

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675979	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2026
NAME OF PROVIDER OR SUPPLIER Crestview Retirement Community		STREET ADDRESS, CITY, STATE, ZIP CODE 2505 E Villa Maria Rd Bryan, TX 77802	
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** Based on observation, interview and record review the facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for one of six residents (Resident #1) reviewed for abuse and neglect. The facility failed to ensure Resident #1 was free from abuse and neglect on 05/03/2026 when CNA A verbally abused Resident #1 and neglected to give care when Resident #1 requested assistance to the bathroom. This failure placed residents at risk of abuse, neglect, trauma, and psychosocial harm. Findings included: Review of Resident #1's face sheet reflected an [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: unspecified dementia, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance or anxiety (A group of symptoms that affects memory, thinking and interferes with daily life but the exact cause is not clearly identified. It falls between mild and severe dementia in terms of impact on independence and quality of life.), difficulty with walking (can be caused by physical injuries or underlying medical conditions.), need assistance with personal care (a person may struggle to perform ADLs independently such as: bathing, grooming, toileting and dressing), and age-related osteoporosis without fracture (a person's bones have lost density and strength due to aging, increasing future fracture risk, even though no bones are currently broken). Review of Resident #1's admission MDS dated [DATE] reflected Resident #1 was assessed to have a BIMS score of 15 which indicated her cognition was intact. She used a wheelchair or walker for mobility. Resident #1 required partial/moderate assistance (helper does less than half the effort) with the following: eating, oral hygiene, showers, toilet transfer (ability to get on and off the toilet) and personal hygiene. She required substantial/ maximal assistance (helper does more than half the effort) for the following: lower body dressing, toileting, hygiene, putting on/ taking off footwear. Roll left and right when in bed. Sit to lying. Lying to sitting on side of bed. Sit to stand. Chair/ bed-to-chair transfer. Tub/shower transfer. Review of Resident #1's Quarterly MDS Assessment, dated 05/24/2026, reflected Resident #1's BIMS score was 99 (resident was unable to complete the interview). She was assessed to have short term memory recall. Her long-term memory was intact. She used a walker or wheelchair for mobility. Resident #1 was dependent on staff for toileting hygiene. She required substantial/maximal assistance (helper does more than half the effort) with the following: Upper and lower body dressing. Putting on /taking off footwear. Personal Hygiene. Sit to lying. Lying to sitting on side of bed. Sit to stand. Chair/bed-to-chair transfer. Toilet Transfer. Review of Resident #1's comprehensive care plan revised on 6/03/2026 reflected there was an electronic monitoring device in her room that family has consented to and was care planned on 04/13/2026. Interventions: Discuss during care plan meetings any questions/ feedback/concerns regarding monitoring. The Care Plan dated 02/20/2026 reflected Resident #1 had ADL self-care performance deficit related to activity intolerance, fatigue (a state of extreme physical or mental weariness or lack of energy that does not improve with rest), and shortness of breath. Interventions: Toilet Use: Resident #1 required supervision with staff for toileting. She required supervision with staff to move between surfaces. The Care plan initiated on 02/20/2026 reflected Resident #1 was at risk for falls related to (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
--	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675979	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2026
NAME OF PROVIDER OR SUPPLIER Crestview Retirement Community		STREET ADDRESS, CITY, STATE, ZIP CODE 2505 E Villa Maria Rd Bryan, TX 77802	
