STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675141	A. BUILDING _____ B. WING _____	03/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CRESTVIEW HEALTHCARE RESIDENCE	1400 LAKE SHORE DR WACO, TX 76708

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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 5 of 5 residents reviewed for personal hygiene, in that: A) Staff failed to get Resident #70 out of bed. B) Staff failed to provide showers as scheduled to maintain personal hygiene for Residents #70, 54, 10, 17 and 36. These failures placesd residents at risk of diminished self-worth and diminished quality of life. The findings include: A. Review of Resident # 70's Face Sheet, dated 3/3/20, revealed a [AGE] year-old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #70's MDS dated [DATE] revealed a BIMS score of 15, indicating she does not have a cognitive deficit. Resident #70's MDS also indicated she required extensive assistance of two staff for bed mobility, dressing, toilet use and personal hygiene. For bathing the MDS notes total dependence. Review of Resident #70's Care Plan revealed a problem identified on [DATE] of, the resident has an ADL self-care performance deficit related to [MEDICAL CONDITION]. Interventions include: Two staff for repositioning and turning in bed, total dependence on staff for toilet use, dressing, transfers and bathing. Observations on 3/2/20, 3/3/20 and 3/4/20 at multiple various times revealed Resident #70 remained in her room in bed. In an interview on 3/2/20 at 11:56 a.m. Resident #70 stated she rarely gets out of bed. Resident #70 stated she would like to get up and she thinks there is a doctor's order to get up daily, but she doesn't ask them because she knows it's a lot of work for them to get her up. In an interview on 3/4/20 at 12:00 p.m. CNA-D stated she is currently working Resident #70's hall. When asked if Resident #70 gets out of bed, CNA-D stated Resident #70 hasn't asked to get up. She stated they don't ask her to get up but there is a chair for her to get up in, she just doesn't know where it is. In an interview on 3/4/20 at 12:08 p.m. CNA-C stated she worked with Resident #70 during the first part of her shift. She stated she did not ask her if she wanted to get up because there is not a wheelchair available for her to sit in. In an interview on 03/04/20 at 05:07 p.m. Administrator stated they got Resident #70 up last week. The Administrator reported it takes a lot of people to get her up. She bought an extra wide geri chair that Resident #70 and another bariatric resident can share. The facility has a lift that will lift up to 600 pounds, when Resident #70 went to the hospital recently we found out she weighs just under 500 pounds. The Administrator stated she told staff there is no reason why we shouldn't be getting her up. B. Review of Resident # 70's Face Sheet, dated 3/3/20, revealed a [AGE] year-old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #70's MDS dated [DATE] revealed a BIMS score of 15, indicating she does not have a cognitive deficit. Resident #70's MDS also indicates she requires extensive assistance of 2 staff for bed mobility, dressing, toilet use and personal hygiene. For bathing the MDS notes total dependence. Review of Resident #70's Care Plan revealed a problem identified on [DATE] of, the resident has an ADL self-care performance deficit related to [MEDICAL CONDITION]. Interventions include: Two staff for repositioning and turning in bed, total dependence on staff for toilet use, dressing, transfers and bathing. In an interview on 3/4/20 at 12:05 p.m. Resident #70 stated she rarely gets a bed bath or a shower. She stated she usually doesn't ask but when she does most of the time they tell her there is not enough staff. She stated her scheduled time is during the 2-10 shift, her roommate doesn't have the same problem because her time is on the 6-2 shift when they have more staff. Review of Resident #70's Shower Documentation from 2/4/20 through 3/4/20 reflected he was given a shower on 2/6, 2/15, 2/23, 2/27 and 3/4. No refusals are documented. Review of the facility Shower Schedule revealed Resident #70 was scheduled to get showers on