STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395459	A. Building B. Wing	03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestview Center	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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, facility policy, and staff interview, it was determined the facility failed to timely identify and implement interventions to ensure that Resident R1 did not develop pressure ulcers. This failure resulted in actual harm to Resident R1 who developed an unstageable sacral pressure ulcer requiring hospitalization for one of two residents reviewed (Resident R1). Findings include: Review of the facility policy Skin Integrity and Wound Management, revised 2025, revealed staff are to perform comprehensive initial and ongoing assessments of factors affecting skin integrity, develop care plans reflective of assessment findings, and implement as well as revise interventions as needed to prevent skin breakdown. The policy further revealed staff are responsible for identifying residents at risk and implementing appropriate prevention and treatment interventions. Review of Resident R1's clinical record revealed resident was admitted to the facility on [DATE], with diagnoses including Chronic Respiratory Failure with Hypoxia (long term condition where the lungs cannot provide enough oxygen to the blood), type 2 Diabetes Mellitus (chronic condition where the body doesn't use insulin properly, causing high blood sugar overtime) and Vascular Dementia (type of dementia caused by problems with blood flow to the brain, usually from strokes or damaged blood vessels). Review of Resident R1's comprehensive care plan, initiated February 19, 2026, revealed Resident as being at risk for skin breakdown. Interventions included application of barrier cream, observation of skin for signs and symptoms of breakdown, evaluation of localized skin issues, and weekly skin checks. Review of Resident R1's Braden Scale (assessment of resident's level of risk for development of pressure ulcers), dated February 19, 2026, revealed a score of 13, indicating the resident is at moderate risk for pressure ulcer development. Review of Resident R1's Minimum Data Set (MDS - federally mandated resident assessment and care screening), dated February 27, 2026, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 5 indicating severe cognitive impairment. Further review of Resident R1's MDS assessment, dated March 2, 2026, revealed the resident was dependent on staff for bed mobility, including rolling left and right, and transfers. Further review of the MDS assessment revealed the resident was incontinent bladder. Review of Resident R1's nursing skin assessment notes, dated February 19, 2026, through February 24, 2026, revealed that the resident had no skin breakdown to the sacral area (lower part of the back, just above the buttocks). Review of Resident R1's skin assessment note dated February 25, 2026, revealed the development of an unstageable pressure injury to the sacral area, described as covered with slough and/or eschar and identified as facility acquired. Review of Resident R1's nursing progress note, dated February 26, 2026, revealed the sacral wound had deteriorated, and measured length (cm - centimeter): 7.15 x width (cm): 8.96 x depth (cm): 0.1 with slough and eschar (dead tissue that forms in wounds) present, seropurulent (mix of clear serous fluid and pus, often signaling early infection or inflammation) drainage, and odor noted after cleansing. Additional wounds were observed on the resident's right foot. The physician documented concern for ischemic (condition related to blood flow) changes, noting absent pulses in the lower extremities, and ordered transfer to the hospital for urgent evaluation. Review of Resident R1's nursing note, dated February 27, 2026, revealed the resident was admitted to the hospital with a diagnosis of a sacral wound on this date. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident R1's sacral wound measured length (cm): 12 x width (cm): 11 x depth (cm): 0.1. Review of Resident R1's hospital records, dated February 28, 2026, revealed Initial skin assessment on admission to [facility] reportedly showed no open or reddened areas. On February 20, (she/he) was evaluated for a possible fungal infection in the right 4th-5th toes. Later, staff identified a sacral wound not previously documented on admission, described as unstageable. Within 24 hours, the sacral wound reportedly worsened significantly. The following information as reported by facility nurse practitioner; Resident R1's initial skin assessment reportedly showed no open areas or redness. Staff later identified a sacral wound on February 25, 2026, that had not been present or documented upon admission, which was described as unstageable. Within 24 hours, the sacral wound reportedly worsened significantly, and additional wounds developed on the resident's right foot. The resident was evaluated by the physician, who expressed concern for vascular etiology and recommended urgent hospital evaluation. Further review of Resident R1's hospital records revealed, upon evaluation in the emergency department, the physical examination was notable for an open sacral wound with purulent, foul-smelling drainage, as well as discoloration of the toes. Review of witness statements provided by the facility revealed non licensed staff, nurse aide Employee E2, on February 25, 2026, provided Resident R1 with a bed bath during the 3:00 p.m.-11:00 p.m. shift after complaints of Resident R1's bottom hurting. Further review of Nurse aide, Employee E2's witness statement revealed I called the nurse and we turned and saw plaster, removed it, it was a hole on her bottom, Review of Employee E3, Licensed Practical Nurse, witness statement, dated February 26, 2026, revealed Employee E3 worked on February 24, 2026 from 7:00 p.m.-7:00 a.m. and did not observe skin injury/wound or observe any interventions in place for Resident R1 (turning reposting devices) during her shift. Interview conducted on March 16, 2026, at 11:15 a.m. with the Director of Nursing (DON), Employee E1, confirmed, there were no interventions in the resident's care plan to addressing turning and repositioning of the resident. Resident R1 was provided a standard mattress; which is pressure redistribution mattress which considered standard. DON stated staff do turn and reposition but that it is not always documented. Review conducted of Resident R1's clinical record failed to reveal documentation/tasks/intervention of resident being turned/repositioned to prevent a sacral pressure ulcer. The facility failed to timely identify and implement interventions to ensure that Resident R1 did not develop pressure ulcers. This failure resulted in actual harm to Resident R1 who develop an unstageable pressure ulcer, requiring hospitalization for further evaluation and treatment. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1) Nursing services