviewed for abuse. The facility's failure to implement its Abuse Policy placed all residents at risk of unreported and uninvestigated abuse. On 2/26/2026, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause serious injury, harm, impairment, or death to residents.On 2/26/2026 at 5:30 pm, the Administrator was notified that Immediate Jeopardy (IJ) was identified to have existed on 10/19/2025, when R9 made an allegation that a male resident, R10, sexually abused her by touching her in between her legs on that date.An Acceptable Removal Plan was received on 3/1/2026. Based on observation, record review, a review of facility policies as outlined in the Removal Plan, and staff interviews, it was validated that the corrective plans and the immediacy of the deficient practice were removed on 3/1/2026. The facility remained out of compliance while the facility continued management-level staff oversight, as well as continuing to develop and implement a Plan of Correction (POC). This oversight process includes monitoring residents and investigating/preventing abuse.Findings included:1. The facility's administration failed to ensure residents remained free from neglect and abuse when the following occurred:a. R1 made an allegation of abuse, and the Administration failed to ensure adequate action was taken to prevent further potential abuse by staff or residents.b. R2 reported an allegation of R3 touching her in the private area, and the Administration failed to ensure adequate action was taken to prevent further potential abuse by residents. c. R6 made an allegation of abuse, and the Administration failed to ensure adequate action was taken to prevent further potential abuse by staff after a staff member grabbed R6 by the shirt and threw him against the doorframe, causing a laceration above his eye. d. R4 made an allegation that R5 was touching her inappropriately. The incident was observed by staff, and the Administration failed to ensure adequate actions were taken to prevent further potential abuse by R5. e. R9 made the allegations of sexual abuse against R10, and the Administration failed to ensure adequate action was taken to prevent further potential abuse by residents. f. The facility failed to ensure adequate action was taken to prevent further potential sexual abuse by R7 for R8 after an incident of sexual abuse.g. The facility failed to ensure R22 was not physically abusive to R23 after R22 slapped R23 in the face without provocation.2. The Administrator failed to ensure a thorough investigation of allegations of abuse for 14 Residents (R) (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R13, R21, R22, and R23) out of a total of 25 residents reviewed for abuseDuring an interview with the Administrator and Director of Nursing (DON) on 2/27/2026 at 9:00 am confirmed that the facility lacked policies and procedures directing staff on how to identify, report, investigate, and prevent resident abuse. A review of the Administrator's Job Description as of 3/9/2021 indicated, The Long Term Care Administrator is responsible for the successful strategic, administrative, and clinical operations of Crestview. The individual represents the organization in influencing government and public policy in a manner that optimizes the care provided to residents. Assures that the care provided promotes quality, safety, and respect.