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	gait/balance problems and deconditioning (the decline in physical fitness, and muscle strength that occurs as a result of prolonged inactivity, bed rest, or a highly sedentary lifestyle.) Interventions initiated on 02/20/2026: Anticipate and meet Resident #1's needs. Ensure Resident #1's call light was in reach and encourage Resident #1 to use the call light for assistance as needed. Resident #1 needed prompt response to all requests for assistance. Resident #1 had impaired visual function and wears glasses. Intervention: Explain all care and services before providing care. Review of the video footage recorded on 05/03/2026 at 4:28 p.m. revealed CNA A entered Resident #1's room to answer call light. Resident #1 was in her bed. CNA A stated What? in a rude tone when she entered Resident #1's room. Resident #1 stated Can you please tell me how to go to the bathroom? CNA A stated I'm not taking you to the bathroom honey. Stop saying that. I'm going to change you. CNA A stated I will not assist you out of bed to go to the bathroom. You can go to the bathroom in your brief. Resident #1 stated she wanted to use the bathroom. CNA A stated to Resident #1, No ma'am. You are too weak for that, and you can do that in your diaper. CNA A stated to Resident #1 go to sleep. CNA A turned off the call light during the conversation with Resident #1. CNA A would not allow Resident #1 to express herself verbally via talking loudly when Resident #1 was attempting to talk to CNA A. Resident #1 did say she needed to go to the bathroom. CNA A was walking away from Resident #1 and stated You are too weak. We do not get up. No, I am not going to play with you. Let me know when you are finished (referring to using the bathroom in her brief). Record review of the facility investigation, began on 05/14/2026, reflected Family provided on 5/14/2026 of two videos dated 05/03/2026 to Director of Nursing and Social Worker of CNA A in Resident #1's room to answer a call light. CNA A tells Resident #1 that she will not assist her out of bed to go to the bathroom and to go to the bathroom in her brief. CNA A then leaves the room and tells Resident #1 to use the call light when she is done using the restroom so CNA A can return to change the brief. DON and Social Worker notified Administrator (Admin was out of town at a conference) about the meeting with Resident #1's family and the content of the videos. The team agreed to initiate a self-report for neglect and to suspend CNA A. CNA A was immediately suspended on 5/14/2026 pending the results of the investigation. Administrator notified corporate team of the allegation and self-report. DON and Social Worker coordinated to begin the investigation and in-servicing. Social Worker informed Resident #1's family and Medical Director of the self-report. Investigation Summary: Summary of Video 1: Length: 37 seconds - Date: 05/03/2026 CNA A entered Resident #1's room to answer call light and ask resident what they needed. Resident #1 is lying in her bed at this time. Resident #1 stated she wanted to go to the bathroom CNA A responded with, No ma'am. Uh-uh. No ma'am. Too weak for that. Uh-uh. You do that in your diaper. No ma'am. Go to sleep yep. During the above statements, CNA A turned off the call light to Resident #1 is trying to talk to CNA A, but CNA A is talking over the resident without pausing to listen and then respond to Resident #1 once she has finished talking. The audio is unable to pick up the words that Resident #1 is saying, but inference can be made that she is continuing to ask about going to the bathroom. CNA A then turns off over-the-bed light and begins to walk out of the room stating: You know, uh-uh, we do not get up. No, I'm not going to play with you. As CNA A is leaving the room, she makes the following statements: You are too weak. Let me know when you finish. During this time, CNA A is facing towards the hallway with her back to Resident #1. CNA A closes the door to Resident #1's room after last statement is made. Video ends Summary of Video 2: Length: 36 seconds - Date: 05/03/2026 Resident #1 is lying in her bed. CNA A enters Resident #1's room and states, What? with a negative tone of voice from the doorway/just inside the room. Resident #1 then asks, Can you please tell me how to go to the bathroom? CNA A responds with, I'm not taking you to the bathroom honey. Stop saying that. I'm going to change you. CNA A approaches Resident #1 in her bed and states, I'm irritated you said that. ***next few words were unintelligible***. you're too weak. CNA A gets to the bed and turns off the call light. CNA A then walks back across the room and enters the bathroom. CNA A can be heard saying, ***First part is hard to understand but sounds like ? Apparently two at a time***. to go to the bathroom, no ma'am. You can hear cabinets and what sounds like CNA A gathering supplies. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675979	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2026
NAME OF PROVIDER OR SUPPLIER Crestview Retirement Community		STREET ADDRESS, CITY, STATE, ZIP CODE 2505 E Villa Maria Rd Bryan, TX 77802	
