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	07/03/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on observation, review of facility policy, clinical record review and staff interviews, it was determined that the facility failed to ensure that resident assessments accurately reflected resident diagnoses for one of nine residents reviewed. (Resident R148) Finding includes:Review of facility policy titled Social Service Assessment revised March 15, 2024, revealed residents will have a social service assessment completed upon admission, quarterly, annually and with a significant change in condition.Review of Resident R148's clinical record revealed that on October 21, 2024, resident was given the diagnosis of anorexia. Review of Resident R148's care plan last revised on May 28, 2025, revealed that this resident has potential for nutrition hydration risk due to advanced age currently stable nutritionally.Interview with DON Employee E2 on July 3, 2025, at 09:40 a.m. revealed that the diagnosis of anorexia for Resident R148 was not accurate. It is believed that the diagnosis of Anorexia was used for that practitioners visit for the purpose of a billing code and transcribed into residence list of diagnosis in the resident's record. 28 Pa. Code 211.5 (f) Clinical records

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

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observations, review of facility policy, review of clinical records, and staff interview, it was determined that the facility failed to develop and implement a person center care plan related to elopement for one out of 33 residents reviewed. (Resident R77) Findings include: Review of facility policy titled Center Operations Policies and Procedures dated October 24, 2022, revealed A comprehensive, individualized care plan will be developed within seven days after completion of the comprehensive assessment (admission, annual or significant change in status) and review and revise the care plan after each assessment. Review of review of Resident R 77's was admitted into the facility February 2, 2023, with diagnosis' including autistic disorder (significant language delays, social and communication challenges, unusual behaviors and interests) anxiety disorder, personal history of traumatic brain injury, dementia severity with agitation, depression and psychotic disturbance, mood disturbance. Review of the quarterly Minimum Data Set (MDS- a federal mandated assessment tool for all residents) dated May 16, 2025, revealed that Resident R77's BIMS (Brief Interview for Mental Status) score of 4, indicating the resident was cognitive impairment. Observation conducted on July 1, 2025, at 10:44 a.m., revealed that the Unit Manager Employee E8 brought Resident R77 to the front lobby and said, Relax and wait until outside time occurs. Resident R77 replied, Don't tell me what to do-I don't take orders from a woman. Employee E8 left Resident R77 in the lobby. Resident R77 started to propel on his own towards the entry door. The front lobby secretary, Employee E5, said, I'll unlock the door. Can you go back? Resident R77 was observed wearing a wanderguard (devices adject to the body that function in alarming doors to the outside of the facility), and the door alarm began sounding. Employee E5 was observed, trying to move Resident R77 away from the door by the wheelchair handles. Resident R77's behavior began to escalate, and the resident started arguing and cursing at Employee E5. Employee E5 went to get another staff member to assist with Resident R77. Resident R77 propelled himself toward the doors again, triggering the alarm a second time. Employee E5 again asked Resident R77 to move away from the door and silenced the alarm. The Business Office Manager, Employee E7, approached and pulled Resident R77's wheelchair backward to allow the family member to exit the building. Resident R77 began yelling and cursing again. The Business Office Manager, Employee E7, wheeled Resident R77 out onto the porch, where he attempted to propel himself down the ramp. The Director of Nursing, Employee E2, and the Regional Nurse, Employee E10, arrived on the scene. Staff asked Resident R77 where he was trying to go, which escalated the situation further. Resident R77 continued cursing, yelling, and attempting to propel himself toward the parking lot. A staff member went inside to call a female nursing aide, Employee E9. Upon arrival, Employee E9 got down to eye level with the resident and calmly said, It's Employee E9. I'm here to help you, while offering him a snack. She continued, Let's go watch TV in your room. I'm here to help you. Resident R77 appeared to recognize her voice, accepted the snack, and allowed Employee E9 to return him to his room without further verbal altercation. On July 1, 2025, at 1:05 p.m., an interview was conducted with Nursing Aide, Employee E9, who had successfully de-escalated an elopement attempt involving Resident R77. Employee E9 shared that Resident R77 has certain comfort items, including oatmeal pies and chocolate pudding, and that he enjoys watching TV in his room with the door closed as a way to calm himself. Review of Resident R77's comprehensive care plan, last revised on April 7, 2025, revealed that no specific or practicable interventions were documented to help de-escalate Resident R77's behaviors An interview with the Nursing Home Administrator (Employee E1) and Director of Nursing (Employee E2) confirmed the staff assigned to supervise the resident were unaware of the appropriate de-escalation interventions, which were only known to Employee E5. It was further confirmed that Resident R77's care plan had not been updated to include these interventions. 28 Pa. Code 211.10 (d) Resident care policies 28 Pa. Code 211.12(d)(1) Nursing services

