

| | | | |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675141 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 02/11/2025 |
| NAME OF PROVIDER OR SUPPLIER Crestview Healthcare Residence | | STREET ADDRESS, CITY, STATE, ZIP CODE 1400 Lake Shore Dr Waco, TX 76708 | |

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) |
|--|---|
| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50360</p> <p>Based on interviews and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 6 residents (Resident #13) reviewed for accidents hazards and supervision, in that:</p> <p>On 01/23/2025 Resident #13 was transferred by CNA C using standing pivot transfer x 1 staff instead of a mechanical lift. During transfer Resident #13 pivoted into the chair, her leg did not pivot well, and the knee twisted and popped which later caused swelling and pain to the left knee.</p> <p>This failure could lead to injury or death to residents.</p> <p>Findings include:</p> <p>Record review of Resident #13's face sheet dated 02/11/2025, revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included Multiple Sclerosis (a chronic, autoimmune disease that affects the central nervous system-brain and spinal cord, Muscle Weakness (a lack of muscle strength or the inability to control voluntary muscle force), and Unspecified Abnormalities of Gait and Mobility.</p> <p>Record review of Resident #13's Quarterly MDS assessment, dated 01/30/2025, reflected a BIMS of 15 which suggested the resident's cognition was intact. Section G revealed Resident #13 required extensive assistance with 2 persons for transfers. The prior Quarterly MDS assessment, dated 12/28/2024, in effect at the time of the event, revealed the resident was classified as requiring substantial/maximal assistance-Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. There was no designation for 2 person assist with a mechanical lift.</p> <p>Record review of Resident #13's Care Plan dated 03/27/2015 and revised on 02/03/2025, revealed Resident #13 required a mechanical lift X 2 staff assist for all transfers. The previous Care Plan dated 12/6/24 did not specifically address the resident's transfer needs.</p> <p>(continued on next page)</p> |

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 |
|---|-------|-----------|

| | | | |
|--|---|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675141 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 02/11/2025 |
| NAME OF PROVIDER OR SUPPLIER Crestview Healthcare Residence | | STREET ADDRESS, CITY, STATE, ZIP CODE 1400 Lake Shore Dr Waco, TX 76708 | |
| 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) | | |
| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Record review of the Provider Investigation Report, dated 02/05/2025, related to the facility's self-report of Resident #13's injury on 01/23/2025, revealed on 01/23/2025 at 5:15 PM, [CNA C] performed a one person standing assist, as the resident pivoted into the chair the leg did not pivot well and the knee twisted and popped. At the time the resident denied any pain. X-ray results received on 01/24/2025 were negative with no acute fractures. On 01/24/2025 the resident did not communicate any pain. On 01/25/2025 the knee was found to be visibly swollen. The resident declined pain medications. An order for prednisone for inflammation was given and referral for an Orthopedic Physician appointment was given. The Orthopedic appointment is scheduled for 2/11/2025. Upon medical record review it was discovered that there was no order for transfer with a lift. At that time an order was placed for two-person mechanical lift device for transfer. The Administrator was informed of the event by Resident #13 on 01/29/2025 and the event was reported to HHSC on 01/29/2025 at 5:44 PM. Record review of the statement from the Director of Therapy reflected he stated he verbally communicated a transfer status change sometime during the dates of 1/20/2025 to 1/24/2025 from one person assist to two person Hoyer lift to another CNA but had not appropriately communicated the transfer status change to clinical leadership. As a result, an appropriate order was not received to officially change the status to a 2 person assist with a mechanical lift. This failure to communicate the resident's transfer status created confusion amongst the front-line staff and led to the injury. On 01/23/2025 when CNA C performed the transfer, Resident #13's order still reflected the need for a one person standing assist. Further record review revealed in-services on Safe Lifting and Movement of Resident and Use of Mechanical Device, Transfer List Communication, and Accessing Kardex were implemented with the staff.</p> <p>Interview with the Administrator was conducted on 02/11/2025 at 3:00 PM. The Administrator described the facts as disclosed in the Facility Investigation Report. The administrator stated after the investigation was completed, an Ad Hoc QAPI Committee was convened, a Root Cause Analysis was completed, and the Director of Therapy received a corrective action for his failure to communicate. A Performance Improvement Plan was initiated. The Administrator described the current process of monitoring of resident transfer needs. The Administrator stated the transfer needs of each resident is discussed in the facility's morning meeting.</p> <p>On 02/11/2025 Record Review of the Interview with CNA C was conducted. CNA C stated she was not aware Resident #13's transfer status had changed prior to the implementation of the transfer.</p> <p>Record Review of the facility policy titled, Safe Lifting & Movement of Residents policy statement reads, In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and moved residents.</p> | | |