STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675979	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestview Retirement Community	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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. (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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to assess the resident for risk of entrapment from bed rails prior to installation and review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation for 6 of 12 (Residents #1, #5, #6, #7, #20 and #40) residents reviewed for bed rails. The facility failed to assess Residents #1, #5, #6, #7, #20 and #40 for entrapment from bed rails or obtain documentation of informed consent before using bed rails on the residents' beds. This failure could place residents at risk of injury from entrapment. Findings include: 1. Record review of Resident #1's, undated, face sheet reflected an [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included dementia, lack of coordination, muscle weakness, fatigue (extreme tiredness), cognitive communication deficit (difficulty communicating due to cognitive impairment), difficulty in walking, attention and concentration deficit, abnormalities of gait and mobility, anxiety disorder, and Alzheimer's disease. Record review of Resident #1's significant change MDS assessment, dated 07/01/25, reflected a BIMS score of 99, which indicated he could not complete the assessment. It reflected he was not able to roll left to right in his bed and was not able to go from sitting to lying in his bed. Record review of Resident #1's care plan, dated 09/03/24, reflected the following: [Resident #1] has an ADL self-care performance deficit r/t Confusion, impaired balance, impaired mobility, other abnormalities of gait and mobility. [Resident #1] will receive assistance as needed with ADLs and transfers through review period. Record review of the clinical admission evaluation for Resident #1, dated 08/01/24, reflected no section related to risk of entrapment from bed rails. Record review of all assessments and evaluations for Resident #1, from 08/01/24 to 08/07/25, reflected no assessment for risk of entrapment from bed rails. Record review of all informed consent documents for Resident #1 from 08/01/24 to 08/07/25, reflected no consent for the use of bed rails. 2. Record review of Resident #5's, undated, face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included abnormalities of gait and mobility, lack of coordination, muscle weakness, cognitive communication deficit (difficulty communicating due to cognitive impairment), attention and concentration deficit, fatigue (extreme tiredness), need for assistance with personal care, and depression. Record review of Resident #5's quarterly MDS assessment for Resident #5, dated 05/22/25, reflected a BIMS score of 99, which indicated she was unable to complete the assessment. It reflected she required supervision or touching assistance with rolling left to right in her bed and partial/moderate assistance with sitting on to lying in the bed. Record review of Resident #5's care plan, dated 03/01/25, reflected the following: [Resident #5] has an ADL self-care performance deficit r/t activity intolerance, impaired balance, musculoskeletal impairment. [Resident #5] will receive assistance as needed with ADLs and transfers through review period. Record review of Resident #5's clinical admission evaluation, dated 02/12/25, reflected no section related to risk of entrapment from bed rails. Record review of all assessments and evaluations for Resident #5, from 02/12/25 to 08/07/25, reflected no assessment for risk of entrapment from bed rails. Record review of all informed consent documents for Resident #5, from 02/12/25 to 08/07/25, reflected no consent for the use of bed rails. 3. Record review of Resident #6's, undated, face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included neurocognitive disorder with Lewy bodies (dementia caused by protein deposits in the brain), psychotic disorder with delusions, anxiety disorder, abnormal posture, bipolar disorder, Alzheimer's disease, major depressive disorder, neuroleptic-induced parkinsonism (symptoms similar to Parkinson's disease such as tremors and muscle stiffness, brought on by use of antipsychotic medication), need for assistance with personal care, fatigue (extreme tiredness), cognitive communication deficit (difficulty communicating due to cognitive impairment), lack of coordination, abnormalities of gait and mobility, and muscle weakness. Record review of Resident #6's quarterly MDS assessment, dated 07/22/25, reflected a BIMS score of 13, which indicated intact cognition. Resident #6 required substantial/maximal assistance moving from left to right in her bed and moving from a seated to a lying position in her bed. Record review of Resident #6's care plan, dated 02/01/25, reflected the following: [Resident #6] is at risk for falls r/t Parkinson's, Imbalance, weakness. [Resident #6] will not have major or minor injury r/t a fall thru review date. Record review of Resident #6's clinical admission evaluation, dated 01/20/23, reflected no section related to risk of entrapment from bed rails. Record review of all assessments and evaluations for Resident #6, from 01/20/23 to 08/07/25, reflected no assessment for risk of entrapment from bed rails. Record review of all informed consent documents for

