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	03/21/2024

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 27070 Based on observation, interview and record review the facility failed to ensure all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown origin were reported immediately to the State agency for one (Resident #6) of six residents reviewed for injuries of unknown origin. The facility failed to report to the State Survey Agency on 03/08/24, when Resident #6 was noted with an injury of unknown origin. This failure could place residents at risk for unreported abuse and/or neglect. Findings included: Review of Resident #6's dated 03/11/24 Admission Record revealed the resident was a [AGE] year-old female initially admitted to the facility on [DATE]. Review of Resident #6's quarterly MDS assessment, dated 05/17/24, revealed she was a [AGE] year-old-female admitted to the facility on [DATE] with diagnoses including: atrial fibrillation, (irregular pulse), coronary artery disease (clogged up arteries), heart failure (heart not pumping like it should), hypertension (high blood pressure), end stage renal disease (kidneys not working), dialysis (machine assisting to purify the blood and urine), diabetes (increased blood sugar), anxiety disorder (anxious), disorder of bone density (bones not strong), osteoarthritis (bone disease), and osteoporosis (bone disease). The MDS indicated the resident's cognition was severely impaired and unable to make decisions for herself. The resident required the extensive assistance of two staff for activities of daily living. Review of Resident #6's comprehensive care plan, updated 03/11/24, revealed the resident had a care plan goals for osteoarthritis, osteoporosis, and a care plan for risk of injury due to these diagnoses. Further review reflected goals and approaches related to the finger fracture. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(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	Review of the nursing progress notes dated 03/08/24 at 2:59 p.m. reflected the family approached LVN A concerning Resident #6's left hand and her finger was swollen, and she was compling of pain. Further review of the nursing progress notes, reflected LVN A assessed the left hand or Resident #6, the fourth digit distal finger of the left hand was swollen and administered pain medication for the pain Resident #6 expressed. LVN A documented she called the physician and got x-ray ordered. It was documented by LVN A the x-rya results for the left hand were positive fracture to the left proximal phalanx of the left finger, the physician assistant and physician were informed, and splint was ordered to apply to the finger. In an interview on 03/20/24 at 3:00 p.m. with LVN A revealed she had been the nurse in charge when Resident #6's family approached her about the swelling in her hand. LVN A stated that she and treatment nurse assessed the finger, there was a small amount of swelling, with no bruising noted on the back side of the ring finger and the resident was expressing pain. I called the physician assistant and the physician, an x-ray was ordered the results came back showing a fracture of her ring finger, I called the physician and the Physician assistant. A splint was ordered, and we taped the two fingers together, while waiting on the splint. I informed the DON that the finger was broken on the same day. Review of an accident/incident report dated 03/08/24 revealed Resident #6's family reported a swollen left ring finger with complaints of pain. This nurse (LVN A) assessed the residents' left hand and noticed swelling at the fourth distal finger. The resident stated she felt pain. Pain medication was administered. Resident stated that she hit her finger while studying by the window. The family stated Resident #6 complained of pain while she was washing her hands. Contacted physician, new orders for x-ray results Findings AP (anterior and posterior) and lateral views of the left hand demonstrate a diffuse osteoporosis (bone disease). The fourth proximal phalangeal (top of fourth finger) oblique (top) fracture is visualized. The pisiform (wrist bone) is laterally subluxed (partial dislocated). The scapholunate (torn ligament) joint is widened. No bony erosion of destruction is present. The soft tissues are unremarkable. There is no radiopaque foreign body (any object that enters the body, that can be seen by x-ray). RP aware. Observation and interview on 03/19/24 at 9:15 a.m. Resident #6 sitting in a wheelchair at the nurse's station, her hand was in a pink cast. Attempts to interview the resident revealed that she thought she had caught her hand in something but could not recall what. The resident smiled and stated but it is doing better now. Review of the Providers Investigation Report dated 03/11/2024 reflected incident category: of an unknown fracture made by the family on 03/11/24. Description of the allegation: reflected that the nurse noticed swelling on the resident's finger. After getting x-rays the finger came back fractured. The next day the family states they watched video and saw a CNA being rough. They denied abuse but she was rough. The family refused to show the video to the facility. (There was no other dates provided in this section) Assessment description: Assessed hand on 03/08/24 after an allegation of rough body assessment on 03/10/24. Provider Action taken post investigation was signed by the Administrator and dated 03/12/24. