

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/21/2025
NAME OF PROVIDER OR SUPPLIER Eagle Crest Rapid Recovery		STREET ADDRESS, CITY, STATE, ZIP CODE 9602 Huffmeister Rd Houston, TX 77095	
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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** Based on observation, interview and record review the facility failed develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and time frames to meet a resident's medical, nursing, and mental, and mental and psychosocial needs that were identified in the comprehensive assessment for 6 of 7 residents (Residents #4, #41, #30, #1 #37 and #62) reviewed for care plans. 1. The facility failed to develop and implement a plan of care that addressed the prevention of facility acquired pressure ulcers/injury . 2. The facility failed to develop a plan of care for the continuous use of heel protectors for Residents #4, #41, #1 and #37 who developed facility acquired pressure ulcers/injuries to their feet. 3. The facility failed to develop a plan of care for the continuous use of a special pillow for Resident #30, who developed a pressure ulcer on the leg. 4. The facility failed to develop a care plan to address Resident #62's significant weight loss. An Immediate Jeopardy (IJ) situation was identified on 08/08/25. The IJ template was provided to the Interim Administrator on 08/08/25 at 4:24 PM. While the IJ was removed on 08/11/25 at 5:51 PM, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their plan of removal. These failures could place residents at risk of not getting their needs met and hospitalization. Findings include: Resident #4Record review of Resident #4's Braden scale for predicting pressure ulcers risk evaluation dated 06/24/25 revealed his score was 14 indicating moderate risk.Record review of Resident #4's undated care plan revealed: Focus - Resident #4 had a pressure injury stage 4 to the right medial heel, 6/26/25. Goal - Resident #4 will have intact skin, free of redness, blisters or discoloration by review date, target date 10/09/25. Interventions included - administer treatments as ordered and monitor for effectiveness, low air loss mattress for pressure reducing measures. Further review of the care plan revealed the interventions did not include heel protector boots (specifically designed for wound care to help prevent heel pressure ulcers by keeping the heel elevated and off the bed surface).Record review of Resident #4's May 2025 Task Care Record revealed, Resident #4 was scheduled for turning/reposition every 2 hours (12 times a day); the task was not completed 12 times a day.Record review of Resident #4's June 2025 Task Care Record revealed, Resident #4 was scheduled for turning/reposition every 2 hours (12 times a day); the task was not completed 12 times a day.Record review of Resident #4's July 2025 Task Care Record revealed, Resident #4 was scheduled for turning/reposition every 2 hours (12 times a day) from 07/01/25 to 07/20/25; the task was not completed 12 times a day. On 07/20/25 the task was changed so the resident was only turned/repositioned every shift (three times a day). The task was completed and signed for no more than 3 times each day.Record review of Resident #4's Progress Notes from 01/2025 to 07/2025 revealed, a new in-house unstageable pressure ulcer on the right heel was first identified on 06/26/25.Record review of Resident #4's Wound Care Note 07/02/25, Skin: Stage 4 pressure injury observed on the posterior heel of the lower extremity. Adherent dark firm eschar (describing dead, black, leather-like tissue that is tightly bound to the base of a deep wound. It (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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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	risk evaluation on 07/04/25 revealed a score of 12, which indicated high risk. Record review of Resident #41's quarterly MDS dated [DATE] revealed severe impaired cognitive skills for daily decision making. She was coded for functional limitations in range of motion to both sides of upper and lower extremities. Resident #41 was dependent on staff for all ADLs. Resident #41 had a feeding tube for receiving nutrition. Resident #41 was at risk of developing pressure ulcers and no pressure ulcers were listed. Resident #41 had pressure reducing devices for the chair and the bed. Record review of Resident #41's undated care plan revealed: Focus - Resident #41 had stage 3 pressure ulcer to the left medial great toe, 8/1/25. Goal - Resident #41 will remain free from infection through the review date, target date 09/29/25. Interventions included - low air loss mattress, monitoring for changes in skin status and daily observations of skin. Interventions did not include the application of bilateral heel boots every shift. Focus - Resident #41 had stage 3 pressure ulcer to the left medial forefoot, 8/1/25. Goal - Resident #41 will remain free from infection through the review date, target date 9/29/25. Interventions included - low air loss mattress, monitoring for changes in skin status and daily observations of skin. Interventions did not include the application of bilateral heel boots every shift. Further review of Resident #41's care plan revealed there was no plan for Resident #41's risk for developing pressure ulcers and interventions to help prevent pressure ulcers/injuries. Record review of Resident #41's Progress Notes 07/08/25 through 08/08/25 revealed, - 08/01/2025 05:07 PM signed by the Wound Care Nurse: Wound care nurse was notified by charge nurse that the resident has new wounds. Upon assessment resident was found to have two new wounds to the left medial forefoot and left medial great toe. Wounds were cleansed and treated with basic first aid. Wound care MD was notified, awaiting orders. - 08/01/2025 05:10 PM signed by the Wound Care Nurse: Left 1 st toe: Laterality / Orientation: Medial. Issue type: Pressure ulcer / injury. Pressure ulcer staging: Stage 3 Pressure ulcer / injury - full thickness skin loss. Wound acquired in-house. Wound is new. Record review of Resident #41's July 2025 Task Care Record revealed, Resident #41 was only scheduled to be turned/repositioned every shift (three times a day). The task was completed and signed for no more than 3 times each day. Record review of Resident #41's August 2025 Task Care Record revealed, Resident #41 was only scheduled to be turned/repositioned every shift (three times a day). The task was completed and signed for no more than 3 times each day. Record review of Resident #41's skin issues evaluation form effective 08/01/25, by the Wound Care Nurse, revealed a new issue, in-house acquired stage 3 pressure ulcer to the upper surface of the left great toe. Record review of Resident #41's Hospice visit note report date 08/06/25 revealed, Resident #41 had one stage 2 pressure ulcer. On the left medial foot, she had a stage 3. That was 3cm x 2cm x 0 centimeters. There was no granulation tissue. The edges were distinct, the shape was round, there was no drainage, 50% to 75% in necrotic slough (dead or dying tissue that appears stringy, soft and yellowish that blocks healing or increases risk of infection, no tunneling (tunnel from surface of wound into deeper tissue). Wound care was not provided on that visit. Record review of Resident #41's 08/06/25 follow up wound evaluation note by the NP revealed the resident had a new wound to the left foot: an unstageable pressure injury on the left great toe, another injury located on the plantar surface of the foot below the great toe that had black eschar tissue (dead tissue) and an unstageable pressure injury to the left lateral foot. Further review of the evaluation revealed preventative measures: continue offloading techniques. Record review of Resident #41's order summary report printed on 08/07/25 revealed an active order for low air loss mattress dated 07/20/25, an order for nurse to ensure bilateral heel boots were in place every shift for DTI dated 07/26/25; an order for daily wound care orders for an unstageable left lateral foot pressure injury, dated 08/07/25; a wound care order three times a week for an unstageable left lower great toe pressure injury, dated 08/07/25. Resident #41 had an active order for Hospice services, dated 07/03/25. Record review of Resident #41's September 2025 Task Care Record revealed, - Resident #41 was only scheduled to be turned/repositioned every shift (three times a day). The task was completed and signed for no more than 3 times each day. An observation on 08/05/25 at 09:21 AM revealed, Resident #41 lying in bed with both legs contracted and pulled up (continued on next page)		

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	while receiving continuous feeding via her G-tube (tube that goes into the stomach to provide feedings or medication). The resident was non-responsive to the surveyor and she had heel protection and cushions in place. Resident #30Record review of Resident #30's face sheet dated 08/07/25 revealed an [AGE] year-old admitted to the facility on [DATE] with diagnoses to include dementia, stroke, anxiety, right wrist contracture, chronic pain and palliative care.Record review of Resident #30's Braden scale for predicting pressure ulcers risk evaluation on 06/05/25 revealed a score of 14, which indicated moderate risk. Record review of Resident #30's quarterly MDS dated [DATE] revealed severe impaired cognitive skills for daily decision making. She was coded for functional limitations in range of motion to upper and lower extremities. Resident #30 was dependent on staff for all ADLs. Resident #30 had one stage 4 pressure ulcer that was present upon admission.Record review of Resident #30's undated care plan revealed: Focus - Resident #30 had a stage 4 pressure ulcer to the right medial calf, 3/4/25. Goal - Resident #30's right medial calf will be healed. Interventions included: place resident's pressure reducing device/product on bed/chair. Further review of the intervention did not specify the pillow between the legs.Record review of Resident #1's Skin Monitoring: Comprehensive CNA Shower Review revealed, he had no marked areas of concern (bruising, skin tears, rashes, dryness, lesions, bed sores, blisters, scratches, abnormal color, abnormal skin, or hardened skin) on: 03/25, 6/02/25, 06/04/25, 06/06/25, 06/09/25, 06/11/25, 06/13/25, 06/16/25, 06/18/25, 06/20/25, 06/23/25, 06/25/25, 06/27/25, 06/30/25, 07/02/25, 04/04/25, 07/07/25, 07/09/25, 07/11/25, 07/14/25, 07/18/25, 07/21/25, 07/23/25, 07/25/25, 07/28/25, 07/30/25, 08/01/25, 08/04/25, 08/06/25, 08/08/25, 08/11/25, 08/13/25, 08/15/25, 08/18/25, 08/20/25, 08/22/25, 08/25/25, 08/27/25, 08/29/25, 09/03/25 08, 05/25, 09/05/25, 9/12/25.Record review of Resident #30's February 2025 Task Care Record revealed, Resident #30 was only scheduled to be turned/repositioned every shift (three times a day). The task was completed and signed for no more than 3 times each day.Record review of Resident #30's March 2025 Task Care Record revealed, Resident #30 was only scheduled to be turned/repositioned every shift (three times a day). The task was completed and signed for no more than 3 times each day.Record review of Resident #30's April 2025 Task Care Record revealed, Resident #30 was only scheduled to be turned/repositioned every shift (three times a day). The task was completed and signed for no more than 3 times each day.Record review of Resident #30's May 2025 Task Care Record revealed, Resident #30 was only scheduled to be turned/repositioned every shift (three times a day). The task was completed and signed for no more than 3 times each day.Record review of Resident #30's June 2025 Task Care Record revealed, Resident #30 was only scheduled to be turned/repositioned every shift (three times a day). The task was completed and signed for no more than 3 times each day.Record review of Resident #30's July 2025 Task Care Record revealed, Resident #30 was only scheduled to be turned/repositioned every shift (three times a day). The task was completed and signed for no more than 3 times each day.Record review of Resident #30's August 2025 Task Care Record revealed, Resident #30 was only scheduled to be turned/repositioned every shift (three times a day). The task was completed and signed for no more than 3 times each day.Record review of the facility weekly pressure report dated 08/01/25 revealed Resident #30's stage 4 pressure ulcer to the right medial calf was in-house acquired and identified on 03/04/25.Record review of Resident #30's order summary report printed on 08/06/25 revealed an active order to cleanse the DTI (deep tissue injury) to the right medial calf with dermal wound cleanser, pat dry, apply medihoney, cover with border dressing as needed for compromised dressing, dated 03/06/25; an order for Low air loss mattress for pressure reducing measures every shift, dated 07/20/25; an order for Nurses to ensure pillow between legs for pressure reduction as tolerated ever shift, dated 07/20/25; an order for: Stage 4 right lower medial leg pressure injury: cleanse with wound cleanser. Pat dry, apply Adaptec (non-adherent wound dressing), allograft skin graft (tissue transferred from one person to another) and silicone bordered foam dressing every 5 days and as needed for wound care, date ordered 08/07/25.Record review of Resident #30's follow up wound evaluation notes, date of service was (continued on next page)		

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	07/16/25, written by the Wound Care Physician, revealed the evaluation was of the stage 4 ulceration on the right lower extremity around knee joint, follow up for the skin graft application (cellular based tissue product). Preventative measures included to continue with offloading techniques. Record review of Resident #30's September 2025 Task Care Record revealed, Resident #30 was only scheduled to be turned/repositioned every shift (three times a day). The task was completed and signed for no more than 3 times each day. An observation on 08/05/25 at 09:27 AM revealed, Resident #30 sleeping in bed with legs contracted. There was no pressure relieving pillow between her legs. Observation and interview of wound care for Resident #30 on 08/06/25 at 3:30 PM by the NP and Wound Care Nurse revealed Resident #30 had severe contractures of the lower extremities. There was a rolled-up bed linen between the resident's knees. Resident #30 had an open area, pink in color to the right medial shin, the surrounding skin was intact. The measurements per NP were: Length 2.7cm, Width 2.0cm, Depth 0.2cm. Wound Care Nurse stated the resident was supposed to have a donut pillow placed between the knees. Resident #30 denied pain during the procedure. Low air loss mattress was in place and heel protectors were replaced after the procedure. In an interview and observation on 08/10/25 at 10:45 AM, Resident #31 who was the roommate of Resident #30 stated the aides were not trained on the use of the special pillow, especially during evening and night shift. Resident #31 stated on one occasion the nursing staff stated the pillow was not doing any good and removed the pillow. Resident #31 did not know the name of the nursing staff. Resident #31 stated overall nursing staff were inconsistent when applying the pillow even though there was a sign above the bed with instructions. The sign read: Do not remove pillow from between Resident #30's legs, middle needs to be positioned under wound. Call Wound Care Nurse with any questions. Resident #1 Record review of Resident #1's face sheet dated 08/07/25 revealed an [AGE] year-old admitted to the facility on [DATE] and initially admitted on [DATE] with diagnoses to include cancer of the tongue and of the throat; Hemiplegia (one side paralysis or severe loss of strength on one side) following a stroke; high blood pressure, irregular often rapid heartbeat, and muscle wasting. Record review of Resident #1's Braden scale for predicting pressure ulcers risk evaluation on 05/22/25 revealed a score of 15 indicating he was at risk. Record review of Resident #1's quarterly MDS dated [DATE] revealed a BIMS score of 13 out of 15 indicating intact cognition. He required substantial/maximum assistance with bed mobility. Resident #1 had one unstageable pressure ulcer. Skin and ulcer treatment: pressure reducing device for the chair, pressure reducing device for the bed, pressure ulcer/injury care and application of dressings to the feet. Resident #1 had a feeding tube to receive nutrition. Record review of Resident #1's undated care plan revealed: Focus - Resident #1 had an unstageable pressure ulcer to the left heel 7/23/25. Goal - Resident #1 will remain free of infection. Interventions included - monitor for changes in skin status and notify physician, refer resident to wound specialist, resident needs to float heels on pillow, resident needs weekly evaluation of wound healing. Further review of the care plan revealed no specific intervention to apply heel protector boots. Record review of Resident #1's July 2025 Task Care Record revealed, Resident #1 was only scheduled to be turned/repositioned every shift (three times a day). The task was completed and signed for no more than 3 times each day. Record review of Resident #1's August 2025 Task Care Record revealed, Resident #1 was only scheduled to be turned/repositioned every shift (three times a day). The task was completed and signed for no more than 3 times each day. Record review of Resident #1's Skin Monitoring: Comprehensive CNA Shower Review revealed, he had no marked areas of concern (bruising, skin tears, rashes, dryness, lesions, bed sores, blisters, scratches, abnormal color, abnormal skin, or hardened skin) on:- 06/17/25, 07/18/25, 07/28/25, 08/01/25, 08/06/25, 08/08/25, 08/11/25, 08/17/25, 07/05/25,- On 08/12/25 he was marked with a skin tear in the inguinal region (where the thigh meets the torso) and sacrum (triangular area below the spine)- On 08/14/25 he was marked with a skin tear on the sacrum. Record review of the facility's weekly pressure report dated 08/01/25 revealed Resident # had an unstageable pressure ulcer to the left heel that was acquired in house and identified on 07/23/25. Record review of Resident #1's wound (continued on next page)		

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	assessment report for 07/30/25 written by the wound care MD revealed the stage 4 pressure injury to the left posterior heel was acquired in house on 07/23/25. Record review of Resident #1's order summary report printed on 08/06/25 revealed active order to cleanse unstageable pressure injury to the left heel with normal saline, pat dry, apply Santyl to the wound bed, cover with silicone border dressing every day shift for wound care, start date was 07/25/25; an active order to check placement of pressure reduction mattress every shift for preventative measures, dated 07/16/25; an active order to check pressure reduction device to the wheelchair every shift for preventative measures. Further review of the order summary report revealed there was no order for heel protector boots. Record review of Resident #1's follow up wound evaluation noted, date of service 08/06/25, by the Wound Care NP revealed the assessment included unstageable pressure ulcer of the left heel and the plan was to continue offloading boots for pressure relief. Resident #37 Record review of Resident #37's face sheet dated 8/05/25 revealed a [AGE] year-old admitted to the facility on [DATE], initially admitted on [DATE] and originally admitted on [DATE]. Diagnoses included Guillain-Barre syndrome (a rare condition in which the immune system attacks the nerves causing weakness, numbness or paralysis), heart attack, Quadriplegia (condition characterized by partial or complete paralysis of all four limbs and torso), and dementia. Record review of Resident #37's annual MDS dated [DATE] revealed a BIMS score of 13 out of 15 indicating intact cognition, impairment on both sides of upper and lower extremities and required substantial/maximal assistance for bed mobility. Section M-Skin Conditions revealed Resident #37 was at risk of developing pressure ulcers/injuries and did not have any unhealed pressure ulcers/injuries. Record review of Resident 37's Braden scale for predicting pressure ulcers risk evaluation on 07/04/25 revealed a score of 12 indicating high risk. Record review of Resident #37's undated Care Plan Report revealed: Focus - Resident #37 has actual pressure ulcer development r/t impaired mobility and incontinence. Right heel, 5/7/25. Revision was made on 07/01/25. Goal - The resident will have intact skin, free of redness, blisters or discoloration by/through review date. Target date was 08/25/25. Interventions included - Administer treatments as ordered and monitor for effectiveness, follow facility policies/protocols for the prevention/treatment of skin breakdown, monitor/document/report PRN any changes in skin status, weekly skin assessments. Record review of Resident #37's Skin Monitoring: Comprehensive CNA Shower Review revealed, he had no marked areas of concern (bruising, skin tears, rashes, dryness, lesions, bed sores, blisters, scratches, abnormal color, abnormal skin, or hardened skin) on: 6/03/25, 06/05/25, 06/05/25, 06/10/25, OHH 6/12/25, 06/14/25, Both 6/17/25, 06/19/25, 06/21/25, 06/24/25, 06/26/25, 06/28/25, 07/01/25, 07/03/25, 07/05/25, 07/08/25, 07/10/25, 07/12/25, 07/12/25, 07/19/25, 07/15/25, 07/17/25, 07/19/25 07/22/25, 07/24/25, 07/26/25, 07/29/25, 07/31/25, 08/02/25, 08/05/25, 08/07/25, 08/09/25, 08/12/25, 08/14/25, 08/21/25, 08/26/25, 09/02/25, 09/04/25, 09/09/25. Record review of Resident #37's May 2025 Task Care Record revealed, Resident #37 was scheduled for turning/reposition every 2 hours (12 times a day); the task was not completed 12 times a day. Record review of Resident #37's Progress Notes 04/01/25 to 08/08/25 revealed, the first time Resident #37's wound was observed on 05/07/25.- 05/07/2025 09:46 AM: The Change In Condition/s reported on this CIC Evaluation are/were: Change in skin color or condition. Record review of Resident #37's Wound Assessment Report dated 05/07/25 revealed, Location: Right Heel Etiology: Bullae (large blister containing serous fluid), Pressure Injury Stage/Severity: Deep Tissue Injury Acquired in House: Yes Date Wound Acquired: 05/07/2025 In Remission: No Wound Status: New Record review of Resident #37's June 2025 Task Care Record revealed, Resident #37 was scheduled for turning/reposition every 2 hours (12 times a day); the task was not completed 12 times a day. Record review of Resident #37's July 2025 Task Care Record revealed, Resident #37 was scheduled for turning/reposition every 2 hours (12 times a day) from 07/01/25 to 07/20/25; the task was not completed 12 times a day. On 07/20/25 the task was changed so the resident was only turned/repositioned every shift (three times a day). The task was completed and signed for no more than 3 times each day. Record review of Resident #37's August (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Eagle Crest Rapid Recovery		STREET ADDRESS, CITY, STATE, ZIP CODE 9602 Huffmeister Rd Houston, TX 77095	
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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2025 Task Care Record revealed, Resident #37 was only scheduled to be turned/repositioned every shift (three times a day). The task was completed and signed for no more than 3 times each day. Record review of the facility weekly pressure report dated on 08/01/25 revealed Resident #37 had a stage 4 pressure ulcer to the right heel that was acquired in house and identified on 05/07/25. Record review of Resident #37's physician order summary report dated 08/06/25 revealed an order for the stage 4 pressure injury (a deep wound that exposes underlying muscle, tendon, cartilage or bone) to the right heel: cleanse with wound cleanser, pat dry, apply Santyl and calcium alginate with silver and cover with border foam dressing every day shift and as needed, dated 08/05/25; an order for low air loss mattress for pressure reducing measures every shift, dated 07/20/25. Record review of Resident #37's follow up wound evaluation note dated 08/06/25 by the wound care NP revealed the recommended treatment included air boots while in bed. Record review of Resident #37's September 2025 Task Care Record revealed, Resident #37 was only scheduled to be turned/repositioned every shift (three times a day). The task was completed and signed for no more than 3 times each day. Observation and interview of wound care for Resident #37 on 08/07/25 at 10:00 AM, by the Wound Care Nurse and the Physical Therapist revealed the resident had two large circular red spots to the right heel with light colored edges and the surrounding skin was pinkish red in color. The Wound Care Nurse stated the wound was originally one large wound. The Physical Therapist performed the ultramist wound therapy (a painless, non-contact treatment that uses low-frequency ultrasound energy and a saline mist to promote healing in chronic and difficult-to-heal wounds) which took approximately 3 minutes, then the wound care nurse completed the wound care without incident. In an interview on 08/06/25 at 9:45 AM, the Wound Care Nurse stated there have been issues with heel boots not being applied when supposed to particularly with Resident #41 and Resident #30. The Wound Care Nurse stated the orders for the boots were in the MAR, but she would find that the residents would not have the boots on. The Wound Care Nurse stated the CNAs would immediately place the heel protectors on the residents when the wound care nurse was seen rounding. The Wound Care Nurse stated Resident #30 had a special pillow for between her knees because of the wound on the leg and that the pillow went missing. The Wound care nurse stated in services included heel protectors were conducted with the CNAs but the issue continued, the heel protectors were still not being applied when they were supposed to and that there was a failure in the system. In an interview on 08/06/25 at 11:42 AM, the DON stated pressure relieving boots for Resident #4 was supposed to be in the physician orders and in the MAR/TAR but the electronic health records would not populate when she checked. The DON stated areas more prone to developing pressure ulcers would be over bony prominences and treatment to help reduce pressure ulcers would be turning, repositioning, checking skin frequently as well as weekly skin checks. The DON stated orders for prophylactic heel protection would be devices like heel boots and wedges to float heels. The DON stated she started working at the facility 2 months ago and just learned the facility had a lot of in-house acquired heel ulcers, was investigating and the plan was to do in-services on skin issues effective immediately. In an interview on 08/06/25 at 4:00 PM, the DON stated the wound care nurse was responsible to ensure all the Wound Care MD recommendations and orders were followed. In an interview on 08/08/25 at 7:30 AM, the ADON stated the purpose of the heel protectors was to protect the resident's skin integrity, reduce pressure and protect bony prominences for any resident who was in bed all the time. The ADON stated the physician orders heel protectors, and any nurse can enter the order into PCC, then the information for heel protectors should also be in the Kardex. The ADON stated heel protectors should be used whenever the resident lays down or up in a chair and that the nurses were ultimately responsible to ensure they were being used. The ADON stated the expectation was that the CNAs notify the nurses if heel protectors continuously fall off and for repeated resident refusals. The ADON denied seeing any issues with heel protectors not being used as ordered. In an interview on 08/08/25 at 8:10 AM, the Wound Care Nurse stated there were certain CNAs who ensured heel protectors were in place, but other aides were inconsistent. The Wound Care Nurse (continued on next page)		

