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	06/14/2025

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement written policies and procedures that prohibit and prevent abuse and neglect for one of three incidents (Resident #1) reviewed for reporting according to facility policy. CNA A failed to follow the facility's policy to report allegations of neglect when she failed to report Resident #1 fell over hitting her shoulder/neck on the bedrail when she reached for the wheelchair during attempted transfer, in which she did not use a gait belt, on 06/12/25. This failure could place the residents in the facility at risk of neglect and lack of timely reporting of incidents. Findings included: Review of Resident #1's face sheet dated 06/14/25 revealed Resident #1 was [AGE] year-old female, admitted to the facility on [DATE]. Review of Resident #1's MDS dated [DATE] revealed Resident #1 had a BIMS score of 00, indicating Resident #1 was not able to complete. Resident #1 utilized a wheelchair, Resident #1 required partial/moderate assistance with lying to sitting on side of bed and chair/bed to chair transfer. The resident's active diagnoses included Non-Alzheimer's Dementia (loss of memory and other intellectual functions), Malnutrition (deficiency of essential nutrients), Anxiety Disorder (intense, excessive and persistent worry and fear about everyday situations), Depression (mood disorder causing persistent feeling of sadness and loss of interest), and Bipolar Disorder (extreme mood swings that include emotional highs). Review of Resident #1's undated care plan reflected Resident #1's activities of daily living functions required extensive assist by 1 staff and gait belt with transfers, locomotion, toileting/hygiene, dressing, and bathing. Limited assist by 1 staff with eating-responsible party request resident in dining room for meals and bed mobility. Goal: Resident #1 will maintain a sense of dignity by being clean, dry, order free, and well groomed. Interventions included Encourage independence, praise when attempts are made. Assist with activities of daily living as needed. Offer tray set-up, assist with verbal cueing/feeding as needed. Review of Resident #1's progress notes written by LVN B reflected: (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676112	A. Building B. Wing	06/14/2025

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	06/13/25 5:30 PM - Note Text: Resident's Family Member reported to this Nurse that he saw through surveillance camera that Aide who worked 2-10 Pm shift on previous day (6/12/2025) at around 6:11 PM, Aide dropped resident to bed and was stopped by bed rail, resident Family Member suspected that resident might have sustained injuries to right shoulder and right side of neck. Aide did not report to this Nurse about it. This Nurse notified facility DON and Physician; received and carried out STAT X-Ray orders for Right shoulder and Right side of neck. 06/13/25 8:35 PM - Note Text: Local Lab Technician in facility, STAT X-Ray done to Right shoulder and Right side of neck, resident tolerated well, results pending. Family notified via phone call. 06/14/25 6:38 AM - Note Text: Xray resulted: labs sent to MD AWAITING RESPONSE. Review of the facility's grievance report with a date range of March 2025 - June 2025 revealed no grievances regarding Resident #1. Review of the facility's Incident and Accident reports with a date range of March 2025-June 2025 revealed no incidents or accident involving Resident #1. Review of a video footage dated 06/12/25 6:01 PM revealed an aide (later identified as CNA A) assisting Resident #1 with getting dressed with the lights off. Resident #1 was lying flat in bed. CNA lifted Resident #1 up placing her left hand underneath the right back side of her neck, and Resident #1 could be heard saying why are you hurting me old women. Resident #1 was then positioned to be sitting up on the side of the bed while being held by CNA A's left hand to the right side of Resident #1's head. Resident #1's pants were pulled to her hips as she sat on the side of the bed. CNA A then stepped to the Resident's left side to grab the wheelchair that was out of reach. CNA A stepped back placing both hands on Resident #1's shoulder saying, Mama, we are going to dinner. CNA A then tried to pull Resident #1's pants up. Resident #1 then leaned to the right hitting her shoulder/neck on the bedrail.CNA A was observed trying to place her body in position to keep Resident #1 from falling off the bed. CNA A was not using a gait belt during the attempted transfer. Review of Resident #1's Radiology report dated 06/13/26 9:36 PM for Shoulder complete minimum 2 view/Cervical Spine 2 or 3 views. Examination date:06/13/25 6:51 PM Reported Date: 06/13/25 9:36 PM Procedure: Shoulder complete minimum 2 views Interpretation: Reason for Study: Pain in Right shoulder Findings: The right shoulder, clavicle, and scapula demonstrate no acute fracture. No dislocation. Conclusion:1. Mild-moderate right shoulder arthritis. No obvious or acutely displaced fracture on todays provided shoulder views. (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 B. Wing	06/14/2025