Tuesdays, Thursdays and Saturdays from the 2-10 shift. Showers for the dates reviewed (2/4- 3/4) should have occurred on 2/6, 2/8, 2/11, 2/13, 2/15, 2/18, 2/22, 2/25, 2/27, 2/29 and 3/3. In an interview on 3/4/20 at 12:16 p.m. and 2:00 p.m. DON stated they have only given one shower to Resident #70, that she was refusing showers. The DON stated Resident #70 finally agreed when she (DON) told her the doctor had ordered a shower. Resident #70 agreed and told them this was her first shower in 3 years. The DON stated Resident #70 really enjoyed it and did not want to get out of the shower. Review of Resident # 54's Face Sheet, dated 3/3/20, reflected a [AGE] year-old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #54's MDS dated [DATE] revealed a BIMS score of 15, indicating she does not have a cognitive deficit. Resident #54's MDS also indicates she requires extensive assistance of 2 staff for dressing, toilet use and personal hygiene. For bathing and transfers the MDS notes total dependence. Review of Resident #54's Care Plan revealed a problem identified on 3/3/15 of, the resident has an ADL self-care performance deficit related to stroke, BLE amputation, limited mobility, impaired balance, Impaired coordination and [MEDICAL CONDITION]/[MEDICAL CONDITION]. Interventions include: Hoyer (mechanical) lift for transfers with assist x two, resident is dependent on staff x two for repositioning and turning in bed and resident requires staff x two for participation with showering. In an interview on 03/02/20 at 9:04 a.m. Resident #54 stated she hasn't had a bed bath or shower in over 2 weeks. She stated she is scheduled for the evenings but when she asks the staff they say there is not enough staff to give her a shower. Resident #54 stated at times like last Thursday there was only one staff. She stated she feels horrible and dirty. Review of Resident #54's Shower Documentation from 2/4/20 through 3/4/20 she was given a shower on 2/4, 2/8, 2/19, 2/21 and 2/25. No refusals are documented. Review of the facility Shower Schedule revealed Resident #54 was scheduled to get showers on Tuesdays, Thursdays and Saturdays from the 2-10 shift. Showers for the dates reviewed (2/4- 3/4) should have occurred on 2/6, 2/8, 2/11, 2/13, 2/15, 2/18, 2/22, 2/25, 2/27, 2/29 and 3/3. Review of Resident #10's Face Sheet, dated 3/3/20, reflected an [AGE] year-old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #10's MDS dated [DATE] revealed a BIMS score of 15, indicating she does not have a cognitive deficit. Resident #10's MDS also indicates she requires extensive assistance of one staff for dressing, bed mobility and personal hygiene. For bathing the MDS notes total dependence. Review of Resident #10's Care Plan revealed a problem identified on 3/3/15 of, the resident has an ADL self-care performance deficit related to limited mobility, limited ROM, Musculoskeletal impairment. The goal is to maintain a sense of dignity by being clean, dry, odor free and well groomed. Interventions include: Provide shower, shave, oral care, hair care and nail care per schedule and when needed. In an interview on 3/2/20 at 9:35 a.m. Resident #10 stated staff haven't been offering her a shower and she has missed the last 3-4 she was supposed to get. She stated it makes her feel bad to not be clean. Review of Resident #10's Shower Documentation from 2/4/20 through 3/4/20 she was given a shower on 2/6, 2/15, 2/19, 2/21, 2/25 and 2/26. No refusals are documented. Review of the facility Shower Schedule reflected Resident #10 was scheduled to get showers on Monday, Wednesday and Friday from the 2-10 shift. Showers for the dates reviewed (2/4- 3/4) should have occurred on 2/5, 2/7, 2/10, 2/12, 2/14, 2/17, 2/19, 2/21, 2/24, 2/26, 2/28 and 3/2. Review of Resident # 17's Face Sheet, dated 3/3/20, reflected an [AGE] year-old male admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #17's MDS dated [DATE] revealed a BIMS score of 10, indicating a moderate cognitive deficit. Resident #10's MDS also indicates he requires extensive assistance of two staff for dressing, bed

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

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.