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	stated the purpose of the heel protector boots was to prevent pressure injuries, infection or new injuries from developing especially with the hospice residents, the residents who were contracted, those who prefer to stay in bed and those less mobile in bed. The Wound Care Nurse stated Resident #41 developed new injurie[TRUNCATED]		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure, based on the comprehensive assessment of a resident, that a resident received care, consistent with professional standards of practice, to prevent pressure ulcers and did not develop pressure ulcers unless the individual's clinical condition demonstrated that they were unavoidable for 5 of 7 (Residents #4, #41, #30, #1 and #37) residents reviewed for pressure ulcers.- The facility failed to turn and reposition Resident #4 every 2 hours and failed to identify skin issues during CNA skin monitoring during showers and nurse skin assessments. Resident #4 developed an in-house stage 4 pressure to his heel without any previously documented skin concern. - The facility failed to ensure Resident #4's low-air-loss mattress was in use as ordered by his physician. - The facility failed to turn and reposition Resident #41 every 2 hours and failed to identify skin issues during CNA skin monitoring during showers and nurse skin assessments. Resident #4 developed an in-house stage 3 pressure to the upper surface of the left great toe and foot without any previously documented skin concern. - The facility failed to ensure Resident #41's low-air-loss mattress was not covered by a fitted sheet that could restrict the pressure relieving function of the mattress and cause pressure points that increased pressure to the resident. - The facility failed to turn and reposition Resident #30 every 2 hours and failed to identify skin issues during CNA skin monitoring during showers and nurse skin assessments. Resident #30 developed an in-house stage 3 pressure to her calf without any previously documented skin concern.- The facility failed to ensure Resident #30's ordered donut pillow was in place which resulted in deterioration of the resident's pressure ulcer to her leg.- The facility failed to turn and reposition Resident #1 every 2 hours and failed to identify skin issues during CNA skin monitoring during showers and nurse skin assessments. Resident #1 developed an in-house stage 4 pressure to his left heel without any previously documented skin concern.- The facility failed to turn and reposition Resident #37 every 2 hours and failed to identify skin issues during CNA skin monitoring during showers and nurse skin assessments. Resident #1 developed an in-house stage 4 pressure to his left heel without any previously documented skin concern. The visit was reopened on 08/08/25. The IJ template was provided to the Interim Administrator on 08/08/25 at 4:24 PM. While the IJ was removed on 08/11/25 at 5:51 PM, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their plan of removal. These failures could place residents at risk for a delay in treatment or diagnosis, a decline in the resident's condition, pain, and/or the need for hospitalization and prolonged treatment. Findings include: Resident #4 Record review of Resident #4's face sheet dated 08/07/25 revealed a [AGE] year-old admitted to the facility on [DATE] with the diagnoses to include Hemiplegia (one sided paralysis or severe loss of strength on one side) following a stroke, Diabetes, high blood pressure, mental disorder and muscle weakness. Record review of Resident #4's quarterly MDS dated [DATE] revealed a BIMS score of 5 out of 15 indicating severe impaired cognition. He required substantial/maximum assistance with bed mobility. Resident #4 was at risk of developing pressure/ulcers/injuries and did not have any unhealed pressure ulcers. Resident #4 had pressure reducing device for the bed and for the chair. Record review of Resident #4's Braden scale for predicting pressure ulcers risk evaluation dated 06/24/25 revealed his score was 14 indicating moderate risk. Record review of Resident #4's undated care plan revealed: Focus - Resident #4 had a pressure injury stage 4 to the right medial heel, 6/26/25. Goal - Resident #4 will have intact skin, free of redness, blisters or discoloration by review date, target date 10/09/25. Interventions included - administer treatments as ordered and monitor for effectiveness, low air loss mattress for pressure reducing measures. Further review of the care plan revealed the interventions did not include heel protector boots (specifically designed for wound care to help prevent heel pressure ulcers by keeping (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	the heel elevated and off the bed surface).Record review of Resident #4's May 2025 Task Care Record revealed, Resident #4 was scheduled for turning/reposition every 2 hours (12 times a day); the task was not completed 12 times a day.Record review of Resident #4's June 2025 Task Care Record revealed, Resident #4 was scheduled for turning/reposition every 2 hours (12 times a day); the task was not completed 12 times a day.Record review of Resident #4's July 2025 Task Care Record revealed, Resident #4 was scheduled for turning/reposition every 2 hours (12 times a day) from 07/01/25 to 07/20/25; the task was not completed 12 times a day. On 07/20/25 the task was changed so the resident was only turned/repositioned every shift (three times a day). The task was completed and signed for no more than 3 times each day.Record review of Resident #4's Progress Notes from 01/2025 to 07/2025 revealed, a new in-house unstageable pressure ulcer on the right heel was first identified on 06/26/25.Record review of Resident #4's Wound Care Note 07/02/25, Skin: Stage 4 pressure injury observed on the posterior heel of the lower extremity. Adherent dark firm eschar (describing dead, black, leather-like tissue that is tightly bound to the base of a deep wound. It is a form of necrosis, or tissue death, often associated with severe injury or poor blood supply) present in the affected area. Marked tenderness noted. Callusing skin observed in the surrounding area. WOUND ASSESSMENT:Wound: 1Status: NewLocation: Right Medial HeelPrimary Etiology: Pressure InjurySeverity: Stage 4Size: 2.3 cm x 2.5 cm x 1 cm. Actual area is 5.75 cm2. Actual volume is 5.75 cm3Wound Base: [NAME] escharPeri wound: CallusExudate: NoneWound Odor: NoneWound Pain at Rest: 2Record review of Resident #4's Skin Monitoring: Comprehensive CNA Shower Review from 07/2025 to 09/2025 revealed, he had no marked areas of concern (bruising, skin tears, rashes, dryness, lesions, bed sores, blisters, scratches, abnormal color, abnormal skin, or hardened skin) on: - 07/01/25, 07/03/25, 7/08/25, 07/10/25, 07/12/25, 07/17/25, 07/19/25, 07/22/25, 07/24/25, 7/26/25, 07/29/25, 07/31/25, 08/02/25, 08/05/25, 08/07/25, 08/09/25, 8/12/25, 08/14/25, 8/16/25, 08/19/25, 08/21/25, 08/26/25, 08/30/25, 09/04/25, 09/06/25, 09/09/25, 09/11/25, 09/13/25.Record review of Resident #4's Skin Issues form, effective date 07/30/25 and evaluated by the Wound Care Nurse revealed a stage 4 pressure ulcer/injury to the right heel, in-house acquired, new onset and heel suspension/protection device was listed as additional care.Record review of the facility weekly pressure report dated 08/01/25 revealed Resident #4's stage 4 pressure ulcer to the right heel was in-house acquired and identified on 06/26/25.Record review of Resident #4's August 2025 Task Care Record revealed, Resident #4 was only scheduled to be turned/repositioned every shift (three times a day). The task was completed and signed for no more than 3 times each day.Record review of Resident #4's order summary report dated 08/07/25 revealed an active order for pressure injury stage 4 to the right medial heel: cleanse with wound cleanser, pat dry, apply Santyl, skin prep to peri wound and silicone bordered foam dressing daily and as needed every day shift for wound care, dated 08/07/25; low air loss mattress for pressure reducing measures every shift, dated 07/20/25. Further review revealed no orders for heel protector boots.Record review of Resident #4's Kardex (automated storage systems) as of 8/08/25 revealed Monitors included: monitor pressure relieving mattress, pressure relieving pad for the chair as well as turn and reposition. Further review of the Kardex revealed it did not include monitoring for heel protectors. Record review of Resident #4's September 2025 Task Care Record revealed, Resident #4 was only scheduled to be turned/repositioned every shift (three times a day). The task was completed and signed for no more than 3 times each day In an interview and observation of wound care on 08/07/25 at 11:00 AM, Resident #4 was lying on his back on a low air loss mattress, alert and watching television. Resident #4 had no heel protector boots on his feet; the soft boots were on the floor in a corner of the room. Resident #4 said the wound on his right foot hurt and that it was an 8 out of 10 on the pain scale. He stated he had the wound a long time and did not know how he got it. The wound to the right heel was round, pink in the center with white edges and surrounding skin was intact. He was in no distress and tolerated the wound care. The Wound Care Nurse applied the soft heel protector boots to both feet.In an interview on 08/07/25 at 11:30 AM, CNA N stated Resident #4 was supposed to have boots on to (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	help protect his heels from injuries while in bed and while up in the wheelchair. CNA N stated Resident #4 would get agitated, either kick them off his feet or ask to have them removed. CNA N stated she did not notify the charge nurse that he did not have them on in the morning because she was distracted and forgot. CNA N stated usually she would chart whether the boots were on or if the resident refused in the task list under ADLs. An observation on 08/05/25 at 09:18 AM revealed, Resident #4 in bed. The resident kept rubbing his right heel against his left shin and said he had a wound on his right heel that he received wound care for. The resident did not have boots on, just a pair of non-slip socks. A pair of Prevalon heel protection boots (soft boots used to prevent the development of heel pressure ulcer) was observed in the corner of the resident's room, under a bedside table and behind a wheelchair. Resident #41Record review of Resident #41's face sheet dated 08/07/25 revealed an [AGE] year-old admitted to the facility on [DATE] and initially admitted on [DATE] with the diagnoses to include Senile Degeneration (a progressive deterioration of the brain tissue and function that occurs with aging), high blood pressure, COPD (chronic obstructive pulmonary disease) (a lung condition caused by damage to the airway), lack of coordination, muscle weakness, reduced mobility, and dementia.Record review of Resident #41's Braden scale for predicting pressure ulcers risk evaluation on 07/04/25 revealed a score of 12, which indicated high risk.Record review of Resident #41's quarterly MDS dated [DATE] revealed severe impaired cognitive skills for daily decision making. She was coded for functional limitations in range of motion to both sides of upper and lower extremities. Resident #41 was dependent on staff for all ADLs. Resident #41 had a feeding tube for receiving nutrition. Resident #41 was at risk of developing pressure ulcers and no pressure ulcers were listed. Resident #41 had pressure reducing devices for the chair and the bed.Record review of Resident #41's undated care plan revealed: Focus - Resident #41 had stage 3 pressure ulcer to the left medial great toe, 8/1/25. Goal - Resident #41 will remain free from infection through the review date, target date 09/29/25. Interventions included - low air loss mattress, monitoring for changes in skin status and daily observations of skin. Interventions did not include the application of bilateral heel boots every shift. Focus - Resident #41 had stage 3 pressure ulcer to the left medial forefoot, 8/1/25. Goal - Resident #41 will remain free from infection through the review date, target date 9/29/25. Interventions included - low air loss mattress, monitoring for changes in skin status and daily observations of skin. Interventions did not include the application of bilateral heel boots every shift. Further review of Resident #41's care plan revealed there was no plan for Resident #41's risk for developing pressure ulcers and interventions to help prevent pressure ulcers/injuries.Record review of Resident #41's Progress Notes 07/08/25 through 08/08/25 revealed,- 08/01/2025 05:07 PM signed by the Wound Care Nurse: Wound care nurse was notified by charge nurse that the resident has new wounds. Upon assessment resident was found to have two new wounds to the left medial forefoot and left medial great toe. Wounds were cleansed and treated with basic first aid. Wound care MD was notified, awaiting orders.- 08/01/2025 05:10 PM signed by the Wound Care Nurse: Left 1 st toe: Laterality / Orientation: Medial. Issue type: Pressure ulcer / injury. Pressure ulcer staging: Stage 3 Pressure ulcer / injury - full thickness skin loss. Wound acquired in-house. Wound is new.Record review of Resident #41's July 2025 Task Care Record revealed, Resident #41 was only scheduled to be turned/repositioned every shift (three times a day). The task was completed and signed for no more than 3 times each day.Record review of Resident #41's August 2025 Task Care Record revealed, Resident #41 was only scheduled to be turned/repositioned every shift (three times a day). The task was completed and signed for no more than 3 times each dayRecord review of Resident #41's skin issues evaluation form effective 08/01/25, by the Wound Care Nurse, revealed a new issue, in-house acquired stage 3 pressure ulcer to the upper surface of the left great toe.Record review of Resident #41's Hospice visit note report date 08/06/25 revealed, Resident #41 had one stage 2 pressure ulcer. On the left medial foot, she had a stage 3. That was 3cm x 2cm x0 centimeters. There was no granulation tissue. The edges were distinct, the shape was round, there was no drainage, 50% to 75% in necrotic slough (dead or dying (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	tissue that appears stringy, soft and yellowish that blocks healing or increases risk of infection, no tunneling (tunnel from surface of wound into deeper tissue). Wound care was not provided on that visit. Record review of Resident #41's 08/06/25 follow up wound evaluation note by the NP revealed the resident had a new wound to the left foot: an unstageable pressure injury on the left great toe, another injury located on the plantar surface of the foot below the great toe that had black eschar tissue (dead tissue) and an unstageable pressure injury to the left lateral foot. Further review of the evaluation revealed preventative measures: continue offloading techniques. Record review of Resident #41's order summary report printed on 08/07/25 revealed an active order for low air loss mattress dated 07/20/25, an order for nurse to ensure bilateral heel boots were in place every shift for DTI dated 07/26/25; an order for daily wound care orders for an unstageable left lateral foot pressure injury, dated 08/07/25; a wound care order three times a week for an unstageable left lower great toe pressure injury, dated 08/07/25. Resident #41 had an active order for Hospice services, dated 07/03/25. Record review of Resident #41's September 2025 Task Care Record revealed, - Resident #41 was only scheduled to be turned/repositioned every shift (three times a day). The task was completed and signed for no more than 3 times each day. An observation on 08/05/25 at 09:21 AM revealed, Resident #41 lying in bed with both legs contracted and pulled up while receiving continuous feeding via her G-tube (tube that goes into the stomach to provide feedings or medication). The resident was non-responsive to the surveyor and she had heel protection and cushions in place. Resident #30 Record review of Resident #30's face sheet dated 08/07/25 revealed an [AGE] year-old admitted to the facility on [DATE] with diagnoses to include dementia, stroke, anxiety, right wrist contracture, chronic pain and palliative care. Record review of Resident #30's Braden scale for predicting pressure ulcers risk evaluation on 06/05/25 revealed a score of 14, which indicated moderate risk. Record review of Resident #30's quarterly MDS dated [DATE] revealed severe impaired cognitive skills for daily decision making. She was coded for functional limitations in range of motion to upper and lower extremities. Resident #30 was dependent on staff for all ADLs. Resident #30 had one stage 4 pressure ulcer that was present upon admission. Record review of Resident #30's undated care plan revealed: Focus - Resident #30 had a stage 4 pressure ulcer to the right medial calf, 3/4/25. Goal - Resident #30's right medial calf will be healed. Interventions included: place resident's pressure reducing device/product on bed/chair. Further review of the intervention did not specify the pillow between the legs. Record review of Resident #1's Skin Monitoring: Comprehensive CNA Shower Review revealed, he had no marked areas of concern (bruising, skin tears, rashes, dryness, lesions, bed sores, blisters, scratches, abnormal color, abnormal skin, or hardened skin) on: 03/25, 6/02/25, 06/04/25, 06/06/25, 06/09/25, 06/11/25, 06/13/25, 06/16/25, 06/18/25, 06/20/25, 06/23/25, 06/25/25, 06/27/25, 06/30/25, 07/02/25, 04/04/25, 07/07/25, 07/09/25, 07/11/25, 07/14/25, 07/18/25, 07/21/25, 07/23/25, 07/25/25, 07/28/25, 07/30/25, 08/01/25, 08/04/25, 08/06/25, 08/08/25, 08/11/25, 08/13/25, 08/15/25, 08/18/25, 08/20/25, 08/22/25, 08/25/25, 08/27/25, 08/29/25, 09/03/25 08, 05/25, 09/05/25, 9/12/25. Record review of Resident #30's February 2025 Task Care Record revealed, Resident #30 was only scheduled to be turned/repositioned every shift (three times a day). The task was completed and signed for no more than 3 times each day. Record review of Resident #30's March 2025 Task Care Record revealed, Resident #30 was only scheduled to be turned/repositioned every shift (three times a day). The task was completed and signed for no more than 3 times each day. Record review of Resident #30's April 2025 Task Care Record revealed, Resident #30 was only scheduled to be turned/repositioned every shift (three times a day). The task was completed and signed for no more than 3 times each day. Record review of Resident #30's May 2025 Task Care Record revealed, Resident #30 was only scheduled to be turned/repositioned every shift (three times a day). The task was completed and signed for no more than 3 times each day. Record review of Resident #30's June 2025 Task Care Record revealed, Resident #30 was only scheduled to be turned/repositioned every shift (three times a day). The task was completed and signed for no more than 3 times each day. Record review of Resident #30's July 2025 Task Care (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Eagle Crest Rapid Recovery		STREET ADDRESS, CITY, STATE, ZIP CODE 9602 Huffmeister Rd Houston, TX 77095	
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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record revealed, Resident #30 was only scheduled to be turned/repositioned every shift (three times a day). The task was completed and signed for no more than 3 times each day. Record review of Resident #30's August 2025 Task Care Record revealed, Resident #30 was only scheduled to be turned/repositioned every shift (three times a day). The task was completed and signed for no more than 3 times each day. Record review of the facility weekly pressure report dated 08/01/25 revealed Resident #30's stage 4 pressure ulcer to the right medial calf was in-house acquired and identified on 03/04/25. Record review of Resident #30's order summary report printed on 08/06/25 revealed an active order to cleanse the DTI (deep tissue injury) to the right medial calf with dermal wound cleanser, pat dry, apply medihoney, cover with border dressing as needed for compromised dressing, dated 03/06/25; an order for Low air loss mattress for pressure reducing measures every shift, dated 07/20/25; an order for Nurses to ensure pillow between legs for pressure reduction as tolerated ever shift, dated 07/20/25; an order for: Stage 4 right lower medial leg pressure injury: cleanse with wound cleanser. Pat dry, apply Adaptec (non-adherent wound dressing), allograft skin graft (tissue transferred from one person to another) and silicone bordered foam dressing every 5 days and as needed for wound care, date ordered 08/07/25. Record review of Resident #30's follow up wound evaluation notes, date of service was 07/16/25, written by the Wound Care Physician, revealed the evaluation was of the stage 4 ulceration on the right lower extremity around knee joint, follow up for the skin graft application (cellular based tissue product). Preventative measures included to continue with offloading techniques. Record review of Resident #30's September 2025 Task Care Record revealed, Resident #30 was only scheduled to be turned/repositioned every shift (three times a day). The task was completed and signed for no more than 3 times each day. An observation on 08/05/25 at 09:27 AM revealed, Resident #30 sleeping in bed with legs contracted. There was no pressure relieving pillow between her legs. Observation and interview of wound care for Resident #30 on 08/06/25 at 3:30 PM by the NP and Wound Care Nurse revealed Resident #30 had severe contractures of the lower extremities. There was a rolled-up bed linen between the resident's knees. Resident #30 had an open area, pink in color to the right medial shin, the surrounding skin was intact. The measurements per NP were: Length 2.7cm, Width 2.0cm, Depth 0.2cm. Wound Care Nurse stated the resident was supposed to have a donut pillow placed between the knees. Resident #30 denied pain during the procedure. Low air loss mattress was in place and heel protectors were replaced after the procedure. In an interview and observation on 08/10/25 at 10:45 AM, Resident #31 who was the roommate of Resident #30 stated the aides were not trained on the use of the special pillow, especially during evening and night shift. Resident #31 stated on one occasion the nursing staff stated the pillow was not doing any good and removed the pillow. Resident #31 did not know the name of the nursing staff. Resident #31 stated overall nursing staff were inconsistent when applying the pillow even though there was a sign above the bed with instructions. The sign read: Do not remove pillow from between Resident #30's legs, middle needs to be positioned under wound. Call Wound Care Nurse with any questions. Resident #1 Record review of Resident #1's face sheet dated 08/07/25 revealed an [AGE] year-old admitted to the facility on [DATE] and initially admitted on [DATE] with diagnoses to include cancer of the tongue and of the throat; Hemiplegia (one side paralysis or severe loss of strength on one side) following a stroke; high blood pressure, irregular often rapid heartbeat, and muscle wasting. Record review of Resident #1's Braden scale for predicting pressure ulcers risk evaluation on 05/22/25 revealed a score of 15 indicating he was at risk. Record review of Resident #1's quarterly MDS dated [DATE] revealed a BIMS score of 13 out of 15 indicating intact cognition. He required substantial/maximum assistance with bed mobility. Resident #1 had one unstageable pressure ulcer. Skin and ulcer treatment: pressure reducing device for the chair, pressure reducing device for the bed, pressure ulcer/injury care and application of dressings to the feet. Resident #1 had a feeding tube to receive nutrition. Record review of Resident #1's undated care plan revealed: Focus - Resident #1 had an unstageable pressure ulcer to the left heel 7/23/25. Goal - Resident #1 will remain free of infection. Interventions included - monitor for changes in skin status and notify (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	physician, refer resident to wound specialist, resident needs to float heels on pillow, resident needs weekly evaluation of wound healing. Further review of the care plan revealed no specific intervention to apply heel protector boots. Record review of Resident #1's July 2025 Task Care Record revealed, Resident #1 was only scheduled to be turned/repositioned every shift (three times a day). The task was completed and signed for no more than 3 times each day. Record review of Resident #1's August 2025 Task Care Record revealed, Resident #1 was only scheduled to be turned/repositioned every shift (three times a day). The task was completed and signed for no more than 3 times each day. Record review of Resident #1's Skin Monitoring: Comprehensive CNA Shower Review revealed, he had no marked areas of concern (bruising, skin tears, rashes, dryness, lesions, bed sores, blisters, scratches, abnormal color, abnormal skin, or hardened skin) on: 06/17/25, 07/18/25, 07/28/25, 08/01/25, 08/06/25, 08/08/25, 08/11/25, 08/17/25, 07/05/25, - On 08/12/25 he was marked with a skin tear in the inguinal region (where the thigh meets the torso) and sacrum (triangular area below the spine)- On 08/14/25 he was marked with a skin tear on the sacrum. Record review of the facility's weekly pressure report dated 08/01/25 revealed Resident # had an unstageable pressure ulcer to the left heel that was acquired in house and identified on 07/23/25. Record review of Resident #1's wound assessment report for 07/30/25 written by the wound care MD revealed the stage 4 pressure injury to the left posterior heel was acquired in house on 07/23/25. Record review of Resident #1's order summary report printed on 08/06/25 revealed active order to cleanse unstageable pressure injury to the left heel with normal saline, pat dry, apply Santyl to the wound bed, cover with silicone border dressing every day shift for wound care, start date was 07/25/25; an active order to check placement of pressure reduction mattress every shift for preventative measures, dated 07/16/25; an active order to check pressure reduction device to the wheelchair every shift for preventative measures. Further review of the order summary report revealed there was no order for heel protector boots. Record review of Resident #1's follow up wound evaluation noted, date of service 08/06/25, by the Wound Care NP revealed the assessment included unstageable pressure ulcer of the left heel and the plan was to continue offloading boots for pressure relief. Resident #37 Record review of Resident #37's face sheet dated 8/05/25 revealed a [AGE] year-old admitted to the facility on [DATE], initially admitted on [DATE] and originally admitted on [DATE]. Diagnoses included Guillain-Barre syndrome (a rare condition in which the immune system attacks the nerves causing weakness, numbness or paralysis), heart attack, Quadriplegia (condition characterized by partial or complete paralysis of all four limbs and torso), and dementia. Record review of Resident #37's annual MDS dated [DATE] revealed a BIMS score of 13 out of 15 indicating intact cognition, impairment on both sides of upper and lower extremities and required substantial/maximal assistance for bed mobility. Section M-Skin Conditions revealed Resident #37 was at risk of developing pressure ulcers/injuries and did not have any unhealed pressure ulcers/injuries. Record review of Resident 37's Braden scale for predicting pressure ulcers risk evaluation on 07/04/25 revealed a score of 12 indicating high risk. Record review of Resident #37's undated Care Plan Report revealed: Focus - Resident #37 has actual pressure ulcer development r/t impaired mobility and incontinence. Right heel, 5/7/25. Revision was made on 07/01/25. Goal - The resident will have intact skin, free of redness, blisters or discoloration by/through review date. Target date was 08/25/25. Interventions included - Administer treatments as ordered and monitor for effectiveness, follow facility policies/protocols for the prevention/treatment of skin breakdown, monitor/document/report PRN any changes in skin status, weekly skin assessments. Record review of Resident #37's Skin Monitoring: Comprehensive CNA Shower Review revealed, he had no marked areas of concern (bruising, skin tears, rashes, dryness, lesions, bed sores, blisters, scratches, abnormal color, abnormal skin, or hardened skin) on: 6/03/25, 06/05/25, 06/05/25, 06/10/25, OHH 6/12/25, 06/14/25, Both 6/17/25, 06/19/25, 06/21/25, 06/24/25, 06/26/25, 06/28/25, 07/01/25, 07/03/25, 07/05/25, 07/08/25, 07/10/25, 07/12/25, 07/12/25, 07/19/25, 07/15/25, 07/17/25, 07/19/25 07/22/25, 07/24/25, 07/26/25, 07/29/25, 07/31/25, 08/02/25, 08/05/25, 08/07/25, 08/09/25, 08/12/25, 08/14/25, 08/21/25, 08/26/25, (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	09/02/25, 09/04/25, 09/09/25. Record review of Resident #37's May 2025 Task Care Record revealed, Resident #37 was scheduled for turning/reposition every 2 hours (12 times a day); the task was not completed 12 times a day. Record review of Resident #37's Progress Notes 04/01/25 to 08/08/25 revealed, the first time Resident #37's wound was observed on 05/07/25.- 05/07/2025 09:46 AM: The Change In Condition/s reported on this CIC Evaluation are/were: Change in skin color or condition. Record review of Resident #37's Wound Assessment Report dated 05/07/25 revealed, Location: Right Heel Etiology: Bullae (large blister containing serous fluid), Pressure Injury Stage/Severity: Deep Tissue Injury Acquired in House: Yes Date Wound Acquired: 05/07/2025 In Remission: No Wound Status: New Record review of Resident #37's June 2025 Task Care Record revealed, Resident #37 was scheduled for turning/reposition every 2 hours (12 times a day); the task was not completed 12 times a day. Record review of Resident #37's July 2025 Task Care Record revealed, Resident #37 was scheduled for turning/reposition every 2 hours (12 times a day) from 07/01/25 to 07/20/25; the task was not completed 12 times a day. On 07/20/25 the task was changed so the resident was only turned/repositioned every shift (three times a day). The task was completed and signed for no more than 3 times each day. Record review of Resident #37's August 2025 Task Care Record revealed, Resident #37 was only scheduled to be turned/repositioned every shift (three times a day). The task was completed and signed for no more than 3 times each day. Record review of the facility weekly pressure report dated on 08/01/25 revealed Resident #37 had a stage 4 pressure ulcer to the right heel that was acquired in house and identified on 05/07/25. Record review of Resident #37's physician order summary report dated 08/06/25 revealed an order for the stage 4 pressure injury (a deep wound that exposes underlying muscle, tendon, cartilage or bone) to the right heel: cleanse with wound cleanser, pat dry, apply Santyl and calcium alginate with silver and cover with border foam dressing every day shift and as needed, dated 08/05/25; an order for low air loss mattress for pressure reducing measures every shift, dated 07/20/25. Record review of Resident #37's follow up wound evaluation note dated 08/06/25 by the wound care NP revealed the recommended treatment included air boots while in bed. Record review of Resident #37's September 2025 Task Care Record revealed, Resident #37 was only scheduled to be turned/repositioned every shift (three times a day). The task was completed and signed for no more than 3 times each day. Observation and interview of wound care for Resident #37 on 08/07/25 at 10:00 AM, by the Wound Care Nurse and the Physical Therapist revealed the resident had two large circular red spots to the right heel with light colored edges and the surrounding skin was pinkish red in color. The Wound Care Nurse stated the wound was originally one large wound. The Physical Therapist performed the ultramist wound therapy (a painless, non-contact treatment that uses low-frequency ultrasound energy and a saline mist to promote healing in chronic and difficult-to-heal wounds) which took approximately 3 minutes, then the wound care nurse completed the wound care without incident. In an observation and interview on 09/16/25 at 03:00 PM, Resident #37 lying in bed with pressure relieving boots on. She said her pressure ulcer on her heel started off as a blister and at the time she did not use pressure relieving boots. Resident #37 said she only started wearing the boots after she developed her pressure ulcer. In an interview on 08/06/25 at 9:45 AM, the Wound Care Nurse stated there have been issues with heel boots not being applied when supposed to particularly with Resident #41 and Resident #30. The Wound Care Nurse stated the orders for the boots were in the MAR, but she would find that the residents would not have the boots on. The Wound Care Nurse stated the CNAs would immediately place the heel protectors on the residents when the wound care nurse was seen rounding. The Wound Care		

