| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676112 | A. Building<br>B. Wing | 02/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Crestview Court | 224 W Pleasant Run Rd<br>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 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27070<br><br>Based on observations, interviews, and record reviews, the facility failed to ensure resident was free from physcial abuse for 1 (Resident #1) of 7 residents reviewed for abuse and neglect.<br><br>1. The facility failed to protect Resident #1 from physical abuse by CNA A and LVN B. While attempting to collect a urine sample by in and out Cath, CNA held Resident #1's hands down, while LVN B attempted to force apart the legs of the resident. The LVN continued to force the legs and try to catheterize Resident #1 as the resident was screaming, resisting, and asking them to stop. Resident #1 was later assessed by LVN C as he was collecting the urine, by taking the resident to the bathroom, vaginal bleeding was noted. The LVN C assessed Resident #1 she had a laceration to her vaginal area.<br><br>This failure could place residents at risk of abuse, injury, and emotional distress.<br><br>The noncompliance was identified as PNC. The IJ began on 09/24/2024 and ended on 09/25/2024. The facility had corrected the noncompliance before the survey began.<br><br>Findings include:<br><br>Record review of Resident #1's face sheet dated 2/01/2025 reflected a [AGE] year-old female who was admitted to the facility 7/31/2014 with diagnoses which included: coronary heart disease (heart disease), hypertension (high blood pressure), non-Alzheimer's dementia (confusion), and bipolar disorder (mental illness).<br><br>Record review of Resident #1 quarterly MDS assessment dated [DATE] reflected a BIMS score of 00 which indicated the interview was unable to be completed Resident #1 was unable to make decisions for herself, is not able to understand and required one staff member for completion of activities of daily living.<br><br>Record review of Resident #1 care plan dated 01/4/2025 reflected Resident #1 had impaired cognitive function and impaired thoughts and communication problem related to dementia, ADL self-care performance deficit related to dementia, confusion, and limited mobility. (Requires total assistance with, bed mobility, transfers, dressing, toilet use and personal hygiene)<br><br>(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 |
|---|---|---|---|
| | 676112 | A. Building<br>B. Wing | 02/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Crestview Court | 224 W Pleasant Run Rd<br>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 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | Record review of complaint investigation report dated 9/24/2024 reflected video footage of CNA A entering the room, placing Resident #1 in bed. LVN B and CNA A enter the room and attempt to collect a urine sample by in and out straight-line catheter performed by the nurse. Resident # 1 resists to part her legs and keeps asking what you are doing and telling the LVN B to stop and do not do that. CNA A is holding Resident #1's hands and LVN B is attempting force Resident #1's legs apart. Resident #1 screams at the nurse to stop and ask what areyou doing, LVN B continues to try and force legs apart, while trying to insert the catheter to collect the urine. The last clip of video revealed the resident cannot been seen but is heard outside the room yelling loudly. LVN B was unable to collect the urine and informed the family. The family arrived at the facility to assist LVN C with the collection of the urine, in the bathroom. While collecting the urine LVN C and CNA D noticed blood in Resident #1's brief. LVN C assessed Resident #1 revealing a laceration inside Resident #1's vaginal area. The physician was notified. The family reviewed the video, revealing what had happened when CNA A and LVN B attempted to collect the urine earlier. The family member went to the DON showing him the video. Further investigation, documentation, and evidence confirmed the allegation.<br><br>Record review revealed a nurses note dated 9/24/2024 on Resident #1 reflected LVN B documented, an order from the physician to collect a urine sample due to a change in the resident's mental status. Further review reflected LVN B attempted to collect the urine sample times two extensive (by in and out Cath) but unsuccessful as resident was combative. LVN B notified LVN C that she was unable to collect the urine sample.<br><br>Record Review of the physician orders dated 09/24/2024 reflected to collect urine for culture and sensitivity due to change in altered mental status.<br><br>Record review revealed a nurse note dated 09/24/2024 reflected LVN C documented while collecting the urine sample from Resident #1 blood stains were noted on the resident's bed, upon assessment laceration noted to vaginal area with scanty bleeding. Head to toe assessment conducted, skin dry and warm to touch, vital signs within normal limits. Resident #1 was transferred to bathroom and urine sample was collected via clean catch. The family was at bedside. The nurse (LVN C) notified the physician, DON, and nurse practitioner, the physician ordered for the resident to be sent to the hospital for further evaluation, but the family refused. DON and nurse probationer was made aware.