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and observation on 06/14/25 at 9:25 AM Resident #1 was sitting in the television room, yelling out for help, when approached by surveyor Resident #1 started to cry. Resident #1 expressed I can't help it; this is just what happens. Resident #1 revealed she was ok; she was missing family members. Resident #1 revealed she did not recall falling over and hitting the bedrail. Resident #1 was observed with no bruising or skin tears to her right shoulder and neck area. Interview on 06/14/25 at 12:18 PM with LVN B revealed CNA A was working with Resident #1 on 06/12/25 during the second shift. According to LVN B, after asking CNA A to prepare Resident #1 for dinner, she reported to him that Resident #1 was refusing to go to the dining room. LVN B stated he entered the room to assist with encouraging her out of the bed. LVN B stated he was never notified by CNA A that Resident #1 fell over on her right side hitting the bedrail while being dressed and prepared for dinner. LVN B stated on 06/13/25 around 4:00 PM he received a call from Family Member asking why the facility had not followed up about Resident #1 falling onto the bedrail. LVN B stated he replied that he was not notified about a possible injury, and at that point, Family Member requested an x-ray. LVN B stated he reported the information to the DON, the DON stated, he was aware of the situation and to go ahead and call the physician for an order to x-ray. LVN B stated he completed an assessment and notified the doctor, requested an x-ray. LVN B reiterated that he was never notified by CNA A that Resident #1 hit her shoulder or neck on the bedrail. LVN B stated he expected aides to report incidents to him immediately so that he could assess the situation and resident for injuries. LVN B stated he was responsible to report those incidents to the DON, not doing so placed residents at risk of neglect. Interview on 06/14/25 at 12:46 PM with DON revealed he was not aware of the incident until he received messages from Family Member on 06/12/25 at 10:00 PM requesting that an aide be removed from working with Resident #1. The DON stated the Family Member complained that the aide almost dropped Resident #1. After confirming that CNA A was the aide working with Resident #1, the DON stated CNA A reported Resident #1 was not almost dropped. Resident #1 was sitting at the edge of the bed when I reached for the wheelchair. According to the DON, he had not been alerted by staff that Resident #1 had almost been dropped, refused care or that there was an incident involving Resident #1. The DON revealed he had not done anything further concerning this incident after speaking with CNA A. Interview by phone on 06/14/25 at 1:13 PM with CNA A revealed she was asked by LVN B to get Resident #1 out of bed and dressed for dinner. CNA A reported she did not almost drop Resident #1 while preparing her for dinner. CNA A stated she went to prepare Resident #1 for dinner by getting her dressed while she was in bed. CNA A stated, I sat Resident #1 up on the side of the bed, supporting Resident #1 with my body, the wheelchair was not in reach, so I had to reach for it. At that time, she did not want to transfer so I laid her back down on the bed. CNA stated she went to alert LVN B, and they returned to the room together to encourage her to get up for dinner. According to CNA A, she had not had any training from the facility on appropriate way to transfer/assist residents when transferring. (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 B. Wing	06/14/2025

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview with CNA on 06/14/25 at 2:30 PM, video footage of Resident #1 was reviewed. CNA A confirmed she was in the video providing care to Resident #1. CNA A stated, I'm not going to lie. I did not inform the nurse of the incident. I laid her [Resident #1] back down. CNA A stated she was supposed to report this incident to the nurse; however, she did not. CNA A stated she was not aware Resident #1 hit her head on the bedrail; however, she heard the resident say she did not want to eat, so she laid Resident #1 in bed and went to inform the nurse that Resident #1 refused to eat. According to CNA A, not reporting incidents placed residents at risk of not getting the care they required. She stated it was her responsibility to report everything to the nurse. During observation and interview with the DON on 06/14/25 at 2:39 PM, video footage of Resident #1 was reviewed. The DON revealed Resident #1 was sat up on the side of the bed by CNA A, who supported Resident #1's head with her left hand. When CNA A went to reach for the wheelchair without a gait belt, Resident #1 fell over unto the rail. The DON stated all aides were expected to use a gait belt when transferring residents. The DON stated he expected the aide to have