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pain management consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 8 residents (Resident #82) reviewed for pain management. - The facility failed to continuously assess Resident #82's pain for more than 24 hours after her admission on [DATE]. This failure could place residents at risk for decreased quality of life, uncontrolled, irretractable pain, and hospitalization. Findings Include: Record review of Resident #82's Face Sheet, dated 08/06/25, revealed an [AGE] year-old female, admitted to the facility from a private home for hospice-respite services, with diagnoses of: Alzheimer's Disease, protein-calorie malnutrition. Record review of Resident #82's Admin Census revealed, she admitted to the facility on [DATE] at 1:16 PM. Record review of Resident #82's Entry MDS dated [DATE] revealed, Resident #82 entered from hospice. Record review of Resident #82's Baseline Care Plan, signed by LVN J on 08/05/25, revealed, comments- Resident #82 was confused and blind. Medications Resident #82 was taking: opioids was not documented/selected. Medical conditions; does resident need terminal care was documented as NO. Record review of Resident #82's Clinical admission documentation, dated 08/05/25 at 09:04 PM, revealed, the resident arrived on a stretcher with no family/support person in attendance. The resident's baseline neurological information was unknown, she had highly impaired hearing, had chronic disorganized thinking, severe cognitive impairment, and mood was pleasant, and no unwanted behaviors witnessed was marked as ?not met.' Under special care: the options of hospice, respite and palliative care were not selected. Under pain; indicators of pain was marked as none. Mouth or facial pain, discomfort or difficulty with chewing was not assessed. Under the clinical care plan section, pain was blank. Vocal complaints of pain was not assessed. The following clinical suggestions were left blank/unchecked: Evaluate for factors that aggravate the pain (position, activity, etc.); Evaluate the side effects of pain medication(s); Administer pain medication as ordered - monitor effectiveness; Administer pain medication as ordered - monitor effectiveness; Evaluate for pain and discomfort. Record review of Resident #82's Order Summary Report dated 08/06/25 revealed:- Admit to facility under the care of the Medical Director for hospice or respite care. With a start date of 08/05/25.- Morphine 20 mg/5ml: give 0.5 ml by mouth every 1 hours as needed for SOB/pain. With a start date of 08/05/25.- Monitor pain and record per scale. Use the 0-10 Pain Scale or PAINAD Scale. Document vital signs,interventions, and outcomes, in the progress notes as needed. Use non-pharmacological pain interventionsas needed. NOTIFY PHYSICIAN IF PAIN IS NOT CONTROLLED. every shift. With a start date of 08/06/25.- Monitor for Decreased Respiratory rate, Drowsy, Change in Cognition, Pain control effectiveness, constipation, nausea, vomiting, or itching every shift. If any of these occur notify MD immediately.She had no other orders for any pain medication and no pain monitoring orders active on the day she admitted [DATE]. Record review of Resident #82's August MAR printed on 08/06/25 at 04:21 PM revealed,- Resident #82 had not received her morphine since admission.- on 08/06/25 LVN M had monitored the resident for pain but there was no documented pain scale. Record review of Resident #82's Pain Level: Weights & Vitals records on 08/06/25 at 04:22 PM revealed, the facility had not assessed or recorded any pain levels for Resident #82. Record review of Resident #82's Progress Notes printed on 08/06/25 at 04:25 PM revealed;- 08/05/25 at 08:19 PM signed by LVN J: Upon arrival, the resident presented with agitation, which was consistent with her baseline behavior. Obtaining vital signs was challenging, and the resident refused a full skin assessment.- 08/05/25 at 08:46 PM signed by LVN J: Resident not cooperative with transfers. Resident is not cooperative with repositioning.- 08/05/25 at 09:02 PM signed by LVN J: Behaviors: Repetitive: Chronic. Disruptive: Chronic. Resident has frequent delusions (e.g., suspicions, verbal disruption) that are harmful to self or others or limits participation in activities. Resident has behavior (i.e., combativeness, verbal disruptions) that is harmful to self or others or (continued on next page)		

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F 0697 Level of Harm - Actual harm Residents Affected - Few	limits participation in activities. Resident has anxiety or nervousness that impairs his/her quality of life or limits participation in activities. Medication Evaluation: Non-pharmacologic approaches have been used prior to prescribing the medication. Medication improved some of the resident's above symptoms.- 08/05/25 at 09:04 PM signed by LVN J: Mental Status: Resident was disorganized in thinking. Oriented to person.Disorganized thinking: Chronic. Level of cognitive impairment: Severe impairment (affecting all areas of judgement).- 08/06/25 at 07:42 PM signed by LVN G: staff in room to obtain vital signs when patient became agitated and upset and told staff to get the hell out.-08/07/25 at 09:00 AM signed by LVN S: Hospice was called regarding resident's behavior, and this nurse was told that one of the nurses would call her ASAP after getting an order from the MD for ABH cream for agitation and anxiety. Response still pending.- 08/07/25 at 01:05 PM signed by the DON: Resident observed in bed, hollering out at staff as they attempted to assist and resident observed saying don't touch me.-08/07/25 at 02:00 PM signed by LVN S: Resident was able to eat most of her dinner. she has been calm. there was no screaming and hollering at all and there was much more cooperation from her. Record review of Resident #82's Pain Assessments revealed, a pain assessment was completed on 08/06/25 at 05:49 PM by the Unit Manager. Resident #82 was unable to answer any questions about her pain frequency, the effect of pain on her function. The resident's numeric rating of pain was documented as 0 but the verbal descriptor scale was documented as not assessed. Staff documented Resident #82 had no indicators of pain or possible pain, and the pain management section that documented non-medication and medication management of pain was left blank. The final comment read: Resident denies pain at this time. Record review of Resident #82's POC Response History dated 08/06/25 at 07:25 PM revealed; there was no documentation of any assessment of pain. No data was found for Question 1: Resident Complained of Pain with answer options of Yes, No, Resident not available, Resident Refused and Not Applicable. In an observation and interview on 08/06/25 at 02:13 PM, inspection of the 200 Hall Nurse Cart with LVN M revealed:- a clear Ziploc bag with text that read loose [Resident #82] return to family; give to DON, loose narcotics no label that contained 12 prefilled 1 ml syringes with 0.5 ml of blue liquid labeled Morphine 20 mg/5ml. The syringe labels did not contain pharmacy information, prescriber information, resident information or directions for use.- Resident #82 had no control sheets for any medications including the morphine syringesLVN M said the prefilled syringes arrived with Resident #82, but they could not be used. She said the medication could not be used because they did not have the appropriate labeling so their contents could not be verified. LVN M said she had no other morphine available for Resident #82 and she had not administered any morphine to Resident #82 during her shift. In an interview on 08/06/25 at 03:15 PM, the DON said LVN J received the medications for Resident #82. She said the medication was not appropriately labeled so they could not be used. In an interview on 08/06/25 at 04:30 PM, the surveyor notified the DON that Resident #82 had not received any pain medication since admission and nursing staff reported they had no pain medication available for the resident. In an interview on 08/06/25 at 04:40 PM, LVN M said Resident #82 had not reported pain but she was agitated. She said she had checked on Resident #82 only 3 times during her shift that started at 6 AM. She said Resident #82 was only oriented to herself but she could press the call bell and the resident had not pressed it to report pain. LVN M said she had not done any specific pain monitoring for Resident #82. An observation on 08/06/25 at 04:43 PM revealed, Resident #82 in her room screaming out for a family member. The resident continuously bit the bed remote and the cord to the bed remote. She screamed saying give me my clothes that she stole. Do you know where some of my things are, I am fitting to call [the police department]. I assume she stole my clothes. The resident called people trash and said she was going to bop the shit out of someone and said she wanted to fight staff. Resident #82 continued to scream you're stupid that's what's wrong with you, you're dumb, she then calmed down and said I don't feel good someone try to take my pulse, I feel bad while biting her hand. In an interview on 08/06/25 at 04:43 PM, CNA AP said Resident #82 had been combative since admission on [DATE]. The resident was combative when providing incontinent care. The resident (continued on next page)		

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F 0697 Level of Harm - Actual harm Residents Affected - Few	was calm when she slept but when she was awake, she was fidgeting and trying to get out of bed. In an interview on 08/06/25 at 05:00 PM, LVN M said earlier she talked to the resident and she calmed down and laid back down but no one told her the resident was biting herself and attempting to hit staff. An observation on 08/06/25 at 05:05 PM revealed, LVN M talking to Resident #82 in the resident's room. LVN M asked Resident #82 if she wanted to drink and the resident said well, thank you darling. Resident #82 began screaming and said, Get that stuff off me, in my eye or nose she did not want it and it tastes awful and asked for a family member. LVN M asked Resident #82 who for a family member was and Resident #82 responded a good friend but get out of my face. Resident #82 said I don't feel good today I feel kind of bad, she continued to ask for a family member and said, I am going to lay back down, I don't feel good, I am tired. Resident #82's behaviors continued until 05:22 PM, as she shouted and insulted staff. Resident #82 said I don't feel good, that hurts, I don't feel so good. In an interview on 08/06/25 at 05:40 PM, the DON said Resident #82's hospice provider had not delivered the resident's pain medication and she requested it be ordered stat so at this moment Resident #82 had no medications available for pain management. She said she notified the Medical Director, who said he could not prescribe anything for Resident #82 since her initial medications were prescribed by hospice The DON said at this moment the facility could only use non-pharmacological methods like massage/repositioning and distraction if Resident #82 reported pain, so she notified the hospice medical director to call in a stat order for Resident #82's pain medications. She said based on the records she reviewed the nursing staff called the hospice provider to notify them they could not accept the medication and while Resident #82 had orders to receive morphine in the system there was none at hand at the time. The DON said she could attempt to get an alternative pain medication in the interim but she had not done so because she had just learned Resident #82 did not have any pain medication on hand. The DON said she did not know the frequency Resident #82 received pain medications in the past but due to the fact the resident had every 1-hour prn pain medication, nursing staff should check on the resident every 1 hour and document in the EMR. She said failure to adequately manage a resident's pain could result in withdrawal symptoms of nervousness, headaches, and nausea. The DON said with Resident #82's use of prn morphine the resident should have had orders for pain monitor and she said the facility needs to round on [Resident #82] often. An observation on 08/07/25 at 08:33 AM revealed, Resident #82 screamed at staff with the room door closed and a staff member later identified as CNA AE was heard responding to the resident. Resident #82 said I don't want bacon, are you that dumb, if you don't have any food with some food in it. If you throw one more piece of food in my face shut up. Is that clear if not the next piece is going to be in your face. I don't want Bacon, eggs, grits is there nothing else to eat. CNA AE said bacon, eggs and grits was for breakfast when Resident #82 said Can I get a piece of bread to make a sandwich, this is pathetic I want something to eat. I asked you a question, shut up, I wanna see what you are going to tell me. Resident #82 then asked, is the bacon the bacon, eggs the only thing you got? to which CNA AE said yes. The resident then screamed If you put one more thing in my mouth, I am going to slap you. If this falls in my lap, I am going to slap you in your face. Is there anything I can eat except that crap you showed me? to which CNA AE said, that's all we have. Resident #82 said I am trying to think of something I can eat, are you sure that's the only thing to which CNA AE said, yes mam, that's all we have. Resident #82 said Tell you a secret, bacon, eggs and grits are not what I want for breakfast lunch or dinner. CNA AE told Resident #82 that she would leave, and Resident #82 responded Is there anything else for dinner, you don't know a damn thing. Resident #82 said I there anything else for dinner, you don't know a damn thing. She said something inaudible and then die before asking for lunch meat, to which CNA AE said there was no lunch meat and lunch was at 12:00. In an interview on 08/07/25 at 08:45 AM, CNA AL said Resident #82 was very aggressive. He said when the resident admitted she tried to hit staff and said staff should Kill yourself and called people a piece of shit when they tried to weigh her in the mechanical lift (a device used to transfer individuals with limited mobility). As the surveyor interviewed CNA AL, Resident #82 was heard screaming I don't feel good (continued on next page)		

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F 0697 Level of Harm - Actual harm Residents Affected - Few	do you have anything to eat, mam mam, is there anyone in the house that has a brain. You are just downright dumb. CNA AL said he had not received any special instructions or directives on how to provide care to Resident #82. He just knew, in his professional experience, to make sure the resident's bed was in low position since the resident moved around in her bed and to keep the door open. Resident #82 was heard screaming y'all are dumb assess and CNA AE came out of the resident's room. An observation and interview on 08/07/25 at 08:49 AM revealed, Resident #82's breakfast tray. Her cup of orange juice was full and her bacon eggs and grits looked untouched. CNA AE said the resident was combative, while she was trying to assist her with breakfast and threw food at her. She said Resident #82 only ate 1 piece of bread, some grapes. In an interview on 08/07/25 at 08:52 AM, LVN S said Resident #82 had behaviors all morning and they were unable to treat her with her PRN medications because the resident refused medications. In an interview on 08/07/25 at 10:12 AM, the Medical Director said hospice was expected to provide all medications for hospice residents. He said if a resident admitted with inappropriately labeled medications nursing staff were supposed to rectify the issue while reconciling the medication. He said he was ok with the facility using Resident #82's inappropriately labeled medication and that's on hospice. In regard to ordering alternative medications in the interim when hospice medications were not available, the Medical Director said since it was a hospice resident, hospice had the responsibility for taking care of their patient. He said failure to have appropriate medications for hospice residents would place them at risk for pain, anxiety, and restlessness. The Medical Director said an opioid tolerant patient could experience withdrawal symptoms which included: tachycardia (fast heart rate), and increased agitation. He said when he assessed the resident she was resting comfortably. The Medical Director said facility staff had not notified him that the resident was yelling, screaming and threatening staff upon admission. He said if a hospice resident displayed those symptoms, the facility must call the hospice provider so they can address the behaviors. The Medical director said he expected residents with behaviors be seen immediately and medication administered to address the behaviors but he was not notified about the behaviors or the unavailable medication. He said he would intervene if hospice was not responding to the facility's requests and he wanted hospice to step up their game in regard to medication availability. The Medical director said he was notified yesterday of Resident #82's behaviors, and he would expect hospice to provide a response to reported behaviors or unavailable medications within 1-2 hours and facility to contact him within an 8-hour shift if hospice had not responded. When the Medical Director was asked at what point he would intervene, since Resident #82 had not had medications since admission, he would not provide an answer. The Medical Director said he had not been notified that Resident #82 was refusing her medications and failure to treat behaviors could place residents at risk for increased discomfort and escalating behaviors. An observation on 08/07/25 at 10:43 AM revealed, Resident #82 in bed screaming is anybody here. The DON was observed and heard on the phone at the nursing station talking to the hospice provider. She said Resident #82 had been at the facility since the 5th and asked if anyone was coming to see the resident. The DON said the resident had behaviors and hospice needed to come to the facility to complete an evaluation. In an interview on 08/07/25 at 11:22 AM, LVN J said he admitted Resident #82 around 6 PM on 08/05/25. He said the resident arrived at the facility unaccompanied via EMS transport but the hospice staff came in to tuck Resident #82 in. He said Resident #82's medications were found in her personal items in a dirty plastic bag with a pressed sealed, the medications were not appropriately labeled so they could not be used. LVN J said a medication had to have the resident's name, and strength. He said Resident #82's medications were mixed with red and green so he could not confirm what it was. He said he notified and showed the hospice staff the inappropriately labeled medication on the day Resident #82 admitted and the hospice nurse said she would take care of it. LVN J did not report Resident #82 experiencing any pain at admission. In an interview on 08/07/25 at 11:39 AM, the DON said Resident #82's Morphine came in at 1:30 AM on 08/07/25 (36 hours after the resident admitted). She said the information was just communicated to her and did (continued on next page)		