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CRESTVIEW HEALTHCARE RESIDENCE	1400 LAKE SHORE DR WACO, TX 76708

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F 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) mobility and personal hygiene. For bathing the MDS notes total dependence. Review of Resident #17's Care Plan revealed a problem identified on 5/1[DATE]9 of, the resident has an ADL self-care performance deficit related to [MEDICAL CONDITION]/[MEDICAL CONDITION], confusion, impaired balance and muscle weakness. The goal is to maintain a sense of dignity by being clean, dry, odor free and well groomed. Interventions include: Provide shower, shave, oral care, hair care and nail care per schedule and when needed. Observation on 3/3/20 at 9:13 a.m. of Resident #17 revealed his skin has white flaky areas (he's African American) that appear to be dry dead skin. His fingernails are noted to have a black substance underneath them. Resident #17's bed was noted to be filled with food crumbs from his shoulder to his buttock area and on top of his chest. Review of Resident #17's Shower Documentation from 2/4/20 through 3/4/20 he was given a shower on 2/6, 2/15, 2/21, 2/25 and 2/26. No refusals are documented. Review of the facility Shower Schedule reflected Resident #17 was scheduled to get showers on Monday, Wednesday and Friday from the 2-10 shift. Showers for the dates reviewed (2/4- 3/4) should have occurred on 2/5, 2/7, 2/10, 2/12, 2/14, 2/17, 2/19, 2/21, 2/24, 2/26, 2/28 and 3/2. Review of Resident # 36's Face Sheet, dated 3/3/20, reflected a [AGE] year-old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #36's MDS dated [DATE] revealed a BIMS score of 13, indicating a slight cognitive deficit. Resident #36's MDS also indicates she requires extensive assistance of 2 staff for dressing, bed mobility and personal hygiene. For bathing and transfers the MDS notes total dependence. Review of Resident #36's Care Plan revealed a problem identified on 10/17/19 of ADL's, goal is to maintain a sense of dignity by being clean, dry, odor free and well groomed. Interventions include: Encourage independence, praise when attempts re made Set-up, assist, give shower, shave, oral, hair, nail care per schedule and prn . Review of Resident #36's Shower Documentation from 2/4/20 through 3/4/20 she was given a shower on 2/5, 2/6, 2/15, 2/16, 2/21, 2/22, 2/29 and 3/1. No refusals are documented. Review of the facility Shower Schedule reflected Resident #36 was scheduled to get showers on Monday, Wednesday and Friday from the 2-10 shift. Showers for the dates reviewed (2/4- 3/4) should have occurred on 2/5, 2/7, 2/10, 2/12, 2/14, 2/17, 2/19, 2/21, 2/24, 2/26, 2/28 and 3/2. In an interview on 3/4/20 at 12:16 p.m. and 2:00 p.m. DON stated they had recognized there is a problem with showers being given to the residents. She stated it was because of staffing issues, that they've been having a hard time being fully staffed but it is getting better. In an interview on 03/04/20 at 5:07 p.m. Administrator stated she was aware there was a problem with showers getting completed. She stated they have been working on ensuring residents are getting showers. Review of the facility Admission Kit, undated, pg 5, Statement of Resident Rights, includes the following: You have a right to: 1. All care necessary for you to have the highest possible level of health; 2. Safe, decent and clean conditions
F 0582 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide a SNFABN for one of three residents reviewed (Resident #57) who received Medicare skilled services but was discharged prior to using all the skilled days. Resident #57 was not given a SNFABN when she was discharged from skilled services. This deficient practice could place residents who receive skilled services at risk for being discharged prior to using up all their benefits and at risk for denial of their right to be fully informed about services covered by Medicare. Findings include: Review of Resident #57's face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. Record review of the SNF Beneficiary Protection Notification Review form completed by the MDS Coordinator, undated, revealed Resident #57 was admitted to Medicare skilled services on 11/04/2019 and was discharged from skilled services to long term care at the facility on 01/30/2020, prior to exhausting her benefits. In an interview on [DATE] at 3:23 p.m. the BOM stated the MDS nurses are responsible for issuing the NOMNC and they keep a copy. She stated she is not familiar with the ABN form. She stated the MDS nurses will be the best to ask because she has not done ABNs before. In an interview on [DATE] at 3:28 p.m. MDS 1 stated the MDS nurses give the NOMNC within 48 hours prior to the resident being discharge from skilled services. She stated the ABN form is also given along with the NOMNC. She stated if there are remaining days on the Part A services, she will not complete the ABN. She stated if the Part A services stop and the family wants to appeal then the ABN will be