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/21/24 at 7:45 a.m. with the Administrator revealed she was the facility's abuse prohibition coordinator and responsible for conducting facility investigations. When asked about an investigation of Resident #6's left hand and the broken finger, she stated she had been made aware of the broken finger, it was on a Friday, the eighth of March. The Administrator stated that she had not reported the broken finger separately because then the family had come back on 03/09/24 and stated there was a CNA that was rough with Resident #6 but would not provide the video to me. I guess I got confused and just combined them all because it was the weekend, and I did not call the reports in separately. The Administrator stated she would take that because she understood that the two should have been reported separately, the allegation of injury of unknown origin and the other, allegation of abuse. Review of the facility's abuse prohibition policy/procedure dated April 2019 was provided by the Administrator on 03/19/24 and identified as current, reflected . 6. Accidents and Incidents internally and externally must be reported and investigate in accordance with the Reportable Incident Protocol .The policy/procedure reflected events of injuries of unknown origin would be identified and thoroughly investigated. 32581

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27070 Based on observation, interview and record review, the facility failed to have evidence that all alleged violations were thoroughly investigated for one (Resident #6) of six residents reviewed for injury of unknown origin. The Administrator failed to start thoroughly investigating an injury of unknown origin when Resident #6 was discovered with fracture of proximal phalanx of left ring finger on 03/08/2024. Failure to timely investigate injuries of unknown origin placed residents at risk for unidentified abuse or neglect. Findings included: Review of Resident #6's dated 03/11/24 Admission Record revealed the resident was a [AGE] year-old female initially admitted to the facility on [DATE]. Review of Resident #6's quarterly MDS assessment, dated 05/17/24, revealed she was a [AGE] year-old-female admitted to the facility on [DATE] with diagnoses including: atrial fibrillation, (irregular pulse), coronary artery disease (clogged up arteries), heart failure (heart not pumping like it should), hypertension (high blood pressure), end stage renal disease (kidneys not working), dialysis (machine assisting to purify the blood and urine), diabetes (increased blood sugar), anxiety disorder (anxious), disorder of bone density (bones not strong), osteoarthritis (bone disease), and osteoporosis (bone disease). The MDS indicated the resident's cognition was severely impaired and unable to make decisions for herself. The resident required the extensive assistance of two staff for activities of daily living. Review of Resident #6's comprehensive care plan, updated 03/11/24, revealed the resident had a care plan goals for osteoarthritis, osteoporosis and a care plan for risk of injury due to these diagnoses. Further review reflected goals and approaches related to the finger fracture. Review of the nursing progress notes dated 03/08/24 at 2:59 p.m. reflected the family approached LVN A concerning Resident #6's left hand and her finger was swollen, and she was compling of pain. Further review of the nursing progress notes, reflected LVN A assessed the left hand or Resident #6, the fourth digit distal finger of the left hand was swollen and administered pain medication for the pain Resident #6 expressed. LVN A documented she called the physician and got x-ray ordered. It was documented by LVN A the x-rya results for the left hand were positive fracture to the left proximal phalanx (fourth finger, ring finger)of the left hand , the physician assistant and physician were informed, and splint was ordered to apply to the finger. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/20/24 at 3:00 p.m. with LVN A revealed she had been the nurse in charge when Resident #6's family approached her about the swelling in her hand. LVN A stated that she and treatment nurse assessed the finger, there was a small amount of swelling, with no bruising noted on the back side of the ring finger and the resident was expressing pain. I called the physician assistant and the physician, an x-ray was ordered the results came back showing a fracture of her ring finger, I called the physician and the Physician assistant. A splint was ordered, and we taped the two fingers together, while waiting on the splint. I informed the DON that the finger was broken on the same day. Review of an accident/incident report dated 03/08/24 revealed Resident #6's family reported a swollen left ring finger with complaints of pain. This nurse (LVN A) assessed the residents' left hand and noticed swelling at the fourth