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F 0697 Level of Harm - Actual harm Residents Affected - Few	not require documentation in the resident's chart. An observation and interview on 08/07/25 at 12:26 PM, the Hospice Nurse was talking to Resident #82 in the resident's room. The Hospice Nurse said she provided care to Resident #82 prior to the resident's admission to the facility. She said the resident was doing pretty good but she had a bad headache this morning. The Hospice Nurse said she did not tuck the resident in when she arrived and this was the first time she saw the resident since she admitted to the facility. She reviewed Resident #82's orders on her cellphone and said Resident #82's Morphine was ordered for prn every 1 hour, but the resident did not always receive pain medication. In an interview on 08/11/25 at 02:01 PM, the DON said failures with Resident #82's medications started with the hospice providers failure to provide appropriate medication. She said the facility has since educated their contracted hospice providers on the medication expectations and if a medication was unavailable nursing staff must immediately notify the doctor to get an alternative treatment that could be pulled from the automated dispensing system. She said the facility completed audits to ensure all residents had their pain medications, had appropriate pain monitoring orders, and ensured pain monitoring reflected the residents needs depending on how frequently the medication was administered. The DON said the facility completed audits to ensure all residents had their medications, trained staff on documentation of behaviors and the clinical management team will continue to audit the 24-hour report to ensure all identified behaviors are addressed. Record review of the undated facility policy titled Pain Management with no revision date revealed, Purpose: Ensure that residents receive pain management in accordance with professional standards of practice, the comprehensive person-centered care plan and the residents' goals and preferences. Procedure: The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan and the residents' goals and preferences. Pain management is based on the comprehensive assessment of a resident. In order to help a resident attain or maintain his or her highest practicable level of well-being and to prevent or manage pain, the facility, to the extent possible: 1. Recognizes when the resident is experiencing pain and identifies circumstances when pain can be anticipated. Medication regimens for residents receiving end of life, palliative or hospice care may include opioids alone or combining opioids and benzodiazepines. Their use must be consistent with accepted standards of practice for this specialty of care. Pharmacological as well as non-pharmacological interventions will be implemented in accordance with the comprehensive resident assessment. These interventions will be included in the resident's plan of care. Record review of the facility policy titled admission Order with no revision date revealed, Policy: admission Orders Purpose: Ensure each resident receives necessary care and services upon admission. Procedure: At the time each resident is admitted, this facility must have physician orders for the resident's immediate care. Physician orders for immediate care are those written and/or verbal orders this facility's staff need to provide essential care to the resident, consistent with the resident's mental and physical status upon admission to the facility. These orders should, at a minimum, include dietary, medications (if necessary) and routine care to maintain or improve the resident's functional abilities until staff can conduct a comprehensive assessment and develop an interdisciplinary care plan		

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F 0755 Level of Harm - Actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident and ensure it had a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable accurate reconciliation and that drug records were in order and an account of all controlled drugs was maintained and periodically reconciled for 1 of 3 (200 Hall Medication Cart) medication carts and 5 of 8 residents (Resident #49, Resident #69, Resident #71, Resident #75 and Resident #82) reviewed for pharmacy services. - The facility failed to acquire medications hospice residents and residents admitted for respite care (a short term stay in a nursing facility that provides temporary relief for caregivers of individuals needing assistance, allowing them to take a break from their caregiving duties) immediately after admission which resulted in: Resident #82 not having morphine available at admission and not having her ABH gel (a topical containing Alprazolam/Benadryl/Haldol that is applied to the wrist used to treat behaviors) leaving the resident with uncontrolled behaviors, unable to eat and combative with staff.- The facility failed to have a system in place to log and track ABH gel (lorazepam/Benadryl/Haldol) and Morphine received for Resident #82 on 08/05/25.- The facility failed to ensure the 200 Hall Nursing Cart did not contain expired Insulin for administration to Resident #69.- The facility failed to ensure nursing staff administered pre-prandial (before a meal) insulin to Resident #2, Resident #8, Resident #19, and Resident #65 safely by administering it more than 30 minutes before scheduled meals. These failures could place residents at risk for misappropriation of controlled substances, uncontrolled pain, uncontrolled behaviors and hospitalization. Findings include: Record review of the facility In-service/Education Sheet dated 01/08/25 revealed, Subject- Ordering Medication. When ordering medication, we only order medications for long-term residents who are not hospice. Any resident on hospice service that need medication. Hospice should be notified and called to fill those RX. Any respite residents should come in with their own medication. We DO NOT order medication for hospice or respite residents. IF YOU HAVE ANY QUESTIONS/CONCERNS PLEASE REACH OUT TO THE UNIT MANAGER. Record review of Resident #82's Face Sheet, dated 08/06/25, revealed an [AGE] year-old female, admitted to the facility from a private home for hospice-respite services, with diagnoses of: Alzheimer's Disease, protein-calorie malnutrition. Record review of Resident #82's Admin Census revealed, she admitted to the facility on [DATE] at 1:16 PM. Record review of Resident #82's Entry MDS dated [DATE] revealed, Resident #82 entered from hospice. Record review of Resident #82's Baseline Care Plan, signed by LVN J on 08/05/25, revealed, comments- Resident #82 was confused and blind. Medications Resident #82 was taking: opioids was not documented/selected. Medical conditions; does resident need terminal care was documented as NO. Record review of Resident #82's Clinical admission documentation, dated 08/05/25 at 09:04 PM, revealed, the resident arrived on a stretcher with no family/support person in attendance. The resident's baseline neurological information was unknown, she had highly impaired hearing, had chronic disorganized thinking, severe cognitive impairment, and mood was pleasant, and no unwanted behaviors witnessed was marked as 'not met.' Under special care: the options of hospice, respite and palliative care were not selected. Under pain; indicators of pain was marked as none. Mouth or facial pain, discomfort or difficulty with chewing was not assessed. Under the clinical care plan section, pain was blank. Vocal complaints of pain was not assessed. The following clinical suggestions were left blank/unchecked: Evaluate for factors that aggravate the pain (position, activity, etc.); Evaluate the side effects of pain medication(s); Administer pain medication as ordered - monitor effectiveness; Evaluate for pain and discomfort. Record review of Resident #82's Progress Notes printed on 08/06/25 at 04:25 PM revealed;- 08/05/25 at 08:19 PM signed by LVN J: Upon arrival, the resident (continued on next page)		

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F 0755 Level of Harm - Actual harm Residents Affected - Few	presented with agitation, which was consistent with her baseline behavior. Obtaining vital signs was challenging, and the resident refused a full skin assessment.- 08/05/25 at 08:46 PM signed by LVN J: Resident not cooperative with transfers. Resident is not cooperative with repositioning.- 08/05/25 at 09:02 PM signed by LVN J: Behaviors: Repetitive: Chronic. Disruptive: Chronic. Resident has frequent delusions (e.g., suspicions, verbal disruption) that are harmful to self or others or limits participation in activities. Resident has behavior (i.e., combativeness, verbal disruptions) that is harmful to self or others or limits participation in activities. Resident has anxiety or nervousness that impairs his/her quality of life or limits participation in activities. Medication Evaluation: Non-pharmacologic approaches have been used prior to prescribing the medication. Medication improved some of the resident's above symptoms.- 08/05/25 at 09:04 PM signed by LVN J: Mental Status: Resident was disorganized in thinking. Oriented to person.Disorganized thinking: Chronic. Level of cognitive impairment: Severe impairment (affecting all areas of judgement).- 08/06/25 at 07:42 PM signed by LVN G: staff in room to obtain vital signs when patient became agitated and upset and told staff to get the hell out.-08/07/25 at 09:00 AM signed by LVN S: Hospice was called regarding resident's behavior, and this nurse was told that one of the nurses would call her ASAP after getting an order from the MD for ABH cream for agitation and anxiety. Response still pending.- 08/07/25 at 01:05 PM signed by the DON: Resident observed in bed, hollering out at staff as they attempted to assist and resident observed saying don't touch me.-08/07/25 at 02:00 PM signed by LVN S: Resident was able to eat most of her dinner. she has been calm. there was no screaming and hollering at all and there was much more cooperation from her. Record review of Resident #82's Order Summary Report dated 08/06/25 revealed.- Admit under the care of the [Medical Director] for hospice or respite care with a start date of 08/05/25.- Escitalopram 10 mg: give 1 tablet by mouth one time a day for depression with a start date of 08/05/25.- Mirtazapine 15 mg: give 1 tablet by mouth at bedtime for depression with a start date of 08/05/25.- Lorazepam 1 mg: give 1 tablet by mouth every 2 hours as needed for anxiety/agitation with a start date of 08/05/25.- ABH Gel 1mg/25mg/1mg/mL gel: apply 1 ml to inner wrist every 6 hours prn severe agitation with a start date of 08/05/25.- Morphine 20 mg/5ml: give 0.5 ml by mouth every 1 hours as needed for SOB/pain. With a start date of 08/05/25. In an observation and interview on 08/06/25 at 02:13 PM, inspection of the 200 Hall Nurse Cart with LVN M revealed:- a clear Ziploc bag with text that read loose [Resident #82] return to family; give to DON, loose narcotics no label that contained 12 prefilled 1 ml syringes with 0.5 ml of blue liquid labeled Morphine 20 mg/5ml. The syringe labels did not contain pharmacy information, prescriber information, resident information or directions for use.- Resident #82 had no control sheets for any medications including the morphine syringesLVN M said the prefilled syringes arrived with Resident #82, but they could not be used. She said the medication could not be used because they did not have the appropriate labeling so their contents could not be verified. LVN M said she had no other morphine available for Resident #82 and she had not administered any morphine to Resident #82 during her shift. In an interview on 08/06/25 at 03:15 PM, the DON said LVN J received the medications for Resident #82. She said the medication was not appropriately labeled so they could not be used. In an interview on 08/06/25 at 04:30 PM, the surveyor notified the DON that Resident #82 had not received any pain medication since admission and nursing staff reported they had no pain medication available for the resident. In an interview on 08/06/25 at 04:40 PM, LVN M said Resident #82 had not reported pain but she was agitated. She said she had checked on Resident #82 only 3 times during her shift that started at 6 AM. She said Resident #82 was only oriented to herself but she could press the call bell and the resident had not pressed it to report pain. LVN M said she had not done any specific pain monitoring for Resident #82. An observation on 08/06/25 at 04:43 PM revealed Resident #82 in her room screaming out for a family member. The resident continuously bit the bed remote and the cord to the bed remote. She screamed saying give me my clothes that she stole. Do you know where some of my things are, I am fitting to call [the police department]. I assume she stole my clothes. The resident called people trash and said she was going to bop the shit out of someone and said she wanted to fight staff. (continued on next page)		

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F 0755 Level of Harm - Actual harm Residents Affected - Few	Resident #82 continued to scream you're stupid that's what's wrong with you, you're dumb. She then calmed down and said, I don't feel good someone try to take my pulse, I feel bad while biting her hand. In an interview on 08/06/25 at 04:43 PM, CNA AP said Resident #82 had been combative since admission on [DATE]. The resident was combative when providing incontinent care. The resident was calm when she slept but when she was awake, she was fidgeting and trying to get out of bed. In an interview on 08/06/25 at 05:00 PM, LVN M said earlier she talked to the resident and she calmed down and laid back down but no one told her the resident was biting herself and attempting to hit staff. An observation on 08/06/25 at 05:05 PM revealed. LVN M talking to Resident #82 in the resident's room. LVN M asked Resident #82 if she wanted to drink and the resident said well, thank you darling. Resident #82 began screaming and said, Get that stuff off me, in my eye or nose she did not want it and it tastes awful and asked for . LVN M asked Resident #82 who was and Resident #82 responded a good friend but get out of my face. Resident #82 said I don't feel good today I feel kind of bad, she continued to ask for a family member and said, I am going to lay back down, I don't feel good, I am tired. A staff member attempted to put a pillowcase on her pillow and Resident #82 snatched at it, tugging at it before the staff member released the pillow and the resident said, you better shut up, you ain't got nothing but yourself. LVN M retrieved Lorazepam and attempted to administer it to Resident #82 and the resident said get out of my face, I want you all to get out of my house or I will call the police. Need a brain in your head. LVN M was unable to administer the medication and walked towards her nursing cart and then Resident #82 said Need a brain in your head, I don't feel feel good, I feel real sick. LVN M hid the Lorazepam in pudding and administered the medication to Resident #82 who then said, I don't like you; I don't want you here. I know how you are; you are a liar. Resident #82's behaviors continued until 05:22 PM, as she shouted and insulted staff. Resident #82 said I don't feel good, that hurts, I don't feel so good. In an interview on 08/06/25 at 05:40 PM, the DON said Resident #82's hospice provider had not delivered the resident's pain medication and she requested it be ordered stat so at this moment Resident #82 had no medications available for pain management. She said she notified the Medical Director, who said he could not prescribe anything for Resident #82 since her initial medications were prescribed by hospice The DON said at this moment the facility could only use non-pharmacological methods like massage/repositioning and distraction if Resident #82 reported pain, so she notified the hospice medical director to call in a stat order for Resident #82's pain medications. She said based on the records she reviewed the nursing staff called the hospice provider to notify them they could not accept the medication and while Resident #82 had orders to receive morphine in the system there was none at hand at the time. The DON said she could attempt to get an alternative pain medication in the interim but she had not done so because she had just learned Resident #82 did not have any pain medication on hand. The DON said she did not know the frequency Resident #82 received pain medications in the past but due to the fact the resident had every 1-hour prn pain medication, nursing staff should check on the resident every 1 hour and document in the EMR. She said failure to adequately manage a resident's pain could result in withdrawal symptoms of nervousness, headaches, and nausea. The DON said with Resident #82's use of prn morphine the resident should have had orders for pain monitor and she said the facility needs to round on [Resident #82] often. An observation on 08/07/25 at 08:33 AM revealed, Resident #82 screamed at staff with the room door closed and a staff member later identified as CNA AE was heard responding to the resident. Resident #82 said I don't want bacon, are you that dumb, if you don't have any food with some food in it. If you throw one more piece of food in my face shut up. Is that clear if not the next piece is going to be in your face. I don't want Bacon, eggs, grits is there nothing else to eat. CNA AE said bacon, eggs and grits was for breakfast when Resident #82 said Can I get a piece of bread to make a sandwich, this is pathetic I want something to eat. I asked you a question, shut up, I wanna see what you are going to tell me. Resident #82 then asked, is the bacon the bacon, eggs the only thing you got? to which CNA AE said yes. The resident then screamed If you put one more thing in my mouth, I am going to slap you. If this falls in my lap, I am going to slap you in your face. Is there (continued on next page)		

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F 0755 Level of Harm - Actual harm Residents Affected - Few	anything I can eat except that crap you showed me? to which CNA AE said, that's all we have. Resident #82 said I am trying to think of something I can eat, are you sure that's the only thing to which CNA AE said, yes mam, that's all we have. Resident #82 said Tell you a secret, bacon, eggs and grits are not what I want for breakfast lunch or dinner. CNA AE told Resident #82 that she would leave, and Resident #82 responded Is there anything else for dinner, you don't know a damn thing. Resident #82 said I there anything else for dinner, you don't know a damn thing. She said something inaudible and then die before asking for lunch meat, to which CNA AE said there was no lunch meat and lunch was at 12:00. In an interview on 08/07/25 at 08:45 AM, CNA AL said Resident #82 was very aggressive. He said when the resident admitted she tried to hit staff and said staff should Kill yourself and called people a piece of shit when they tried to weigh her in the mechanical lift (a device used to transfer individuals with limited mobility). As the surveyor interviewed CNA AL, Resident #82 was heard screaming I don't feel good do you have anything to eat, mam mam, is there anyone in the house that has a brain. You are just downright dumb. CNA AL said he had not received any special instructions or directives on how to provide care to Resident #82. He just knew, in his professional experience, to make sure the resident's bed was in low position since the resident moved around in her bed and to keep the door open. Resident #82 was heard screaming y'all are dumb assess and CNA AE came out of the resident's room. An observation and interview on 08/07/25 at 08:49 AM revealed, Resident #82's breakfast tray. Her cup of orange juice was full and her bacon eggs and grits looked untouched. CNA AE said the resident was combative, while she was trying to assist her with breakfast and threw food at her. She said Resident #82 only ate 1 piece of bread, some grapes. In an interview on 08/07/25 at 08:52 AM, LVN S said Resident #82 had behaviors all morning and they were unable to treat her with her PRN medications because the resident refused medications. In an interview on 08/07/25 at 10:12 AM, the Medical Director said hospice was expected to provide all medications for hospice residents. He said if a resident admitted with inappropriately labeled medications nursing staff were supposed to rectify the issue while reconciling the medication. He said he was ok with the facility using Resident #82's inappropriately labeled medication and that's on hospice. In regard to ordering alternative medications in the interim when hospice medications were not available, the Medical Director said since it was a hospice resident, hospice had the responsibility for taking care of their patient. He said failure to have appropriate medications for hospice residents would place them at risk for pain, anxiety, and restlessness. The Medical Director said an opioid tolerant patient could experience withdrawal symptoms which included: tachycardia (fast heart rate), and increased agitation. He said when he assessed the resident she was resting comfortably. The Medical Director said facility staff had not notified him that the resident was yelling, screaming and threatening staff upon admission. He said if a hospice resident displayed those symptoms, the facility must call the hospice provider so they can address the behaviors. The Medical director said he expected residents with behaviors be seen immediately and medication administered to address the behaviors but he was not notified about the behaviors or the unavailable medication. He said he would intervene if hospice was not responding to the facility's requests and he wanted hospice to step up their game in regard to medication availability. The Medical director said he was notified yesterday of Resident #82's behaviors, and he would expect hospice to provide a response to reported behaviors or unavailable medications within 1-2 hours and facility to contact him within an 8-hour shift if hospice had not responded. When the Medical Director was asked at what point he would intervene, since Resident #82 had not had medications since admission, he would not provide an answer. The Medical Director said he had not been notified that Resident #82 was refusing her medications and failure to treat behaviors could place residents at risk for increased discomfort and escalating behaviors. An observation on 08/07/25 at 10:43 AM revealed, Resident #82 in bed screaming is anybody here. The DON was observed and heard on the phone at the nursing station talking to the hospice provider. She said Resident #82 had been at the facility since the 5th and asked if anyone was coming to see the resident. The DON said the resident had behaviors and hospice needed to come to the facility to (continued on next page)		

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F 0755 Level of Harm - Actual harm Residents Affected - Few	complete an evaluation. In an interview on 08/07/25 at 10:47 AM, LVN S said she called the hospice provider to see if they could bring Resident #82's ABH gel and the resident really needed it. She said the facility currently had nothing in place to prevent/treat Resident #82's behaviors and the only medication she could administer was morphine because it was a liquid. An observation on 08/07/25 at 10:49 AM revealed, VP A and CNA AL in Resident #82's room. Resident #82 said I called about 5 to 8 times for help. VP A asked what Resident #82 needed and the resident said, a potty, I got to TT, got to real bad, oh man that hurts. Resident #82 said, I gotta go real bad, it takes forever for someone to come. She had to go bad but no one was here. Oh, that hurts. VP A instructed CNA AL to go to therapy to get a wheelchair to take Resident #82 to the restroom. At 10:53 AM, CNA AL returned to Resident #82's room with a wheelchair and informed the resident she got a wheelchair to take her to the restroom to which Resident #82 said thank you. In an interview on 08/07/25 at 11:22 AM, LVN J said he admitted Resident #82 around 6 PM on 08/05/25. He said the resident arrived at the facility unaccompanied via EMS transport but the hospice staff came in to tuck Resident #82 in. He said Resident #82's medications were found in her personal items in a dirty plastic bag with a press zipper, and the medications were not appropriately labeled so they could not be used. LVN J said a medication had to have the resident's name, strength and Resident #82's medications appeared to be mixed fluids that were red and green so he could not confirm what it was. He said he notified and showed the hospice staff of the inappropriately labeled medication on the day Resident #82 admitted and the hospice nurse said she would take care of it. LVN J said when the resident arrived, she displayed behaviors, she would tell people they were stupid or say, I love you and he did not remember if he administered her any medications for behaviors but if he did it should be recorded in the resident's chart. LVN J said he worked the morning shift when Resident #82 admitted to the facility, and he was not notified about the resident refusing meals or being difficult. He said he did not remember anything serious being brought to his attention' and there was nothing serious that he had to take any immediate action for in regard to Resident #82. In an interview on 08/07/25 at 11:39 AM, the DON said Resident #82's Morphine came in at 1:30 AM on 08/07/25 (36 hours after the resident admitted). She said the information was just communicated to her and did not require documentation in the resident's chart. An observation and interview on 08/07/25 at 12:26 PM, revealed the Hospice Nurse talking to Resident #82 in the resident's room. The Hospice Nurse said she provided care to Resident #82 prior to the resident's admission to the facility. She said the resident was doing pretty good but she had a bad headache this morning. The Hospice Nurse said she did not tuck the resident in when she arrived and this was the first time she saw the resident since she admitted to the facility. She reviewed Resident #82's orders on her cellphone and said Resident #82's Morphine was ordered for prn every 1 hour, but it was prn so the resident did not always receive pain medication. She said the resident liked to be left alone and the resident did not eat this morning because she did not care about the food. The Hospice Nurse said Resident #82 liked fast food, snacks, and sodas. She called Resident #82's family on the phone and asked them to bring the resident some snacks. The Hospice Nurse said the facility needed ABH gel on hand to be able to provide care to Resident #82, she said she had not seen the resident since she admitted on [DATE]. In an interview on 08/07/25 at 12:52 PM, the Hospice Nurse said sometimes Resident #82 will take her lorazepam but ABH gel was needed when Resident #82 became combative or when she refused her Lorazepam. She said she was not notified until this morning that the resident had behaviors and the facility did not have ABH gel. The Hospice Nurse said she received notification from her office at 09:49 AM this morning that the resident had behaviors, and there was an emergency need for the resident's ABH gel so she put in a stat order. She said the facility needs to notify the hospice provider as soon as possible when a resident had behaviors or needed medications. In an interview at 08/07/25 at 02:46 PM, LVB S said the facility received only 6 doses of ABH gel today, 08/07/25, at 1 PM. Record review of the facility policy Acceptance of medications on Admission with no revision date revealed, Purpose: Establish uniform guidelines for acceptance of medications upon admission of a resident to the facility. (continued on next page)		