completed. She stated in the case of Resident #57, the ABN should have been given to the resident and family because it gives them options. It was not signed so it was not given. In an interview on [DATE] at 3:43 p.m. MDS 2 stated Resident #57 still had days available when she came off Part A and went on Part B services. She stated we didn't talk to the daughter regarding the ABN because of the Part A. She stated Resident #57 needed an ABN. Review of facility's policy titled Notice of Medicare Non-Coverage/Skilled Nursing Facility Advanced Beneficiary Notice updated January 2020 reflected: To ensure that a resident's right to control health care decisions upheld to the greatest extent possible in compliance with all applicable regulations. It is the policy of Concord Healthcare in accordance with Medicare guidelines that a resident/representative will be informed when the Medicare will no longer pay for covered skilled services within the facility.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents unable to carry out activities of daily living (ADLs) receive the necessary services to maintain personal hygiene for 5 of 26 residents reviewed for ADLs. (Residents #70, 54, 10, 17 and 36) The facility staff did not provide showers as scheduled to Residents #70, 54, 10, 17 and 36. This failure could place residents who were incontinent of urine and bowel at risk for odors, decreased self-esteem, skin breakdown and decreased quality of life. Findings Included: Review of Resident # 70's Face Sheet, dated 3/3/20, reflected a [AGE] year-old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #70's MDS dated [DATE] revealed a BIMS score of 15, indicating she does not have a cognitive deficit. Resident #70's MDS also indicates she requires extensive assistance of 2 staff for bed mobility, dressing, toilet use and personal hygiene. For bathing the MDS notes total dependence. Review of Resident #70's Care Plan revealed a problem identified on [DATE] of, the resident has an ADL self-care performance deficit related to [MEDICAL CONDITION]. Interventions include: Two staff for repositioning and turning in bed, total dependence on staff for toilet use, dressing, transfers and bathing. In an interview on 3/4/20 at 12:05 p.m. Resident #70 stated she rarely gets a bed bath or a shower. She stated she usually doesn't ask but when she does most of the time they tell her there is not enough staff. She stated her scheduled time is during the 2-10 shift, her roommate doesn't have the same problem because her time is on the 6-2 shift when they have more staff. Review of Resident #70's Shower Documentation from 2/4/20 through 3/4/20 he was given a shower on 2/6, 2/15, 2/23, 2/27 and 3/4. No refusals are documented. Review of the facility Shower Schedule reflected Resident #70 was scheduled to get showers on Tuesdays, Thursdays and Saturdays from the 2-10 shift. Showers for the dates reviewed (2/4- 3/4) should have occurred on 2/6, 2/8, 2/11, 2/13, 2/15, 2/18, 2/22, 2/25, 2/27, 2/29 and 3/3. In an interview on 3/4/20 at 12:16 p.m. and 2:00 p.m. DON stated they have only given one shower to Resident #70, that she was refusing showers. The DON stated Resident #70 finally agreed when she (DON) told her the doctor had ordered a shower. Resident #70 agreed and told them this was her first shower in 3 years. The DON stated Resident #70 really enjoyed it and did not want to get out of the shower. Review of Resident # 54's Face Sheet, dated 3/3/20, reflected a [AGE] year-old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #54's MDS dated [DATE] revealed a BIMS score of 15, indicating she does not have a cognitive deficit. Resident #54's MDS also indicates she requires extensive assistance of 2 staff for dressing, toilet use and personal hygiene. For bathing and transfers the MDS notes total dependence. Review of Resident #54's Care Plan revealed a problem identified on 3/3/15 of, the resident has an ADL self-care performance deficit related to stroke, BLE amputation, limited mobility, impaired balance, Impaired coordination and [MEDICAL CONDITION]/[MEDICAL CONDITION]. Interventions include: Hoyer (mechanical) lift for transfers with assist x two, resident is dependent on staff x two for repositioning and turning in bed and resident requires staff x two for participation with showering. In an interview on 03/02/20 at 9:04 a.m. Resident #54 stated she hasn't had a bed bath or shower in over 2 weeks. She stated she is scheduled for the evenings but when she asks the staff they say that there is not enough staff to give her a shower. Resident #54 stated at times like last Thursday there was only one staff. She stated she feels horrible and dirty. Review of Resident #54's Shower Documentation from 2/4/20 through 3/4/20 she was given a shower on 2/4, 2/8, 2/19, 2/21 and 2/25. No refusals

