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	10/17/2024

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45268 Based on observation, interview and record review the facility failed to ensure residents received services in the facility with reasonable accommodation of resident needs for two (Resident #1 and Resident #2) of four reviewed for resident call system, in that. 1.Resident #1 and Resident #2's call lights were on the floor and not within reach on 10/10/2024. This failure could place the residents at risk of not receiving the care and services to maintain their highest level of well-being. Findings included: Record review of Resident #1's electronic face sheet, printed on 10/10/2024, revealed a [AGE] year-old female who was admitted to the facility 04/24/2024 with diagnoses that included but not limited to dementia (loss of cognitive function), glaucoma (a condition that damages the optic nerve, often due to increased eye pressure, leading to vision loss or blindness), high blood pressure. Record review of Resident #1's quarterly MDS, dated [DATE], revealed a BIMS score of 03, indicating the was severely cognitively impaired. Review of Section GG functional abilities and goals revealed substantial/ maximal assistance needed with eating, oral hygiene, toileting hygiene, shower, dressing, putting on/ taking off footwear and personal hygiene. Record review of Resident #1 s care plan, dated 05/03/2024, reflected, problems that included skin concerns, pain interference with day-to-day activities, communication issues, resident is able to understand others and able to communicate. Record review of Resident #2's electronic face sheet, printed on 10/11/2024, revealed a [AGE] year-old female who was admitted to the facility 01/03/2024 with diagnoses that included but not limited to dementia (loss of cognitive function), chronic kidney disease(involves gradual loss of kidney function), cellulitis of the lower limbs(bacterial skin infection), major depressive disorder(disorder that causes a persistent feeling of sadness and loss of interest) Record review of Resident #2's quarterly MDS, dated [DATE], revealed a BIMS score of 03, indicating the was severely cognitively impaired. Review of the MDS revealed section GG functional abilities and goals was not completed. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2 s care plan, dated 04/26/2024, reflected, problems that included falls related to self-ambulating while unsteady with intervention to include place call light within reach. Observation on 10/10/2024 at 1:15PM revealed Resident #1 and Resident #2's call lights were out of reach. Resident #1's call light was behind the headboard and out of reach. Resident #2's call light was behind the headboard and not within reach. LVN A came inside the room to pass medication however the nurse did not ensure Resident #1 and Resident #2's call lights were within reach before leaving the room. Interview and observation on 10/10/2024 at 1:30PM revealed Resident #1 was observed lying in bed. She stated she was not sure how she would reach staff if she needed them. The call light was handed to Resident #1 and was observed to be working. Observation on 10/10/2024 at 1:35 PM revealed Resident #2 was lying in bed. Attempted interview revealed Resident #2 did not answer any questions and closed her eyes when questions were asked. Interview on 10/10/2024 at 2:25 PM with the Interim Administrator and the DON revealed staff should have been ensuring call lights were within reach each time they went to a resident room. The DON stated the ADON had been in the room during the morning and had ensured the call lights were within reach. The DON stated the family may have moved the call lights since they were at bedside however LVN A should have ensured the call lights were within reach despite the family being in the room. The Interim Administrator revealed the risk of not having call lights withing reach would be that residents may not have been able to alert staff of their needs. Interview on 10/10/2024 at 3:12PM with the ADON revealed she was in Resident #1 and Resident #2's room during the morning and had made sure the call lights were in reach. She stated she helped Resident #2 into her wheelchair and the call light could have fallen behind the bed when she left. The ADON stated staff should have ensured call lights were within reach each time they entered a resident room. The policy regarding call lights was requested from the Interim Administrator on 10/10/2024 at 2:25PM however she stated the facility did not have a policy regarding the call light being within reach.

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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 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. 45268 Based on observation, interview and record review, the facility failed to store all drugs and biologicals in locked compartments for one (400 hall cart) of four medication carts. The facility failed to lock the 400-hall cart leaving all medications on the carts accessible. These failures could affect all resident by placing them at risk for possible drug diversions. Findings included: Observation on 10/10/2024 at 12:50 PM revealed the 400 hall cart was left unattended and unlocked for approximately one minute. There were no residents observed on the hall. The drawers of the cart were able to be pulled open and all routine medications were accessible. Interview on 10/10/2024 at 12:53 PM LVN A stated she left the cart unlocked due to being called into a resident's room for assistance. LVN A stated she would typically always lock the cart when it was not within eyesight, but she forgot. LVN A stated the 400-hall cart contained all routine medication for the 400 hall. LVN A stated the risk of leaving the medication cart unlocked would be others would have access to the medication. Interview on 10/10/2024 at 2:25 PM with the Interim Administrator and DON revealed the medication carts should have been locked when staff were not within eyesight of the cart. They stated the risk staff not locking the cart would be others could access the medication. The Interim Administrator stated LVN A was still fairly new and she would in- service her regarding medication storage. Review of the facility policy Storage of Medication dated revised April 2007 Compartments (including but not limited to drawers, cabinets, rooms ,refrigerators, carts and boxes) containing drugs and biologicals shall be locked when not in use and trays or carts used to transport such items may not be left unattended if open or otherwise potentially available to others.