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F 0755 Level of Harm - Actual harm Residents Affected - Few	Procedure: 1. Medications (e.g., drugs, sedatives, narcotics, medicated lotions, ointments, etc.) brought by or with the resident upon admission to the facility may not be used after admission unless the contents of the container have been examined and positively identified by the pharmacy/pharmacist or the resident's attending physician. 4. Medications which are accepted, but do not meet the facility's labeling requirements, must be returned to the pharmacy for proper labeling prior to administration. 5. If there is any doubt concerning the identity of a medication, the staff/charge nurse must contact the resident's attending physician and/or facility pharmacist 7. Medications not accepted by the facility must be returned to the resident's representative or destroyed in accordance with the facility's established procedures. 8. The staff/charge nurse will be responsible for documenting the results of the facility's decision to accept or reject medications brought by the resident upon admission. Record review of the facility policy titled admission Order with no revision date revealed, Policy: admission OrdersPurpose: Ensure each resident receives necessary care and services upon admission. Procedure: At the time each resident is admitted , this facility must have physician orders for the resident's immediate care. Physician orders for immediate care are those written and/or verbal orders this facility's staff need to provide essential care to the resident, consistent with the resident's mental and physical status upon admission to the facility. These orders should, at a minimum, include dietary, medications (if necessary) and routine care to maintain or improve the resident's functional abilities until staff can conduct a comprehensive assessment and develop an interdisciplinary care plan. In an interview on 08/11/25 at 02:01 PM, the DON said failures with Resident #82's medications started with the hospice providers failure to provide appropriate medication. She said the facility has since educated their contracted hospice providers on the medication expectations and if a medication was unavailable nursing staff must immediately notify the doctor to get an alternative treatment that could be pulled from the automated dispensing system. She said the facility completed audits to ensure all residents had their pain medications, had appropriate pain monitoring orders, and ensured pain monitoring reflected the residents needs depending on how frequently the medication was administered. The DON said the facility completed audits to ensure all residents had their medications, trained staff on documentation of behaviors and the clinical management team will continue to audit the 24-hour report to ensure all identified behaviors are addressed. 200 Hall Nursing CartRecord review of Resident #69's Face Sheet dated 08/11/25 revealed, a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses which included: hemiplegia and hemiparesis (weakness and paralysis) following cerebral infarction, Type 2 Diabetes Mellitus (DM), high blood pressure, and muscle weakness. Record review of Resident #69's Quarterly MDS dated [DATE] revealed severely impaired cognition as indicated by a BIMS score of 07 out of 15. The indication of use of insulin injections was noted. Record review of Resident #69's undated Care Plan revealed, Focus - Has Diabetes Mellitus and at risk for complications. Intervention: Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Record review of Resident #69's physician orders dated 08/11/25 revealed order dated 02/08/25 for Insulin Lispro Injection Solution 100 UNIT/ML (Insulin Lispro) Inject 10 unit subcutaneously after meals for DM II hold if missing a meal or fasting otherwise DO NOT hold without an order. In an observation and interview on 08/06/25 at 02:13 PM, inspection of the 200 Hall Nurse Cart with LVN M revealed:- An expired open and in-use 10 ml vial of HumaLOG Insulin with an open date of 07/01/25.- a clear plastic bag with text that read loose [Resident #82] return to family; give to DON, loose narcotics no label that contained 12 prefilled 1 ml syringes with 0.5 ml of blue liquid labeled Morphine 20 mg/5ml. The syringe labels did not contain pharmacy information, prescriber information, resident information, or directions for use.- Resident #82 had no control sheets for any medications including the morphine syringes. LVN M said nursing staff are expected to check their carts daily as used for expired and inappropriately labeled medication. She said insulin vials are labeled with the date opened in order to track their expiration date. LVN M said the vial of insulin was opened on 07/01/25 and it was expired because insulin is only good for 28 days after opening. She (continued on next page)		

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F 0755 Level of Harm - Actual harm Residents Affected - Few	said after expiration, insulin can lose its potency or become contaminated placing residents at risk of uncontrolled blood sugars or infections if used so they must be discarded. LVN M said she had administered Resident #69 insulin from that vial after the calculated expiration date of 07/28/25. LVN M said the inappropriately labeled prefilled syringes arrived with Resident #82, but they could not be used. She said the medication could not be used because they did not have the appropriate labeling so their contents could not be verified. LVN M said there were no control log sheets for the medications because it could not be used and they were to be returned to the family. She said normally when the facility received controlled medications nursing staff logged in the medication and documented use as well as disposal to prevent misappropriation. LVN M said since there was no record of the receipt of the medication there was no way to confirm how many syringes arrived with the resident or to track if the contents of the Ziploc were stolen. In an interview on 08/06/25 at 03:15 PM, the DON said LVN J received the medications for Resident #82. She said the medication was not appropriately labeled so they could not be used. She said when nursing staff received controlled substances 2 nurses were supposed to complete a count and then fill out and sign a narcotic log prior to placing the medication in the locked drawer to prevent diversion and to establish the count. She said failure to log controlled substances could place residents at risk of unauthorized access which could result in allergies, safety issues and misappropriation. The DON said nursing staff are expected to check their carts daily as used for expired or inappropriately labeled medication. She said multidose containers including insulin should be labeled with the date opened in order to track the expiration date. She said most insulin expire after 28 days and they can become contaminated or have decreased potency placing residents at risk for infection and hyperglycemia if used. Resident #49 Record review of Resident #49's Face Sheet dated 08/11/25 revealed, a [AGE] year-old male who admitted to the facility on [DATE] with diagnosis which included: Heart failure, Type 2 Diabetes Mellitus (DM), high blood pressure, and muscle weakness. Record review of Resident #49's Quarterly MDS dated [DATE] revealed cognitively intact as indicated by a BIMS score of 14 out of 15. The indication of use of insulin injections was noted. Record review of Resident #49's undated Care Plan revealed, Focus - Has Diabetes Mellitus and is at risk for complications. Intervention: Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Record review of Resident #49's physician orders dated 08/11/25 revealed order date of 05/01/2025 for NovoLOG Flexpen Subcutaneous Solution Pen injector 100 UNIT/ML (Insulin Aspart) Inject 8 units subcutaneously at bedtime for DM 2 HOLD FOR BS LESS THAN 150. Additionally, order date 04/30/2025 for NovoLOG Injection Solution 100 UNIT/ML (Insulin Aspart) Inject as per sliding scale: if 0 - 149 = 0 units; 150 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401 - 450 = 10 unit 10 units and call MD, subcutaneously before meals for DM. Review of Resident #49's MAR Location of Administrator Report revealed, Resident #49's sliding scale insulin was scheduled for 06:00 AM (1.5 hours before the scheduled breakfast); 11:30 AM and 04:30 PM- 07/05/25 Resident #49 received his insulin Aspart scheduled for 06:00 AM at 05:04 AM.- 07/10/25 Resident #49 received his insulin Aspart scheduled for 06:00 AM at 05:25 AM.- 07/13/25 Resident #49 received his insulin Aspart scheduled for 06:00 A		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure assessments accurately reflected the resident's status for 1 of 8 resident (Resident #26 and Resident #62) reviewed for accuracy of assessments. - The facility failed to ensure Resident #26's admission MDS, dated [DATE], accurately reflected the residents use of opioid pain medication, Oxycodone,. - The facility failed to ensure Resident #62's Annual MDS, dated [DATE], accurately reflected the residents significant weight loss of 12.7% over a 6-month period from 01/15/25 to 07/08/25 dated. These failures could place residents at risk of inaccurate assessments, which could compromise their plan of care . Findings include: Resident #62 Record review of Resident #62's face sheet, dated 08/10/25, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #62 had diagnoses which included: seizures, anxiety disorder, hypertension (high blood pressure) and alcohol dependence with alcohol induced persisting dementia. Record review of Resident #62's Annual MDS, dated [DATE], revealed intact cognition as indicated by a BIMS score of 14 out of 15, non-traumatic brain disfunction, non-Alzheimer's dementia. Resident #11 did not have weight loss of 5% of more in the last month or loss of 10% or more in the last 6 months. Record review of Resident #62's, undated, Care Plan revealed, Focus: impaired cognitive function/impaired thought process; Interventions- Administer medications as ordered. Focus- use of antipsychotic medication and at risk for complications. Interventions- monitor/report PRN adverse reactions to antipsychotic therapy; appetite loss & weight loss. There were no focus areas addressing any dietary or weight loss concerns for Resident #62. Record review of Resident #62's weights records revealed:- 01/14/25 at 03:38 PM- 129 lbs.- 07/08/25 at 02:14 PM- 112.6 lbs. Record review of Resident #62's Nutrition/Dietary Notes revealed,- 05/02/25 at 02:03 PM: RD note for weight change. CBW: 115 lbs. Current BMI: 22.5 (slightly under desired range for age). Weight trends: -2.2% x30 days, -7.3% x90 days, -10.9% x180 days. Ordered diet is adequate. Charted meal intake mostly 76-100% with/ a few refusals noted. Although no significant weight change has occurred x30 day, nutritional intervention may be beneficial at this time to prevent continued weight loss/promote weight stability. Ordered diet: Regular, Regular texture, thin consistencyRec: fortified food w/ all meals Goals: adequate PO intake, CBW +/- 5% x30 days. RD to monitor.- 07/09/25 at 03:23 PM: RD note for weight change. CBW: 112.6#. Current BMI: 21.3 (slightly under desired range for age).Weight trends: -1.7% x30 days, -4.1% x90 days, -12.7% x180 days. Ordered diet is adequate. Charted meal intake varies meal to meal, Resident able to make food preferences. Ordered diet: Regular, Regular texture, thin consistency. Goals: adequate PO intake, CBW +/- 5% x30 days RD to monitor.- 08/06/25 at 05:47 PM- Weight Review: CBW: 110 lbs. 61 Current BMI: 20.8 (slightly under desired range for age).Weight trends: -2.5% x30 days, -4.3% x90 days, -11.3% x180 days. Ordered diet: Regular, Regular texture, thin consistency. Charted meal intake varies meal to meal 26-76% depending on meal, Resident able to make food preferences known. Due to weight trends, and highly particular eating habits, RD rec order pre-albumin level x 1 to evaluate recent nutrition status. Res with history of significant weight loss, with non sig weight loss x 90/180 days. Note res has previously desired weight loss but now she is considering borderline underweight for age. RD will continue to monitor. An observation and interview on 08/05/25 at 09:21 AM revealed Resident #62 well groomed, well dressed in no immediate distress. She said the facility provided her sufficient food, her diet was appropriate and she had no issues or concerns. Resident #62 appeared thin but was in good spirits. Resident # 26 Record review of Resident #26's face sheet, dated 08/05/25, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #26 had diagnoses which included: fracture of the right forearm, person injured in traffic collision and orthopedic (having to do with bones, joints, ligaments, tendons and muscles) aftercare. Record review of Resident #26's admission MDS, dated [DATE], revealed intact cognition as indicated by a BIMS score of 14 out of 15, upper extremity (shoulder, elbow, wrist, hand) functional limitation in range of motion, and other (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	fracture. Under the pain assessment interview, Resident #26 reported: the presence of pain occasionally, with pain occasionally impacting her sleep, pain rarely or not at all interfering with her therapy activities and her day-to-day activities; and her pain intensity was a 02 out of 10. Under pain management, Resident #26 was coded no for: received scheduled pain medication regimen; no for received PRN pain medications or was offered and declined; and received non-medication intervention for pain. Record review of Resident #26's, undated, Care Plan revealed Focus: risk for pain related to recent fracture; Goal- resident will not have an interruption in normal activities due to pain through the review date; intervention- administer analgesic (drug to relieve pain) as per orders, monitor/record pain characteristics per shift and as needed. Record review of Resident #26's Order Summary Report, dated 08/10/25, revealed, - Acetaminophen 500 mg: give 2 tablets by mouth every 8 hours as needed for pain with order start date of 07/15/25- Oxycodone 5 mg: Give 1 tablet by mouth every 6 hours as needed for severe pain for 3 days 7-10 pain scale with order state of 07/15/25 and end date of 07/18/25.- Oxycodone 5 mg: Give 1 tablet by moth every 6 hours for severe pain with order start date of 07/16/25. - Oxycodone 5 mg: Give 1 tablet by mouth every 12 hours for severe pain with order start date of 07/17/25. - Lidocaine 5% patch: apply to lower back and right shoulder topically for lower back pain and right shoulder pain order start date 07/24/25.- Oxycodone 5 mg: Give 1 tablet by mouth every 8 hours as needed for pain with order start date of 08/01/25. Record review of Resident #26's Progress Notes revealed, 07/17/25 signed by the NP, - Resident #26's reported pain was adequately controlled; she is currently on oxycodone 5 mg every 12 hours. Patient currently has cast in place with minor swelling noted in fingers. Neurologically intact. Pain is adequately controlled with oxycodone 5 mg every 12 hours. Will continue current pain management regimen and wound care. Record review of Resident #26's July- August MAR revealed, -Resident #26 received scheduled and PRN oxycodone in July and PRN oxycodone in August. -Resident #26 was administered Lidocaine 5% Lidocaine patches to her back in July and August An observation and interview on 08/05/25 at 09:45 AM revealed Resident #26 lying in bed with a cast covered with a band aid wrap on her right lower arm. The resident said she broke her arm in a car accident, and she received scheduled pain medication, but it stopped when she was feeling better, and starting receiving PRN pain medication when she started experiencing pain again. Resident #26 reported her pain was controlled by her current pain regimen and she took her pain medications to get ahead of the pain. An observation on 08/06/25 at 08:15 AM revealed, LVN M applied a Lidocaine 5% patch to Resident #26 as ordered. In an interview on 08/11/25 at 07:37 AM, the MDS Nurse said she was the MDS coordinator for 2 years and she was responsible for completing MDS and Care Planning for the facility. She said the MDS was an assessment completed in collaboration with other facility staff that addressed the diagnosis, medications and treatments of a resident. The MDS nurse said she was responsible for the accuracy of the MDS, and no other staff verified the contents of the MDS after her. She said an inaccurate MDS placed residents at risk of the facility not having a true representation of the residents and the resident's needs not being met. In an interview on 08/11/25 at 01:13 PM, after reviewing Resident #62's MDS the MDS Nurse said the resident's MDS was inaccurate and significant weight loss should have coded in Resident #62's care plan. She said Resident #26 was administered pain medications scheduled and PRN in July prior to the completion of her MDS so her MDS should have been coded for received pain medications. She could not provide a reason Resident #26 and Resident #62's MDSs were inaccurate. Record review of the facility's policy titled Resident Assessment with no revision date revealed, .Procedure: This facility conducts initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. The comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, uses the resident assessment instrument (RAI) specified by CMS.		