distal finger. The resident stated she felt pain. Pain medication was administered. Resident stated that she hit her finger while studying by the window. The family stated Resident #6 complained of pain while she was washing her hands. Contacted physician new orders for x-ray results Findings AP (anterior and posterior) and lateral views of the left hand demonstrate a diffuse osteoporosis(bone disease) . The fourth proximal phalangeal (fourth finger,ring finger) oblique fracture is visualized. The pisiform (wrist bone) is laterally subluxed (partially dislocated). The scapholunate (torn ligament) joint is widened. No bony erosion of destruction is present. The soft tissues are unremarkable. There is no radiopaque foreign body (an object that has entered the body that can be visualized by x-ray). RP aware. Observation and interview on 03/19/24 at 9:15 a.m. Resident #6 sitting in a wheelchair at the nurse's station, her hand was in a pink cast. Attempts to interview the resident revealed that she thought she had caught her hand in something but could not recall what. The resident smiled and stated but it is doing better now. Review of the Providers Investigation Report dated 03/11/2024 reflected incident category: of an unknown fracture made by the family on 03/11/24. Description of the allegation: reflected that the nurse noticed swelling on the resident's finger. After getting x-rays the finger came back fractured. The next day the family states they watched video and saw a CNA being rough. They denied abuse but she was rough. The family refused to show the video to the facility. (There were no other dates provided in this section) Assessment description: Assessed hand on 03/08/24 after a allegation of rough body assessment on 03/10/24. Provider Action taken post investigation was signed by the Administrator and dated 03/12/24. In an interview on 03/21/24 at 7:45 a.m. with the Administrator revealed she was the facility's abuse prohibition coordinator and responsible for conducting facility investigations. When queried about an investigation of Resident #6's left hand and the broken finger, she stated she had been made aware of the broken finger, it was on a Friday, the eighth of March. The Administrator stated that she had not reported the broken finger separately because then the family had come back on 03/09/24 and stated there was a CNA that was rough with Resident #6but would not provide the video to me. I guess I got confused and just combined them all because it was the weekend, and I did not call the reports in separately. The Administrator stated she would take that because she understood that the two should have been reported separately, the allegation of injury of unknown origin and the other, allegation of abuse. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's abuse prohibition policy/procedure dated April 2019 was provided by the Administrator on 03/19/24 and identified as current, reflected . 6. Accidents and Incidents internally and externally must be reported and investigate in accordance with the Reportable Incident Protocol .The policy/procedure reflected events of injuries of unknown origin would be identified and thoroughly investigated. 32581

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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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32581 Based on interview and record review, the facility failed to within 14 days after a facility completed a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS system for two (Residents #24 and #48) of eight residents reviewed for resident assessments. The facility failed to ensure Residents #24 and #48's Admission, Quarterly and Annual MDS assessments was transmitted within 14 days after their MDS Assessments were completed. The MDS Assessments were not completed and submitted timely and accurately on 07/16/23, 10/17/23, 11/01/23, 11/16/23, 02/16/24 and 03/15/24. This failure could place residents at risk of not getting appropriate care and services at the facility if CMS was unable to track the location and condition of the residents, which could cause a loss of their healthcare benefits and lead to increased room and board fees and discharge notices, resulting in distress and decline in their psycho-social well-being. The findings included: A) Record review of Resident #24's Quarterly MDS assessment dated [DATE] by MDS Coordinators B and D revealed a [AGE] year-old female who admitted [DATE] with a BIMS Score of 01 (Severe cognitive impairment). She used a wheelchair, substantial assistance needed with Shower/bathe, upper and lower body dressing and putting taking off foot ware. She needed partial/moderate assist to sit/stand and chair/bed transfer, toilet transfer, tub/shower transfer and always incontinent of bowel and bladder. She had medically complex conditions. Record review of Resident #24 's CMS Submission Report/MDS 3.0 NH Final Validation (Simple LTC) report revealed an ARD target date of 03/15/24 accepted with a Warning: completed late: and OBRA assess (comprehensive or quarterly) is due every quarter unless the resident is no longer in the facility. A prior record with no ARD (2300) within 