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	04/20/2022

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42971 Based on interview, and record review the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one (Resident #1) of seven residents reviewed for quality of care. The facility failed to identify an ulceration to Resident #1's bottom of the right great toe. A family member discovered the ulceration on 11/29/2021, resulting in Resident #1 going to the podiatrist on 11/30/2021 and being diagnosed with an infected wound to the bottom of the right great toe. This failure placed residents with ulcerations at risk for worsening wounds, infection, or hospitalization . Findings Included: Observation on 04/19/2022 at 4:15 of the Resident#1 right great toe reflected a scar tissue of healed wound on the bottom of the right great toe. Review of Resident #1's MDS assessment, dated 02/28/22, reflected she was [AGE] year-old female admitted to the facility on [DATE]. Her BIMS score was 08 which indicated she is moderately impaired. The assessment of functional status reflected Resident #1 could perform locomotion on unit and eating with supervision. The assessment reflected she required extensive assistance with toilet use and personal hygiene. Her diagnoses included: peripheral vascular disease (blood circulation disorder), diabetes mellitus, coronary artery disease (narrowing or blockage of the heart arteries), and Alzheimer's disease. Review of Resident #1 care plan dated 02/10/2022 reflect Resident #1 at risk for circulatory concerns of the lower extremities and feet. As evidenced by callus to right distal plantar great toe (bottom of the right great toe). Interventions included monitor lower extremities and feet for cuts, cracks, blisters, calluses, redness, and edema. Monitor for appropriate fitting footwear. Podiatry intervention as ordered. Review of Resident#1 nurses notes of the month of November (11/01/2021 through 11/28/2021) reflected no wound on the right great toe. (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: 676112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/20/2022
NAME OF PROVIDER OR SUPPLIER Crestview Court		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Actual harm Residents Affected - Few	Review of Resident#1 nurses notes dated 11/29/2021 reflected resident noted with dark eschar area to bottom of right great toe. Review of Resident # 1 physician order dated 09/17/2020 reflected weekly head to toe assessment one time weekly. Review of Resident #1's weekly skin assessments dated: 11/01/21, 11/08/21, 11/15/21, 11/22/21, completed by LVN F all reflected her skin condition as normal and indicated there were not any ulcers. In a telephone interview on 04/18/22 at 9:45 AM, Resident #1's family member said she had arrived to visit Resident #1 on 11/29/21. She stated that she discovered and open wound on the bottom of resident #1's right foot that was 5 millimeters deep. She said the facility failed to find the wound. It was diagnosed as an ischemic ulcer. She stated, on 11/30/21 Resident#1 saw an outside podiatrist and Resident#1 had been going to an outside wound doctor for treatment after 11/30/2021. In an interview on 04/18/22 at 9:20 AM, CNA A said she was the CNA assigned to Resident #1 frequently. She said she did not recall finding any skin lesion on the resident right toe. She said resident wear socks and shoes. In an interview on 04/20/22 at 11:52 AM, ADON C said skin assessments were done every week by the floor nurse, if any finding of any abnormal findings the floor nurse would report to the treatment nurse, and the treatment nurse would collaborate with the wound doctor. She said I don't know how Resident#1's wound was missed. In a telephone interview on 04/20/22 at 12:51 PM, DPM D said Resident#1 came with a family member to the foot center on 11/30/21 for a fungus on the top of the right toe. Up on assessment the resident had a wound on the bottom of her right big toe. DPM D said the wound characteristics suggested the wound was there for couple weeks. DPM D said we did the culture, and the result came back positive with infection. DPM D said the risk of delay in treatment would be worsening of the wound and the resident may loss her toe. In a telephone interview on 04/20/22 at 2:30 PM, Wound Doctor E said she was not aware Resident #1 had a skin problem/wound on the right great toe prior to Resident #1 going to the podiatrist and coming back. She said I assessed the wound after Resident#1 came back from the podiatrist. However, the family wanted both, myself and the outside doctor to take care of the wound. However, because of the insurance purposes we could not. The family chose to take Resident#1 to an outside doctor. In an interview on 04/20/22 at 2:45 PM, the Administrator said regarding Resident #1's wound on the right toe, the family member, on 11/29/2021, brought to our attention that resident had a callus dark color on the bottom of Resident#1 right great toe. The wound care nurse LVN F looked at it, she said it may be a diabetic ulcer. The facility podiatrist came the next day or the same day and assessed Resident#1 toe. She said the family at that point made her an appointment with outside podiatrist. She said the expectation that nursing staff supposed to do weekly skin assessment on every resident. On 4/20/22 at 3:00 PM, attempted to call LVN F without success, she was not reached. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of facility's podiatrist report dated 11/30/2021 reflected, right hallux pulp eschar noted, no active drainage, no malodor, no edema, no erythema. Confidential interview reflected; a family member was not satisfied with the facility podiatrist findings, so they took Resident #1 to an outside podiatrist on the same day, 11/30/2021. Review of Resident #1's foot center records, dated 11/30/21, reflected the resident was brought to the foot center by a family member on 11/30/22. The records reflected Resident #1 presented to the foot center with an ulcer on the bottom of the right 1st toe with presence of small purulent (containing pus) drainage. Type: Ischemic (reduced blood flow) ulcer. Size: 20 millimeters long by 15 millimeters wide by 5 millimeters deep. Records reflected the ulceration extends fully through skin. Duration of the ulceration: several days. Records reflected that the podiatry doctor debrided the ulcer (removed damaged tissue from the ulcer) and collected a sample from the ulcer for culture and sensitivity (test to find germs such as bacteria or a fungus). Review of lab results dated 12/03/2021 revealed presence of Methicillin Resistant Staphylococcus Aureus (Bacteria) on the ulcer. Resident was referred to a wound care center for treatment. Review of Resident#1 medication administration records reflected an order dated 12/01/2021 for clindamycin 300 mg (antibiotic) two times per day for ten days related to the ulcer on the right toe. Review of the facility policy titled, Patient Care Management System 1, reflected the following: . 2. The treatment nurse/designee must complete a head-to-toe assessment and document in the EMR to validate the findings of the initial skin assessment. Head-to-toe assessments must be completed weekly and prior to discharge/transfer of a Patient . 9. The Certified Nurse Aide will notify the treatment nurse or charge nurse of any newly identified skin issues The faciliyt initated and completed inservice training related to skin assessments and initiated monitoring prior to entry for this investigation. Reveiw of the following reflected the facility was in compliance on 12/31/21. Review of Inservice Training dated 12/01/21 through 12/31/21 reflected training subject matter was regarding the responsibility of nurses and nurse aides when there are changes with a resident'skin. Nurses were trained to complete skin assessments weekly and document any skin issues found; if there are any skin issues found the nures report (to treatment nurse). CNAs are to report all skin issues to charge nurses and document on the shower sheets. In an interview on 04/20/22 at 3:25 PM, RN G Regional Nurse said that she started working at the facility after the incident. RN G said the expectations were a skin assessment to be done on every resident upon admission and every week after. She said I don't know what happen exactly to Resident#1. Risk of any wound went unidentified or untreated would be worsening of the wound and infection. RN G stated the ADON, and the RN G monitor the skin assessment completion daily, using the smart board on the electronic system. During this time the RN G showed how this is monitored in the facility's electronic record by the administrative team.