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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 9%, based on 3 errors out of 32 opportunities, which involved 2 of 7 residents (Resident #48 and Resident #56) and 1 of 3 staff (LVN M) reviewed for medication errors.- LVN M failed to accurately administer medication to Resident #48 by crushing extended release Mucinec (a medication used for phlegm and congestion).- LVN M failed to accurately administer medications to Resident #56 by failing to administer the resident's Lexapro 5 mg (used to treat depression) and attempting to administer 10 ml of seizure medication (Levetiracetam) instead of 7.5 ml as ordered by the resident's physician. These failures could place all residents receiving medication at risk of inadequate therapeutic outcomes, increased negative side effects, and a decline in health. Findings include: Resident #56 Record review of Resident #56's Face Sheet dated 08/06/25 revealed, a [AGE] year-old male, who admitted to the facility on [DATE] with diagnoses which included: brain damage, type 2 diabetes, epilepsy (a brain condition in which abnormal electrical activity in the brain causes recurring seizures), MDD, difficulty swallowing, protein-calorie malnutrition (malnutrition caused by insufficient protein and calories), quadriplegia (full body paralysis) and gastrostomy status (a tube placed in the stomach through a hole in the abdomen). Record review of Resident #56's Annual MDS dated [DATE] revealed, short- and long-term memory problems, severely impaired cognitive skills for daily decision making, total dependence for all ADLs, aphasia (brain damage that affects the person's ability to communicate), feeding tube while a resident, received 51% or more of his intake via tube feeding and 501 ml per day or more via tube feeding. Record review of Resident #56's undated Care Plan revealed, Focus: may require tube feeding r/t dysphagia; intervention- the resident is dependent with tube feeding and water flushes. PPE required for high resident contact care activities. Focus: history of seizure disorders r/t anoxic (complete lack of oxygen) brain injury. Risk of infection- EBP at all time; interventions: Staff is to wear PPE's for all contact with resident as long as the resident is on EBP precautions, for things such as dressing, changing linens, transfers, providing hygiene, wound care, device care (or use), bathing or showering, changing briefs or assisting with toileting. Record review of Resident #56's Order Summary Report dated 08/06/25 revealed, - Bolus: ISOSOURCE 1.5 administer 1 can six times a day.- Check for residual. Hold feeding and notify MD if residual >150 mL every shift.- Flush tube with 30mL before and after feeding, Every shift.- Flush tube with 30mL before and after meds. Every shift.- Allopurinol Tablet 100 MG: Give 1 tablet by mouth two times a day for Gout. - Carvedilol Oral Tablet 3.125 MG: Give 1 tablet via PEG-Tube two times a day for hypertension; hold for SBP less 110 &or HR less than 60.- Entresto Oral Tablet 24-26 MG (Sacubitril-Valsartan) : Give 1 tablet via PEG-Tube two times a day for Hypertension; hold for SBP less than 110 &or HR 60.- Levetiracetam Oral Solution 100 MG/ML: Give 7.5 ml via PEG-Tube two times a day for seizure.- Lexapro Oral Tablet 5 MG (Escitalopram Oxalate) : Give 1 tablet via PEG-Tube one time a day for Depression. - Memantine HCl Oral Tablet 10 MG: Give 1 tablet via PEG-Tube two times a day for dementia.- Tramadol HCl Oral Tablet 50 MG: Give 1 tablet via PEG-Tube two times a day for Pain.- Valproic Acid Oral Solution 250 MG/5ML: Give 5 ml via PEG-Tube two times a day for seizure. Record review of Resident #56's August 2025 MAR revealed, LVN M did not administer Resident #56's Escitalopram 5 mg scheduled on 08/09/25 at 09:00 AM. An observation on 08/09/25 at 09:52 AM revealed, LVN M preparing medication for administration for Resident #56. She popped out 1 tablet of: Entresto, Memantine, Carvedilol, Allopurinol and Tramadol into individual medication cups; and poured out 5 ml of Valproic Acid and 10 ml of Levetiracetam. LVN M checked all drawers in her cart that contained blister packed medication but could not locate Resident #56's Lexapro so she proceeded without the medication. At 09:56 AM, she crushed each medication separately and returned them to their individual medication cups and at 10:00 LVN M she entered into Resident #56's room with all the medications. Resident #56 (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Eagle Crest Rapid Recovery		STREET ADDRESS, CITY, STATE, ZIP CODE 9602 Huffmeister Rd Houston, TX 77095	
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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was observed to be non-verbal.; He displayed an exaggerated smile intermittently and some nonverbal sounds. She dissolved each medication with 10-15 ml of water and mixed each with individual spoons. At 10:07 AM, she drew 30 ml of warm water into a syringe, connected it to Resident #56's G-tube port and pushed all 30 mL of water. Right after LVN M withdrew her first liquid medication and attempted to start administering the resident's medication, the surveyor stopped her and asked her to verify the volume of Levetiracetam she was going to administer. LVN M confirmed the volume was 10 ml instead of 7.5 ml and she wasted approximately 2.5 mL into the trash. LVN M then administered all 7 medications to Resident #56 by pushing them through the syringe with approximately a 10-15 ml of water flush in between each medication. In an interview on 08/09/25 at 03:15 PM, the DON said nursing staff are expected to check orders prior to administering medications and they must ensure the medications are the appropriate formulation that can be crushed. Resident #48Record review of the Resident #48's Face Sheet dated 08/06/25 revealed, a 75year-old male, who admitted to the facility on [DATE], with diagnoses including diagnosis which included: stage 4 pressure ulcer to the hip, left sided weakness and paralysis, and end stage renal disease.Record review of Resident #48's undated Care Plan revealed, Special Instructions: Crush Medications. Focus: acid reflux and risk for complications; interventions- give medications as ordered.Record review of Resident #48's Order Summary revealed, Guaifenesin ER Tablet Extended Release 12 Hour600 MG Give 1 tablet by mouth every 12 hours for congestion with start date of 08/05/25.An observation on 08/06/25 at 08:32 AM revealed, LVN M preparing for medication administration to Resident #48. She retrieved a Guaifenesin ER 600 mg (Mucinex) pill and crushed it along with 4 other solid form medications, mixed them in pudding and administered it to resident #48.In an interview on 08/09/25 at 02:23 PM, LVN M said she had not administered Resident #56's Lexapro because the pharmacy had not delivered the medication. She said she had access to the automated dispensing system; but she had not checked if it contained Lexapro and she did not know if it usually did. LVN M said nursing staff were expected to check the automated dispensing system when a medication was not available because failure to administer medications as ordered could place residents at risk for untreated health conditions and worsening of symptoms. She said ER medications could not be crushed because crushing these formulations would impact how the medication was absorbed.Record review of LVN M's Competency Assessment: Medication Administration dated 06/03/25 revealed, LVN M was deemed competent and was assessed for the right drug, right dose.Record review of the facility policy titled Medication Administration, General, with no revision date revealed, purpose: Safely and accurately administer physician-ordered medication to each resident. 5. Remember the six (6) Rs of correct medication administration: a. Right Resident; b. Right Drug; c. Right Dose: Verify against MAR, Check the medical record for the physician's order if unsure. d. Right Dosage Form, ^ Verify against the MAR; e. Right Time; f. Right Route. Only crush medications as ordered. The consulting pharmacy will provide a Do Not Crush list of medications. Consult a pharmacist before crushing medications if unsure. Some medications that are never to be crushed include: a. Enteric-coated medications; b. Sustained or extended-release tablets; c. Sublingual or buccal tablets; d. Effervescent tablets.Record review of the facility policy titled Medication Error, undated, with no revision date revealed, Definitions: Medication Error means the observed or identified preparation or administration of medications or biologicals which is not in accordance with: 1. The prescriber's order; 2. Manufacturer's specifications (not recommendations) regarding the preparation and administration of the medication or biological or 3. Accepted professional standards and principles which apply to professionals providing services. Accepted professional standards and principles include the various [NAME] Healthcare(R) 203 Operational Guidelines: Long-Term Care practice regulations in each State, and current commonly accepted health standards established by national organizations, boards, and councils.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents were free from any significant medication errors for 4 of 11 residents (Residents #2, #8, #19, and #65) reviewed for significant medication errors. - The facility failed to ensure nursing staff administered pre-prandial (before a meal) insulin to Resident #2, Resident #8, Resident #19, and Resident #65 safely by administering it more than 30 minutes before meals. This failure could place residents at risk of uncontrolled blood sugars, hypoglycemia (low blood sugars), hyperglycemia (high blood sugars) and worsening of diabetes. Findings included: Record review of the facility provided Schedule of Mealtimes with no revision date revealed:- Breakfast - Dining Room: 8:00 - 8:30; Hallway: 7:30 - 8:00.- Lunch - Dining Room: 12:00 - 12:30; Hallway: 11:30 - 12:00.- Dinner - Dining Room: 5:30 - 6:00; Hallway: 5:00 - 5:30. Record review of the American Diabetes Association: Glycemic Goals and Hypoglycemia- Standards of Care in Diabetes 2025 revealed, Blood sugars were in range when between 70- 180 mg/dL; level 1 hyperglycemia (181- 250 mg/ dL); Level 2 hyperglycemia (greater than 250 mg/dL)TIR 70-180 mg/dL; Goal of greater than 50 Percent of time in range.TAR >250 mg/dL; Goal of less than 10 Percent of time in level 2 hyperglycemia.TAR 181-250 mg; Goal of less than 50 Percent of time in level 1 hyperglycemia. In an interview and observation on 08/06/25 at 07:20 AM, LVN K said she had already administered insulin to her residents, including sliding scale insulins that must be administered before meals. The surveyor observed at the time of the interview breakfast was not yet served in the halls or in the dining room. In an interview an observation on 08/06/25 at 07:22 AM, LVN C said she had already administered insulin to her residents, including sliding scale insulins that must be administered before meals. She said she administered her morning insulins at approximately 6:45 AM, since they were scheduled at 7:00 AM. The surveyor observed at the time of the interview breakfast was not yet served in the halls or in the dining room and LVN C said breakfast was normally served at 08:00 AM. In an interview and observation on 08/06/25 at 07:25 AM, LVN M said she had already administered insulin to her residents including sliding scale insulins that must be administered before meals. The surveyor observed at the time of the interview breakfast was not yet served in the halls or in the dining room. Observations on 08/06/25 revealed- 07:34 AM: no breakfast on halls or in the dining area.- 07:45 AM: no breakfast on halls or in the dining area- 07:50 AM: no breakfast on halls or in the dining area.- 07:55 AM: no breakfast on halls or in the dining area.- 08:00 AM: no breakfast on halls or in the dining area.- 08:09 AM: no breakfast on halls or in the dining area- 08:15 AM: no breakfast on halls or in the dining area- 08:35 AM: no breakfast on 100, 200, 300, and 400 Halls, staff passed breakfast on 800, 500, 600 & 700 halls and breakfast served in the dining room.- 08:35 AM: Nursing staff passing breakfast on the 800 hall. In an interview on 08/06/25 at 11:26 AM, the Medical Director said pre-prandial/short acting insulin should be served 15-30 minutes before meals to adjust blood sugar for anticipated meals. He said administration of short acting insulin could place residents at risk for hypoglycemia (low blood sugar). In an interview on 08/06/25 at 11:42 AM, the DON said nursing staff were expected to wait until meal trays were on the halls and trays are being passed before administering insulin. She said the facility had insulin scheduled for 07:00 AM while breakfast was scheduled for 07:30- 08:00 AM. She said pre-prandial (before meals) insulin should be administered within 15 minutes of meals in order to prevent anticipated hyperglycemia (high blood sugar) associated with meals and to prevent hypoglycemia if insulin was administered too early before meals. The DON said she did not know when the facility staff administered insulin but she was unaware breakfast was not served until past 08:15 am. She said it was absolutely not appropriate for insulin to be administered an hour or more before a meal. The DON said breakfast was late that morning because one of the dietary staff did not show up for work. She said snacks were served after meals and at bedtime and facility residents did not receive any stacks between 6 AM and breakfast. Resident #2 Record review of Resident #2's Face Sheet dated 08/11/25 revealed, an [AGE] year-old (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	female who admitted to the facility on [DATE] with diagnoses including: Type 2 Diabetes Mellitus (DM), high blood pressure, blindness, generalized anxiety disorder, and muscle weakness. Record review of Resident #2's Quarterly MDS dated [DATE] revealed severely impaired cognition as indicated by a BIMS score of 01 out of 15. The indication of use of insulin injections was noted. Record review of Resident #2's undated Care Plan revealed, Focus - Has Diabetes Mellitus. Intervention: Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Record review of Resident #2's physician orders dated 08/11/25 revealed order date of 04/01/2025 for Insulin Lispro Injection Solution 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if 0 - 200 = 0 units; 201 - 250 = 2 units; 251 - 300 = 4 units; 301 - 350 = 6 units; 351 - 400 = 8 units GREATER THAN 400 = 10 UNITS & CALL MD & LAB AS ORDERED, subcutaneously with meals for ANTIDIABETICS. Record review of Resident #2's MAR Location of Administration Report revealed:- on 08/06/25 LVN C administered Resident #2's Insulin Lispro at 07:17 AM. Resident #8 Record review of Resident #8's Face Sheet dated 08/11/25 revealed, a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses including: Type 2 DM with hyperglycemia, Atherosclerotic Heart Disease (a buildup of plaque in blood vessels that can cause a heart attack, chest pain and stroke), high blood pressure, and end stage renal disease on dialysis. Record review of Resident #8's Quarterly MDS dated [DATE] revealed moderately impaired cognition as indicated by a BIMS score of 12 out of 15. The indication of use of insulin injections was noted. Record review of Resident #8's undated Care Plan revealed, Focus - Has Diabetes Mellitus and is at risk for complications. Intervention: Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Record review of Resident #8's physician orders dated 08/11/25 revealed order date of 03/21/2025 for Insulin Lispro (1 Unit Dial) Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if 150 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units 401 +/- Give 12 units and notify MD, subcutaneously before meals and at bedtime. Review of Resident #8's MAR revealed:- the resident's sliding scale insulin was scheduled for 07:00 AM, 11:00 AM 04:00 PM (1 hr. before dinner) and 08:00 PM- on 07/20/25 Resident #8 was administered his Humalog at 06:49 AM by LVN T Record review of Resident #8's blood sugar levels from 07/01/25 to 08/06/25 revealed, the resident had no recorded episodes of hypoglycemia (blood sugars under 70). He spent greater than 50% of time within the goal ADA range of 70-180. Resident #19 Record review of Resident #19's Face Sheet dated 08/11/25 revealed, a [AGE] year-old male who admitted to the facility on [DATE] with diagnosis which included: Alzheimer's Disease, Type 2 Diabetes Mellitus (DM), high blood pressure, and muscle wasting and atrophy. Record review of Resident #19's Quarterly MDS dated [DATE] revealed severely impaired cognition as indicated by a BIMS score of 03 out of 15. The indication of use of insulin injections was noted. Record review of Resident #19's undated Care Plan revealed, Focus - Has Diabetes Mellitus and is at risk for complications. Intervention: Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Record review of Resident #19's physician orders dated 08/11/25 revealed order date of 03/21/2025 for Insulin Lispro (1 Unit Dial) Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if 150 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units 401 +/- Give 12 units BS > Give 12 units and notify MD, subcutaneously before meals and at bedtime. Review of Resident #19's MAR Location Administration Report revealed, the resident's insulin lispro was scheduled for 07:00 AM, 11:00 AM, 4:00 PM (1 hr before dinner) and 08:00 PM.- on 08/07/25 Resident #19 was administered his 11:00 AM dose of insulin at 01:07 PM. Record review of Resident #19's blood sugar levels from 07/01/25 to 08/06/25 revealed, the resident had no recorded episodes of hypoglycemia (blood sugars under 70). He spent greater than 50% of time within the goal ADA range of 70-180. Resident #65 Record review of Resident #65's Face Sheet dated 08/11/25 revealed, a [AGE] year-old female who admitted to the facility on [DATE] with diagnosis which included: Aphasia (inability to speak) following cerebral infarction, Type 2 Diabetes Mellitus (DM), high blood pressure, (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	unspecified psychosis, and muscle weakness. Record review of Resident #65's Quarterly MDS dated [DATE] revealed severely impaired cognition as indicated by a BIMS score of 02 out of 15. The indication of use of insulin injections was noted. Record review of Resident #65's undated Care Plan revealed, Focus - Has Diabetes Mellitus and is at risk for complications. Intervention: Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Record review of Resident #65's physician orders dated 08/11/25 revealed order date of 07/23/2025 for Insulin Glargine Solution 100 UNIT/ML Inject 23 unit subcutaneously at bedtime for diabetes. Additionally, dated 07/01/2025 Insulin Lispro (1 Unit Dial) Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Lispro) Inject 4 unit subcutaneously before meals for DM and dated 06/04/25 Insulin Lispro (1 Unit Dial) Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if 200 - 249 = 4 units; 250 - 299 = 6 units; 300 - 349 = 8 units; 350 - 399 = 10 units, subcutaneously before meals and at bedtime for DMII inject subcutaneously per order. Review of Resident #65's MAR Location of Administrator Report revealed, Resident #65's sliding scale insulin was scheduled for 07:00 AM, 11:00 AM and 04:00 PM (1 hr. before dinner) in June.- 06/05/25 Resident #65 received his Insulin Lispro scheduled for 04:00 PM at 03:23 PM.- 06/06/25 Resident #65 received his Insulin Lispro scheduled for 11:00 PM at 10:47 AM.- 06/10/25 Resident #65 received his Insulin Lispro scheduled for 07:00 AM at 09:22 AM.- 06/13/25 Resident #65 received his Insulin Lispro scheduled for 07:00 AM at 06:44 AM.- 06/15/25 Resident #65 received his Insulin Lispro scheduled for 04:00 PM at 03:39 PM.- 06/20/25 Resident #65 received his Insulin Lispro scheduled for 07:00 AM at 06:29 AM.- 06/23/25 Resident #65 received his Insulin Lispro scheduled for 07:00 AM at 06:48 AM.- 06/25/25 Resident #65 received his Insulin Lispro scheduled for 04:00 PM at 03:52 PM. Review of Resident #65's MAR Location of Administrator Report revealed, Resident #65's sliding scale insulin was scheduled for 06:00 AM (1 1/2 hrs before scheduled breakfast), 11:00 AM and 04:00 PM (1 hr. before dinner) in JULY.- 07/03/25 Resident #65 received his Insulin Lispro scheduled for 06:00 AM at 06:47 AM.- 07/04/25 Resident #65 received his Insulin Lispro scheduled for 04:00 PM at 04:15 PM.- 07/04/25 Resident #65 received his Insulin Lispro scheduled for 04:00 PM at 04:06 PM.- 07/05/25 Resident #65 received his Insulin Lispro scheduled for 06:00 AM at 06:14 AM.- 07/05/25 Resident #65 received his Insulin Lispro scheduled for 04:00 PM at 04:16 PM.- 07/06/25 Resident #65 received his Insulin Lispro scheduled for 06:00 AM at 06:11 AM.- 07/09/25 Resident #65 received his Insulin Lispro scheduled for 06:00 AM at 06:48 AM.- 07/10/25 Resident #65 received his Insulin Lispro scheduled for 06:00 AM at 06:20 AM.- 07/11/25 Resident #65 received his Insulin Lispro scheduled for 06:00 AM at 06:00 AM.- 07/12/25 Resident #65 received his Insulin Lispro scheduled for 06:00 AM at 06:54 AM.- 07/17/25 Resident #65 received his Insulin Lispro scheduled for 06:00 AM at 05:43 AM.- 07/20/25 Resident #65 received his Insulin Lispro scheduled for 06:00 AM at 06:39 AM. Review of Resident #65's MAR Location of Administrator Report revealed, the resident received Insulin Lispro at:- 08/01/25 at 04:23 PM- 08/02/25 at 04:18 PM- 08/05/25 at 06:49 AM.- 08/05/25 at 04:09 PM- 08/06/25 at 06:32 AM. Record review of Insulin Lispro (HumaLOG) Highlights of Prescribing Information revised 03/2013 revealed, HUMALOG is a rapid-acting insulin. You should take HUMALOG within fifteen minutes before eating or right after eating a meal. Record review of Insulin Aspart Highlights of Prescribing Information revised 02/2023 revealed, How should I take Insulin Aspart?: Insulin Aspart starts acting fast. You should eat a meal within 5 to 10 minutes after you take your dose of Insulin Aspart. Record review of FIASP Highlights of Prescribing Information revised 06/2023 revealed, How should I take FIASP?: FIASP(R) starts acting fast. You should take your dose of FIASP(R) at the beginning of the meal or within 20 minutes after starting a meal. Record review of the facility policy Medication Administration, General with no revision date revealed, no instructions on the administration of insulin. Record review of the facility policy titled Pharmacy Services with no revision dated revealed, Procedure- the facility must. 3. Employ or obtain services of a licensed pharmacist who. b- establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable accurate reconciliation. Record review of the Highlights of Prescribing (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Information for HumaLOG revealed, when in use (opened) 10 mL vials of HumaLOG are to be used within 28 days when stored in the refrigerator or at room temperature.		