<br><br>In an observation of the video clips reflected that on 09/24/2024 prior to 2:00 pm, while attempting to collect a urine sample by in and out Cath, CNA A held Resident #1's hands down, while LVN B attempted to force apart the legs of the resident. The LVN continued to force the legs and try to catheterize Resident #1 as the resident was screaming, resisting, and asking them to stop. Resident #1 was later assessed by LVN C as he was collecting the urine, by taking the resident to the bathroom, vaginal bleeding was noted. The LVN C assessed Resident #1 she had a laceration to her vaginal area.<br><br>In an interview on 2/20/2025 at 9:30 am, Resident #1's representative stated Resident #1 room had video surveillance camera. The representative stated on 9/24/24 sometime after 2:00 p.m., he reviewed the video clips footage and observed two staff members attempting to collect urine using a catheter, while holding her hands and trying to force her legs apart while she is yelling, screaming and asking them to stop. Resident #2's representative stated after viewing the video footage he went directly to the DON, showing him the video clips and wanting something done.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676112 | A. Building<br>B. Wing | 02/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Crestview Court | 224 W Pleasant Run Rd<br>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 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | Observation and interview on 2/20/2025 at 9:15 a.m. Resident #1 were observed sitting up in her wheelchair, singing. The state surveyor attempted to interview Resident #1, who said she was fine, the staff was sweet, and if they were not, she would yell.<br><br>In an interview on 2/20/2025 at 1:15 p.m., the DON stated Resident #1 is verbal and require total care and is dependent on staff for ADL's. He stated on 9/24/2024 at approximately 2:00 p.m. to 3:00 p.m., resident #1's family had come to him with video surveillance camera clips, reflecting the staff attempting to collect a urine sample by in and out cath. He stated on 9/24/2024 at approximately 1:00 p.m., the video clips revealed CNA A and LVN B attempting to collect a urine from Resident #1. The DON stated he contacted the Administrator and then started an investigation and self-reported to the state. He stated on 9/24/2024, the facility started their investigation and, in services on abuse, neglect, resident rights, and behaviors for all staff, provided by the DON. A follow-up test was given to all staff concerning, abuse, neglect, behaviors, and collecting urinalysis. The DON stated he followed-up with Resident #1 every day, she was her normal baseline and exhibited no post trauma.<br><br>In an interview on 02/20/2025 at 4:00 p.m. with LVN C revealed he was the nurse in charge for Resident #1 on the evening shift. LVN C stated when he arrived for the change of shift, he was told by LVN B that she was unable to collect a urine from Resident #1. LVN C asked how she tried to collect, LVN B stated that she tired a in and out cath. LVN C stated that was all she said, except she had informed the family she could not collect the urine and they were coming. LVN C stated he had collected urine form Resident#1 previously and he placed her on the toilet and she would urinate. LVN C stated the family and CNA D assisted him with the collection of the urine. When removing Resident #1's brief, he noticed blood in the brief, he told the family he had to assess the resident. LVN C assessed Resident #1, which revealed a vaginal, labial laceration.<br><br>In an interview on 2/20/2025 at 4:45 p.m., CNA D stated she worked full time on the 2 p.m.-10 p.m. shift at the facility. She stated she assisted LVN C to collect a urine on Resident #1, by taking her to the bathroom and she urinated in the toilet. CNA D stated that when she prepared to remove her brief there was a red stain on the linens in her bed and then when she removed her brief there was a red stain in her brief. CNA D assisted the nurse stated it was blood. The family was in the room with us when this was occurring. She stated she was in serviced on abuse and neglect, resident rights, and behaviors the next day and she had to take a test. She stated the risks of staff failing to report abuse or neglect could put the residents a harm for continued abuse.<br><br>In an interview on 02/21/2025 at 9:00 a.m the Medical Director revealed he was informed concerning the incident with Resident #1. The physician stated he came to the facility the next day and examined the resident; she had a labial injury laceration from attempting an in and catheter. There was concern for post catheter bleeding and a tear of the labia. The physician stated he had advised the night before to send the resident to hospital to have the labial laceration or tear evaluated in the emergency room , but the family did not want her to go, since she had calmed down had previously suffered through the trauma. The physician said he agreed. The physician stated he ordered for Resident #1 to have an antibiotic ointment two times a day until it heals. He also ordered stat lab work, since the UA was negative, showing only 2 plus blood, (blood was seen in the urine sample) the physician stated it was related to the labia laceration or tear. The physician stated Resident #1 was at her baseline.