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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395459	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/11/2026
NAME OF PROVIDER OR SUPPLIER Crestview Center		STREET ADDRESS, CITY, STATE, ZIP CODE 262 Toll Gate Road Langhorne, PA 19047	

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 - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, review of facility documentation and interviews with staff, it was determined the facility failed to ensure Resident R1 was free from neglect related to failing to provide wound treatment in accordance with physician orders. This failure resulted in actual harm for Resident R1 who developed an infection of the left foot surgical site, for one of nine residents reviewed. This deficiency was cited as past non-compliance. (Resident R1). Findings include: Review of facility policy titled Abuse Prohibition, revised November 14, 2025, indicates Neglect is defined as the failure, indifference, or disregard of the center, its employees, or service providers to provide care, comfort, safety, goods and services to a patient that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. This includes the failure to implement an effective communication system across all shifts for communicating necessary care and information between center, patient, practitioner and patient representative. Review of facility policy titled Skin integrity and wound management revised September 15, 2025, indicates the A comprehensive initial and ongoing nursing assessment of intrinsic and extrinsic factors that influence skin health, skin/ wound impairment, and the ability of a wound to heal will be performed. The plan of care for the patient will be reflective of assessment findings from the comprehensive patient assessment and wound evaluation. Staff will continually observe and monitor patients for changes and implement revisions to the plan of care as needed, furthermore for surgical wound, follow specific orders from the surgeon. Review of Resident R1's clinical record revealed that resident was admitted to the facility on [DATE], with diagnosis of orthopedic aftercare for a left fibula (leg) fracture. Review of Resident R1's MDS (Minimum Data Set-assessment of resident care needs), dated January 8, 2026, revealed a BIMS (Brief Interview of Mental Status) score of 14, indicating resident is cognitively intact. Review of Resident R1's care plan developed, December 20, 2025, indicated Resident at risk of skin breakdown related to occasional refusals of wound care, decreased activity and has actual skin breakdown: left ankle surgical wound. Interventions include providing wound care as ordered. Continued review of Resident R1's care plan dated, revealed a care plan, initiated December 22, 2025, which revealed patient is at risk for MDRO (Multi Drug Resistant Organism) colonization/infection due to wounds. Interventions include enhanced barrier precautions (are infection control measures using targeted gown and glove use during high-contact care activities to prevent the spread of multidrug-resistant organisms (MDROs). Review of Resident R1's physician order, dated December 20, 2025, revealed Change dressing every 3 days. Dress the wound with Xeroform (sterile, non-adherent wound dressing made of fine mesh gauze coated in a petrolatum blend), gauze, cling and ace bandage. Order discontinued on February 13, 2026. Review of Resident R1's Orthopedic Surgery Note, dated January 29, 2026, The wound looks fantastic. There are no open wounds and there is no evidence of infection. Swelling is improved; incisions are well-healed. Continue local wound care as per the wound care team at her facility however her wound does look very good at this time. Review of Resident R1's nursing note, by Employee E3, Registered Nurse, dated February 12, 2026, revealed New skin issue: Left foot surgical incision swollen and inflamed with scant amount of purulent drainage noted. Review of Resident R1's (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 - Actual harm Residents Affected - Few	skin assessment dated [DATE], revealed that a surgical wound on the left shin Length (cm): 12.02 Width (cm): 3.41 Depth (cm): 0.1 Area (cm2): 23.23. Left foot surgical incision swollen and inflamed with scant amount of purulent drainage noted. Review of facility documentation submitted to the State Survey Agency dated February 13, 2026, revealed On February 12, 2026, at approximately 2:00 p.m. the daughter of Resident R1 met with the DON (Director of Nursing) and Unit Manager regarding concerns with care. The daughter believes the dressing on a surgical wound on (resident) left foot is not being changed and treatments are not being done as ordered by physician. The daughter believes the foot looks swollen and inflamed. Continue review of facility documentation dated February 13, 2026, submitted to the State Survey Agency, revealed On February 12, 2026, resident had an active order for left ankle wound treatment to be completed