STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675141	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestview Healthcare Residence	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)
F 0600 Level of Harm - Minimal harm or potential for 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** 50360 Based on observations, interviews, and record review the facility failed to protect the residents' right to be free from neglect for 1 (Resident #3) of 6 residents reviewed for neglect. The facility failed to ensure Resident #3's safety and well-being when RN D and CNA E left her in the Shower Room in soiled undergarments unattended for approximately 30 minutes. This failure could result in residents receiving injuries and possible skin breakdown. Noncompliance existed from 02/13/2025 to 02/18/2025, but the facility corrected the noncompliance through inservicing, one on one inservicing and the QAPI process. Therefore, the findings are of past noncompliance. Findings included: Record review of Resident #3's undated Admission Record reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] with a diagnoses of Generalized Atherosclerosis (a widespread buildup of plaque in the arteries throughout the body, which can lead to narrowing and blockage of blood vessels), Unspecified Dementia (a decline in cognitive function that cannot be attributed to a specific underlying cause), and Unspecified Abnormalities of Gait and Mobility (difficulty walking or moving without a specific cause). Record review of Resident #1's quarterly MDS, dated [DATE], reflected a BIMS score of 3, indicating she had a significant level of cognitive impairment. Her Functional Status reflected she required partial/moderate assistance with mobility, Supervision or touching assistance with toileting hygiene, and Substantial/maximal assistance with showering. Record review of Resident #3's care plan, initiated on 06/27/2019 and most recently update 02/04/2025, reflected she had an ADL Self Care Performance Deficit related to diagnosis of Dementia/schizoaffective Disorder, and Major Depressive Disorder. Care Planned Interventions include the following: Resident requires staff x 1 for participation with bathing. Resident requires staff x 1 to use toilet. Resident participates in toileting process. (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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident requires assist of staff x 1 for transfers. Resident participates in transfer process. Resident requires staff x 1 to choose simple comfortable clothing and for ability to dress self. Resident requires staff xx1 for a sponge bath when a full bath or shower cannot be tolerated. Resident requires staff x 1 for reminding, prompting, cueing, for assistance with eating. Resident requires setup help with meals but can feed self independently. Resident requires staff x 1 to set up or assist with oral care. Check nail length and trim and clean on bath day. Report any changes to the nurse. Praise all efforts at self-care. Record review of the facility's investigation report on 02/26/2025 at 12:21 PM reflected the facility was notified of this event by the outside representative on 02/13/2025 at 11:00 AM. According to the Facility's Investigation Report, RN D walked thru the Dining Room on 02/07/2025 after lunch and the outside representative notified him that Resident #3 needed to be changed as she had urinated on the floor. RN D notified CNA E that the resident needed to be changed. RN D placed Resident #3 in the Shower Room per CNA E's request. CNA E reported to RN D she would finish her round and attend to Resident #3. The outside representative later called Social Worker to report Resident #3 was alone in the shower for approximately 30 minutes unattended. Record review of the Facility follow up included the following: 02/13/2025 RND and CNA E are suspended pending further investigation. 02/13/2025 Ad Hoc QAPI 02/13/2025 and 02/14/2025 Notification of Medical Director 02/13/2025-02/14/2025 All staff inservicing to include Abuse and Neglect, Resident rights/Dignity-Bowel and Bladder, Communication-Clarification of Task Assignment, and Shower Room Monitoring. 02/14/2025 Attempted notification of responsible party. 02/17/2025 Education sent to outside providers regarding reporting of Abuse and Neglect. 02/18/2025 One on One communications with RN D and CNA E to include Communication and Clarification and Shower supervision. Record review of Resident #3's medical record on 02/26/2025 at 11:00 AM ,reflected the Social Worker completed an assessment for injury on 02/13/2026 at 4:45 PM. According to the note, Resident #3 did not demonstrate any signs of a negative outcome from this event. Skin Assessment completed on 02/14/2025 at 1:09 PM is negative for any physical injury. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #3 was conducted on 02/26/2025 at 11:33 AM. Resident #3 stated the staff are good to her and always help her. She has no recollection of being left in the Shower Room unattended. Interview with DON on 02/26/2025 was conducted at 10:26 AM. The DON stated it was her expectation that residents are not to be left alone in the Shower Room even if they can shower themselves. The DON stated the following interventions were implemented. RN D and CNA E were suspended on 02/12/2025 pending investigation. One on one communication with RN D and CNA E for training on staff-to-staff communication was completed on 02/18/2025. One on one training on Shower Supervision was completed with RN D and CNA E on 02/18/2025. The following in-service training was also implemented with direct care staff on 2/13/25 and 2/14/2025: Abuse and Neglect Resident Rights/Dignity related to Bowel and Bladder needs. Communication-Clarification of Task Assignment Shower Room Monitoring Interview conducted with CNA F was conducted on 02/26/2025 at 2:23 PM. She confirmed receiving training as listed above and described that a resident is never to left alone in the shower room. She also stated staff should always communicate clearly with coworkers and nurse to make sure everyone understands what is going on. Interview conducted with Activity Therapy staff G on 2/26/2025 at 2:35 PM. AT staff G confirms having received training as list above. She stated the main theme of the training was regarding monitoring residents in the shower and residents should never be left alone in the shower. Confirms receiving training on clear communication with coworker. Also reported having received training on reporting abuse and/or neglect the facility Administrator. Interview conducted with CNA H on 02/26/2025. CNA H confirms receipt of training as listed above. CNA stated she was trained on the types of abuse and neglect and to whom to report. CNA H verbalized receipt of training on rights and dignity. CNA H stated staff are to be in the shower room with any resident regardless of their mobility status. Interview with LVN I was conducted on 02/26/2025 at 2:51 PM. LVN, I confirmed receipt of training on abuse/neglect/exploitation and Resident Rights. LVN I stated residents are never to left unattended in the shower room for any reason. Interview with the Social Worker on 02/26/2025 at 1:27 PM revealed, he had received information about this event from the outside representative on 02/13/2025 at 11:00 AM. The outside representative reported she thought Resident #3 was in the shower room unattended for approximately 30 minutes. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the outside representative by phone on 02/26/2025 at 2:07 PM was conducted. The outside representative stated she heard CNA E tell RN D to take Resident #3 to the shower and CNA E would be there in a little bit. The outside representative stated she did not know exactly how long Resident #3 was in the Shower Room, but she guessed it was about 30 minutes. The outside representative stated she did not realize Resident #3 was in the Shower Room alone until she heard her yell out. Interview with RN D on 02/26/2025 at 1:55 PM stated Resident #3 was taken to the Shower Room to await CNA E. He stated, I should have just done the hygiene care myself. RN D also reported he will change his practice by not ever leaving anyone in the Shower Room but, rather outside in the hallway. RN D also stated he should have communicated better with CNA E. Interview with CNA E was conducted at 02/26/2025 at 2:01 PM. CNA E stated she and RN D did not communicate regarding how long it was going to take CNA E to get to Resident #3. CNA E stated she should have let RN D know how long it was going to take her to get to Resident #3. Interview with the Administrator was conducted 02/26/2025 at 4:54 PM. The Administrator stated every resident must be supervised while in the Shower Room. If the resident can shower independently, the CNA was to stand outside the door, knock and check on the resident frequently. Additionally, the Administrator was asked about the existence of documentation of notification of the physician and the resident representative regarding the event. The Administrator responded the physician was not notified because there was no injury, and the Resident Representative was not notified because Resident #3 was legally her own representative. A telephone interview was conducted with Resident #3's family member at 5:42 PM. He stated he was pleased with the care and treatment Resident #3 received from the facility and was thankful for the assistance. He stated: they're doing a great job and I'm thankful for that. Review of the facility's Abuse Prohibition policy, dated 12/2019, reflected: Each resident has the right to be free from verbal, sexual, physical and mental abuse, mistreatment, neglect, involuntary seclusion and misappropriate of property.