92 days of the submitted record could not be found. Record review of Resident #24 's CMS Submission Report/MDS 3.0 NH Final Validation (Simple LTC) Report revealed an ARD target date of 11/01/23 accepted with a Warnings: Assessment completed late . Resident information mismatched .Payment reduction warning .incorrect RUG/PDPM version .care plan completed late. B) Record review of Resident #48's Quarterly MDS assessment dated [DATE] by MDS Coordinators B and D revealed a [AGE] year-old male who admitted [DATE] with a BIMS Score of 12 (No cognitive impairment). He used a wheelchair, needed partial/moderate assistance with shower/bathe and upper body dressing and substantial/maximal assistance with sit to stand and tub/shower transfers. He had medically complex conditions. Record Review of Resident #48 's CMS Submission Report/MDS 3.0 NH Final Validation (Simple LTC) Report revealed an ARD target date 02/16/24 was accepted with Warnings: Records submitted late . Resident information mismatch .Assessment completed late. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of Resident #48 's CMS Submission Report/MDS 3.0 NH Final Validation (Simple LTC) Report revealed an ARD target date 11/16/23 was accepted with Warnings: Incorrect RUG/PDPM value . incorrect RUG/PDPM version .assessment completed late. Record Review of Resident #48 's CMS Submission Report/MDS 3.0 NH Final Validation (Simple LTC) Report an ARD target date 10/17/23 was accepted with warnings: Invalid ICD (international classification of diseases) Code .Resident information mismatch .Assessment completed late. Record Review of Resident #48 's CMS Submission Report/MDS 3.0 NH Final Validation (Simple LTC) Report an ARD target date 07/16/23 was accepted with a Warning: Assessment completed late: An OBRA comprehensive assessment with the care area assessment is due every year unless the resident is no longer in the facility. A prior record with an ARD within 366 days of the submitted record could not be found. Interview on 03/20/24 at 11:44 am, MDS Coordinator D stated there were no issues with submitting the MDS Assessments in a timely manner. She stated MDS Assessments were due every 90 days and when residents had a hospital visit and when they returned. She stated Residents #24 and #48's MDS Assessments were all submitted within 14 days. She stated in the Medicaid Simple LTC portal was where they found out if an MDS Assessment was rejected or had warnings and to her knowledge their MDS Assessment had no issues. She stated since the new MDS forms came out in October 2023 they have had a lot of changes and they were not able to get the errors resolved for some of the residents. She stated she would get with her Regional Corporate RN to help her figure out why Resident #24 and #48 MDS Assessments did not transmit right, or they would just have to redo them. Interview on 03/20/24 at 12:02 pm, MDS Coordinator B stated Residents #24 and #48 had no late MDS Assessments, rejections, or warnings of which she was aware. Interview on 03/21/24 at 1:44 pm, MDS Coordinator D stated after reviewing the Medicaid Simple LTC portal, Residents #24 and #48's MDS Assessments had a lot of transmission issues, but it was hard to tell which residents had issues. She stated she was not able to track transmission errors but once she checked Medicaid Simple LTC she was able to get the validation results of the transmissions. She stated Residents #24 and #48's MDS Assessments just got lost in the mix and added she needed to check and re-check the validation results to make sure the transmissions went through. She stated Corporate RN planned to do the monitoring of their submissions and transmissions daily and they were currently doing audits of other resident's MDS Assessments and would continue to do to prevent this from happening again. She stated the resident's payments may be affected if MDS Assessments were not submitted on time or with errors. She stated she was responsible for ensuring the MDS Assessments were submitted timely and accurately. Interview on 03/21/24 at 1:55 pm, MDS Coordinator B stated, after review of the Medicaid Simple LTC portal she saw where they had a lot of warnings in 10/2023 because of MDS updates. She stated when she saw validation issues, she informed RN Corporate MDS so that the MDS could be opened and re-submitted. She stated she submitted MDS Assessments mostly in the evening and the next morning checked the transmittal status of them. She stated she did not know the MDS Assessment were transmitted late but said going forward she would do the Medicare Resident Assessments and Corporate RN would do the MDS transmissions. She stated she, MDS Coordinator D and RN Corporate MDS were responsible for ensuring the MDS Assessments were submitted timely and accurately. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/21/24 at 6:11 pm, the Administrator stated they had problems submitting the MDS Assessments last year and by looking in Medicaid Simple LTC (long-term care) for gaps in payments, and validation reports. She stated not being aware of the coding errors of their MDS Assessments. She stated she, MDS and RN Corporate were responsible for ensuring the MDS Assessments were competed on time. She stated MDS coding errors typically affected the resident's payments. She stated she thought the transmission issues had been resolved and today 03/21/24 she requested an audit to be completed for all residents because of the warning errors and late submissions of Residents #24 and #48's MDS Assessments. Record Review of the Facility's MDS Error Correction policy revised September 2010 revealed, Policy Statement: The assessment coordinator and/or interdisciplinary assessment team will follow the established processes for making correction to the MDS. Policy interpretation and implementation: 4. If an error is discovered after the encoding and editing period and the record in error is an entry, discharge, or PPS assessment, then correct the record an submit to the QIES ASAP system. 6. If an error is discovered in the record that has already been accepted by QIES ASAP system, implement procedures for either modification or inactivation of the information in the system within 14 days of the discovery of the error .7. Modification requests are used when information in the record contains clinical or demographic errors Record review of the Facility's MDS Assessment Coordinator job description revised November 2019 revealed, Policy Statement: a registered nurse (RN) shall be responsible for conducting and coordinating the development and completion of the resident assessment (MDS). Policy interpretation and implementation: 1. A Registered nurse (RN) shall be designated the responsibility of conducting each resident's assessment (MDS). 2. The resident assessment coordinator must date and sign each assessment (MDS) to certify that the assessment is completed. 3. Each individual who completes a portion of the assessment (MDS) must certify the accuracy of that portion of the assessment by: a. dating and signing the assessment (MDS); and b. identifying each section completed . Record review of CMS Minimum Data Set Error message Reference Guide dated January 3, 2024, revealed, 4. File processing error messages for MDS Data: The MDS 3.0 Final Validation Report is automatically generated within 24 hours of successful submission of a file. A file may include one or more records. The report details the errors, if any, in the submitted records within the file. Go to the Reports section in iQUIES to view this report .all error warnings should be reviewed and corrected if appropriate, to ensure the data uploaded is accurate and complete .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46486 Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs for one (Resident #76) of six residents reviewed for care plans. The facility failed to develop a comprehensive person-centered care plan on 03/04/2024 to address Resident #76's need for assistance with Activities of daily living needs due to fracture. This failure could place residents at risk for not receiving the necessary care or receiving inappropriate care for their condition and diagnosis. Findings included: Review of Resident #76's MDS assessment dated [DATE], reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included fracture of the upper and lower end of right tibia and fibula. Review of Resident #76's Baseline Care Plan dated 02/05/24, reflected the resident had a fall related to fracture. Interventions included low bed, one person assist and therapy three days a week. An observation and interview on 03/19/24 at 11:02 AM revealed Resident d#76 sitting in wheelchair, watching tv and writing in a composition notebook. Bed was low. The resident was alert and able to answer questions. An interview on 03/21/24 at 12:45 AM with LVN C revealed Resident #76 received therapy for her right leg. Only one person assist for transfer, but able to do daily living activities on her own. Interview on 03/20/24 at 2:00 pm with MDS Coordinator B revealed she was responsible for doing the comprehensive care plans. She stated all the care plans are in the electronic medical recor d and if they were not there then they were not trigger. She tried to pulled Resident #76 care plan up on the system and stated it was not there and that she would trigger it manually and bring me a copy. She stated there should be a care plan for all medical diagnosis and specialized medications so that the residents can be properly monitored and to ensure that the care plans were person centered. She stated if there were missing care plans that the potential harm to the residents could be missing interventions to protect the residents. She was unsure why Resident #76 care plan did not trigger. Interview on 10/12/23 at 04:13 pm with the Administrator revealed the care plan had not been triggered had been brought to her attention today, the MDS nurse will verify no other care plan was needed to be manually triggered. She stated her expectation was that the care plans are completed on time and accurately. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facilities policy titled Care Plans, Comprehensive Person-Centered revealed a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the residents physical, psychosocial, and functional needs is developed and implemented for each resident.