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	Video endsInterview with CNA A: DON spoke with CNA A via phone call on 05/18/2026 about the content on the videos.CNA A denied the content and the statements the DON quoted back to CNA A. DONkept reiterating to CNA A that we have videos and can clearly see and hear the content.CNA A continued to deny that she acted the way the DON described the videos. Administrator met with CNA A on 05/19/2026 in his office. Administrator explained to CNA A that he understands DON informed CNA A about the videos. CNA A confirmedthe meeting. Administrator then played both videos for CNA A and explained that we want CNA A to watch and then help us understand what was happening during this time. Halfwaythrough the second video, CNA A stated, Administrator, I understand if you need to fire me.CNA A continually stated that she does not remember that night or saying/acting the wayshe did in the videos. CNA A apologized for her behavior and statedthat she understands whatever decision the facility needs to make.Interview with Resident #1 Social Worker interviewed Resident #1 but was unable to gather viable information. Resident#1 stated that she has never had an issue with someone helping her to the bathroom.Resident Safe Surveys:Resident #2 stated he felt safe and did not feel he had been mistreated. He did suggest that we do undercoverboss with the night shift because it needs attention. When Social Worker attempted to gather more information,Resident #2 stated everything was okay, and our night shift is much better than the night shiftwhere he used to live.Resident #3 stated he felt safe and did not have any concerns. He stated he would contact the Administrator if he had any issues. Feels safe with no concerns and knows he can contact Administrator if he has an issue.Resident #4 stated she felt safe and did not have any concerns. Investigation Findings:CNA A was found to have not followed proper procedures to assist with Resident #1 going tothe bathroom. CNA A instructed Resident #1 to use the bathroom in her brief and informed Resident #1that she is too weak to get out of bed. CNA A's employment with the facility was terminatedeffective 05/20/2026 via phone call from Administrator and HR Director.Post Investigation:Administrator or designee will make random rounds on night shift to visit with staff to ensureunderstanding of in-service provided. Social Worker or designee will conduct follow-up interviews with a randomsample of residents on each floor weekly for four weeks to see if residents have any further concerns.The Interdisciplinary Team will continue to have ongoing relationship with Resident #1 family to check-in tosee if there are any concerns with care. Resident #1 family is happy with response from the facility's investigation and does not have any further concerns at this time. Record Review of Resident #1's Psychosocial Harm assessment dated [DATE] reflected Resident was not experiencing any anxiety (feeling of worry, nervousness, or unease, typically about something with an uncertain outcome), depression (a serious mood disorder that causes persistent sadness, loss of interest, and a lack of energy), behaviors (observable actions, reactions, and conduct of individuals in response to their environment), distress (a state of extreme physical or mental suffering, pain, or danger), etc. Resident #1 was at her baseline. Record reviews of the facility in-service on Abuse, Neglect and Exploitation, Resident Rights and Customer Service on 05/15/2026 reflected all staff employed at the facility received in-service. Record review of QA (a structured review of care standards, safety protocols, and resident outcomes) meeting on 05/18/2026 at 9:00 a.m. reflected the investigation and CNA A was reviewed and the video of CNA A's interaction with Resident #1 was viewed by the following staff:AdministratorMedical DirectorExecutive DirectorSocial WorkerHuman Resource ManagerDONADON Observation and interview with Resident #1 on 06/24/2026 at 9:30 a.m. revealed Resident #1 in room sitting in her wheelchair. Resident #1 stated sometimes staff comes in her room and say they will be back and take care of her, however, they do not come back. Resident #1 did not respond to any further questions about the staff and her care. Interview on 06/24/2026 at 9:50 a.m. CNA B stated Resident #1 was capable of being assisted by staff to use the bathroom on the toilet in her room. She stated it was not difficult to transfer her on and off the toilet. She stated she had given care to Resident #1 numerous times. CNA B stated she did not recall the number of times she had been assigned to Resident #1. She stated she did not have any issues with Resident #1 reporting her needs. CNA B stated she had been in-serviced on abuse, (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675979	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2026