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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 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. Based on observation, interview, and record review the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, included the appropriate accessory and cautionary instructions, the expiration date when applicable and stored all drugs and biologicals in locked compartments and under proper temperature controls, and permitted only authorized personnel to have access to the keys for 2 of 3 medication carts (500/600/700 Hall Medication aide Cart, 200 Hall Nursing Care) and 1 of 1 (500/600 Hall Med Room) Medication Rooms reviewed for medication storage. - The facility failed to ensure the 500/600/700 Hall Medication Aide Cart did not contain open multidose liquid supplements with no open date and loose pills.- The facility failed to ensure medication in the 500/600 Hall Med Room were stored under proper temperature controls- The facility failed to ensure the 200 Hall Med Cart did not contain supplements stored outside of proper temperature controls and controlled medication without proper pharmacy labeling. These failures could place residents at risk of not receiving the therapeutic benefit of medications or adverse reactions to medications. Findings include: 500/600 Hall Med Room In an observation and interview on 08/06/25 at 12:40 PM, inspection of the 500/600 Hall Med Room Cart with LVN K revealed,- The medication refrigerator with no thermometer or device to determine the temperature. The fridge contained varied containers of Insulin, eye drops, vaccinations and TB test. - The refrigerator temperature log had not been signed on 08/05/25 and 08/06/25. All previous temperatures were checked during the night shift between 01:00 AM and 04:00 AM. LVN K said the medication refrigerator was supposed to have a thermometer sitting on the shelf but she did not know what happened to it. She said the night shift was responsible for checking the temperature and documenting it on the log. 500/600/700 Med Aide Cart In an observation and interview on 08/06/25 at 02:03 PM, inspection of the 500/600/700 Hall Med Aide Cart with CMA F revealed,- an open and in use bottle of Pro-stat protein supplement with no open date with manufacturer instructions that read Discard 3 months after opening.- 2nd drawer with 11 lose pills of assorted colors and sizes.CMA F said nursing staff are expected to check their carts daily as used for loose pills and inappropriately labeled medications. She said multidose containers must be labeled with the date opened in order to track the expiration date. CMA F said she did not know the beyond use date for the bottle of pro-stat so it could not be used because if expired it could cause residents GI upset.In an observation and interview on 08/06/25 at 02:13 PM, inspection of the 200 Hall Nurse Cart with LVN M revealed:An open and in-use bottle of acidophilus probiotic at room temperature with manufacturer instructions to Refrigerate after opening.- a clear plastic bag with text that read loose [Resident #82] return to family; give to DON, loose narcotics no label that contained 12 prefilled 1 ml syringes with 0.5 ml of blue liquid labeled Morphine 20 mg/5ml. The syringe labels did not contain pharmacy information; prescriber information, resident information or directions for use. LVN M said nursing staff were expected to check their carts daily as used for storage temperature and inappropriately labeled medication. She said the bottle of acidophilus (a probiotic) was supposed to be stored in the fridge because leaving it at room temperature could impact the potency. LVN M said the inappropriately labeled prefilled syringes arrived with Resident #82, but they could not be used. She said all medication was is supposed to have the pharmacy labeling which identified the resident, the drug, provider, dose and instructions for use. LVN M said inappropriately labeled medications could place residents at risk of adverse drug events, and side effects.In an interview on 08/06/25 at 03:15 PM, the DON said nursing staff were expected to check their carts daily as used for inappropriately labeled/packaged, expired medications, and medications stored out of manufacturer recommended temperatures daily as used and nursing management completed audits on Mondays. She said all medications were expected to be in their blister packs with pharmacy labeling, not lose to prevent a (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication error or loss of inventory. She said multidose containers like pro-stat, should be labeled with the open date to track the expiration date, because if administered residents could become sick. The DON said all medications must be stored at the correct temperature and the night shift nurses were expected to check the temperature of the med room Fridge daily and document it on the log. She said without the thermometer, staff were unable to ensure that medications were stored at the correct temperature so they must be discarded immediately. The DON said medication stored in an uncontrolled or inappropriate temperature environment can become damaged and if administered can result in damage or infection to residents. Record review of the facility policy titled Storage of Medications with no revision date revealed, Policy: Storage of Medications. Purpose: Ensure that medications are stored in a safe, secure, and orderly manner. Procedure: 1. Medications are stored in the containers in which they are received. Transfer between containers is performed only by the dispensing pharmacy. 2. Drug containers having soiled, illegible, worn, makeshift, incomplete, damaged, or missing labels are returned to the pharmacy for proper labeling before storing. 3. No discontinued, outdated, or deteriorated medications are to be used for use in this facility. All such medications are destroyed according to facility policy. 8. Medications requiring refrigeration must be stored in the refrigerator located in the drug room at the nurse's station. Medications must be stored separately from food and must be properly labeled. Proper temperature in the refrigerator must be maintained in accordance with manufacturer specification and national guidelines. 11. Multi-dose vials that have been opened or accessed should be dated and discarded within 28 days of opening/initial access unless the manufacturer specifies a shorter or longer date. Record review of the facility policy titled Labeling Medications with no revision date revealed, Purpose: Ensure that all medications maintained in the facility are properly labeled in accordance with current state and federal guidelines. Procedure: General Guidelines: 1. Drug labels must be legible at all times. 2. Any drug label that is soiled, incomplete, illegible, worn or makeshift must be returned and replaced by the dispensing pharmacy, not merely covered over. 3. Labels for individual drug containers must include: a. Resident's name. b. Prescribing physician's name. c. Name, address, and telephone number of dispensing pharmacy. d. Name, strength, and quantity of the drug. e. Prescription number. f. Date drug was dispensed. g. Appropriate accessory and cautionary statements. h. Expiration date. i. Directions for use. j. Remaining refills. 7. Containers that are soiled, cracked or without secure closures will not be used.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/21/2025
NAME OF PROVIDER OR SUPPLIER Eagle Crest Rapid Recovery		STREET ADDRESS, CITY, STATE, ZIP CODE 9602 Huffmeister Rd Houston, TX 77095	
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 3of 5 residents (Residents #37, Resident #48 and Resident #56) reviewed for infection control practices.-PT E failed to follow proper infection control and hand hygiene after providing wound care to Resident #37. - -PT E failed to perform hand hygiene prior to leaving the resident's room.-CNA N failed to follow proper infection control practices by washing hands in the clean utility room after handling dirty trash bags.- LVN M failed to wear the appropriate PPE when administering medications via G-tube to Resident #56. - LVN M failed to administer medications to Resident #48 and Resident #56 without touching the medication with her hands.Findings included:Resident #37Record review of Resident #37's face sheet dated 8/05/25 revealed a [AGE] year-old admitted to the facility on [DATE], initially admitted on [DATE] and originally admitted on [DATE]. Diagnoses included Guillain-Barre syndrome (a rare condition in which the immune system attacks the nerves causing weakness, numbness, or paralysis), heart attack, Quadriplegia (condition characterized by partial or complete paralysis of all four limbs and torso), and dementia.Record review of Resident #37's annual MDS dated [DATE] revealed a BIMS score of 13 out of 15 indicating intact cognition, impairment on both sides of upper and lower extremities and required substantial/maximal assistance for bed mobility. Section M-Skin Conditions revealed Resident #37 was at risk of developing pressure ulcers/injuries and did not have any unhealed pressure ulcers/injuries.Record review of Resident #37's physician order summary report dated 08/06/25 revealed and order for the stage 4 pressure injury (a deep wound that exposes underlying muscle, tendon, cartilage or bone) to the right heel: cleanse with wound cleanser, pat dry, apply Santyl and calcium alginate with silver and cover with border foam dressing every day shift and as needed. Dated 08/05/25.Record review of Resident #37's undated Care Plan Report revealed: Focus - Resident #37 has actual pressure ulcer development r/t impaired mobility and incontinence. Right heel, 5/7/25. Revision was made on 07/01/25. Goal - The resident will have intact skin, free of redness, blisters or discoloration by/through review date. Target date was 08/25/25. Interventions - Administer treatments as ordered and monitor for effectiveness: Responsible position LVN, RN. Follow facility policies/protocols for the prevention/treatment of skin breakdown: CNA, LVN, RN. Monitor/document/report PRN any changes in skin status: Weekly skin assessment: CNA, LVN, RN. Further review revealed Ultra mist therapy (a cutting-edge debridement ultrasound used in wound care) was not included in the interventions.Record review of Resident #37's Skin Issues form effective date 07/30/25 and evaluated by the Wound Care Nurse revealed, modality used was Ultrasound Mist and heel suspension/protection device was listed as additional care.Observation of wound care on 08/07/25 at 10:00 AM, PT E and Wound Care Nurse performed hand hygiene, put on gowns and gloves and entered Resident #37's room. PT E completed the Ultra mist procedure on Resident #37's stage 4 pressure ulcer wound to the right heel. Wound Care Nurse completed the wound care to Resident #37's right heel. PT E removed used gown and gloves, placed them into trash bag then securing the bag. PT E stepped out of the room, walked down the hallway to the dirty utility room and put the trash bag into the bin. PT E walked across the hallway and washed hands in the clean utility room.In an interview on 08/07/25 at 10:30 AM, PT E was asked why did she wash hands in the clean utility room and not in Resident #37's room prior to leaving, PT E stated that she had to make sure the used Ultra Mist tubing that had hard plastic pieces was taken to the dirty utility room right away and that the clean utility room door was open so she used that sink to wash hands. PT E stated she should not have done that because infection could be spread that way and instead, she should have sanitized hands prior to leaving the resident room first.During an observation and interview on 08/07/25 at 11:30 AM, CNA N walked to the dirty utility room with trash bags then (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	walked across the hall touched the keypad and door handle of the clean utility room and washed hands in the sink of the clean utility room. CNA N stated she would use the clean utility room to wash hands all the time and no one ever said anything about it. When asked the question what could go wrong, CNA N stated bacteria could be transferred from the dirty utility room to the clean utility room and then possibly to the residents. CNA N stated she should have used hand sanitizer when coming out of the dirty utility room instead of using the clean utility room sink. In an interview on 08/07/25 at 4:00 PM, the DON stated the expectation after completing resident care and before leaving the resident room was for staff to hand wash or hand sanitize and after exposure to any bodily fluids the staff must use hand soap and water. The DON stated it was important to do so to alleviate the spread of germs for infection control. The DON stated staff should not use the clean utility room sink to wash hands after resident care and at minimum perform hand sanitization then go to the rest room or staff employee room to wash hands. Record review of the undated facility policy for Hand Hygiene, Operational Guidelines: Long-Term Care read in part: Purpose: Handwashing will be regarded by this facility as the single most important means of preventing the spread of infection. Procedure: 1. Staff will follow the facility's established hand hygiene procedures to prevent the spread of infection and disease to other staff, residents and visitors. 2. Hands should be washed under the following conditions. d. After having direct contact with the resident. h. After handling used dressings, contaminated equipment, etc. i. After contact with non-intact skin. m. After removing gloves. Resident #56 Record review of Resident #56's Face Sheet dated 08/06/25 revealed, a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included: brain damage, type 2 diabetes, epilepsy (a brain condition in which abnormal electrical activity in the brain causes recurring seizures), MDD, difficulty swallowing, protein-calorie malnutrition (malnutrition caused by insufficient protein and calories), quadriplegia (full body paralysis) and gastrostomy status. Record review of Resident #56's Annual MDS dated [DATE] revealed, short- & long-term memory problems, severely impaired cognitive skills for daily decision making, total dependence for all ADLs, aphasia (brain damage that affects the person's ability to communicate), feeding tube while a resident, received 51% or more of his intake via tube feeding and 501 ml per day or more via tube feeding. Record review of Resident #56's undated Care Plan revealed, Focus: may require tube feeding r/t dysphagia; intervention- the resident is dependent with tube feeding and water flushes. PPE required for high resident contact care activities. Focus: history of seizure disorders r/t anoxic (complete lack of oxygen) brain injury. Risk of infection- EBP at all time; interventions: Staff is to wear PPE's for all contact with resident as long as the resident is on EBP precautions, for things such as dressing, changing linens, transfers, providing hygiene, wound care, device care (or use), bathing or showering, changing briefs or assisting with toileting. Record review of Resident #56's Order Summary Report dated 08/06/25 revealed, - Allopurinol Tablet 100 MG: Give 1 tablet by mouth two times a day for Gout. - Carvedilol Oral Tablet 3.125 MG: Give 1 tablet via PEG-Tube two times a day for hypertension; hold for SBP less 110 & or HR less than 60. - Entresto Oral Tablet 24-26 MG (Sacubitril-Valsartan) : Give 1 tablet via PEG-Tube two times a day for Hypertension; hold for SBP less than 110 & or HR 60. - Levetiracetam Oral Solution 100 MG/ML: Give 7.5 ml via PEG-Tube two times a day for seizure. - Lexapro Oral Tablet 5 MG (Escitalopram Oxalate) : Give 1 tablet via PEG-Tube one time a day for Depression. - Memantine HCl Oral Tablet 10 MG: Give 1 tablet via PEG-Tube two times a day for dementia. - Tramadol HCl Oral Tablet 50 MG: Give 1 tablet via PEG-Tube two times a day for Pain. - Valproic Acid Oral Solution 250 MG/5ML: Give 5 ml via PEG-Tube two times a day for seizure. An observation on 08/09/25 at 09:52 AM revealed, LVN M preparing medication for administration for Resident #56. She popped out 1 tablet of: Entresto, Memantine, Carvedilol, Allopurinol and Tramadol into individual medication cups; and poured out 5 ml of Valproic Acid and 10 ml of Levetiracetam. LVN M touched the tramadol pill with her hands as she placed it in the cup. At 09:56 AM, she crushed each medication separately and returned them to their individual medication cups and at 10:00 LVN M she entered into Resident #56's room with all the medications. She did not wear a gown when she entered (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the residents room or through the medication administration process. She dissolved each medication with 10-15 ml of water and mixed each with individual spoons and then wore gloves. At 10:07 AM, she drew 30 ml of warm water into a syringe, connected it to Resident #56's G-tube port and pushed all 30 mL of water. Right after LVN M withdrew her first liquid medication and attempted to start administering the resident's medication, the surveyor stopped her and asked her to verify the volume of Levetiracetam she was going to administer. LVN M confirmed the volume was 10 ml instead of 7.5 ml and she wasted approximately 2.5 mL into the trash. LVN M then administered all 7 medications to Resident #56 by pushing them through the syringe with approximately a 10-15 ml of water flush in between each medication. Resident #48Record review of the Resident #48's Face Sheet dated 08/06/25 revealed, a 75year-old male who admitted to the facility on [DATE] with diagnosis which included: stage 4 pressure ulcer to the hip, left sided weakness and paralysis, and end stage renal disease.Record review of Resident #48's undated Care Plan revealed, Special Instructions: Crush Medications. Focus: acid reflux and risk for complications; interventions- give medications as ordered.Record review of Resident #48's Order Summary revealed, Cholecalciferol Oral Capsule 50 MCG (2000 UT)(Vitamin D3) Give 1 capsule by mouth one time a day for supplement.An observation on 08/06/25 at 08:32 AM revealed, LVN M preparing for medication administration to Resident #48. She retrieved a caplet of Cholecalciferol touching it with her bare hands and placed it in a medication cup and administered it along with 5 crushed solid form medications and 1 emptied capsule mixed in pudding and administered it to resident #48.Record review of LVN M's Competency Assessment: Medication Administration dated 06/03/25 revealed, LVN M was deemed competent. Record review of the facility policy titled Enhanced Barrier Precautions , PURPOSE: Prevent the spread of novel or targeted multidrug-resistant organisms (MDROs). Enhanced Barrier Precautions expand the use of PPE beyond situations in which exposure to blood and body fluids is anticipated and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing.High-contact resident care activities include device care or use of a device: central line, urinary catheter, feeding tube, tracheostomy/ventilator. Enhanced Barrier Precautions apply to: All residents with any of the following. Wounds and/or indwelling medical devices (i.e., central line, urinary catheter, feeding tube, tracheostomy/ventilator) regardless of MDRO colonization status. Procedure: 1. Perform hand hygiene with ABHR before entering the resident room. 2. Wear gloves and a gown when providing high-contact resident care activities (see General Information).		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to immediately inform the resident, consult with the resident's physician; and notify, consistent with his or her authority, the resident representative when there was a significant change in condition in the resident's physical, mental, or psychosocial status and a need to alter treatment significantly for 1 of 8 residents (Resident #11) reviewed for notification of changes. The facility failed to notify the physician of Resident #11's reported chest pain and SOB which resulted in the discontinuation of her PT session on 08/08/25. This failure could place residents at risk of delayed identification and treatment of undiagnosed illnesses, hospitalization, pain, and suffering. Findings include: Record review of Resident #11's Face Sheet, dated 08/08/25, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #11 had diagnoses which included: osteoarthritis (breakdown of cartilage and bone in a joint), lack of coordination, irregular heartbeat, hypertension (high blood pressure), anemia (condition where blood doesn't carry enough oxygen to the rest of the body) and back fracture. Her diagnosis did not include hypotension (low blood pressure), orthostatic hypotension (a sudden drop in blood pressure when standing up from a sitting or lying down position), or heart failure. Record review of Resident #11's Quarterly MDS, dated [DATE], revealed intact cognition as indicated by a BIMS score of 15 out of 15, no lower or upper extremity functional limitations in range of motion, maximum assistance needed to: roll left and right, move from sitting to lying and lying to sitting on the side of the bed, to move from sit to stand, and transfer from a bed to a chair. Resident #11's primary reason for admission was her orthopedic condition (having to do with bones, joints, ligaments, tendons and muscles), and she had anemia and hypertension. Resident #1's MDS did not include orthostatic hypotension or heart failure. Record review of Resident #11's, undated, Care Plan revealed Focus initiated on 04/10/25: chronic heart failure and at risk for complications; Goal- resident will have clear lung sounds, heart rate and rhythm within normal limits; Interventions- give cardiac medications as ordered, monitor vital signs every shift and notify MD of significant abnormalities. Monitor/document/report PRN s/sx of congestive heart failure: SOB upon exertion; weakness and/or fatigue, increased heart rate, lethargy (a state of persistent tiredness, lack of energy and sluggishness), and disorientation. Focus initiated on 04/10/25: hypotension and at risk for complications. Record review of Resident #11's Physician's Orders revealed, - Discontinued Midodrine 2.5 mg: give 1 tablet by mouth two times a day for hypotension, hold for SBP greater than 130. Written on 03/20/25. - Ivabradine 5 mg: give 1 tablet by mouth two times a day for chronic heart failure dated 04/05/25.- Active Midodrine 5mg: give 1 tablet by mouth every 8 hours for hypotension hold for BP more than 160. Written on 08/06/25. Record review of Resident #11's Vitals: Blood Pressure, Weights and Vitals Summary, dated 08/08/25 at 02:55 PM, revealed, 08/08/25 at 08:10 AM- 100/51 mmHg taken on the right arm while resident was lying, with alert of Diastolic Low of 60 exceeded.08/07/25 at 07:05 PM- 91/55 mmHg taken on the right arm while resident was lying, with alert of Diastolic Low of 60 exceeded.08/07/25 at 05:03 PM- 103/65 mmHg, taken on the right arm while resident was lying.08/07/25 at 08:15 AM- 98/64 mmHg, taken on the right arm while resident was lying.08/06/25 at 08:19 PM- 102/63 mmHg, taken on the right arm while resident was lying.08/06/25 at 04:08 PM- 91/56 mmHg, taken on the right arm while resident was lying.08/06/25 at 08:38 AM- 111/73 mmHg, taken on the right arm while resident was lying.08/05/25 at 08:24 PM- 113/68 mmHg, taken on the right arm while resident was lying.08/04/25 at 08:52 AM- 102/66 mmHg, taken on the right arm while resident was lying.08/04/25 at 09:38 AM- 102/63 mmHg, taken on the right arm while resident was lying.08/03/25 at 07:57 PM- 95/63 mmHg, taken on the right arm while resident was lying.08/03/25 at 10:37 AM- 128/63 mmHg, taken on the right arm while resident was lying.08/02/25 at 07:09 PM- 108/66 mmHg, taken on the right arm while resident was lying. Record review of Resident #11's (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Progress Notes, dated 08/08/25 at 02:53 PM, revealed;- 08/06/25 at 11:25 AM, signed by the Medical Director- Chief Complaint- follow up orthostatic hypotension. Resident #11 was seen this morning. Patient and therapy staff report that patient continues to have orthostatic hypotensive episodes. Her blood pressure drops precipitously with change of position from lying/sitting in bed to seated upright in a chair or standing. Patient becomes very lightheaded. She is currently on midodrine 2.5 mg twice a day for management of her hypotension. We will increase midodrine to 5 mg every eight hours. Assessment and Plan- Orthostatic hypotension: Patient continues to have orthostatic hypotensive episodes with position changes from lying/sitting to upright position, causing lightheadedness. Currently on Midodrine 2.5 mg twice daily. Will increase Midodrine to 5 mg every eight hours to better manage blood pressure fluctuations. Hold parameters remain in place for SBP - 130.- 08/06/25 at 11:29 PM signed by LVN G- new order to d/c Midodrine 2.5 mg increase to 5 mg every eight hours hold for SBP greater than 160- 08/07/25 at 04:18 PM signed by the Wound Care Nurse- Resident refused wound care stating that she is too dizzy. Charge nurse notified.- 08/07/25 at 11:27 PM signed by LVN G- night 2/3 after new order to d/c Midodrine 2.5 mg increase to 5 mg every eight hours hold for SBP greater than 160. No adverse reactions noted.- 08/08/25- there were no notes from LVN J. Record review of Resident #11's PT: Treatment Encounter Notes, completed by PT E, revealed;- 08/05/25: PT assessed vitals pre-treatment: 101/62 and HR = 78bpm. PT aced wrapped legs to increase bp. PT assessed vitals sitting EOB: 92/64 and HR = 74bpm. PT transferred Resident #11 with stand pivot with max assistance-dependence and attempted to take Bp, but machine reported error. Resident #11 reported severe dizziness, so PT transferred resident to bed dependent and sit to supine with moderate assistance. PT assessed vitals: 78/54 and HR = 84bpm. PT and floor nurse scooted Resident #11 to HOB. PT assessed vitals post-treatment: 109/62 and 42bpm. Response to treatment: Pt. reports dizziness with stand pivot transfer. Barriers Impacting Treatment: orthostatic hypotension. Consultation Note: PT notified floor nurse LVN J about s/s of orthostatic hypotension.-08/08/25: PT assessed vitals: Bp = 96/62 and HR = 88bpm. PT wrapped both legs with ace wrap to improve bp. PT supervised Resident #11 perform long sitting to EOB sitting. PT assessed vitals: Bp = 105/72 and HR = 115bpm. PT stretched resident 3x30sec . to improve ROM. PT assessed vitals after 10 min . sitting EOB: Bp = 107/53 and HR = 48bpm. Resident #11 reports not feeling right. Resident reports having chest pain and SOB, so PT instructed resident to perform EOB sitting to long sitting with moderate assistance. PT notifies floor nurse LVN J. PT assessed vitals: O2 = 93-95%, HR dropped from 94 to 84 to 70 on pulse oximeter then went back up; RR = 29; Bp = 106/83. Floor nurse LVN J came to give pt. medicine for chestpains, but pt. reported it resolved. Response to Session Interventions: Pt. passively and actively participates with skilled interventions until chest pains and SOB reported, then session was stopped and floor nurse LVN J was notified immediately. Barriers Impacting Treatment: pt. reported chest pains and SOB. Treatment Modifications to Overcome Barriers: session discontinued. Consultation Note: PT reported to floor nurse that pt. reports chest pain and SOB. Floor nurse LVN J came to give pt. medicine for chest pains, but pt. reported it resolved. In an interview on 08/08/25 at 03:05 PM, LVN J said Resident #11 normally suffered from hypotension. He said earlier Resident #11 told therapy she was not feeling well, but she was ok when he checked on her. He said the facility did not have an alert value set to notify the physician when a resident had low blood pressure, and Resident #11's orders only set to hold her Midodrine for SBP over 160. LVN J said he did not have to notify the doctor because the resident was not symptomatic when he checked on her. LVN J said nursing staff were expected to notify the physician when there was anything abnormal, and if Resident #11 was symptomatic he would call the doctor. He said if a resident had an abnormal value of symptomatic, nursing staff were expected to document a change of condition in the residents chart and notify the physician. LVN J said Resident #11 was ok when he checked on her and he knew his patient. In an observation and interview on 08/08/25 at 03:20 PM, PT E said she completed PT with Resident #11 earlier in the day. She said at the beginning of their session that day the resident said she was not feeling well, and she was shaky, so she checked her (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	blood pressure. PT E said Resident #11 had been dealing with orthostatic hypotension and in today's session the resident kept saying she just doesn't feel like herself. After 10 minutes of sitting Resident #11 said she did not feel good and even though the resident usually reported dizziness, today Resident #11 said her chest hurt and she had trouble breathing. PT E said in response to Resident #11's complaint of chest pain and SOB she set the resident back in bed because this complaints of chest pain and difficulty breathing was new. She said she checked Resident #11's vitals: her oxygenation was fluctuating; she had a high respiration rate and high heart rate. PT E said she notified LVN J of the resident's complaints and when LVN J entered to administer medication to Resident #11, the resident said she was no longer having chest pain and medication was not administered. PT E said due to the resident's complaints of chest pain and difficulty breathing she notified Resident #11 that she had to discontinue therapy. Record review of PT E's PT Notes for Resident #11 dated 08/08/25 revealed, Observation of PT E's notes for Resident #11 revealed handwritten notes that read: pain 0/0 and BP of 96/62 pretreatment, The notes included multiple blood pressure and heart rate readings recorded over the treatment session. In an interview on 08/08/25 at 03:36 PM, the Medical Director said Resident #11 suffered from hypotension and he saw the resident earlier in the week. He said the resident did not get out of bed much but when she did, she reported lightheadedness. The Medical Director said after evaluating the resident, he increased her Midodrine to 5 mg every 8 hours. He said Resident #11's blood pressure ran low frequently with the SBP sometimes in the 90s, but he would not have immediate concerns unless the resident was showing signs and symptoms of low blood pressure. The Medical Director said, facility staff had not notified him Resident #11 experienced chest pain and SOB and notification should have been sent to the NP and himself because Resident #11's symptoms indicated possible syncope (a temporary loss of consciousness caused by a brief reduction in blood flow to the brain). In an interview on 08/08/25 at 03:44 PM, the NP said Resident #11 usually did not have complaints but she was aware the resident suffered from orthostatic hypertension. The NP said she was not notified by facility staff that Resident #11 experienced chest pain and SOB and she should have been notified since such symptoms were changes of condition. In an interview on 08/08/25 at 03:51 PM, the DON said if a resident suffered from SOB or chest pain the MD must be notified and it be documented as a change of condition in the resident's chart. An observation and interview on 08/08/25 at 04:08 PM revealed, Resident #11 appeared to be in no immediate distress. Resident #11 said earlier, during therapy, she was sitting on the side of the bed and felt a sharp pain in her chest and her breathing became heavy/short so PT E laid her back in bed and she started feeling better. Resident #11 said LVN J came in and offered her some medication, but she felt better so she did not take it and that was that. She said LVN J had not checked on her since then and no one else had checked on her since LVN J offered her medication. Resident #11 said she was always dizzy during therapy but the chest pain is something new, she had dizziness at home and did not know she had orthostatic hypotension, and she fainted. She said even though she did not break anything when she fainted that was why she was at the facility. Record review of the facility Notification Manual' revealed, immediate notification should be the NP and if you cannot reach the NP; then call: the Medical Director. Symptom or sign: Chest pain, pressure and tightness; immediate: new abrupt onset, unrelieved by medications or accompanied by sweating, change in vital signs or new EKG changes. Non-Immediate- relieved by antacids or nitroglycerin, without other symptoms, but recurring more often than usual. Record review of the facility's, undated, policy titled Condition change of Resident revealed, Purpose: observe, record and report any condition change to the physician so proper treatment can be implemented. 3. Assess the resident and notify the attending physician of the resident's condition. Compare the resident's current condition to his/her prior level of function. 4. 6. Notify resident's responsible party. 7. Monitor resident's condition frequently until stable. 8. Document assessment observations in medical record. Record review of the facility's, undated, policy titled Notification of Change revealed, Purpose: Ensure resident and/or resident representative notification of specific changes during the resident's stay in (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility. Procedure: 1. The facility must immediately inform the resident, consult with the resident's physician, and notify, consistent with his/her authority, the resident representative(s) when there is; A significant change in the resident's physical, mental or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications).		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to develop and implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care that met professional standards of quality of care for one of 8 residents (Resident #82) reviewed for base line care plans. The facility failed to develop and implement a baseline plan of care that addressed Resident #82 who admitted to the facility for 5 days of respite care (a short term stay in a nursing facility that provides temporary relief for caregivers of individuals needing assistance, allowing them to take a break from their caregiving duties) needs for the administration of morphine for her pain, and behaviors that became so severe she required administration of ABH gel. This failure could place residents at risk of not having their individual, medical, functional, and psychosocial needs identified, and services provided which could cause a physical or psychosocial decline in health. Findings Include: Record review of Resident #82's face sheet, dated 08/06/25, revealed an [AGE] year-old female who was admitted to the facility with Alzheimer's Disease and protein-calorie malnutrition. She admitted to the facility from a private home for hospice-respite services. Record review of Resident #82's Admin Census revealed, she admitted to the facility on [DATE] at 01:16 PM. Record review of Resident #82's Entry MDS, dated [DATE], revealed Resident #82 entered from hospice. Record review of Resident #82's Baseline Care Plan, signed by LVN J on 08/05/25, revealed Vision and Hearing: Vision and Hearing impaired. There was no documented active diagnoses contributing to admission; no initial admission goals and under comments- Resident #82 was confused and blind. Medications Resident #82 was taking: psychotropic medications documented but opioids were not documented. Medical conditions; does resident need terminal care was documented as no. Under Social Services; Mental health needs and behavioral concerns were blank and no further comments were documented. The baseline care plan did not include any goals or interventions for any of the areas documented. Record review of Resident #82's Clinical admission documentation, dated 08/05/25 at 09:04 PM, revealed the resident arrived on a stretcher with no family/support person in attendance. The resident's baseline neurological information was unknown, she had highly impaired hearing, had chronic disorganized thinking, severe cognitive impairment, and mood was pleasant, no unwanted behaviors witnessed was marked as 'not met.' No options were selected for mood (cheerful, pleasant, anxious, tearful, flat affect or agitated); anxious, agitated, behavior(s) present (yes, no); disruptive (new, chronic); refuses care (new chronic), resists care (new, chronic) and there was no mood & behavior note. Under special care: the options of hospice, respite and palliative care were not selected. The entire 'care planning section' that included a focus, goal and intervention for behavior management was blank and unselected. Record review of Resident #82's Pain Level: Weights & Vitals records, on 08/06/25 at 04:22 PM, revealed the facility had not assessed or record any pain levels for Resident #82. Record review of Resident #82's Order Summary Report, dated 08/06/25, revealed,- Admit under the care of the [Medical Director] for hospice or respite care.- Escitalopram 10 mg: give 1 tablet by mouth one time a day for depression.- Mirtazapine 15 mg: give 1 tablet by mouth at bedtime for depression.- Lorazepam 1 mg: give 1 tablet by mouth every 2 hours as needed for anxiety/agitation.- ABH Gel 1mg/25mg/1mg/mL gel: apply 1 ml to inner wrist every 6 hours PRN severe agitation. - Morphine 20 mg/5ml: give 0.5 ml by mouth every 1 hours as needed for SOB/pain. An observation on 08/06/25 at 04:43 PM revealed, Resident #82 in her room screaming out. The resident continuously bit the bed remote and the cord to the bed remote. She screamed saying give me my clothes that she stole. Do you know where some of my things are, I am fitting to call [the police department]. I assume she stole my clothes. The resident called people trash and said she was going to bop the shit out of someone and said she wanted to fight staff. Resident #82 continued to scream you're stupid that's what's wrong with you, you're dumb, she would then calm down and said I (continued on next page)		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	don't feel good someone try to take my pulse, I feel bad while biting her hand. In an interview on 08/06/25 at 04:43 PM with CNA AP, Resident #82 had been combative since admission on [DATE]. The resident was combative when providing incontinence care. The resident was calm when she slept but when she was awake, she was fidgeting and trying to get out of bed. In an interview on 08/06/25 at 05:00 PM, LVN M said earlier she talked to the resident, and she calmed down and laid back down but no one told her the resident was biting herself and attempting to hit staff. An observation on 08/06/25 at 05:05 PM revealed LVN M talking to Resident #82 in the resident's room. LVN M asked Resident #82 if she wanted to drink and the resident said well, thank you darling. Resident #82 began screaming and said, Get that stuff off me, in my eye or nose she did not want it and it tastes awful and asked for. LVN M asked Resident #82 who was and Resident #82 responded a good friend but get out of my face. Resident #82 said I don't feel good today I feel kind of bad, she continued to ask for and said, I am going to lay back down, I don't feel good, I am tired. A staff member attempted to put a pillowcase on her pillow and Resident #82 snatched at it, tugging at it before the staff member released the pillow and the resident said, you better shut up, you ain't got nothing but yourself. LVN M retrieved Lorazepam and attempted to administer it to Resident #82 and when the resident said get out of my face, I want you all to get out of my house or I will call the police. Need a brain in your head. LVN M was unable to administer the medication and walked towards her nursing cart and then Resident #82 said Need a brain in your head, I don't feel good, I feel real sick. LVN M hid the Lorazepam in pudding and administered the medication to Resident #82 who then said, I don't like you; I don't want you here. I know how you are; you are a liar. Resident #82's behaviors continued until 05:22 PM, as she shouted and insulted staff. Resident #82 said I don't feel good, that hurts, I don't feel so good. An observation on 08/07/25 at 08:33 AM revealed, Resident #82 screamed at staff with the room door closed and a staff member later identified as CNA AE was heard responding to the resident. Resident #82 said I don't want bacon, are you that dumb, if you don't have any food with some food in it. If you throw one more piece of food in my face shut up. Is that clear if not the next piece is going to be in your face. I don't want Bacon, eggs, grits is there nothing else to eat. CNA AE said bacon, eggs and grits was for breakfast when Resident #82 said Can I get a piece of bread to make a sandwich, this is pathetic I want something to eat. I asked you a question, shut up, I wanna see what you are going to tell me. Resident #82 then asked, is the bacon, eggs the only thing you got? to which CNA AE said yes. The resident then screamed If you put one more thing in my mouth, I am going to slap you. If this falls in my lap, I am going to slap you in your face. Is there anything I can eat except that crap you showed me? to which CNA AE said, that's all we have. Resident #82 said I am trying to think of something I can eat, are you sure that's the only thing to which CNA AE said, yes mam, that's all we have. Resident #82 said Tell you a secret, bacon, eggs and grits are not what I want for breakfast lunch or dinner. CNA AE told Resident #82 that she would leave, and Resident #82 responded Is there anything else for dinner, you don't know a damn thing. Resident #82 said Is there anything else for dinner, you don't know a damn thing. She said something inaudible and then die before asking for lunch meat, to which CNA AE said there was no lunch meat and lunch was at 12:00. In an observation and interview on 08/07/25 at 08:45 AM, CNA AL said Resident #82 was very aggressive. He said when the resident admitted she tried to hit staff and said staff should Kill yourself and called people a piece of shit when they tried to weigh her in the Hoyer lift (a device used to transfer individuals with limited mobility). CNA AL said Resident #82 had selective hearing and came with mitts in her back and they could have been some kind of restraint. As the state surveyor interviewed CNA AL, Resident #82 was heard screaming I don't feel good do you have anything to eat, mam mam, is there anyone in the house that has a brain. You are just downright dumb. CNA AL said he had not received any special instructions or directives on how to provide care to Resident #82. He just knew, in his professional experience, to make sure the resident's bed was in the low position since the resident moved around in her bed and to keep the door open. Resident #82 was heard screaming y'all are dumb asses CNA AE came out of the resident's room. CNA AE said the resident was combative, while she was trying to (continued on next page)		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assist her with breakfast and threw food at her. In an interview on 08/07/25 at 08:52 AM, LVN S said Resident #82 had behaviors all morning and they were unable to treat her with her PRN medications because the resident refused medications. An observation on 08/07/25 at 10:43 AM revealed Resident #82 in bed screaming is anybody here. The DON was observed and heard on the phone at the nursing station talking to the hospice provider. She said Resident #82 was at the facility since the 5th and asked if anyone was coming to see the resident. The DON said the resident had behaviors and hospice needed to come to the facility to complete an evaluation. In an interview on 08/07/25 at 10:47 AM, LVN S said she called the hospice provider to see if they could bring Resident #82's ABH gel and the resident really needed it. She said the facility currently had nothing in place to prevent/treat Resident #82's behaviors and the only medication she could administer was morphine because it was a liquid. An observation on 08/07/25 at 10:49 AM revealed, VP A and CNA AL in Resident #82's room. Resident #82 said 1 called about 5 to 8 times for help. VP A asked what Resident #82 needed and the resident said, a potty, I got to TT, got to real bad, oh man that hurts. Resident #82 said I gotta go real bad, it takes forever for someone to come. She had to go bad, but no one was here. Oh, that hurts. VP A instructed CNA AL to go to therapy to get a wheelchair to take Resident #82 to the restroom. At 10:53 AM, CNA AL returned to Resident #82's room with a wheelchair and informed the resident she got a wheelchair to take her to the restroom to which Resident #82 said thank you. In an interview at 08/07/25 at 02:46 PM, LVN S said the facility received only 6 doses of ABH gel today, 08/07/25 at 1 PM. In an interview on 08/11/25 at 02:44 PM, VP A said the baseline care plan was opened by the admitting nurse, and then the IDT team completed it. She said the baseline care plan should be completed within 48 hours of admission, and it should address the immediate needs of the system addressing the major systems. VP A said the facility did not accurately capture Resident #82's use of opioid pain medication or her behaviors in the baseline care plan. She said an inaccurate baseline care plan placed resident's at risk of things being missed. Record review of the facility's, undated, policy Baseline Care Plan/Summary revealed, Purpose: Promote continuity of care and communication among staff, increase resident safety and safeguard against adverse events that are most likely to occur right after admission. Also, to ensure the resident and representative, if applicable, are informed of the initial plan for delivery of care and services by receiving a written summary of the Baseline Care Plan. A Baseline Care Plan for each resident will be developed within 48 hours of the resident's admission to this facility. The Baseline Care Plan will be based on information available from the transferring provider as well as discussions with the resident/representative. It will include interim approaches for meeting the resident's immediate needs and will reflect changes to approaches, as necessary, that occur before the development of the comprehensive care plan. 2. This Baseline Care Plan will include, but not limited to this information needed to care for the resident: a. Initial goals based on admission orders; b. Instruction needed to provide effective and person-centered care that meets professional standards of quality care; c. Resident's immediate health and safety needs; d. Physician orders.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming and personal and oral hygiene for 1 of 8 residents (Resident #43) reviewed for ADL care. The facility failed to provide nail care to Resident #43, leaving the resident with fingernails approximately 1/2 inch longer than the nail bed and his toenails were long with some curling around the tip of his toes. Findings include: Record review of Resident #43's face sheet, dated 08/11/25, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #43 had diagnoses which included weakness & paralysis after a stroke, high cholesterol, muscle weakness and muscle wasting. Record review of Resident #43's Quarterly MDS, dated [DATE], revealed moderately impaired cognition as indicated by a BIMS score of 09 out of 15, no behavioral symptoms, no rejection of care, and supervision or touching assistance with personal hygiene. Record review of Resident #43's, undated, Care Plan revealed, Focus: Resident #43 has an ADL self-care performance deficit related to hemiplegia (paralysis on one side of the body), intervention: personal hygiene with 1 person assistance. Record review of Resident #43's POC Response History, dated 08/11/25, revealed in the last 30 days the resident had not received any manicures and had not refused any manicures. Record review of Resident #43's Progress Notes from 10/30/24 to 08/06/25 revealed, no documented refusal of nail care. In an observation and interview on 08/05/25 at 09:15 AM, Resident #43 was observed in bed with long fingernails. He said he preferred his fingernails short and had no problem with his nails being cut. An observation on 08/06/25 at 08:05 AM revealed Resident #43 lying in bed as the resident was administered oral medications. The DON and a staff nurse interrupted medication administration to assess Resident #43 and then the DON began to cut the residents nails. His nails were approximately 1/2 inches beyond the nail bed on his right hand except for his 3rd finger, which was short, Resident #43's left fingernails were all greater than 1/2 inch beyond his nail bed. Resident #43's toenails were overgrown, his 2nd to 4th toenails curled around the tip of his toes, his big toes were 1/4 to 1/2 inch beyond the nail bed. Only Resident #43's smallest toenails were at normal length. In an interview on 08/11/25 at 03:36 PM, the DON said nursing staff were expected to provide ADL care to residents which included personal hygiene and nail care. She said CNAs and Nurses were responsible for performing nail care to residents without diabetes. She said failure to provide nail care and maintaining nails at a short length placed residents at risk for infection, skin breakdown and injury if their nails snagged. The DON said the resident was known to be verbally aggressive, but she did not know of any issues with nail care. She said prior to her cutting the resident's nails on 08/06/25 she did not know Resident #43 had not received nail care. Record review of the facility's, undated, policy Bath, Bed revealed, purpose: Cleanse, refresh and soothe the resident Stimulate circulation; Inspect the body. Supplies/Equipment: Orange stick for nail care, if used by the facility. Procedure: 22. Care of fingernails and toenails is part of the bath. Be certain nails are clean. If toenails are difficult to cut, inform the charge nurse. 23. Check care plan for specifics regarding nail care, i.e., podiatrist or licensed nurse may need to do this.		