reported the incident to the nurse, and the nurse to have notified him. The DON stated he would have completed an in-service with staff. During observation and interview with the Administrator on 06/14/25 at 3:20 PM, video footage of Resident #1 was reviewed. The Administrator revealed she was not aware of the incident or video. The Administrator stated observation of the video revealed CNA A was getting Resident #1 up in the wheelchair, and Resident #1 slumped over and hit her neck area on the side rail. The Administrator stated she expected the aide to have reported this incident to the nurse, the nurse should then investigate and complete incident report, pain assessment, x-ray if needed and complete neuro checks or at least follow up on her. The Administrator stated not reporting the incident placed residents at risk of injuries and neglect. Review of the facility's Accidents and Incidents-Investing and Reporting policy, dated July 2017, reflected: All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator. The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident . Review of the facility's Abuse Prohibition Protocol policy, dated August 2024, reflected: . The Patient has the right to be free from abuse, neglect, misreatmentof resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required in treatin the Patient's symtoms. . Our Facility will not condone Patient abuse or neglect by anyone, including staff members . . the Executive Director, or in his/her absence, the Director of Nursing, will perform the duties of the Abuse Prevention Coordinator. . The Abuse Prevention Coordinator will assure that all Facility staff is in-serviced on recognizing abuse, abuse prevention and abuse reporting upon employment, and as necessary to maintain an abuse free environment . (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 B. Wing	06/14/2025

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.The Charge Nurse will immediately examine the Patient and notify the Abuse Prevention Coordinator upon receiving reports of mental, physical or sexual abuse. Findings of the examination will be recorded in the Patient's medical record. (Protection) .The Abuse Prevention Coordinator will: Immediately (within 2 hours) report to the State agency and other appropriate authorities incidents of Patient Abuse as required under applicable regulations and regulatory guidance. Report events that cause reasonable suspicion of serious bodily injury immediately (within 2 hours) after forming the suspicion to The State agency and other appropriate authorities as required under applicable regulations and regulatory guidance. Immediately (within 24 hours) suspend the employee for an abuse allegation until an investigation is completed. Conduct and document on a Patient Abuse Investigation (see Form 3-5) a thorough investigation of each incident of Patient Abuse, neglect, exploitation or mistreatment to include: observations, interviews and reviews of all Patient's involved interviews of all witnesses, including Patients, staff and family members notifying physicians notifying families and responsible parties of the involved Patient's recording all relevant physical findings. Complete an appropriate assessment of all Patient's involved Take all steps necessary to protect the Facility's Patients from further incidents of Patient Abuse, neglect, exploitation or mistreatment while the investigation is in progress. Be responsible for carrying out any interventions or follow-up steps subsequent to the investigation of any abuse or alleged abuse, neglect, exploitation or mistreatment. (Investigation) .The Facility will provide orientation and regular in-services to employees on abuse prevention practices

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	06/14/2025

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	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** Based on observation, interview and record review, the facility failed to ensure that all alleged violations involving abuse were reported immediately to the Administrator of the facility for 1 of 3 residents (Resident #1) reviewed for reporting abuse and neglect. The facility failed to report an incident to HHSC involving CNA A failing to perform a safe, proper transfer using a gait-belt for Resident #1 which resulted in the resident bumping against the siderail. The failure placed residents at risk of injuries and neglect of care. Findings included: Review of Resident #1's face sheet dated 06/14/25 revealed Resident #1 was [AGE] year-old female, admitted to the facility on [DATE]. Review of Resident #1's MDS dated [DATE] revealed Resident #1 had a BIMS score of 00, indicating Resident #1 was not able to complete. Resident #1 utilized a wheelchair, Resident #1 required partial/moderate assistance with lying to sitting on side of bed and chair/bed to chair transfer. The resident's active diagnoses included Non-Alzheimer's Dementia (loss of memory and other intellectual functions), Malnutrition (deficiency