every 3 days. The treatment in place was dated February 1, 2026. According to e-TAR (Electronic treatment administration record), it was documented as completed on February 3, 2026, and February 6, 2026. On February 9, 2026, it was documented as a refusal. The nurse assigned to [Resident R1] on February 3, 2026, and February 6, 2026, admits to signing it out without completing it. The surgical wound was assessed by her attending physician on February 13, 2026, and she was started on antibiotics for signs and symptoms of wound infection. Allegation of neglect was substantiated. Review of Resident R1's nursing note, by Employee E3, Registered Nurse, dated February 13, 2026, revealed Change of Condition: physician notified, resident started on Cephalexin Capsule 500 milligrams (mg). Wound care order changed to daily. Review of Resident R1's nursing note, Employee E3, Registered Nurse, dated February 13, 2026, revealed Resident's left foot surgical site assessed at bedside by Employee E4 Physician. Continue Cephalexin for 7 days as prescribed. Further review of Resident R1's physician order, dated February 13, 2026, revealed Left ankle surgical wound: cleanse with wound cleanser, pat dry, apply xeroform then wrap with kling, every day shift and as need for soilage or displacement. Review of Resident R1's physician order, dated February 13, 2026, revealed on order for an antibiotic Cephalexin Capsule 500mg Give 1 capsule by mouth every 6 hours for wound infection for 7 days. Review of facility's February 2026 Infection Control Log revealed, Resident R1 obtained a facility acquired infection, onset date of February 13, 2026, left foot wound treated with Cephalexin Capsule 500mg. Review of facility's investigation, revealed an interview statement with Resident R1, dated February 13, 2026, which indicated the resident stated It has been a while (since the last dressing change). I think that nice male nurse on the weekend was the last to do it. Review of facility investigation revealed an interview statement with Employee E5, Registered Nurse, dated February 13, 2026, revealed I got to be honest, I didn't do them. I have a bad habit of signing them out and writing them down to complete, but I must have gotten side-tracked those days. Continue review of facility investigation revealed that Employee E5, Registered Nurse, dated February 13, 2026, revealed I had [Resident R1] on February 3, 2026, and on February 6, 2026, as my resident. I signed out the dressing change prior to completing the task. On February 3, 2026, when I went to her room she was dressed and eating. My intention was to return later that day. On February 6, 2026, I once again signed out the task prior to completion. There were several activities happening on another unit when I looked for (resident) in (his/her) room. Unfortunately, I became very busy later that afternoon and it slipped my attention. Interview with Employee E1, Director of Nursing, on March 11, 2026, at approximately 2:00 p.m. confirmed the above findings and further confirmed the allegation of neglect was substantiated. This deficiency was identified as actual harm past non-compliance for the facility failure to ensure Resident R1's was free of neglect related not providing wound treatment in accordance with physician orders. This failure resulted in actual harm to Resident R1 who sustained a wound infection of the left foot. On March 11, 2026, the Nursing Home Administrator presented documentation, indicating that the facility initiated a plan of correction on February 13, 2026, to address the failure to provide surgical wound treatment not completed per the physician orders, which resulted in Resident R1 sustaining an infection of the surgical wound. The facility alleged compliance date of March 5, 2026. Facility plan of correction included the following:The facility notified the physician and responsible party of treatment not being (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	completed as ordered.The facility revaluated Resident R1's wound by physician.The facility initiated an investigation into neglect.The facility placed nurse on administrative leave during investigation.The facility re-educated licensed nurses on Abuse and Neglect Policy.The facility re-educated licensed nurses on Skin integrity and Wound Management Policy with the focus of following MD orders.The facility re-educated licensed nurses on change in condition policy.The facility conducted an initial audit of current residents' treatment records to ensure treatments were completed and documented as per MD order.The facility conducted an initial audit of current residents with wounds, had their dressings observed to verify the treatment was completed as per the MD order.The facility to have DON (Director of Nursing)/ designee to conduct random audits weekly for 4 weeks, the monthly for 2 months of resident treatment administration records to verify treatments were completed and documented as per the physician order. The DON or designee will conduct random observations of 5 residents with wounds weekly for 4 weeks, then monthly for 2 months, to verify treatments were completed as per physician order. Results of the audits will be presented at QAPI (Quality Assurance Performance Improvement) meetings for review. Interviews with nursing staff on March 11, 2026, confirmed that they had all been in-serviced on reviewing and following the physician orders, skin integrity and wound care policy, abuse and neglect policy. Review of nursing education and audit results for resident treatment administration completed. This deficiency was identified as past non-compliance. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, review of facility documentation and interviews with staff, it was determined that the facility failed to ensure that Resident R1 was providing wound treatment in accordance with physician orders. This failure resulted in actual harm for Resident R1 who developed a wound infection of the left foot surgical site for one of nine residents reviewed. This deficiency was cited as past non-compliance. (Resident R1).Findings include: Review of facility policy titled Skin integrity and wound management revised September 15, 2025, indicates the A comprehensive initial and ongoing nursing assessment of intrinsic and extrinsic factors that influence skin health, skin/ wound impairment, and the ability of a wound to heal will be performed. The plan of care for the patient will be reflective of assessment findings from the comprehensive patient assessment and wound evaluation. Staff will continually observe and monitor patients for changes and implement revisions to the plan of care as needed, furthermore for surgical wound, follow specific orders from the surgeon. Review of Resident R1's clinical record revealed that resident was admitted to the facility on [DATE], with diagnosis of orthopedic aftercare for a left fibula (leg) fracture. Review of Resident R1's MDS (Minimum Data Set- assessment of resident care needs), dated January 8, 2026, revealed a BIMS (Brief Interview of Mental Status) score of 14, indicating resident is cognitively intact. Review of Resident R1's care plan dated developed December 20, 2025, indicated Resident at risk of skin breakdown related to occasional refusals of wound care, decreased activity and has actual skin breakdown: left ankle surgical wound. Interventions include providing wound care as ordered. Review of Resident R1's care plan developed December 22, 2025, indicated patient is at risk for MDRO (Multi Drug Resistant Organism) colonization/infection due to wounds. Interventions include Enhanced barrier precautions (are infection control measures using targeted gown and glove use during high-contact care activities to prevent the spread of multidrug-resistant organisms (MDROs). Review of Resident R1's physician order, dated December 20, 2025, revealed Change dressing every 3 days. Dress the wound with Xeroform, gauze, cling and ace bandage. Order discontinued on February 13, 2026. Review of Resident R1's Orthopedic Surgery Note, dated January 29, 2026, The wound looks fantastic. There are no open wounds and there is no evidence of infection. Swelling is improved; incisions are well-healed. Continue local wound care as per the wound care team at her facility however her wound does look very good at this time. Review of facility documentation submitted to the State Survey Agency dated February 13, 2026, revealed On February 12, 2026, at approximately 2:00 p.m. the daughter of Resident R1 met with the DON (Director of Nursing) and Unit Manager regarding concerns with care. The daughter believes that the dressing on a surgical wound on her left foot is not being changed and treatments are not being done as ordered by physician. The daughter believes the foot looks swollen and inflamed. Review of Resident R1's nursing note, by Employee E3, Registered Nurse, dated February 12, 2026, revealed New skin issue: Left foot surgical incision swollen and inflamed with scant amount of purulent drainage noted. Review of Resident R1's skin assessment dated [DATE], revealed that a surgical wound on the left shin Length (cm): 12.02 Width (cm): 3.41 Depth (cm): 0.1 Area (cm2): 23.23. Left foot surgical incision swollen and inflamed with scant amount of purulent drainage noted. Review of Resident R1's nursing note, by Employee E3, Registered Nurse, dated February 13, 2026, revealed Change of Condition: Physician notified, Resident started on Cephalexin Capsule 500 milligrams (mg). Wound care order changed to daily. Continued review of Employee E3, Registered Nurse, nursing note, revealed Resident's left foot surgical site assessed at bedside by Employee E4, Physician. Continue Cephalexin for 7 days as prescribed. Further review of Resident R1's physician order, dated February 13, 2026, revealed Left ankle surgical wound: cleanse with wound cleanser, pat dry, apply xeroform then wrap with kling, every day shift and as need for soilage or displacement. Review of Resident R1's physician order, dated