NAME OF PROVIDER OR SUPPLIER Crestview Retirement Community		STREET ADDRESS, CITY, STATE, ZIP CODE 2505 E Villa Maria Rd Bryan, TX 77802	
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	neglect, resident rights and the protocol of customer service. She stated the Administrator was the abuse coordinator. CNA B stated abuse was considered hitting a resident, cussing a resident, speaking to a resident in a rude tone, etc. She stated neglect was considered refusing to assist a resident to bathroom when the resident requests, refusing to give resident their meal, refusing to give a resident a shower, etc. She stated if she observed any staff abusing or neglecting a resident she would ask the staff to leave the area and she would ensure the resident was ok and immediately report it to the Administrator, DON, and her nurse supervisor. She stated no one had reported to her not to assist Resident #1 to the bathroom due to Resident #1 being weak. CNA B stated it was on their assignments Resident #1 needed assistance to be transferred to the toilet. Interview on 06/24/2026 at 12:15 p.m. R/P of Resident #1 stated she was very satisfied with the facility's administration listening to her and investigating immediately. She stated I do not want anything like this to happen to Resident #1 or to any resident. I am very pleased with the investigation from the facility. She stated she was not worried about the care from the staff at the facility. Interview on 06/24/2026 at 2:30 p.m. CNA A stated she did view the video of the incident with Resident #1 wanting to go to the bathroom. She stated she did not recall the date or time the incident occurred during the month of May. CNA A stated I did tell [Resident #1] to use the bathroom in her brief and that she was too weak to go the toilet. I told her I was not going to play with her, and I did not mean for it to sound the way it did on the video. This is the normal way I speak, and it can be mistaken of me being rude. I explained to [Resident #1] I would come back and clean her when she finished using bathroom in her brief. I do believe this was resident neglect. [Resident #1] is capable of going to the bathroom with assistance and she did ask me to take her to the bathroom. I did what I always do and tell her to use her brief. I did not listen to [Resident #1] when she was telling me she wanted to go to the bathroom and use the toilet. I do not believe I verbally abused [Resident #1], but I can understand where someone who did not know me would believe I was talking rude to [Resident #1]. I did view the video with the Administrator, and I could not watch all the video. I was talking to my [family member] with my ear buds in my ears when I was exiting the room. I was not speaking to [Resident #1]. I was suspended and later terminated due to neglecting [Resident #1]. She stated she spoke with Administrator and the DON about the situation. She stated I cannot talk anymore at this time. I will return your call at a later date. CNA A did not return phone call. In an interview on 06/24/2026 at 3:00 p.m. the DON stated it was determined during the investigation Resident #1 was neglected by CNA A. She stated Resident #1 did request for CNA A to assist her to the restroom. The DON stated Resident #1 was expected to be assisted by staff to the bathroom anytime during the day or night. She stated Resident # 1 was physically able to go to the restroom with staff assistance. DON stated it was not the facility's protocol to ask a resident to use the bathroom in their brief. She stated the tone of voice CNA A used in the video was not the standards of the facility. DON stated the staff was expected to allow the resident to speak and to not speak over a resident and to use a calm tone when speaking. She stated CNA A was using a rude tone when speaking to Resident #1 and it could be perceived as verbal abuse. DON stated when the family showed the video to her and the Social Worker, the Administrator was contacted immediately, and they began their investigation of the incident that occurred between CNA A and Resident #1. She stated Resident #1 has remained at her baseline physically, mentally and psychosocially. DON stated they immediately began in servicing all the staff on abuse, neglect, resident rights and customer service. She stated the facility did confirm neglect by CNA A during the investigation and CNA A was terminated. She stated anytime someone abused or neglected a resident the staff would immediately be suspended until an investigation is completed and if it is determined neglect or abuse occurred the staff would be terminated immediately. She stated the police was contacted, however, they did not come to the facility for investigation. In an interview on 06/24/2026 at 3:40 p.m. LVN Charge Nurse C stated she had been giving care to Resident #1 for the past few months. She stated she did not recall how many times she had given care to Resident #1. She stated Resident #1 was capable of using the toilet with assistance of being (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675979	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2026