of essential nutrients), Anxiety Disorder (intense, excessive and persistent worry and fear about everyday situations), Depression (mood disorder causing persistent feeling of sadness and loss of interest), and Bipolar Disorder (extreme mood swings that include emotional highs). Review of Resident #1's undated care plan reflected Resident #1's activities of daily living functions required extensive assist by 1 staff and gait belt with transfers, locomotion, toileting/hygiene, dressing, and bathing. Limited assist by 1 staff with eating-responsible party request resident in dining room for meals and bed mobility. Goal: Resident #1 will maintain a sense of dignity by being clean, dry, order free, and well groomed. Interventions included Encourage independence, praise when attempts are made. Assist with activities of daily living as needed. Offer tray set-up, assist with verbal cueing/feeding as needed. Review of Resident #1's progress notes written by LVN B reflected: 06/13/25 5:30 PM - Note Text: Resident's Family Member reported to this Nurse that he saw through surveillance camera that Aide who worked 2-10 Pm shift on previous day (6/12/2025) at around 6:11 PM, Aide dropped resident to bed and was stopped by bed rail, resident Family Member suspected that resident might have sustained injuries to right shoulder and right side of neck. Aide did not report to this Nurse about it. This Nurse notified facility DON and Physician; received and carried out STAT X-Ray orders for Right shoulder and Right side of neck. 06/13/25 8:35 PM - Note Text: Local Lab Technician in facility, STAT X-Ray done to Right shoulder and Right side of neck, resident tolerated well, results pending. Family notified via phone call. (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 B. Wing	06/14/2025

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	06/14/25 6:38 AM - Note Text: Xray resulted: labs sent to MD AWAITING RESPONSE. Review of the facility's grievance report with a date range of March 2025 - June 2025 revealed no grievances regarding Resident #1. Review of the facility's Incident and Accident reports with a date range of March 2025-June 2025 revealed no incidents or accident involving Resident #1. Review of a video footage dated 06/12/25 6:01 PM revealed an aide (later identified as CNA A) assisting Resident #1 with getting dressed with the lights off. Resident #1 was lying flat in bed. CNA lifted Resident #1 up placing her left hand underneath the right back side of her neck, and Resident #1 could be heard saying why are you hurting me old women. Resident #1 was then positioned to be sitting up on the side of the bed while being held by CNA A's left hand to the right side of Resident #1's head. Resident #1's pants were pulled to her hips as she sat on the side of the bed. CNA A then stepped to the Resident's left side to grab the wheelchair that was out of reach. CNA A stepped back placing both hands on Resident #1's shoulder saying, Mama, we are going to dinner. CNA A then tried to pull Resident #1's pants up. Resident #1 then leaned to the right hitting her shoulder/neck on the bedrail. CNA A was observed trying to place her body in position to keep Resident #1 from falling off the bed. CNA A was not using a gait belt during the attempted transfer. Review of Resident #1's Radiology report dated 06/13/26 9:36 PM for Shoulder complete minimum 2 view/Cervical Spine 2 or 3 views. Examination date:06/13/25 6:51 PM Reported Date: 06/13/25 9:36 PM Procedure: Shoulder complete minimum 2 views Interpretation: Reason for Study: Pain in Right shoulder Findings: The right shoulder, clavicle, and scapula demonstrate no acute fracture. No dislocation. Conclusion:1. Mild-moderate right shoulder arthritis. No obvious or acutely displaced fracture on todays provided shoulder views. Interview and observation on 06/14/25 at 9:25 AM Resident #1 was sitting in the television room, yelling out for help, when approached by surveyor Resident #1 started to cry. Resident #1 expressed I can't help it; this is just what happens. Resident #1 revealed she was ok; she was missing family members. Resident #1 revealed she did not recall falling over and hitting the bedrail. Resident #1 was observed with no bruising or skin tears to her right shoulder and neck area. (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 B. Wing	06/14/2025