February 13, 2026, revealed on order for the antibiotic Cephalexin Capsule 500mg Give 1 capsule by (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	mouth every 6 hours for wound infection for 7 days. Review of facility's February 2026 Infection Control Log revealed Resident R1 obtained a facility acquired infection, onset date of February 13, 2026, left foot wound treated with Cephalexin Capsule 500mg. Review of facility's investigation, revealed an interview statement with Resident R1, dated February 13, 2026, which indicated that the resident stated It has been a while (since the last dressing change). I think that nice male nurse on the weekend was the last to do it. Review of facility investigation revealed an interview statement with Employee E5, Registered Nurse, dated February 13, 2026, revealed I got to be honest, I didn't do them. I have a bad habit of signing them out and writing them down to complete, but I must have gotten side tracked those days. Review of facility investigation, statement from Employee E5, Registered Nurse, dated February 13, 2026, revealed I had [Resident R1] on February 3, 2026, and on February 6, 2026, as my resident. I signed out the dressing change prior to completing the task. On February 3, 2026, when I went to her room she was dressed and eating. My intention was to return later that day. On February 6, 2026, I once again signed out the task prior to completion. There were several activities happening on another unit when I looked for her in her room. Unfortunately, I became very busy later that afternoon and it slipped my attention. Review of facility documentation submitted to the State Survey Agency, dated February 13, 2026, revealed On February 12, 2026, resident had an active order for left ankle wound treatment to be completed every 3 days. The treatment in place was dated February 1, 2026. According to ETAR (Electronic treatment administration record), it was documented as completed on February 3, 2026, and February 6, 2026. On February 9, 2026, it was documented as a refusal. The nurse assigned to Resident R1 on February 3, 2026, and February 6, 2026, admits to signing it out without completing it. The surgical wound was assessed by her attending physician on February 13, 2026, and she was started on antibiotics for signs and symptoms of wound infection. Interview with Employee E1, Director of Nursing, on March 11, 2026, at approximately 2:00 p.m. confirmed the above findings. This deficiency was identified as actual harm past non-compliance for the facility failure to ensure that Resident R1 was provided wound treatment in accordance with physician orders. This failure resulted in actual harm for Resident R1 who developed a wound infection of the left foot surgical site. This deficiency was cited as past non-compliance. On March 11, 2026, the Nursing Home Administrator presented documentation, indicating that the facility initiated a plan of correction on February 13, 2026, to address the failure to provide surgical wound treatment not completed per the physician orders, which resulted in Resident R1 sustaining an infection of the left foot surgical site. The facility alleged compliance date of March 5, 2026. Facility plan of correction included the following:The facility notified the physician and responsible party of treatment not being completed as ordered.The facility revaluated Resident R1's wound by physician.The facility initiated investigation for neglect.The facility placed nurse on administrative leave during investigation.The facility re-educated licensed nurses on Abuse and Neglect Policy.The facility re-educated licensed nurses on Skin integrity and Wound Management Policy with the focus of following MD orders.The facility re-educated licensed nurses on change in condition policy.The facility conducted an initial audit of current residents' treatment records to ensure treatments were completed and documented as per MD order.The facility conducted an initial audit of current residents with wounds, had their dressings observed to verify the treatment was completed as per the MD order.The facility to have DON (Director of Nursing)/ designee to conduct random audits weekly for 4 weeks, the monthly for 2 months of resident treatment administration records to verify treatments were completed and documented as per the physician order. The DON or designee will conduct random observations of 5 residents with wounds weekly for 4 weeks, then monthly for 2 months, to verify treatments were completed as per physician order. Results of the audits will be presented at QAPI (Quality Assurance Performance Improvement) meetings for review. Interviews with nursing staff on March 11, 2026, confirmed that they had all been in-serviced on reviewing and following the physician orders, skin integrity and wound care policy, abuse and neglect policy. Review of nursing education and audit results for resident treatment administration completed. (continued on next page)

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