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) are documented. Review of the facility Shower Schedule reflected Resident #54 was scheduled to get showers on Tuesdays, Thursdays and Saturdays from the 2-10 shift. Showers for the dates reviewed (2/4- 3/4) should have occurred on 2/6, 2/8, 2/11, 2/13, 2/15, 2/18, 2/22, 2/25, 2/27, 2/29 and 3/3. Review of Resident # 10's Face Sheet, dated 3/3/20, reflected an [AGE] year-old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #10's MDS dated [DATE] revealed a BIMS score of 15, indicating she does not have a cognitive deficit. Resident #10's MDS also indicates she requires extensive assistance of one staff for dressing, bed mobility and personal hygiene. For bathing the MDS notes total dependence. Review of Resident #10's Care Plan revealed a problem identified on 3/3/15 of, the resident has an ADL self-care performance deficit related to limited mobility, limited ROM, Musculoskeletal impairment. The goal is to maintain a sense of dignity by being clean, dry, odor free and well groomed. Interventions include: Provide shower, shave, oral care, hair care and nail care per schedule and when needed. In an interview on 3/2/20 at 9:35 a.m. Resident #10 stated staff haven't been offering her a shower and she has missed the last 3-4 she was supposed to get. She stated it makes her feel bad to not be clean. Review of Resident #10's Shower Documentation from 2/4/20 through 3/4/20 she was given a shower on 2/6, 2/15, 2/19, 2/21, 2/25 and 2/26. No refusals are documented. Review of the facility Shower Schedule reflected Resident #10 was scheduled to get showers on Monday, Wednesday and Friday from the 2-10 shift. Showers for the dates reviewed (2/4- 3/4) should have occurred on 2/5, 2/7, 2/10, 2/12, 2/14, 2/17, 2/19, 2/21, 2/24, 2/26, 2/28 and 3/2. Review of Resident # 17's Face Sheet, dated 3/3/20, reflected an [AGE] year-old male admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #17's MDS dated [DATE] revealed a BIMS score of 10, indicating a moderate cognitive deficit. Resident #10's MDS also indicates he requires extensive assistance of two staff for dressing, bed mobility and personal hygiene. For bathing the MDS notes total dependence. Review of Resident #17's Care Plan revealed a problem identified on 5/1[DATE]9 of, the resident has an ADL self-care performance deficit related to [MEDICAL CONDITION]/[MEDICAL CONDITION], confusion, impaired balance and muscle weakness. The goal is to maintain a sense of dignity by being clean, dry, odor free and well groomed. Interventions include: Provide shower, shave, oral care, hair care and nail care per schedule and when needed. Observation on 3/3/20 at 9:13 a.m. of Resident #17 revealed his skin had white flaky areas (he's African American) that appear to be dry dead skin. His fingernails were noted to have a black substance underneath them. Resident #17's bed was noted to be filled with food crumbs from his shoulder to his buttock area and on top of his chest. Review of Resident #17's Shower Documentation from 2/4/20 through 3/4/20 he was given a shower on 2/6, 2/15, 2/21, 2/25 and 2/26. No refusals are documented. Review of the facility Shower Schedule reflected Resident #17 was scheduled to get showers on Monday, Wednesday and Friday from the 2-10 shift. Showers for the dates reviewed (2/4- 3/4) should have occurred on 2/5, 2/7, 2/10, 2/12, 2/14, 2/17, 2/19, 2/21, 2/24, 2/26, 2/28 and 3/2. Review of Resident # 36's Face Sheet, dated 3/3/20, reflected a [AGE] year-old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #36's MDS dated [DATE] revealed a BIMS score of 13, indicating a slight cognitive deficit. Resident #36's MDS also indicates she requires extensive assistance of 2 staff for dressing, bed mobility and personal hygiene. For bathing and transfers the MDS notes total dependence. Review of Resident #36's Care Plan revealed a problem identified on 10/17/19 of ADL's, goal is to maintain a sense of dignity by being clean, dry, odor free and well groomed. Interventions include: Encourage independence, praise when attempts made Set-up, assist, give shower, shave, oral, hair, nail care per schedule and prn. Review of Resident #36's Shower Documentation from 2/4/20 through 3/4/20 she was given a shower on 2/5, 2/6, 2/15, 2/16, 2/21, 2/22, 2/29 and 3/1. No refusals are documented. Review of the facility Shower Schedule reflected Resident #36 was scheduled to get showers on Monday, Wednesday and Friday from the 2-10 shift. Showers for the dates reviewed (2/4- 3/4) should have occurred on 2/5, 2/7, 2/10, 2/12, 2/14, 2/17, 2/19, 2/21, 2/24, 2/26, 2/28 and 3/2. In an interview on 3/4/20 at 12:16 p.m. and 2:00 p.m. DON stated they had recognized there is a problem with showers being given to the residents. She stated it was because of staffing issues, that they've been having a hard time being fully staffed but it is getting better. In an interview on 03/04/20 at 5:07 p.m. Administrator stated she was aware there was a problem with showers getting completed. She stated they have been working on ensuring residents are getting showers. Review of the facility Admission Kit, undated, pg 32, Items and Services Included in the Basic Rate for Medicare Residents, includes the following: assistance in personal care and grooming .