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview and record review the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for 1 of 3 kitchens (main kitchen) reviewed for food safety. 1. The facility failed to ensure the ED and DRM wore a hair restraint while in the kitchen on 08/05/25. 2. The facility failed to ensure the DM wore gloves while preparing prepared ham sandwiches in the kitchen. These failures could place residents at risk of food-borne illness. Findings include: 1. Observation on 08/05/25 at 09:20 AM revealed the ED, who had short hair, and the DRM, who had shoulder length hair, standing in the kitchen and speaking to the cooks. Neither of them wore a hairnet or hair restraint. They both walked out of the kitchen and the DRM returned less than a minute later with a hairnet on. During an interview on 08/05/25 at 09:27 AM, the DRM stated she was required to wear a hairnet in the kitchen. She stated she did not know why she was in the kitchen not wearing one. She stated she was in a hurry and forgot to apply the hairnet. She stated residents could have gotten hair in their food. 2. Observation on 08/05/25 at 11:12 AM revealed the DM on the food preparation line making several ham sandwiches at once. He was handling bread, lettuce, and deli ham with his bare hands and not wearing gloves. He said out loud as if to himself, That's how you know the rookie is on the line. I'm not a chef! He then washed his hands, retrieved and donned gloves, and resumed his food preparation. During an interview on 08/06/25 at 12:20 PM, the LD stated all staff needed to wear hairnets when they entered the kitchen. She stated this was because they did not want hair falling into the food. She stated the DM and all staff who prepared food were to wear gloves while handling the food. She stated the purpose of wearing gloves was to prevent bacteria from going into the food and making residents sick. She stated she performed audits in the kitchen to ensure compliance, and if she saw noncompliance with food safety rules, and in-serviced the staff if she saw issues, but she had not done training with the ED, the DRM or the DM. During an interview on 08/14/25 at 01:01 PM, the DM stated he had been the manager of the facility kitchen for about two and a half years. He stated the kitchen served both the assisted living and the nursing facilities in the building. He stated he had done the food safety training courses and knew he was supposed to wear gloves while handing food directly. He stated he knew better than to try to do 800 things at once and had overlooked putting gloves on as a result. He stated his expectation was all staff wore hairnets in the facility kitchen. He stated the potential negative impacts to residents of his failure was cross contamination and food borne illnesses and even contamination with his own blood if he were to cut himself. He stated he did not provide any training for the ED, because the ED was his boss and had been at the facility for something like 30 years. He stated he worked for a contracted entity, and it would not have been appropriate for him to train the ED. He stated he did train the DRM to wear hairnets in the kitchen. He stated he had been somewhat concerned about some of the activities personnel and volunteers performing food service tasks and thought it would be a good idea to broaden their in-service audience. During an interview on 08/07/2025 at 01:29 PM, the ADM stated his expectation was any staff in the kitchen should have worn a proper hair restraint and staff should have worn gloves during food preparation. He stated he ensured that happened by making random rounds through the kitchen and by running around the facility all the time and looking at what was going on. He stated the responsibility for oversight on food safety compliance was on the dining and kitchen supervisor. He stated the potential negative outcome of breaches in food safety was poor sanitation. Record review of the facility's policy, dated January 2025, and titled Uniform Dress reflected the following: Policies: personal cleanliness and need appearance are essential for the food service worker. In addition to this policy, associates must follow facilities appearance guidelines.Procedures:Associates working with foodWhere the approved hair restraint when on duty, regardless of length or presence of hair. The only exception is to remove hair restraints when delivering trays to patients/residents. Record review of the facility's policy, dated January 2024, and titled Disposable Glove Use reflected the following: Policies: disposable, non-latex gloves must be warm at the following times:When handling ready to eatIn most cases, when serving food or assembling patient meals.