NAME OF PROVIDER OR SUPPLIER Crestview Retirement Community		STREET ADDRESS, CITY, STATE, ZIP CODE 2505 E Villa Maria Rd Bryan, TX 77802	
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	transferred by the staff. She stated Resident #1 was assisted to the toilet by staff during the day and she was capable of being assisted to the toilet at night. LVN Charge Nurse C stated Resident #1's care did not change from daytime to nighttime. She stated Resident #1's type of care was the same 24 hours a day. LVN Charge Nurse C stated she was not aware of Resident #1 being uncooperative with care. She stated anytime a staff refuses to assist a resident to the toilet and explain to a resident to use the bathroom in their brief, this was neglect. She stated she had been in-serviced on abuse , neglect, resident rights, and customer service during the month of May 2026, however, she was unable to recall the exact date. She stated the Administrator was the abuse coordinator. LVN Charge Nurse C stated examples of abuse were when staff yelled at a resident, spoke in a rude tone, hit a resident, sexual, etc. She stated examples of neglect were refusing to give resident their medications, refusing to assist resident to the toilet, refusing to feed a resident, or give a resident their meal. She stated if she witnessed any staff neglecting or abusing a resident she would immediately ask the staff to leave the room and ensure the staff was assisted by another staff to an office or private area. She stated the resident needed to be assessed immediately for any injuries or their mental and emotional status. LVN Charge Nurse C stated she would immediately contact the Administrator, DON, Physician and the responsible party of the resident. She stated the resident had a right to be free from abuse and neglect, had a right to voice their grievances without worrying about any retaliation. In an interview with the Administrator on 06/24/2026 at 4:00 p.m. the Administrator stated it was determined after watching the video of CNA A's interaction with Resident #1 the CNA did neglect Resident#1. He stated Resident #1 did request to be assisted to the bathroom and CNA refused and explained to Resident #1 to use the bathroom in her brief. The Administrator stated CNA A would speak at the same time Resident #1 was attempting to speak to CNA A. He stated during the QA meeting and the facility investigation it was determined CNA A did neglect Resident #1. He stated Resident #1's family was having a care plan conference meeting, and this is when she showed the video to the Social Worker and the Director of Nurses. He stated the event occurred on 05/03/2026. He stated the facility administration did not know about the incident until 05/14/2026. The Administrator stated an investigation began immediately and CNA A was suspended after the video was reviewed. He stated in-services began on abuse, neglect, resident rights and customer service. The Administrator stated the physician and police were notified immediately. He stated the Police did not come to the facility and the facility did not receive a police report. The Administrator stated CNA A did degrade Resident #1 by speaking down to her. He stated he meant degraded Resident#1 by the words and tone of voice CNA A used when speaking to Resident #1. He stated this would be considered verbal abuse by her tone of voice and stating to Resident #1 I'm not going to be playing with you. He stated CNA A also said to Resident #1 we don't get up (in a rude tone) when Resident #1 was requesting to go to the toilet to use the bathroom. The Administrator stated CNA A denied the accusations until she viewed the video. He stated CNA A refused to view the entire video. He stated they followed their abuse /neglect protocol and followed HHSC provider letter pertaining to abuse and neglect. He stated other residents were interviewed and no one had any issues with CNA A. The Administrator stated Resident #1 has remained at her baseline. Record review of CNA A's Personnel Action Form reflected CNA A was terminated on 05/20/2026 and her last day to work was on 05/14/2026 when she was suspended. CNA A was terminated related to a video of CNA A explaining to a resident(Resident #1) to urinate in her brief instead of taking the resident to the bathroom. Record review of the Facility's Policy on Abuse, Neglect , Exploitation and Misappropriation Prevention Program, revised on April 2021, reflected Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. Policy Interpretation and ImplementationThe resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives:1. Protect (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675979	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2026