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676112 | A. Building<br>B. Wing | 02/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Crestview Court | 224 W Pleasant Run Rd<br>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 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | In an phone interview on 02/21/2025 at 9:29 a.m. LVN B revealed the nurse was collecting the urine the physician had ordered for Resident #1, she had an altered mental status. I took the CNA with me because I knew I would have trouble with the resident when collecting the urine. When ask why she choose this method for collection, she did not answer. The LVN stated did you think that she would just lay there when I was trying to Cath her? The LVN stated that there was no blood, that the stain on the sheets was from the cleansing liquid that comes in the Cath kit. The LVN stated that the next day the facility called her in and showed her the video and she just told them she was quitting, she did not want to work there anymore. The LVN would not answer the surveyor about the description of the video, she stated she had to go.<br><br>Attempted interview on 2/21/2025 at 10:00 a.m., the state surveyor attempted to contact CNA A via phone. The CNA answered and stated she could not talk and she would call back. At the time of exit the surveyor had not heard from the CNA.<br><br>In an interview on 2/21/2025 at 10:20 a.m., the DON stated the previous incident involving Resident #1 was reported and the training was completed by an outside trainer. The DON stated it was an all-staff in-service on abuse, neglect, resident rights, and behaviors. We gave a test to all the staff following the training, then I monitored the resident every day for one week and then once a week for another week. The DON stated the two staff LVN B and CNA A were terminated, the family was informed. The DON stated he was shown the video by the family and he had identified LVN A and CNA were the staff in the room. The DON stated he had kept the video, until the investigation was cleared, when he deleted the video. The DON stated his main concern was the resident and monitor her make sure she did not experience any pain or have any noted negative outcome.<br><br>In an interview on 02/21/2025 at 4:00 p.m. with the Administrator revealed the Administrator stated the staff was just trying to collect the urine and there were no intent to harm the resident. The incident had been reported and investigated and the entire staff had been in-serviced concerning abuse, neglect, resident rights, and behaviors. The Administrator stated they had not had any incidents like this before and had none after this occurred. She did understand that the staff should have stopped when she resident ask them to.<br><br>Record review revealed a physician progress note dated 09/25/2024 reflected Resident #1 was seen. There was a concern for alter mental status last night, an urinalysis was ordered. Resident #1 suffered a labial injury laceration vs. contusion ( a tear to the vaginal area vs a bruise) from attempting in an out catheter. There was concern for post catheter bleeding and a tear of the labia. Genitourinary area examined with an aide today (09/24/2024), mild discomfort with exam, small area of redness right labia, no bleeding.<br><br>On 02/21/25 at 3:03 pm the Administrator and the DON were notified of the IJ PNC.<br><br>Record review of in-service training record dated 09/25/2024 revealed nurses, CNAs, CMAs, housekeeper, kitchen staff, and laundry staff were in serviced by an outside nurse trainer on abuse, neglect, resident rights, and behaviors. There was a follow-up test given following the in-service to each staff member. Completion date on 09/28/2024.<br><br>Record review of nurse's notes dated 09/25/2024 through 10/08/2024 reflected the DON assessing and documented Resident #1's baseline behaviors and mental status everyday for one week and then weekly therafter.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676112 | A. Building<br>B. Wing | 02/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Crestview Court | 224 W Pleasant Run Rd<br>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 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | Record review of the facility's policy titled Abuse, neglect, exploitation, mistreatment of resident, or misappropriation of resident property dated April 2019, Policy statement: The facility has designated and implemented processes which strive to reduce the risk of abuse, neglect, exploitation, mistreatment, and misappropriation of residents' property. Definitions: Abuse means the willful infliction of injury, unreasonable confinement/involuntary seclusion, or separation of a resident from other residents or from their room or other area against the resident's will or the will of the resident's legal representative. Intimidation with resulting physical harm, or pain, or mental anguish. Punishment with resulting physical harm, or pain, or mental anguish. Deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm . It also includes controlling behavior through corporal punishment. 1. Residents must bit be subject to abuse by anyone including, but not limited to, facility staff, other residents, consultants or volunteers, staff or other agencies serving the resident, family members or legal guardians, or other individuals. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676112 | A. Building<br>B. Wing | 02/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Crestview Court | 224 W Pleasant Run Rd<br>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 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | Develop and implement policies and procedures to prevent abuse, neglect, and theft.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27070<br><br>Based on interview and record review the facility failed to implement the facility's own written abuse prevention policy and procedure for one (Resident #1) of seven residents reviewed for abuse.<br><br>1. The facility failed to protect Resident #1 from physical abuse by CNA A and LVN B. While attempting to collect a urine sample by in and out Cath, CNA held Resident #1's hands down, while LVN B attempted to force apart the legs of the resident. The LVN continued to force the legs and try to catheterize Resident #1 as the resident was screaming, resisting, and asking them to stop. Resident #1 was later assessed by LVN C as he was collecting the urine, by taking the resident to the bathroom, vaginal bleeding was noted. The LVN C assessed Resident #1 she had a laceration to her vaginal area.<br><br>This failure could place residents at risk of abuse, injury, and emotional distress.<br><br>The noncompliance was identified as PNC. The IJ began on 09/24/2024 and ended on 09/25/2024. The facility had corrected the noncompliance before the survey began.<br><br>Findings included:<br><br>Record review of the facility's policy titled Abuse, neglect, exploitation, mistreatment of resident, or misappropriation of resident property dated April 2019, Policy statement: The facility has designated and implemented processes which strive to reduce the risk of abuse, neglect, exploitation, mistreatment, and misappropriation of residents' property. Definitions: Abuse means the willful infliction of injury, unreasonable confinement/involuntary seclusion, or separation of a resident from other residents or from their room or other area against the resident's will or the will of the resident's legal representative. Intimidation with resulting physical harm, or pain, or mental anguish. Punishment with resulting physical harm, or pain, or mental anguish. Deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm . It also includes controlling behavior through corporal punishment. 1. Residents must bit be subject to abuse by anyone including, but not limited to, facility staff, other residents, consultants or volunteers, staff or other agencies serving the resident, family members or legal guardians, or other individuals.<br><br>Findings include:<br><br>Record review of Resident #1's face sheet dated 2/01/2025 reflected a [AGE] year-old female who was admitted to the facility 7/31/2014 with diagnoses which included: coronary heart disease (heart disease), hypertension (high blood pressure), non-Alzheimer's dementia (confusion), and bipolar disorder (mental illness).<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676112 | A. Building<br>B. Wing | 02/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Crestview Court | 224 W Pleasant Run Rd<br>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 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | Record review of Resident #1 quarterly MDS assessment dated [DATE] reflected a BIMS score of 00 which indicated the interview was unable to be completed Resident #1 was unable to make decisions for herself, is not able to understand and required one staff member for completion of activities of daily living.<br><br>Record review of Resident #1 care plan dated 01/4/2025 reflected Resident #1 had impaired cognitive function and impaired thoughts and communication problem related to dementia, ADL self-care performance deficit related to dementia, confusion, and limited mobility. (Requires total assistance with, bed mobility, transfers, dressing, toilet use and personal hygiene)<br><br>Record review of complaint investigation report dated 9/24/2024 reflected video footage of CNA A entering the room, placing Resident #1 in bed. LVN B and CNA A enter the room and attempt to collect a urine sample by in and out straight-line catheter performed by the nurse. Resident # 1 resists to part her legs and keeps asking what you are doing and telling the LVN B to stop and do not do that. CNA A is holding Resident #1's hands and LVN B is attempting force Resident #1's legs apart. Resident #1 screams at the nurse to stop and ask what areyou doing, LVN B continues to try and force legs apart, while trying to insert the catheter to collect the urine. The last clip of video revealed the resident cannot been seen but is heard outside the room yelling loudly. LVN B was unable to collect the urine and informed the family. The family arrived at the facility to assist LVN C with the collection of the urine, in the bathroom. While collecting the urine LVN C and CNA D noticed blood in Resident #1's brief. LVN C assessed Resident #1 revealing a laceration inside Resident #1's vaginal area. The physician was notified. The family reviewed the video, revealing what had happened when CNA A and LVN B attempted to collect the urine earlier. The family member went to the DON showing him the video. Further investigation, documentation, and evidence confirmed the allegation.