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	03/21/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32581 Based on interviews, and record reviews, in accordance with accepted professional standards and practices, the facility failed to maintain medical records on each resident that were complete and accurately documented for one (Residents #189) of eight residents reviewed for Medical Records. The facility failed to ensure all of Resident #189's MDS Assessments dated 10/18/23 and 01/29/24 were coded accurately, that she was a female. The facility failed to ensure Resident #189's face sheet identified her as a female. These failures could affect residents by placing them at risk of not getting appropriate care and services due to the possible denial of payment for inhouse and outside services. And could get inaccurately prescribed medication dosages, out of range laboratory reports and increased chance of addressing the resident by the wrong gender, resulting in a decline in the resident's health, self-esteem, and psycho-social well-being. Findings included: Record Review of Resident #189's Face Sheet revealed she was a male. Record review of Resident #189's Admission MDS assessment dated [DATE] by MDS Coordinator B revealed an [AGE] year-old male who admitted [DATE] with a BIMS score 15 (No cognitive impairment) partial to moderate assist with most ADL care. He used a wheelchair with other orthopedic conditions, and diagnoses Atrial Fibrillation, Deep Vein Thrombosis, HTN (high blood pressure), DM II (diabetes II), hyperlipidemia (high fat lipids in blood), Thyroid disorder (hormone irregularity), other fracture (broken bone), and anxiety. Record review of Resident #189's Modified MDS assessment dated [DATE] and signed on 03/20/24 by Corporate RN and MDS Coordinator B revealed Resident #189's record was coded to female. Record review of Resident #189's Hospital Discharge Report dated 10/16/23 resident was an [AGE] year-old female. Interview on 03/20/24 at 5:02 pm, the Administrator stated Resident #189 was a female resident that she knew of and would have to go and check with the BOM and Admissions Director. She stated they needed to ensure the resident's medical information was accurate. She stated the face sheet automatically populated the resident's gender onto the MDS Assessments. She stated she reviewed Resident #189's MDS Assessments and Face sheet had her listed as a male. Interview on 03/20/23 at 5:40 pm, the Administrator stated Resident #189's face sheet and MDS Assessments stating she was a male was wrong. She stated the resident's demographic information was received from the hospital system and added she was in the process of correcting the issue. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/21/24 at 1:55 pm, MDS Coordinator B stated Resident #189 was a female but her demographics on her face sheet showed she was a male. She stated she needed to make sure she went and looked at the resident and checked what their gender was for herself. She stated it was missed but now that they know they submitted a modification on all of Resident #189's MDS Assessments and her face sheet. She stated not being sure why she did not notice male was on her face Sheet and MDS Assessments. She stated the BOM and Admissions Director needed to also make sure the demographics were accurate and stated if she came across any inconsistencies, she would let the BOM and Admission Director aware to change it. She stated the Admissions Director, BOM and herself were responsible for ensuring the records were accurate and would be closely monitoring the accuracy of the residents' records. She stated going forward they were currently checking the other residents' records for accuracy. She stated having incorrect gender info could cause a dignity issue if someone thought a female resident was a male and greeted her as Mr . Interview of 03/21/24 at 6:11 pm, the Administrator stated she just found out yesterday (03/20/24) about Resident #189's inaccurate medical records from the HHSC Surveyor. She stated the Admissions Director first verified the resident's demographics with the hospital staff, then the BOM checked the demographics to ensure accuracy. She stated the nurses were to also check for errors and added she was not sure if the typo was from the Admissions Director or someone from corporate also did pre admits and sent the resident's information to them at times. She stated they also received resident's medical information from a hospital-based medical records system and added the Admissions Director received the medical information to ensure the medical records were accurate. She stated ultimately the Medical Records Director was responsible for ensuring the resident's records were accurate. Record Review of the Facility's MDS Error Correction policy revised September 2010 revealed, Policy Statement: The assessment coordinator and/or interdisciplinary assessment team will follow the established processes for making correction to the MDS. Policy interpretation and implementation: .7. Modification requests are used when information in the record contains clinical or demographic errors Record review of the facility's Content of Medical Record policy revised January 2020 revealed, Policy: It is the policy of the facility to maintain clinical records on each patient in accordance with accepted professional health information management standards and practices .Responsibility: Medical Records Technician . Procedures: 2. h. Patient's date of birth, age, sex, race, nationality, and religion .