NAME OF PROVIDER OR SUPPLIER Crestview Retirement Community		STREET ADDRESS, CITY, STATE, ZIP CODE 2505 E Villa Maria Rd Bryan, TX 77802	
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	residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to: a. facility staff; b. other residents; c. consultants; d. volunteers; e. staff from other agencies; f. family members; g. legal representatives; h. friends; i. visitors; and/or j. any other individual. 2. Develop and implement policies and protocols to prevent and identify: a. abuse or mistreatment of residents; b. neglect of residents; and/or c. theft, exploitation or misappropriation of resident property.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675979	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2026
NAME OF PROVIDER OR SUPPLIER Crestview Retirement Community		STREET ADDRESS, CITY, STATE, ZIP CODE 2505 E Villa Maria Rd Bryan, TX 77802	
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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure, in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys to 1 of 2 medication carts (Medication Cart #1) reviewed for drug storage and labeling. The facility failed to ensure Medication Cart #1, was locked, medications secured, and not accessible to other staff, residents, or visitors. This failure could place residents at risk of having unauthorized access to medications, decreased effectiveness of medication, or missing medications. Findings included: During an observation on the left side at the end of 100 hall on 06/21/2026 at 9:18 a.m., revealed Medication Cart #1 was unlocked. Med Aide B exited a room at approximately 9:23 a.m. on 100 hall and walked to Medication Cart #1. No nursing staff were observed near Medication Cart #1 on 06/21/2026 at 9:18 a.m. During an interview with Med- Aide B on 06/24/2026 at 9:30 a.m., she stated she was trained on medication storage. She stated the Nurse or Medication Aide who was working on the cart was responsible for locking the medication cart. She stated if the staff left the medication cart unlocked and unattended a resident could get into the medication cart and take medication that did not belong to them. Med-Aide B stated everyone monitored to ensure the medication carts were locked. Med-Aide B stated she was unable to view Medication Cart #1 from where she was standing in a resident's room. She stated she had been in-serviced on locking medication cart; however, she did not recall the date or time. Med-Aide B did not respond to question of reason she left the Medication Cart #1 unlocked. During an interview with the Director of Nurses on 06/24/2026 at 3:00 p.m., she stated all medication carts were expected to be locked when the Med-Aide or Nurse was not standing in front of the medication cart. She stated the Nurse or the Medication Aide who was on the medication cart was responsible for ensuring the medication cart was locked. She stated if the medication cart was left unlocked and unattended a resident could get into the medication cart and take medications. The Director of Nurses stated leadership monitored to ensure staff locked the medication cart. She stated nurse leadership were to monitor by doing observations and in-service training. She stated she did not know why Med-Aide B left the medication cart unlocked. During an interview with the Administrator on 06/24/2026 at 4:00 p.m., he stated the medication cart was to always be locked. He stated the Nurse or Medication Aide who was assigned the medication cart was responsible for ensuring the medication cart was locked. The Administrator stated if the medication cart was left unlocked and unattended a resident could take medication that was harmful to them or an employee could steal medications. He stated the DON or any management should be monitoring, by observations, to ensure the staff were locking the medication cart. He stated he did not know why Med-Aide B left the medication cart unlocked. Record review of the Facility Policy on Security of Medication Cart, Revised on April 2007, reflected The medication cart shall be secured during medication pass. The nurse must secure the medication cart during the medication pass to prevent unauthorized entry. Medication carts must be securely locked at all times when out of the nurse's view.		