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	Interview on 06/14/25 at 12:18 PM with LVN B revealed CNA A was working with Resident #1 on 06/12/25 during the second shift. According to LVN B, after asking CNA A to prepare Resident #1 for dinner, she reported to him that Resident #1 was refusing to go to the dining room. LVN B stated he entered the room to assist with encouraging her out of the bed. LVN B stated he was never notified by CNA A that Resident #1 fell over on her right side hitting the bedrail while being dressed and prepared for dinner. LVN B stated on 06/13/25 around 4:00 PM he received a call from Family Member asking why the facility had not followed up about Resident #1 falling onto the bedrail. LVN B stated he replied that he was not notified about a possible injury, and at that point, Family Member requested an x-ray. LVN B stated he reported the information to the DON, the DON stated, he was aware of the situation and to go ahead and call the physician for an order to x-ray. LVN B stated he completed an assessment and notified the doctor, requested an x-ray. LVN B reiterated that he was never notified by CNA A that Resident #1 hit her shoulder or neck on the bedrail. LVN B stated he expected aides to report incidents to him immediately so that he could assess the situation and resident for injuries. LVN B stated he was responsible to report those incidents to the DON, not doing so placed residents at risk of neglect. Interview on 06/14/25 at 12:46 PM with DON revealed he was not aware of the incident until he received messages from Family Member on 06/12/25 at 10:00 PM requesting that an aide be removed from working with Resident #1. The DON stated the Family Member complained that the aide almost dropped Resident #1. After confirming that CNA A was the aide working with Resident #1, the DON stated CNA A reported Resident #1 was not almost dropped. Resident #1 was sitting at the edge of the bed when I reached for the wheelchair. According to the DON, he had not been alerted by staff that Resident #1 had almost been dropped, refused care or that there was an incident involving Resident #1. The DON revealed he had not done anything further concerning this incident after speaking with CNA A. Interview by phone on 06/14/25 at 1:13 PM with CNA A revealed she was asked by LVN B to get Resident #1 out of bed and dressed for dinner. CNA A reported she did not almost drop Resident #1 while preparing her for dinner. CNA A stated she went to prepare Resident #1 for dinner by getting her dressed while she was in bed. CNA A stated, I sat Resident #1 up on the side of the bed, supporting Resident #1 with my body, the wheelchair was not in reach, so I had to reach for it. At that time, she did not want to transfer so I laid her back down on the bed. CNA stated she went to alert LVN B, and they returned to the room together to encourage her to get up for dinner. According to CNA A, she had not had any training from the facility on appropriate way to transfer/assist residents when transferring. During observation and interview with CNA on 06/14/25 at 2:30 PM, video footage of Resident #1 was reviewed. CNA A confirmed she was in the video providing care to Resident #1. CNA A stated, I'm not going to lie. I did not inform the nurse of the incident. I laid her [Resident #1] back down. CNA A stated she was supposed to report this incident to the nurse; however, she did not. CNA A stated she was not aware Resident #1 hit her head on the bedrail; however, she heard the resident say she did not want to eat, so she laid Resident #1 in bed and went to inform the nurse that Resident #1 refused to eat. According to CNA A, not reporting incidents placed residents at risk of not getting the care they required. She stated it was her responsibility to report everything to the nurse. (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 B. Wing	06/14/2025

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	During observation and interview with the DON on 06/14/25 at 2:39 PM, video footage of Resident #1 was reviewed. The DON revealed Resident #1 was sat up on the side of the bed by CNA A, who supported Resident #1's head with her left hand. When CNA A went to reach for the wheelchair without a gait belt, Resident #1 fell over unto the rail. The DON stated all aides were expected to use a gait belt when transferring residents. The DON stated he expected the aide to have reported the incident to the nurse, and the nurse to have notified him. The DON stated he would have completed an in-service with staff. During observation and interview with the Administrator on 06/14/25 at 3:20 PM, video footage of Resident #1 was reviewed. The Administrator revealed she was not aware of the incident or video. The Administrator stated observation of the video revealed CNA A was getting Resident #1 up in the wheelchair, and Resident #1 slumped over and hit her neck area on the side rail. The Administrator stated she expected the aide to have reported this incident to the nurse, the nurse should then investigate and complete incident report, pain assessment, x-ray if needed and complete neuro checks or at least follow up on her. The Administrator stated not reporting the incident placed residents at risk of injuries and neglect. Review of the facility's Accidents and Incidents-Investing and Reporting policy, dated July 2017, reflected: All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator. The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident . Review of the facility's Abuse Prohibition Protocol policy, dated August 2024, reflected: . The Patient has the right to be free from abuse, neglect, misreatmentof resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required in treatin the Patient's symtoms. . Our Facility will not condone Patient abuse or neglect by anyone, including staff members . . the Executive Director, or in his/her absence, the Director of Nursing, will perform the duties of the Abuse Prevention Coordinator. . The Abuse Prevention Coordinator will assure that all Facility staff is in-serviced on recognizing abuse, abuse prevention and abuse reporting upon employment, and as necessary to maintain an abuse free environment . .The Charge Nurse will immediately examine the Patient and notify the Abuse Prevention Coordinator upon receiving reports of mental, physical or sexual abuse. Findings of the examination will be recorded in the Patient's medical record. (Protection) .The Abuse Prevention Coordinator will: Immediately (within 2 hours) report to the State agency and other appropriate authorities incidents of Patient Abuse as required under applicable regulations and regulatory guidance. (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 B. Wing	06/14/2025

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	Report events that cause reasonable suspicion of serious bodily injury immediately (within 2 hours) after forming the suspicion to The State agency and other appropriate authorities as required under applicable regulations and regulatory guidance. Immediately (within 24 hours) suspend the employee for an abuse allegation until an investigation is completed. Conduct and document on a Patient Abuse Investigation (see Form 3-5) a thorough investigation of each incident of Patient Abuse, neglect, exploitation or mistreatment to include: observations, interviews and reviews of all Patient's involved interviews of all witnesses, including Patients, staff and family members notifying physicians notifying families and responsible parties of the involved Patient's recording all relevant physical findings. Complete an appropriate assessment of all Patient's involved Take all steps necessary to protect the Facility's Patients from further incidents of Patient Abuse, neglect, exploitation or mistreatment while the investigation is in progress. Be responsible for carrying out any interventions or follow-up steps subsequent to the investigation of any abuse or alleged abuse, neglect, exploitation or mistreatment. (Investigation) .The Facility will provide orientation and regular in-services to employees on abuse prevention practices

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	06/14/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 3 resident (Resident #1) reviewed for supervision. CNA A failed to safely transfer Resident #1 from her bed to the wheelchair, which resulted in her losing her grasp of the resident and the resident bumping against the siderail. The failure placed residents at risk of injury. Findings included: Review of Resident #1's face sheet dated 06/14/25 revealed Resident #1 was [AGE] year-old female, admitted to the facility on [DATE]. Review of Resident #1's MDS dated [DATE] revealed Resident #1 had a BIMS score of 00, indicating Resident #1 was not able to complete. Resident #1 utilized a wheelchair, Resident #1 required partial/moderate assistance with lying to sitting on side of bed and chair/bed to chair transfer. The resident's active diagnoses included Non-Alzheimer's Dementia (loss of memory and other intellectual functions), Malnutrition (deficiency of essential nutrients), anxiety disorder (intense, excessive, and persistent worry and fear about everyday situations), Depression (mood disorder causing persistent feeling of sadness and loss of interest), and bipolar disorder (extreme mood swings that include emotional highs). Review of Resident #1's undated care plan reflected Resident #1's activities of daily living functions required extensive assist by 1 staff and gait belt with transfers, locomotion, toileting/hygiene, dressing, and bathing. Limited assist by 1 staff with eating-responsible party request resident in dining room for meals and bed mobility. Goal: Resident #1 will maintain a sense of dignity by being clean, dry, order free, and well groomed. Interventions included Encourage independence, praise when attempts are made. Assist with activities of daily living as needed. Offer tray set-up, assist with verbal cueing/feeding as needed. Review of Resident #1's progress notes written by LVN B revealed: 06/13/25 5:30 PM - Note Text: Resident's Family Member reported to this Nurse that he saw through surveillance camera that Aide who worked 2-10 Pm shift on previous day (6/12/2025) at around 6:11 PM, Aide dropped resident to bed and was stopped by bed rail, resident Family Member suspected that resident might have sustained injuries to right shoulder and right side of neck. Aide did not report to this Nurse about it. This Nurse notified facility DON and the Physician. Received and carried out STAT X-Ray orders for Right shoulder and Right side of neck. 06/13/25 8:35 PM - Note