STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676112	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestview Court	224 W Pleasant Run Rd Cedar Hill, TX 75104

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46403 Based on observation, interview and record review, the facility failed to ensure all alleged violations involving abuse, and neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately but not later than 24 hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury to the State Survey Agency in accordance with State law through established procedures for one (Resident #1) of three incidents reviewed for reporting. The facility failed to report within 2 hours to the State Survey Agency when Resident #1 had an altercation with LVN A which resulted in Resident#1 falling face first. Resident#1 was transported to the hospital with a major head injury which supports serious bodily injury. These failures could affect place residents by resulting in at risk of a delay of identification of abuse or neglect and lack of timely follow-up on recommended interventions to prevent harm, or impairment. Findings included: Record review of Resident 1's face sheet dated 08/31/24 reflected the resident was an [AGE] year-old male who admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included unspecified Dementia (a group of symptoms affecting memory, thinking and social abilities), Epilepsy (Brain condition that causes recurring seizures), Congestive heart failure (a long-term condition that happens when your heart can't pump blood well enough to meet your body's needs) and muscle spasm. Record review of Resident#1's discharged MDS dated [DATE] reflected Resident #1 had a BIMS of 07, which indicated his cognition was severely impaired, and used a manual wheelchair. Record review of Resident #1's care plan dated 09/05/23 reflected problems: walk in corridor [Resident#1] required supervision. Goals: [Resident #1] walk in corridor with supervision and/or cueing as required. Interventions: instruct [Resident#1] to use hand rails and ambulatory assist devices to maintain balance . [Resident#1 call for assistance before walking in the corridor. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of Resident #1's incident report dated 07/30/24 at 4:53 AM completed by LVN A reflected: This nurse went into residents' room around (0245)to obtain UA prior to lab arrival for pick up. When resident asked for a UA sample resident stated that he was unable to provide a sample. This nurse responded by telling the resident that I could assist him with obtaining the sample. Resident stated no he and set up in the bed and swung his hand at me. This nurse stated to resident that he was confused and that he possibly has a UTI and that w why I was asking for a sample. resident then setup more in the bed where he then punched this nurse in the mouth. This nurse states to the patient that hitting me was unacceptable and that I was not okay to hit the staff. Resident stated that he wanted to do a lot more to me and kicked at me. I stepped back and told resident that he did not have to be physical with me and that I was leaving the room. He shouted I better get out before he did more. As resident jumped out of bed i walked out of the room and closed the door. While walking down the hallway resident opens the door and says there you are and began running towards me. This nurse yelled for assistance stating [Resident#1] was being combative and that he had punched me in the mouth. As resident begin running towards me, he swung and lost his balance and fell face forward to the floor where he hit his head and face . Detail location of injury. Resident has skin abrasions to face, bilateral wrist skin tears. blood from lip and nose Treatment provided by the facility reflected first aid in facility and referred to ER B. Charge nurse interventions post incident:1. Head to toe assessment.2. Administered first aid to assist in stopping the bleeding.3. Resident stabilized and 911 called for assistance.4. Resident transported to the ER for further evaluation. Record review of LVN B witness statement dated 07/30/24 reflected: she heard the nurse yelling for help. Upon getting to the hallway, she saw the resident chasing the nurse down the hallway. Per the employee, the resident noted to have fallen face forward before getting to the nurse. Nurse went to assess the resident and called 911. 911 took the resident to the hospital. Record review of DON statement dated 07/30/24 reflected: At approximately 3:00 AM., I received a call from the charge Nurse [LVN A], in regard to an incident with [Resident#1]. Per [LVN A] she went into the resident's room at 2:45 AM to obtain a urinalysis from the resident due to lab being present to pick it up. Upon entering the room, the nurse asked the resident for a UA sample. The resident voiced to the nurse that he was unable to provide one. Per [LVN A], she advised him that she could assist with obtaining a sample. The resident then sat up in the bed and swung at the nurse. The nurse explained to the resident why she needed to obtain the UA from him. The resident then struck the nurse in the mouth. The nurse expressed to the resident that it was unacceptable. The resident became more upset and told the nurse that he wanted to do more to the resident and started to kick at her. The nurse began leaving the room. He jumped out the bed and came out into the hallway behind the nurse. Nurse states that the resident started running towards her and missed causing him to lose his balance and falling to the floor. The CNA was at the nurse station and saw the resident running towards the nurse. Per [LVN A] the resident did not connect with the nurse and lost his balance and fell face forward to the floor. At that time 911 was called to come and assess the resident as he had some abrasions to his face and arms. 911 came into the facility, assessed, and transported the resident to the ER. [NAME] and ED reviewed the incident, questioned staff as to what was witnessed and what they saw. Witness did not note any physical aggression from the nurse ti the resident as the nurse retreated trying to get away from the resident. The DON and ED reviewed incident/accident as well as the Abuse/Neglect Policy and determined the incident not to be reportable. Outcomes of the investigation determined staff did not abuse the resident and did not meet the criteria for neglect. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of hospital records dated 09/03/24 reflected Resident#1 was admitted on [DATE] and was discharged on [DATE]. Resident#1 impressions reflected: evidence of closes head injury with subarachnoid hemorrhage probably manifested from white matter injury in the periventricular regions. Narrative: CT Trauma head W/O contrast. Findings: Evidence of acute intracranial injury with intraventricular hemorrhage [serious medical condition where bleeding occurs within the brain's ventricular system] probably from shear strain injury [distort and rupture axons, blood vessels and major fibre tacts] the periventricular white matter [white matter that is immediately to the side if the two lateral ventricles of the brain.]regions including a focus of blood along the right lateral ventricle and atrium independently in the right occipital horn. Narrative: CT facial bones w/o contrast Findings: No evidence of facial fracture with significant left supraorbital soft tissue swelling [swelling above the left eye .common causes trauma .] Record review of ED provider notes dated 07/30/24 reflected: Subarachnoid hemorrhage [Bleeding within the subarachnoid, which is the area between the brain and the tissue covering the brain] following injury, no loss of consciousness, initial encounter. Interview on 09/03/24 at 5:35 AM with LVN A who stated she went to Resident#1 room to collect a urine sample from him and stated he could not and punched her in the mouth. LVN A stated that Resident#1 was usually not confrontational, and they suspected he had a UTI. LVN A stated she told the resident that was not appropriate and closed the resident's door and walked out to the nursing station. LVN A stated Resident#1 came out of his room yelling there you are and ran down the hallway. LVN A stated she yelled for help. LVN A stated Resident#1 tried to hit her again and he fell hitting his head and face. LVN A stated the CNA B witness everything and cleaned the blood from Resident#1 face. LVN A stated she did not remember the CNA's name that assisted her. LVN A stated she completed head to toe assessment, called DON, family and doctor. LVN A called 911 to have resident transported to hospital. LVN A stated she reported the incident to the DON and followed the facility fall policy. Interview on 09/03/24 at 7:17 AM with the Regional Director of Operations stated Resident#1 had a fall at the facility because the resident had a change of condition. The Regional Director stated the facility followed the fall and reporting policy correctly. Interview over the phone on 09/03/24 at 7:21 AM with Regional Director of Clinical Services stated that she was responsible for logging the falls and the facility completes the internal investigation. The regional Director of clinical Services stated the DON reported the incident to her and from there they have a meeting and discussed the findings. The regional Director of Clinical services stated they did not feel the incident was related to abuse and did not report it to state. The regional Director of Clinical Services stated they monitor the hospital transfers and based reporting off what is reported. The regional Director of clinical Services stated if an incident accorded that had allegations of abuse it would need to be reported to prevent abuse from happening. Interview over the phone on 09/03/24 at 10:05 AM with the Director of Rehabilitation stated Resident#1 used a walker and would often leave it often. The Director of Rehabilitation stated Resident#1 had a physical and cognitive decline when he came back from the hospital on 07/19/24. The Director of Rehabilitation stated she was not sure if Resident#1 could run. (continued on next page)

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Crestview Court	224 W Pleasant Run Rd Cedar Hill, TX 75104

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 09/30/24 at 1:30 PM with DON stated Resident#1 had a skin tear to his face and arms and staff called 911 because he had a fall and fell face first. The DON stated they did not know that Resident#1 had a head injury. The DON stated he completed a call with the ED and regional to determine if the incident was reportable and the determination was no. The DON stated if an event was reportable to state, and it does not get report the resident could be at risk for abuse and neglect. Interview over the phone on 09/03/24 at 4:00 PM with CNA B stated that she did remember Resident#1. CNA B stated that she heard about the incident with Resident#1 but was not directly involved. Record review of the facility policy dated titles Reportable incident Protocol External Reportable Incidents: In reporting accidents/incidents, the following protocol must be observed: External Reportable Incidents: In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: 1. Ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of patient property, are reported immediately, but no later than 2 hours after allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Executive Director of the facility to other officials (including State Survey Agency and adult protective services where state law provides for jurisdiction in long term care facilities) in accordance with State law through established procedures. 4. Report the results of all investigations to the ED or his or her designee and to other officials in accordance with the state law, including the State Survey Agency within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