<br><br>Record review revealed a nurses note dated 9/24/2024 on Resident #1 reflected LVN B documented, an order from the physician to collect a urine sample due to a change in the resident's mental status. Further review reflected LVN B attempted to collect the urine sample times two extensive (by in and out Cath) but unsuccessful as resident was combative. LVN B notified LVN C that she was unable to collect the urine sample.<br><br>Record Review of the physician orders dated 09/24/2024 reflected to collect urine for culture and sensitivity due to change in altered mental status.<br><br>Record review revealed a nurse note dated 09/24/2024 reflected LVN C documented while collecting the urine sample from Resident #1 blood stains were noted on the resident's bed, upon assessment laceration noted to vaginal area with scanty bleeding. Head to toe assessment conducted, skin dry and warm to touch, vital signs within normal limits. Resident #1 was transferred to bathroom and urine sample was collected via clean catch. The family was at bedside. The nurse (LVN C) notified the physician, DON, and nurse practitioner, the physician ordered for the resident to be sent to the hospital for further evaluation, but the family refused. DON and nurse probationer was made aware.<br><br>In an observation of the video clips reflected that on 09/24/2024 prior to 2:00 pm, while attempting to collect a urine sample by in and out Cath, CNA A held Resident #1's hands down, while LVN B attempted to force apart the legs of the resident. The LVN continued to force the legs and try to catheterize Resident #1 as the resident was screaming, resisting, and asking them to stop. Resident #1 was later assessed by LVN C as he was collecting the urine, by taking the resident to the bathroom, vaginal bleeding was noted. The LVN C assessed Resident #1 she had a laceration to her vaginal area.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676112 | A. Building<br>B. Wing | 02/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Crestview Court | 224 W Pleasant Run Rd<br>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 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | In an interview on 2/20/2025 at 9:30 am, Resident #1's representative stated Resident #1 room had video surveillance camera. The representative stated on 9/24/24 sometime after 2:00 p.m., he reviewed the video clips footage and observed two staff members attempting to collect urine using a catheter, while holding her hands and trying to force her legs apart while she is yelling, screaming and asking them to stop. Resident #2's representative stated after viewing the video footage he went directly to the DON, showing him the video clips and wanting something done.<br><br>Observation and interview on 2/20/2025 at 9:15 a.m. Resident #1 were observed sitting up in her wheelchair, singing. The state surveyor attempted to interview Resident #1, who said she was fine, the staff was sweet, and if they were not, she would yell.<br><br>In an interview on 2/20/2025 at 1:15 p.m., the DON stated Resident #1 is verbal and require total care and is dependent on staff for ADL's. He stated on 9/24/2024 at approximately 2:00 p.m. to 3:00 p.m., resident #1's family had come to him with video surveillance camera clips, reflecting the staff attempting to collect a urine sample by in and out cath. He stated on 9/24/2024 at approximately 1:00 p.m., the video clips revealed CNA A and LVN B attempting to collect a urine from Resident #1. The DON stated he contacted the Administrator and then started an investigation and self-reported to the state. He stated on 9/24/2024, the facility started their investigation and, in services on abuse, neglect, resident rights, and behaviors for all staff, provided by the DON. A follow-up test was given to all staff concerning, abuse, neglect, behaviors, and collecting urinalysis. The DON stated he followed-up with Resident #1 every day, she was her normal baseline and exhibited no post trauma.<br><br>In an interview on 02/20/2025 at 4:00 p.m. with LVN C revealed he was the nurse in charge for Resident #1 on the evening shift. LVN C stated when he arrived for the change of shift, he was told by LVN B that she was unable to collect a urine from Resident #1. LVN C asked how she tried to collect, LVN B stated that she tired a in and out cath. LVN C stated that was all she said, except she had informed the family she could not collect the urine and they were coming. LVN C stated he had collected urine form Resident#1 previously and he placed her on the toilet and she would urinate. LVN C stated the family and CNA D assisted him with the collection of the urine. When removing Resident #1's brief, he noticed blood in the brief, he told the family he had to assess the resident. LVN C assessed Resident #1, which revealed a vaginal, labial laceration.<br><br>In an interview on 2/20/2025 at 4:45 p.m., CNA D stated she worked full time on the 2 p.m.-10 p.m. shift at the facility. She stated she assisted LVN C to collect a urine on Resident #1, by taking her to the bathroom and she urinated in the toilet. CNA D stated that when she prepared to remove her brief there was a red stain on the linens in her bed and then when she removed her brief there was a red stain in her brief. CNA D assisted the nurse stated it was blood. The family was in the room with us when this was occurring. She stated she was in serviced on abuse and neglect, resident rights, and behaviors the next day and she had to take a test. She stated the risks of staff failing to report abuse or neglect could put the residents a harm for continued abuse.