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F 0684 Level of Harm - Minimal harm or potential for 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** Based on observation, interview and record review the facility failed to ensure, based on the comprehensive assessment of a resident, residents received treatment and care and services in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 8 residents (Resident #25) reviewed for quality of care. - The facility failed to provide wound care to Resident #26 on 08/03/25. This failure could place residents at risk of worsening of wounds, infection and pain. Findings include: Record review of Resident #26's face sheet, dated 08/05/25, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #26 had diagnoses which included: fracture of the right forearm, person injured in traffic collision and orthopedic (having to do with bones, joints, ligaments, tendons and muscles) aftercare. Record review of Resident #26's admission MDS, dated [DATE], revealed intact cognition as indicated by a BIMS score of 14 out of 15, upper extremity (shoulder, elbow, wrist, hand) functional limitation in range of motion, and other fracture. Under the pain assessment documented, Resident #26 reported: the presence of pain occasionally, with pain occasionally impacting her sleep, pain rarely or not at all interfering with her therapy activities and her day-to-day activities; and her pain intensity was a 02 out of 10. Under pain management, Resident #26 was coded no for: received scheduled pain medication regimen; no for received PRN pain medications or was offered and declined; and received non-medication intervention for pain. Record review of Resident #26's, undated, Care Plan revealed Focus: risk for pain related to recent fracture; Goal- resident will not have an interruption in normal activities due to pain through the review date; intervention- administer analgesic (drug to relieve pain) as per orders, monitor/record pain characteristics per shift and as needed. Record review of Resident #26's Order Summary Report revealed the following:- Cleanse surgical incision to the right inferior forearm with dermal wound cleanser, pat dry, apply Adaptec wound bed, wrap with kerlix, apply splint, wrap with ace bandage every day shift every other day for wound care -Start Date- 08/01/25- Cleanse laceration to the right medial first digit with dermal wound cleanser, pat dry, apply Adaptec every day shift every other day for wound care -Start Date- 08/01/2025 0600- Cleanse surgical incision to the right inferior forearm with dermal wound cleanser, pat dry, apply Adaptec wound bed, wrap with kerlix, apply splint, wrap with ace bandage every day shift every other day for wound care-start Date- 08/01/2025 0600 Record review of Resident #26's August 2025 MAR printed on 08/05/25 at 12:28 PM revealed the following: - Resident #26 was scheduled to receive wound care on 08/01/25, 08/03/25 and 08/05/25.- On 08/03/25, LVN M documented Resident #26 did not receive wound care to her right arm but she was assessed on the morning and evening shift for: pain, placement of her pressure reduction mattress, her pressure reduction device on her wheelchair, signs and symptoms of bleeding due to blood thinner administration, adverse reactions associated with opioid medication use, edema (fluid buildup in the legs) and her vitals were checked. Record review of Resident #26's Progress Notes, dated 08/05/25 at 12:34 PM, revealed the following: - On 08/03/25 at 05:01 PM signed by LVN M: Patient out on pass with family unable to perform wound care.- On 08/03/25 at 09:31 PM signed by LVN M: patient out on pass with family unable to perform wound care.- On 08/03/25 at 08:57 PM signed by LVN G- Resident received a skilled evaluation. There was no documentation of the resident going out on a day pass, when the resident left or returned, or documentation of refusal of wound care. An observation and interview on 08/05/25 at 09:45 AM revealed Resident #26 lying in bed with a cast covered with a band aid wrap on her right lower arm. The resident said she broke her arm in a car accident. and she had not received wound care over the weekend because the facility did not provide wound care on the weekend. She said she was supposed to receive wound care every other day and the last time she received wound care was on Friday (08/01/25). Resident #26 said she did not have any pain or discomfort due to the missed wound care. In an interview on 08/08/25 at 01:42 PM, the Wound Care Nurse said she was responsible for (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wound care Monday through Friday and floor nurses did wound care on the weekend. She said when a resident was out on a pass, nursing staff were expected to perform wound care prior to the resident leaving and if they were unable to, wound care must be completed immediately after the resident returned to the facility. The Wound Care Nurse said she did not know Resident #26 did not receive wound care on Sunday and she was not notified. In an interview on 08/11/25 at 02:44 PM, the DON said if a resident was going out on a pass, nursing staff should have provided care prior to the resident leaving the facility or when they returned and wound care should not be missed until the next session. She said Resident #26 did not go out for the entire day so her care should have been moved to the next shift. The DON said failure to receive wound care could place residents at risk for infection and worsening of the wound. Record review of the facility's, undated, policy titled Quality of Care revealed, Purpose: Ensure identification and provision of needed care and services that are resident centered, in accordance with the resident's preferences, goals for care and professional standards of practice that will meet each resident's physical, mental and psychosocial needs. Procedure: Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with evidence-based criteria, professional standards of practice, the comprehensive person-centered care plan and resident choices.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who were fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding for 1 of 1 Resident (Resident #56) reviewed for enteral nutrition.- LVN M failed to administer medications and enteral feed safely to Resident #56 by: initiating medication administration without first checking for G-tube (a tube inserted through the abdominal wall into the stomach for the administration of medication and food) placement;; administering a bolus feed immediately following medication administration of 7 medications;; and forcefully pushing medication and the bolus feed through a connected syringe instead of gravity. These failures could place residents at risk of injuries, and hospitalization. Findings include: Record review of Resident #56's Face Sheet dated 08/06/25 revealed, a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included: brain damage, type 2 diabetes, epilepsy (a brain condition in which abnormal electrical activity in the brain causes recurring seizures), MDD, difficulty swallowing, protein-calorie malnutrition (malnutrition caused by insufficient protein and calories), quadriplegia (full body paralysis) and gastrostomy status. Record review of Resident #56's Annual MDS dated [DATE] revealed, short- & long-term memory problems, severely impaired cognitive skills for daily decision making, total dependence for all ADLs, aphasia (brain damage that affects the person's ability to communicate), feeding tube while a resident, received 51% or more of his intake via tube feeding and 501 ml per day or more via tube feeding. Record review of Resident #56's undated Care Plan revealed, Focus: may require tube feeding r/t dysphagia; intervention- the resident is dependent with tube feeding and water flushes. PPE required for high resident contact care activities. Focus: history of seizure disorders r/t anoxic (complete lack of oxygen) brain injury. Risk of infection- EBP at all times; interventions: Staff is to wear PPE's for all contact with resident as long as the resident is on EBP precautions, for things such as dressing, changing linens, transfers, providing hygiene, wound care, device care (or use), bathing or showering, changing briefs or assisting with toileting. Record review of Resident #56's Order Summary Report dated 08/06/25 revealed, - Bolus: ISOSOURCE 1.5 administer 1 can six times a day.- Check for residual. Hold feeding and notify MD if residual greater than 150 mL every shift.- Flush tube with 30mL before and after feeding, Every shift.- Flush tube with 30mL before and after meds. Every shift.- Allopurinol Tablet 100 MG: Give 1 tablet by mouth two times a day for Gout. - Carvedilol Oral Tablet 3.125 MG: Give 1 tablet via PEG-Tube two times a day for hypertension; hold for SBP less 110 &or HR less than 60.- Entresto Oral Tablet 24-26 MG (Sacubitril-Valsartan) : Give 1 tablet via PEG-Tube two times a day for Hypertension; hold for SBP less than 110 &or HR 60.- Levetiracetam Oral Solution 100 MG/ML: Give 7.5 ml via PEG-Tube two times a day for seizure.- Lexapro Oral Tablet 5 MG (Escitalopram Oxalate) : Give 1 tablet via PEG-Tube one time a day for Depression. - Memantine HCl Oral Tablet 10 MG: Give 1 tablet via PEG-Tube two times a day for dementia.- Tramadol HCl Oral Tablet 50 MG: Give 1 tablet via PEG-Tube two times a day for Pain.- Valproic Acid Oral Solution 250 MG/5ML: Give 5 ml via PEG-Tube two times a day for seizure. Record review of Resident #56's August 2025 MAR revealed, LVN M did not administer Resident #56's Escitalopram 5 mg scheduled on 08/09/25 at 09:00 AM. An observation on 08/07/25 at 09:52 AM revealed, LVN M preparing medication for administration for Resident #56. She popped out 1 tablet of: Entresto, Memantine, Carvedilol, Allopurinol and Tramadol into individual medication cups; and poured out 5 ml of Valproic Acid and 10 ml of Levetiracetam. At 09:56 AM, she crushed each medication separately and returned them to their individual medication cups and at 10:00 AM LVN M she entered into Resident #56's room with all the medications. Resident #56 was observed to be non-verbal. He displayed an exaggerated smile intermittently and some nonverbal sounds. She dissolved each medication with 10-15 ml of water and mixed each with (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/21/2025
NAME OF PROVIDER OR SUPPLIER Eagle Crest Rapid Recovery		STREET ADDRESS, CITY, STATE, ZIP CODE 9602 Huffmeister Rd Houston, TX 77095	
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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	individual spoons. At 10:07 AM, she drew 30 ml of warm water into a syringe, connected it to Resident #56's G-tube port and pushed all 30 mL of water. LVN M did not check for placement of Resident #56's G-tube with auscultation (listening to sounds) or by checking residual (the amount of feed that can be withdrawn from the feeding tube that is used to determine stomach fullness) prior to pushing 30 ml of feed, and Resident #56 started making sounds following the 30 mL of fluid. LVN M then administered all 7 medications to Resident #56 by pushing them through the syringe with approximately a 10-15 ml of water flush in between each medication. After administering the medications, LVN M then administered enteral feeding Isosource with the syringe. After the first 30 mL of enteral feed, Resident #56 became visibly agitated, his non-verbal sounds increased in volume, his exaggerated grins increased in frequency, his eyes bulged as they darted between LVN M and the surveyor, and he began to bite his fingers. Resident #56's bulging eyes appeared to be intentionally done and accompanied his exaggerated smile. The Surveyor interrupted the enteral feed and asked LVN M how she could determine if Resident #56 suffered any discomfort from the enteral feed and expressed concern about the increased volume of his non-verbal sounds, his biting of his fingers as well as bulging of his eyes. LVN M said the behaviors the surveyor observed were the resident's baseline and he knew how to communicate, so she knew he did not have discomfort. Resident #56's non-verbal volumes, biting of his finger, bulging, and darting eyes between LVN M and the surveyor subsided but did not stop and the nurse continued the enteral feed. LVN M did not administer approximately 30 ml of the enteral feed to Resident #56. When asked, she said she did not complete the total feed because since administered with the medications it might have been too much fluid for the resident at once and not because the surveyor expressed concern over Resident #56's non-verbal ques. Due to the resident's inability to communicate, the surveyors lack of knowledge of the resident and the decreased volume and frequency of behaviors expressed by Resident #56 at the end of the g-tube administration, the surveyor was unable to determine if the resident experienced any discomfort. In an interview on 08/08/25 at 02:23 PM, LVN M said prior to administering medication via G-tube nursing staff were expected to check for placement with auscultation by injecting 10 cc of air into the tube and listening for sounds. She said she did not check for placement prior to administration of medications and enteral feed to Resident #56 because she checked placement in the morning. She said staff check for placement to ensure that the tube is in the right place (stomach) because if it is not in the stomach the fluid administered could enter the wrong place causing irritation and inflammation. LVN M said the use of gravity vs. syringe for administration depended on the type of the tube and she could not administer medications via gravity for Resident #56 because of the type of tube he had. She said Resident #56's G-tube was too small to administer medications via gravity, so it had to be pushed slowly with the syringe. LVN M said G-tube administration should be performed via gravity because pushing via the syringe can cause the resident to throw up, damage the tubing or cause the resident internal damage. LVN M said during G-tube administration nursing staff are expected to observe the resident for any signs of discomfort. She said she was monitoring Resident #56's facial expressions for pain and she did not observe any. In an interview on 08/9/25 at 03:15 PM, the DON said prior to administering medication or feeding via a resident's G-tube nursing staff must first check for placement by checking the residual (the amount of feed that can be withdrawn from the feeding tube that is was used to determine stomach fullness) because failure to check for placement could result in the liquid being administered into the wrong area if the tube was not in the stomach, resulting in injury and infection. She said medications and feed should be administered via gravity and not through a syringe push because gravity delivers the medication to the stomach at a steady flow to prevent GI spasms. The DON said forceful pushing through the syringe could place residents at risk for cause injury to the GI system and damage to the tube. The DON said medication and bolus feeds were not to be completed concurrently because there was a risk of the medication being diluted. She said when monitoring a resident during G-tube administration, nursing staff should be monitoring the resident's face for the appearance of nausea or (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	grimacing that could indicate pain. Record review of LVN M's Competency Assessment: G-tube Medication Administration, dated 06/03/25, revealed; 12- Check G-tube placement(instill about 10 ml of air and listen for sound- ensure syringe is dated); 13- check for residual (know residual volume- if greater than 10 ml, stop, hold medications and feeding and notify. If the resident is receiving bolus feedings consider the amount of medication and fluid to be instilled. The feeding may need to be at a different time than the medication administration to avoid overload. LVN M was deemed competent for G-tube medication administration. Record review of the facility policy titled Enteral Nutritional Therapy, (Tube Feeding), with no revision date revealed, also known as: Gastrostomy (G-tube) tube feeding, Percutaneous endoscopic gastrostomy (PEG) tube feeding, Bolus tube feeding, Assisted nutrition and hydration. Purpose: Provide liquid nutrition through a tube, inserted into the stomach; . Administer medications directly into the stomach. Procedure: 3. Remove plug from end of feeding tube check position of tube and attach barrel of syringe to end of tubing. 4. Check position of tube by: a. Listening for breath sounds at end of tube or place end of tube in a glass of water below water level to be sure no bubbles appear from nasogastric tube. b. Checking the length of tube for proper position for gastric or jejunostomy tubes. 5. Holding the barrel of the syringe at or below the level of the stomach, pour prescribed amount of water into the syringe (bolus feeding). 6. Administer the amount of feeding to be given by holding the syringe 12 to 14 inches above the level of the stomach. Allow the feeding to flow into the stomach very slowly (bolus feeding). 7. Follow the feeding with the prescribed amount of water and administer in the same manner. Monitoring and care of the feeding tube: 1. Check gastric resident volume (GRV) is no longer recommended for individuals that are alert and able to report symptoms that indicate a feeding is well tolerated. GRV checking may be appropriate for individuals unable to report symptoms such as bloating, nausea or abdominal pain. 2. Verify that the tube is functioning properly and is properly positioned before beginning any feeding as well as before administering any medications.		