F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to assure that all nursing staff possess the competencies and skill sets necessary to provide nursing and related services to meet the residents' needs safely and, in a manner, that promotes each resident's rights, physical, mental and psychosocial well-being for 1 of 5 residents (Residents #7) reviewed for nursing services. RN C failed to assess resident for pain or discomfort after the resident was observed on the floor. This failure could place residents residing in the facility at risk for receiving improper care that could lead to a decline in the overall health and psychosocial wellbeing of each resident. Findings include: Review of Resident #7's medical record reflected an [AGE] year old widowed female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of MDS dated [DATE] reflected a BIMS of 00 showing resident has severe cognitive impairment. Review of resident #7's current care plan dated [DATE] reflected, resident #7 has impaired cognitive function or impaired thought processes related to [DIAGNOSES REDACTED]. Observation on 3/2/20 at 8:05 a.m. revealed Resident #7 sitting on the floor in her room beside her bed. Upon entering the room, Resident #7 raised her hands up to the surveyor for help. Resident #7 stated, help me. CNA A was walking in the hallway and was alerted. Observation at 8:07 a.m. revealed three facility staff (CNA A, CNA B & RN C) rushed into the room. Staff asked resident what happened and if she was ok. Resident #7 stated she was cleaning the floor with her hands. RN C instructed CNA A & B to assist Resident #7 off the floor to her bed. Observation did not revealed RN C to assess the resident for pain or discomfort before moving resident to her bed. Interview on 3/2/20 at 8:20 a.m. CNA A and CNA B stated they were following instructions from the RN C. Interview with RN C on 3/2/20 at 8:50 a.m. stated Resident # 7 said she did not fall; that she was picking her food off the floor. RN C also stated, if resident # 7 had said she fell then RN would have checked her vital signs and told somebody. Interview on 3/4/20 at 4:47 p.m. DON stated nurses should assess any resident found on the floor to make sure nothing is broken and initiate neuro-checks if not witnessed. Review of current facility fall policy (undated) reflected: 5. once a resident has a fall here at the facility, the following must be done: - The nursing supervisor is called to assess the resident and circumstances surrounding the fall. - An incident report is generated by the charge nurse - An incident investigation sheet is started immediately - Statements from witnesses are obtained. If it is unwitnessed, the care providers must give a statement indicating the last time they saw the resident and what the resident was engaged in at that time. - All falls not witnessed by the nurse, must have a neuro- check initiated immediately. A new fall assessment must be completed. A pain evaluation must be done. An entry is placed on the 24 hour report sheet for adequate follow-up. Documentation is done for 9 shifts.
F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** Based on interview and record review, the facility failed to ensure the drug regimen of each resident was reviewed at least once monthly by a licensed pharmacist. Residents medications were not reviewed by a licensed pharmacist from September 2019 to January 2020. This failure placed residents at increased risk of adverse drug consequences and decline in their physical and mental health status. Findings include: Review of Pharmacy Consultant reports did not reflect recommendations from September 2019 through December 2019. In an interview on [DATE] at 2:29 p.m., ADON stated until December 2019 the previous pharmacist was only conducting drug destruction and did not review residents' medications or provide recommendations. In an interview on [DATE] at 9:56 a.m., Administrator stated after they took the building over, in November of 2019, they realized in December of 2019 that the residents had not had their medications reviewed since September of 2019. Administrator stated this is when they brought a pharmacist in to begin the medication reviews. In an interview on [DATE] at 5:10 p.m., Administrator stated the pharmacist will be conducting medication reviews at least monthly moving forward. Review of facility policy, dated December 2019, titled Consultants reflected our facility uses outside resources to furnish specific services provided by the facility. Our facility may use as needed outside resources to furnish specific services

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	675141	A. BUILDING _____ B. WING _____	03/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CRESTVIEW HEALTHCARE RESIDENCE	1400 LAKE SHORE DR WACO, TX 76708

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

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F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 3) to residents and to the facility. Consultant services maybe utilized in the following areas: Pharmacy.