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documentation, review of clinical record, observation and staff interviews, it was determined that the facility failed to provide adequate supervision for two of 33 residents reviewed. (Resident R90 and Resident 136). Findings:Review of facility policy titled Safe Resident Handling/Transfer Equipment, revised 2024, revealed Safe Resident Handling involves the use of assistive devices to ensure that patients can be transferred safely and that care providers avoid performing high risk patient handling tasks. The purpose is to optimize staff safety and the safety, comfort, and function of patients during transfers, ambulation, and/or repositioning. Clinical record review revealed Resident R90 was admitted to the facility on [DATE] with a diagnosis of chronic obstructive pulmonary disease (condition that prevents airflow to the lungs, causing breathing problems), chronic kidney disease (condition where kidneys are damaged and can't filter blood properly), and polyneuropathy (type of nerve disease that affects many nerves). Review of Resident R90's Minimum Data Set (MDS- assessment of a resident's abilities and care needs), dated October 14, 2024, revealed Resident R1 had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Further review of Resident R90's MDS, under section Mobility revealed that Resident R90 was dependent (helper does all of the effort) for chair/bed-to-chair transfer (the ability to transfer to and from a bed to a chair/wheelchair).Review of Resident R90's care plan, dated August 10, 2024, revealed Resident R1 was at risk for decreased ability to perform activities of daily living. Interventions to limit falls included the assistance of 2 staff for transfers using a lift with a full body large green sling. Review of facility documentation, dated October 12, 2024, revealed an investigation was initiated on October 12, 2024 related to Resident R90's complaint of back pain as a result of allegedly falling on the night of October 11, 2024. Resident R1 reported two aides transferred her from her wheelchair to bed without using a sit to stand lift as required. Further review of investigation revealed Resident R1 initially reported falling to the floor and that the two aides fell down with her. When interviewed by director of nursing and nurse practitioner she reported they all fell to the floor and then fell onto the bed. She provided details about them moving the wheelchair close to the bed and having their legs between hers when they stood her up to transfer. Resident said she asked them to use the lift serval times but they did not use it. She provided physical description of both aides.Review of Resident R90's incident report, dated October 12, 2024, revealed Resident is ordered a sit to stand lift for transfers. According to patient, last night she was transferred from her chair to the bed without using a lift. She asked staff to use a lift because she is more comfortable. Two nurse aides attempted to transfer her by themselves and all three of them fell to the floor. She said she did not hit her head. on site nurse practitioner saw her and ordered x-rays due to pain.Further review of facility investigation revealed interview with Resident R90's roommate. Resident R90's roommate confirmed both aides did not use a sit to stand lift. During an interview on July 03, 2025, at 10:15 a.m. with Employee E2, Director of Nursing, confirmed that the two nurse aides failed to use the required sit to stand lift during Resident R90's transfer from chair to bed on October 11, 2024. Interview conducted on July 1, 2025, at 1:28 p.m.,with the front lobby secretary, Employee E5, related to scheduled porch break for the resident revealed that a a scheduled break was set to begin at 1:30 p.m. At that time, it was observed that Resident R136 used his electronic wheelchair to exit the building. Employee E5 did not notice that Resident R136 had wheeled himself out to the front porch.At 1:33 p.m., the surveyor approached Employee E5 and asked if she was aware that a resident was outside unsupervised. Employee E5 responded, No, I wasn't aware. The surveyor and Employee E5 confirmed that Resident R136 was sitting on the front porch without staff supervision.According to the facility's porch supervision schedule, the Maintenance Department was assigned to oversee the 1:30-2:30 p.m. porch break. However, no maintenance staff were present at the time. Employee E5 contacted the Maintenance Department and requested that they report to the front porch to provide supervision.In the meantime, the Human Services Director, Employee E8, brought a laptop outside and remained on the porch to supervise the resident. Shortly after, two additional residents came outside for their scheduled porch time.On July 1, 2025, at 1:29 p.m., an interview was conducted with Resident R136, who was alert and oriented. The resident came outside for the scheduled 1:30 p.m. porch time and, assuming the surveyor was the chaperone, stated, I didn't think we had a chaperone today. R136 shared that he/she regularly comes outside, weather permitting, and is usually accompanied by activity staff or aides. 28 Pa. Code 201.14 (a) Responsibility of licensee.28 Pa. Code 211.10 (d) Resident Care Policies.28 Pa. Code 211.12 (d)(5) Nursing Services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on review of clinical record, facility policy, observations, and interviews with staff, it was determined that the facility failed to exercise proper infection control techniques for one of three nursing units observed (East wing).Findings include:Review of facility policy titled Enhanced Barrier Precautions, revised 2025, revealed personal protective equipment (PPE) should be readily accessible and located outside of the patient's room. Before exiting room, remove and place PPE (e.g., gowns and gloves) in the trash and perform hand hygiene upon exiting room. Observation on June 30, 2025 at 10:10 a.m. on east wing (rooms 300-330) revealed 17 resident rooms (rooms 301, 302, 304, 306, 307, 308, 309, 311, 312, 314, 316, 318, 319, 321, 322, 323, 328) with enhanced barrier precaution (EBP) signage on door and no appropriate disposal container available in the resident room to allow for removal of PPE inside the room. Further observation on June 30, 2025 at 10:20 p.m. revealed 10 of 17 resident rooms on EBP (rooms 304, 306, 309, 311, 312, 314, 316, 319, 323, 328) did not have an appropriate disposal container available outside the resident room. Interview on June 30, 2025 at 10:35 a.m. with License Practical Nurse, Employee E4, confirmed no appropriate disposal container for PPE was available inside or outside the above resident rooms. 28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 211.12(c)(d)(1)(5) Nursing Services