Text: Local Lab Technician in facility, STAT X-Ray done to Right shoulder and Right side of neck, resident tolerated well, results pending. Family notified via phone call. (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 B. Wing	06/14/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	06/14/25 6:38 AM - Note Text: Xray resulted: labs sent to MD AWAITING RESPONSE. Review of the facility's Incident and Accident reports with a date range of March 2025-June 2025revealed no incidents or accident involving Resident #1. Review of a video footage dated 06/12/25 6:01 PM revealed aide (later identified as CNA A) assisting Resident #1 with getting dressed, while laying flat in bed, with the lights off. CNA A lifted Resident #1 to sitting position on the side of the bed Resident #1 could be heard saying why are you hurting me old women. Resident #1 was being supported by CNA's left hand to the right side of Resident #1's head. Resident #1's pants were pulled to her hips as she sat on the side of the bed, CNA then steps to the Resident's left side to grab the wheelchair that was out of reach. CNA A stepped back placing both hands on Resident #1's shoulder (which appears that it was attempting to get her attention/or wake her) saying, Mama, we are going to dinner. CNA A then tried to reach behind Resident #1 to pull Resident #1's pants up. Resident #1 then leaned to the right hitting her should/neck on the bedrail. CNA A was observed trying to place her body in position to keep Resident #1 from falling off the bed. CNA A was not using a gait belt during the attempted transfer. Review of Resident #1's Radiology report dated 06/13/26 9:36 PM for Shoulder complete minimum 2 view/Cervical Spine 2 or 3 views. Examination date:06/13/25 6:51 PM Reported Date: 06/13/25 9:36 PM Procedure: Shoulder complete minimum 2 views Interpretation: Reason for Study: Pain in Right shoulder Findings: The right shoulder, clavicle, and scapula demonstrate no acute fracture. No dislocation. Conclusion:1. Mild-moderate right shoulder arthritis. No obvious or acutely displaced fracture on todays provided shoulder views. Interview and observation on 06/14/25 at 9:25 AM Resident #1 was sitting in the television room, yelling out for help, when approached by surveyor Resident #1 started to cry. Resident #1 revealed she did not recall falling over and hitting the bedrail. Resident #1 was observed with no bruising or skin tears to her right shoulder and neck area. (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 B. Wing	06/14/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/14/25 at 10:12 AM with Family Member revealed Resident #1 has electronic monitoring in her room, and upon reviewing the footage it was observed aide (CNA A) was unprepared and unknowledgeable to work with residents in a nursing facility. According to the Family Member, CNA A was getting Resident #1 dressed for dinner, at such a late time in the day, I feel like they forgot to get her up and was rushing to get her to the dining room. The aide sat Resident #1 up on the side of the bed, without ensuring she was stable, holding Resident #1 by her head while reaching for the wheelchair that was not within reach. Resident #1 fell out of her hands hitting the bedrail. The bed rail was her saving grace. The aide pushed her knee forward to keep her from falling and placed her back in bed, covered her up and left the room. I had not received a call or plan of action from the facility concerning this incident so around 10:00 PM I contacted the DON by text to inform him of the incident and that I did not want this aide to work with Resident #1 anymore. On 06/13/25 around 4:00 PM, I contacted LVN B and asked him about the incident to see if they ordered x-ray, and why have not anyone contacted me, which I was then told he was not aware anything had happened. At this point I requested an x-ray. Review and observation of the message sent to the DON revealed: A video attached to a message that read Hey DON. I do not want this Aide dealing with Resident #1 ever again. She is rough and abrasive, and she appears to have no idea of how to handle an elderly fragile person. She almost dropped Resident #1 because she was holding her by her head and not prepared the chair or herself to transport or move. Another video in the message read I do not know what time dinner was served, but it was 6:11 PM before Resident #1 was gotten out of bed to go to the dining facility. And Resident #1's head and face hit the bed rail in that video. Instead of getting Resident #1 out of the bed, she laid back into the bed. At 6:15 PM, another aide and nurse came to get Resident #1 out of bed. Response from DON revealed: Yes, Sir I will address this. Interview on 06/14/25 at 12:18 PM with LVN B revealed CNA A was working with Resident #1 on 06/12/25 during the second shift. According to LVN B, after asking CNA A to prepare Resident #1 for dinner, she reported to him that Resident #1 was refusing to go to the dining room. LVN B stated he entered the