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to reduce the dose of an antipsychotic drug for one (Resident #23) of twenty-five residents reviewed for medication regime review. - The physician did not review pharmacy recommendations until 25 days after recommendations were made. - The facility administered antipsychotic medication ([MEDICATION NAME]) for 35 days after the physician agreed to the pharmacist recommended dose reduction. This failure could place all residents on psychoactive medication at risks for receiving unnecessary drugs. Findings include: Review of Resident #23's facesheet reflected a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with the [DIAGNOSES REDACTED]. Review of Resident #23's MDS, dated [DATE], reflected resident received a 13 on his BIMS assessment which reflected Resident #23 was cognitively intact. Review of Section I titled Active [DIAGNOSES REDACTED]. Review of Resident #23's care plan, review date of 1[DATE], reflected Resident #23 had a mood problem. Resident #23's care plan reflected he had depression related to disease process of scoliosis and chronic pain. Review of Resident #23's physician orders, dated 6/6/2019, reflected [MEDICATION NAME] Tablet 20 mg to give one tablet by mouth one time a day related to major [MEDICAL CONDITION]. Review of physician order [REDACTED]. Review of pharmacy recommendations dated 1/4/2020 reflected the current orders included [MEDICATION NAME] 20 mg 1T PO QD. Recommendation reflected to attempt to decrease [MEDICATION NAME] to 15 mg PO QD. Review of recommendation reflected the physician acknowledge and in agreement with the recommendation on 1/30/2020. Review of Physician orders [REDACTED]. Observation on [DATE] at 3:13 p.m., conducted with LVN E, revealed medication cart, included medications for Resident #23, revealed [MEDICATION NAME] 20 mg present in the cart. Surveyor did not observe [MEDICATION NAME] 15 mg for Resident #23. In an interview on [DATE] at 3:13 p.m., LVN E stated they receive medications prepackaged from the pharmacy. LVN E stated the [MEDICATION NAME] 20 mg is the only dosage available for Resident #23 at this time. In an interview on [DATE] at 3:29 p.m., ADON stated she discontinued the order for [MEDICATION NAME] 20 mg last night. ADON stated the order for [MEDICATION NAME] 15 mg was ordered on [DATE] and was faxed to the pharmacy; however, does not have a way to confirm if the pharmacy received the new order. ADON stated as far as she knew the order for [MEDICATION NAME] 20 mg was discontinued and the resident was receiving the 15 mg as ordered. In an interview on [DATE] at 4:42 p.m., DON stated it is not reasonable for recommendations to be made on 1/4/2020 and the physician responded on 1/30/2020. DON stated once the pharmacist had their recommendations the facility had 48 hours to have the recommendations followed-up on by the physician. DON stated Resident #23 had never received the [MEDICATION NAME] 15 mg, only the [MEDICATION NAME] 20 mg. Review of facility policy, dated 4/2007, titled Tapering Medications and Gradual Dose Reduction reflected after medications are ordered for a resident, the staff and practitioner shall seeking an appropriate dose and durations for each medication that also minimizes the risk of adverse consequences. All medication shall be considered for possible tapering. Tapering that is applicable to antipsychotic medication shall be referred to as gradual dose reduction. Residents who use antipsychotic drugs shall receive gradual dose reductions and behavioral interventions, unless clinically contraindicated in an effort to discontinue these drugs.
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that the medication error rate was not five percent or greater. The facility had a medication error rate of 7.41%, based on 2 errors out of 27 opportunities, which involved 1 (Resident #23) of 5 residents and 1 (MA A) of 3 staff reviewed for medication error, in that: -MA A administered the wrong dose of the medication [MEDICATION NAME] to Resident #23 according to Physician orders. -MA A failed to administer [MEDICATION NAME] to Resident #23. These failures could place residents who receive medication at risk for less than therapeudic benefits. Findings include: Observations on 3/2/20 from 7:00 a.m. through 7:08 a.m. of a medication pass by MA A revealed she administered 20 mg of [MEDICATION NAME] to Resident #23 in his room. MA A indicated Resident #23 kept his [MEDICATION NAME] on his bedside table. Resident #23 did not use the [MEDICATION NAME] during the observations. MA-A was observed to initial the MAR indicating [MEDICATION NAME] had been given. Review of Resident # 23's Face Sheet, dated 3/3/20, reflected a [AGE] year-old male admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #23's MDS dated [DATE] revealed a BIMS score of 13, indicating a slight cognitive deficit. Review of Resident #23's Care Plan revealed a problem identified on 3/1[DATE]7 of Resident is resistive of care and is at risk for not having needs met in a timely manner. Interventions include: Administer medications as ordered. Monitor/document for side effects and effectiveness. Review of Resident #23's