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	07/01/2026

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 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 review of clinical records, facility policy, facility documentation, and interviews with residents and staff, it was determined the facility failed to ensure one of four residents reviewed was free from sexual abuse, resulting in psychosocial harm including being diagnosed with Post Traumatic Stress Disorder (Resident R1). This deficiency was identified as past noncompliance. Findings include: Review of facility policy titled, Abuse Prohibition revised 2025, revealed abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, injury, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods and services that are necessary to attain or maintain physical, mental or psychosocial well-being. Instances of abuse of all patients, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Sexual Abuse is a non-consensual sexual contact of any type with a patient. It includes but is not limited to sexual harassment, sexual coercion, or sexual assault. Review of Resident R1's clinical record revealed Resident R1 was admitted to the facility on [DATE], with diagnoses of Hemiplegia and Hemiparesis following cerebral infarction (paralysis/weakness on one side of the body commonly resulting from a stroke), Aphasia (disorder that affects how you communicate), Major Depressive Disorder, and generalized anxiety disorder. Review of Resident R1's Minimum Data Set (MDS) assessment (mandated assessment of a resident's abilities and care needs) dated April 25, 2026; revealed the resident had a Brief Interview for Mental Status (BIMS - tool used to assess cognitive function and orientation) score of 14, indicating the resident was cognitively intact. Review of facility investigation dated May 25, 2026, revealed on May 25, 2026, at 8:50 a.m. Resident R1 reported to the Speech Therapist that nurse aide, Employee E1, kissed him/her and asked if he/she wanted a massage. Social Services Director was notified and interviewed Resident R1 further. Resident R1 reported in the morning of May 25, 2026, approximately between 2:00 a.m. and 3:00 a.m. that nurse aide, Employee E1, kissed him/her on the lips twice, called him/her beautiful and asked if he/she wanted a massage. Resident R1 consented to back massage but after massaging resident's back, nurse aide, Employee E1, began touching the resident's breasts and genital area. Resident R1 denies any penetration. Resident R1 reports he/she only consented to the massage but not the kissing. Further review of facility investigation, dated May 27, 2026, revealed email communication between Director of Nursing, Employee E2, and Nurse Aide, Employee E1. Nurse Aide, Employee E1, admitted to kissing Resident R1 on the forehead twice and telling the resident he/she is beautiful to show respect and courtesy. Nurse aide, Employee E1, reported while providing incontinence care a massage was offered and cream was applied to Resident R1's back and breasts because his/her skin was reddened. Additional review of facility investigation revealed the facility concluded the allegation of sexual abuse to be substantiated due to non-consensual kissing. Interview conducted with Resident (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 0600 Level of Harm - Actual harm Residents Affected - Few	R1 on July 1, 2026, at 8:56 a.m., observed Resident R1 became very emotional when discussing the incident which occurred on May 25, 2026. Resident R1 revealed on May 25, 2026, at approximately 3:30 a.m. Nurse Aide, Employee E1, entered the room while he/she was asleep and woke him /her up to provide incontinence care. After incontinence care was provided Nurse Aide, Employee E1, sat on Resident R1's bed, called him/her beautiful, and kissed the resident twice on the lips. Resident R1 told Nurse Aide, Employee E1, no, no then Nurse Aide, Employee E1, offered Resident R1 a massage to which the resident agreed due to past trauma and feeling pressured. Resident R1 stated Nurse Aide, Employee E1, massaged his/her back, then asked the resident to turn over and grabbed both breasts and touched genital area. Resident R1 told Nurse Aide, Employee E1, to stop which he/she did, then exited the room. Further interview with Resident R1 revealed he/she now has severe nightmares since the incident, and the incident has caused him/her to feel not whole and now don't know how to be a person. Review of Resident R1's social service progress note, dated May 25, 2026, revealed Resident observed emotionally distressed following a reported traumatic experience. Resident appeared anxious, tearful, and emotionally overwhelmed during assessment. Resident verbalized feelings of fear, discomfort, and sadness related to the incident. Review of Resident R1's psychiatry note, dated May 25, 2026, revealed (Resident R1) appeared quiet and somewhat tearful during the encounter. The patient disclosed that he/she was sexually assaulted by a male aide a few nights ago and reported inappropriate physical contact. Resident R1 stated that this event has resurfaced memories of prior sexual trauma from earlier in life, contributing to increased emotional distress. Further review of Resident R1's psychiatry note revealed the resident was diagnosed with post-traumatic stress disorder (PTSD) on May 26, 2026. Interview with Employee E2, Administrator, on July 1, 2026, at 10:30 a.m. confirmed the facility substantiated the incident based on admission by Nurse Aide, Employee E1 to behavior of non-consensual kissing Resident R1's forehead. On May 25, 2024, following the incident, the facility immediately implemented the following corrective actions:-On May 25, 2026, trauma informed care plan initiated for Resident R1. -On May 25, 2026, nurse assessment was completed with Resident R1's permission. -On May 25, 2026, the nurse aide [Employee E1] was placed on administrative leave immediately. The conclusion of the investigation on June 5, 2026, revealed a notice was sent to Employee E1's nursing agency indicating the nurse aide (Employee E1) could not return to the facility, or any sister facility due to a Do Not Return (DNR) status because of the findings of the investigation. -On May 25, 2026, emotional support provided by social services director. -On May 25, 2026, alert and oriented residents interviewed regarding inappropriate behavior/touching. -On May 25, 2026, resident with BIMS <10 assessed for s/s of sexual abuse. -On May 26, 2026, abuse training and trauma informed care training was provided to staff. -Social services to follow up 3x per week x2 weeks, then weekly 2x, then PRN (as needed) to monitor signs or symptoms (s/s) of depressed mood or signs of trauma. - Initial audits of residents completed- alert residents interviewed regarding care, residents with BIMS <10 (Less than 10) assessed for s/s of sexual abuse (Completed May 25, 2026). - Designee will conduct interviews of two residents with BIMS >10 Weekly x4, then monthly x 2 on each unit to identify any potential allegations of sexual misconduct. - Designee will conduct random interviews with two family members for residents with BIMS < 10 weekly x4, then monthly x 2 on each unit to identify any potential allegations of sexual misconduct. - The Director of Nursing or designee will conduct random interviews weekly x 4, then monthly x2, of 5 staff to identify any potential concerns or allegations of sexual misconduct. -Will continue to monitor through QAPI meetings (Quality Assurance and Performance Improvement). Review of clinical records, in service training sign-in sheets, interviews with residents and staff, and audits conducted confirmed the plan of correction was implemented. The facility alleged date of compliance was June 8, 2026. The facility failed to ensure Resident R1 free from sexual abuse, resulting in psychosocial harm including being diagnosed with Post Traumatic Stress Disorder (Resident R1). This deficiency was identified as past non-compliance. 28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 211.10(d) Resident care policies28 Pa. Code 211.12(d)(1) Nursing services