room to assist with encouraging her out of the bed. LVN B stated he was never notified by CNA A that Resident #1 fell over on her right side hitting the bedrail while being dressed and prepared for dinner. LVN B stated on 06/13/25 around 4:00 PM he received a call from Family Member asking why the facility had not followed up about Resident #1 falling onto the bedrail. LVN B stated he replied that he was not notified about a possible injury, and at that point, Family Member requested an x-ray. LVN B stated he reported the information to the DON, the DON stated, he was aware of the situation and to go ahead and call the physician for an order to x-ray. LVN B stated he completed an assessment and notified the doctor, requested an x-ray. LVN B stated again that he was never notified by CNA A that Resident #1 hit her shoulder or neck on the bedrail. LVN B stated he expected aides to report incidents to him immediately so that he could assess the situation and resident for injuries. LVN B stated he was responsible to report those incidents to the DON, not doing so placed residents at risk of neglect and unknown injury. (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 B. Wing	06/14/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/14/25 at 12:46 PM with DON revealed he was not aware of the incident until he received messages from Family Member on 06/12/25 at 10:00 PM requesting that an aide be removed from working with Resident #1. The DON stated the Family Member complained that the aide almost dropped Resident #1. After confirming that CNA A was the aide working with Resident #1, DON stated she reported Resident #1 was not almost dropped, she was sitting at the edge of the bed when I reached for the wheelchair but decided to place her back in bed. According to the DON he had not been alerted by CNA A or LVN B that Resident #1 had almost been dropped, refused care or that there was an incident involving Resident #1. Interview by phone on 06/14/25 at 1:13 PM with CNA A revealed she was asked by LVN B to get Resident #1 out of bed and dressed for dinner. CNA A reported that she did not almost drop Resident #1 while preparing her for dinner. CNA A stated she went to prepare Resident #1 for dinner by getting her dressed while she was in bed. CNA A stated I sat Resident #1 up on the side of the bed, supporting Resident #1 with my body, the wheelchair was not in reach, so I had to reach for it. At that time, she did not want to transfer so I laid her back down on the bed. CNA A stated she went to alert LVN B, and they returned to the room together to encourage her to get up for dinner. According to CNA A she had not had any training from the facility on resident transfers. During observation and interview with CNA A on 06/14/25 at 2:30 PM, video footage of Resident #1 being assisted in bed was viewed. CNA A confirmed it was her in the video assisting Resident #1. CNA A stated, I'm not going to lie. I did not inform the nurse of the incident. I laid her back down. CNA A stated, I was supposed to report this incident to the nurse, however I did not. CNA A then stated she was not aware that Resident #1 hit her head on the bedrail but heard Resident #1 say I don't want to eat so she then laid her down in bed and went to inform LVN B that Resident #1 refused to eat. During observation and interview with the DON on 06/14/25 at 2:39 PM, video footage of Resident #1 being assisted in bed by CNA A was viewed. The DON revealed Resident #1 was sat up on the side of the bed by CNA A, supporting Resident #1's head with her left hand, when CNA A went to reach for the wheelchair without a gait belt, Resident #1 fell over unto the rail. The DON stated all aides were expected to use a gait belt when transferring residents. During observation and interview with the Administrator on 06/14/25 at 3:20 PM, video footage of Resident #1 being assisted in bed by CNA A was viewed. The Administrator revealed she was not aware of the incident or video. The Administrator stated observation of the video revealed CNA A was getting Resident #1 up in the wheelchair, and Resident #1 slumped over and hit her neck area on the side rail. The Administrator stated she expected the aide to have used a gait belt during the transfer. Review of the facility's TRANSFERS: Method, Equipment and Preparation policy, reflected: .Firm, stable surfaces for patients to move to and from are required for all transfers. Most transfers are made towards the normal or stronger side of the patient, regardless of the cause of the disability. Know the patient's weight bearing status. Give assistance to the patient's weaker side. (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 B. Wing	06/14/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Use gait belt on all assisted transfers. Patient's shoulder or arms are not appropriate to pull, push or lift upon. Cup your hand under the gait belt for greater control. Plan maneuver before lifting. Keep patient in good alignment. Support the arm or leg as needed