Physician order [REDACTED]. On 6/6/19 an order for [REDACTED]. Review of Resident #23's March MAR revealed on 3/2/20 [MEDICATION NAME] 15 mg was not given and is noted as to see nurses notes as to why not given. [MEDICATION NAME] 20 mg was initialed as having been given and [MEDICATION NAME] 50 mcg was initialed as given. In an interview on 3/2/20 at 7:08 a.m. Resident #23 stated he usually takes his [MEDICATION NAME] in the morning when he wakes up. In an interview on 3/2/20 at 7:10 a.m. MA A stated there were 2 areas for [MEDICATION NAME] for Resident #23 on his MAR. She stated one is for 15 mg which they don't have and the other is for 20 mg which she gave. When asked if both doses are supposed to be given she stated she thought so but it may be a mistake. MA A stated they are waiting on the nurse to get the 15 mg tablets. She stated she is new to the facility but since she's been here Resident #23 keeps his [MEDICATION NAME] at his bedside. She stated she does not observe him taking it that he is able to administer it on his own. Review of MA A's Medication Pass Evaluation dated 2/25/20 noted she successfully passed the evaluation. In an interview on 3/3/20 at 4:05 p.m. DON stated Resident #23 had not been assessed as being able to keep medications in his room. She stated the [MEDICATION NAME] should not be in his room and she was not aware that it was. The DON stated the [MEDICATION NAME] that should be given is 15 mg and whoever wrote the new order for it should have discontinued the 20 mg order. Review of the facility Administering Medications, updated 9/2018 revealed the policy statement is as follows: Medications will be administered in a timely manner and as prescribed by the residents attending physician or the faculties' medical director.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that medications were stored in accordance with established professional standards for one of three medication carts observed during medication pass and for one (Resident #23) of five residents observed during medication pass. A. The secure unit medication cart was left unlocked while LVN B entered a resident's room and spoke to her. LVN B also left medications on top of the cart while she went behind the nurses' station on the secure unit to wash her hands. B. Resident #23 kept his medication [MEDICATION NAME] in his room on top of his bedside table. This failure placed residents residing on the secured unit at risk for drug diversion and receiving medications not ordered for them with potential harmful side effects. Findings included: A. Observations on 3/2/20 from 7:23 a.m. through 7:27 a.m. while waiting for LVN B to complete a medication pass revealed she entered room [ROOM NUMBER] to give a resident her medications and left the medication cart unlocked with the keys on top of the cart which was out of LVN B's sight for 4 minutes. Continued observations from 8:22 a.m. through 8:24 a.m. revealed LVN B returned from obtaining medications from the supply room, placed the medications on top of the cart and left to wash her hands at the sink behind the nurses' station. 5 residents were noted to be in the adjoining living room. Review of LVN B's

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CRESTVIEW HEALTHCARE RESIDENCE	**1400 LAKE SHORE DR WACO, TX 76708**

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

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F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 4) Medication Pass Evaluation dated 1/20/20 reflected she successfully passed the evaluation but the evaluator noted she was very nervous and needed additional training. No additional training was provided for review. B. Review of Resident #23's MDS dated [DATE] revealed a BIMs score of 13, indicating a slight cognitive deficit. Review of Resident #23's Care Plan revealed a problem identified on 3/1[DATE]7 of Resident is resistive of care and is at risk for not having needs met in a timely manner. Interventions include: Administer medications as ordered. Monitor/document for side effects and effectiveness. Observations on 3/2/20 from 7:00 a.m. through 7:08 a.m. of a medication pass by MA A revealed she pointed out that Resident #23 keeps his [MEDICATION NAME] on his bedside table. In an interview on 3/2/20 at 7:08 a.m. Resident #23 stated he usually takes his [MEDICATION NAME] in the morning when he wakes up. In an interview on 3/2/20 at 7:10 a.m. MA A stated she is new to the facility but since she's been here Resident #23 keeps his [MEDICATION NAME] at his bedside. In an interview on 3/3/20 at 4:05 p.m. DON stated Resident #23 had not been assessed as being able to keep medications in his room. She stated the [MEDICATION NAME] should not be in his room and she was not aware that it was. The DON stated all medications should be safely locked away in the medication cart and not on top of the cart. Review of the facility policy titled Storage of Medications updated 1/14/20, included the following: #6. Compartments (including but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays and carts used to transport such items shall not be left unattended if open or otherwise potentially available to others.