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676112 | A. Building<br>B. Wing | 02/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Crestview Court | 224 W Pleasant Run Rd<br>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 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | In an interview on 02/21/2025 at 9:00 a.m the Medical Director revealed he was informed concerning the incident with Resident #1. The physician stated he came to the facility the next day and examined the resident; she had a labial injury laceration from attempting an in and catheter. There was concern for post catheter bleeding and a tear of the labia. The physician stated he had advised the night before to send the resident to hospital to have the labial laceration or tear evaluated in the emergency room , but the family did not want her to go, since she had calmed down had previously suffered through the trauma. The physician said he agreed. The physician stated he ordered for Resident #1 to have an antibiotic ointment two times a day until it heals. He also ordered stat lab work, since the UA was negative, showing only 2 plus blood, (blood was seen in the urine sample) the physician stated it was related to the labia laceration or tear. The physician stated Resident #1 was at her baseline.<br><br>In an phone interview on 02/21/2025 at 9:29 a.m. LVN B revealed the nurse was collecting the urine the physician had ordered for Resident #1, she had an altered mental status. I took the CNA with me because I knew I would have trouble with the resident when collecting the urine. When ask why she choose this method for collection, she did not answer. The LVN stated did you think that she would just lay there when I was trying to Cath her? The LVN stated that there was no blood, that the stain on the sheets was from the cleansing liquid that comes in the Cath kit. The LVN stated that the next day the facility called her in and showed her the video and she just told them she was quitting, she did not want to work there anymore. The LVN would not answer the surveyor about the description of the video, she stated she had to go.<br><br>Attempted interview on 2/21/2025 at 10:00 a.m., the state surveyor attempted to contact CNA A via phone. The CNA answered and stated she could not talk and she would call back. At the time of exit the surveyor had not heard from the CNA.<br><br>In an interview on 2/21/2025 at 10:20 a.m., the DON stated the previous incident involving Resident #1 was reported and the training was completed by an outside trainer. The DON stated it was an all-staff in-service on abuse, neglect, resident rights, and behaviors. We gave a test to all the staff following the training, then I monitored the resident every day for one week and then once a week for another week. The DON stated the two staff LVN B and CNA A were terminated, the family was informed. The DON stated he was shown the video by the family and he had identified LVN A and CNA were the staff in the room. The DON stated he had kept the video, until the investigation was cleared, when he deleted the video. The DON stated his main concern was the resident and monitor her make sure she did not experience any pain or have any noted negative outcome.<br><br>In an interview on 02/21/2025 at 4:00 p.m. with the Administrator revealed the Administrator stated the staff was just trying to collect the urine and there were no intent to harm the resident. The incident had been reported and investigated and the entire staff had been in-serviced concerning abuse, neglect, resident rights, and behaviors. The Administrator stated they had not had any incidents like this before and had none after this occurred. She did understand that the staff should have stopped when she resident ask them to.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676112 | A. Building<br>B. Wing | 02/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Crestview Court | 224 W Pleasant Run Rd<br>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 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | Record review revealed a physician progress note dated 09/25/2024 reflected Resident #1 was seen. There was a concern for alter mental status last night, an urinalysis was ordered. Resident #1 suffered a labial injury laceration vs. contusion ( a tear to the vaginal area vs a bruise) from attempting in an out catheter. There was concern for post catheter bleeding and a tear of the labia. Genitourinary area examined with an aide today (09/24/2024), mild discomfort with exam, small area of redness right labia, no bleeding.<br><br>On 02/21/25 at 3:03 pm the Administrator and the DON were notified of the IJ PNC.<br><br>Record review of in-service training record dated 09/25/2024 revealed nurses, CNAs, CMAs, housekeeper, kitchen staff, and laundry staff were in serviced by an outside nurse trainer on abuse, neglect, resident rights, and behaviors. There was a follow-up test given following the in-service to each staff member. Completion date on 09/28/2024.<br><br>Record review of nurse's notes dated 09/25/2024 through 10/08/2024 reflected the DON assessing and documented Resident #1's baseline behaviors and mental status everyday for one week and then weekly therafter. |