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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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46403 Based on observation, interview, and record review the facility failed to ensure that each resident received adequate supervision and assistance devices to prevent accidents for one (Resident #1) of two residents reviewed for accidents. LVN A failed to provide supervision to prevent accidents when she continued to try to get urine sample after the resident said no, and knowing he was confused and angry, and that he required supervision to ambulate, she saw him get out of bed and closed the door on her way out. This resulted in the resident running down the hall after her and falling, sustain a serious injury. These failures placed the resident at risk for accidents and injuries. Findings included: Record review of Resident 1's face sheet dated [DATE] reflected the resident was an [AGE] year-old male who admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included unspecified Dementia (a group of symptoms affecting memory, thinking and social abilities), Epilepsy (Brain condition that causes recurring seizures), Congestive heart failure (a long-term condition that happens when your heart can't pump blood well enough to meet your body's needs) and muscle spasm. Record review of Resident#1's discharged MDS dated [DATE] reflected Resident #1 had a BIMS of 07, which indicated his cognition was severely impaired, and used a manual wheelchair. Record review of Resident #1's care plan dated [DATE] reflected problems: walk in corridor [Resident#1] required supervision. Goals: [Resident #1] walk in corridor with supervision and/or cueing as required. Interventions: instruct [Resident#1] to use hand rails and ambulatory assist devices to maintain balance . [Resident#1 call for assistance before walking in the corridor. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of Resident #1's incident report dated [DATE] at 4:53 AM completed by LVN A reflected: This nurse went into residents' room around (0245)to obtain UA prior to lab arrival for pick up. When resident asked for a UA sample resident stated that he was unable to provide a sample. This nurse responded by telling the resident that I could assist him with obtaining the sample. Resident stated no he and set up in the bed and swung his hand at me. This nurse stated to resident that he was confused and that he possibly has a UTI and that w why I was asking for a sample. resident then setup more in the bed where he then punched this nurse in the mouth. This nurse states to the patient that hitting me was unacceptable and that I was not okay to hit the staff. Resident stated that he wanted to do a lot more to me and kicked at me. I stepped back and told resident that he did not have to be physical with me and that I was leaving the room. He shouted I better get out before he did more. As resident jumped out of bed i walked out of the room and closed the door. While walking down the hallway resident opens the door and says there you are and began running towards me. This nurse yelled for assistance stating [Resident#1] was being combative and that he had punched me in the mouth. As resident begin running towards me, he swung and lost his balance and fell face forward to the floor where he hit his head and face . Detail location of injury. Resident has skin abrasions to face, bilateral wrist skin tears. blood from lip and nose Treatment provided by the facility reflected first aid in facility and referred to ER B. Charge nurse interventions post incident:1. Head to toe assessment.2. Administered first aid to assist in stopping the bleeding.3. Resident stabilized and 911 called for assistance.4. Resident transported to the ER for further evaluation. Record review of LVN B witness statement dated [DATE] reflected: she heard the nurse yelling for help. Upon getting to the hallway, she saw the resident chasing the nurse down the hallway. Per the employee, the resident noted to have fallen face forward before getting to the nurse. Nurse went to assess the resident and called 911. 911 took the resident to the hospital. Record review of DON statement dated [DATE] reflected: At approximately 3:00 AM., I received a call from the charge Nurse [LVN A], in regard to an incident with [Resident#1]. Per [LVN A] she went into the resident's room at 2:45 AM to obtain a urinalysis from the resident due to lab being present to pick it up. Upon entering the room, the nurse asked the resident for a UA sample. The resident voiced to the nurse that he was unable to provide one. Per [LVN A], she advised him that she could assist with obtaining a sample. The resident then sat up in the bed and swung at the nurse. The nurse explained to the resident why she needed to obtain the UA from him. The resident then struck the nurse in the mouth. The nurse expressed to the resident that it was unacceptable. The resident became more upset and told the nurse that he wanted to do more to the resident and started to kick at her. The nurse began leaving the room. He jumped out the bed and came out into the hallway behind the nurse. Nurse states that the resident started running towards her and missed causing him to lose his balance and falling to the floor. The CNA was at the nurse station and saw the resident running towards the nurse. Per [LVN A] the resident did not connect with the nurse and lost his balance and fell face forward to the floor. At that time 911 was called to come and assess the resident as he had some abrasions to his face and arms. 911 came into the facility, assessed, and transported the resident to the ER. [NAME] and ED reviewed the incident, questioned staff as to what was witnessed and what they saw. Witness did not note any physical aggression from the nurse ti the resident as the nurse retreated trying to get away from the resident. The DON and ED reviewed incident/accident as well as the Abuse/Neglect Policy and determined the incident not to be reportable. Outcomes of the investigation determined staff did not abuse the resident and did not meet the criteria for neglect. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of ED provider notes dated [DATE] reflected: Subarachnoid hemorrhage [Bleeding within the subarachnoid, which is the area between the brain and the tissue covering the brain] following injury, no loss of consciousness, initial encounter. Record review of trauma surgery discharge summary dated [DATE] reflected: Patients family ultimately elected to transition [Resident#1]to hospice care. Patient made DNR and comfort care orders initiated. Patient was extubated prior to leaving ICU and transferred to hospice unit. Record review of hospital records dated [DATE] reflected Resident#1 was admitted on [DATE] and was discharged on [DATE]. Resident#1 impressions reflected: evidence of closes head injury with subarachnoid hemorrhage probably manifested from white matter injury in the periventricular regions. Narrative: CT Trauma head W/O contrast. Findings: Evidence of acute intracranial injury with intraventricular hemorrhage [serious medical condition where bleeding occurs within the brain's ventricular system] probably from shear strain injury [distort and rupture axons, blood vessels and major fibre tacts] the periventricular white matter [white matter that is immediately to the side if the two lateral ventricles of the brain.]regions including a focus of blood along the right lateral ventricle and atrium independently in the right occipital horn. Narrative: CT facial bones w/o contrast Findings: No evidence of facial fracture with significant left supraorbital soft tissue swelling [swelling above the left eye .common causes trauma . Interview on [DATE] at 5:35 AM with LVN A who stated she went to Resident#1 room to collect a urine sample from him and stated he could not and punched her in the mouth. LVN A stated that Resident#1 was usually not confrontational, and they suspected he had a UTI. LVN A stated she told the resident that was not appropriate and closed the resident's door and walked out to the nursing station. LVN A stated Resident#1 came out of his room yelling there you are and ran down the hallway. LVN A stated she yelled for help. LVN A stated Resident#1 tried to hit her again and he fell hitting his head and face. LVN A stated the CNA B witness everything and cleaned the blood from Resident#1 face. LVN A stated she did not remember the CNA's name that assisted her. LVN A stated she completed head to toe assessment, called DON, family and doctor. LVN A called 911 to have resident transported to hospital. LVN A stated she reported the incident to the DON and followed the facility fall policy. Interview on [DATE] at 7:17 AM with the Regional Director of Operations stated Resident#1 had a fall at the facility because the resident had a change of condition. The Regional Director stated the facility followed the fall policy. Interview over the phone on [DATE] at 7:21 AM with Regional Director of Clinical Services stated that she was responsible for logging the falls and the facility completes the internal investigation. The regional Director of clinical Services stated the DON reported the incident to her and from there they have a meeting and discussed the findings. The regional Director of Clinical services stated they did not feel the incident was related to abuse and did not report it to state. The regional Director of Clinical Services stated they monitor the hospital transfers. Interview over the phone on [DATE] at 10:05 AM with the Director of Rehabilitation stated Resident#1 used a walker and would often leave it often. The Director of Rehabilitation stated Resident#1 had a physical and cognitive decline when he came back from the hospital on [DATE]. The Director of Rehabilitation stated she was not sure if Resident#1 could run. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on [DATE] at 1:30 PM with DON stated Resident#1 had a skin tear to his face and arms and staff called 911 because he had a fall and fell face first. The DON stated they did not know that Resident#1 had a head injury. The DON stated he completed a call with the ED and regional to determine if the incident was reportable and the determination was no. The DON stated Resident#1 family member informed facility that Resident#1 had been taken of life support and expired. Interview over the phone on [DATE] at 4:00 PM with CNA B stated that she did remember Resident#1. CNA B stated that she heard about the incident with Resident#1 but was not directly involved. Record review of the facility policy titled Fall Management Guidelines and dated ,d+[DATE] reflected: 9. Staff assigned to the units will conduct rounds for residents at risk for falls or who have experience fall to ensure their fall prevention interventions are implemented. Record review of the facility policy titled, Abuse protocol and dated ,d+[DATE] reflected: 15. If a patient begins to exhibit inappropriate behavior, the facility will assess the patient and take appropriate steps both to minimize further inappropriate behavior and to protect other patients, even if no allegation of abuse is made. These steps will include, as appropriate, providing additional supervision for aggressive patient .