

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676323	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/11/2025
NAME OF PROVIDER OR SUPPLIER  The Crescent		STREET ADDRESS, CITY, STATE, ZIP CODE  11353 Sugar Park Lane Sugar Land, TX 77478	

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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 15976</p> <p>Based on observation, interview, and record review the facility failed to provide pharmaceutical services to include procedures that assured the accurate administration of all drugs to meet the needs of each resident for 2 of 6 residents (Resident #1 and CR#2) reviewed for pharmacy services.</p> <p>The facility failed to ensure that Resident #1 received his prescribed blood pressure medication metoprolol, as ordered by his physician.</p> <p>The facility failed to ensure that CR#4 received his prescribed blood pressure medications metoprolol and Midodrine as ordered by his physician.</p> <p>This failure could place residents at risk of medication overdose, medication under-dose, and ineffective therapeutic outcomes by not documenting when medications were held.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet dated 04/11/2025 revealed he was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1's diagnoses included hypertension (high blood pressure), lack of coordination (a condition that affects the ability to control and execute movements), muscle weakness (decreased strength in the muscles), dysphagia (difficulty swallowing), aphasia (ability to communicate), pneumonia (infection that inflames air sacs in both lungs), anxiety disorder (feeling of fear, dread and uneasiness) and seizures (uncontrolled jerking and blank stares).</p> <p>Record review of Resident #1's Annual MDS dated [DATE] revealed a BIMS score of 06 indicating he was severely impaired for cognition. For ADL's he was coded as dependent on staff for ADL care which included eating, and toilet use, shower/bathe, lower body dressing, and taking off footwear. For personal hygiene and upper body dressing he was substantial/maximal assist. For bowel and bladder, he was coded as always incontinent of bowel and bladder.</p> <p>Observation of Resident #1 on 4/11/2025 at 10:30am revealed the resident was in bed. He was alert and was mumbling words asking for the nurse. He was clean and groomed with no offensive odor. No visible marks or bruises observed.</p> <p>Record review of Resident #1's recapitulated physician's order for April 2025 revealed an order dated 12/01/2024 for the following active medication:</p> <p>(continued on next page)</p>

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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Metoprolol 25mg tartrate tablet, give 0.5mg tablet two time a day. Hold if Systolic blood pressure was less than 110 and Diastolic blood pressure was less than 60 and pulse was less than 60.</p> <p>Record review of Resident #1's medication administration record for April 2025 revealed Metoprolol was not documented as held on 04/02/2025 when Resident #1's blood pressure was 105/65.</p> <p>Record review of Resident #1's nurse's progress notes dated April 2025 revealed no documentation as to why the medication metoprolol was not held.</p> <p>In an interview on 4/11/2025 at 3:15 pm with RN A she said that if Resident #1's blood pressure 105/65 she should have held the medication and document why it was held. She said not documenting correctly would be difficult to determine if the medication was held. She said if the medication was not given it should be indicated on the MAR with a number and in the nurse's notes. She said it medication was not held when there was an order for it to be held the blood pressure could get lower or higher causing the resident to get sick. She said moving forward she will ensure she documents correctly on the MARs on in the nurses' notes.</p> <p>Record review of CR #4's face sheet dated 04/11/2025 revealed CR#4 was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #4's diagnoses included essential hypertension (high blood pressure), depression (a mental health condition with low mood and loss of interest in pleasurable activities), hyperlipidemia (high level of fat in the blood), peripheral vascular disease (narrowing blood vessel that reduce blood flow to the limbs), anxiety disorder (feeling of fear, dread and uneasiness), bipolar disorder (a mental disorder that causes extreme mood swings), muscle weakness (decrease strength in the muscles) and heart failure(a condition where the heart not pumping blood as it should).</p> <p>Record review of CR#4's Quarterly MDS dated [DATE] revealed she was a BIMS of 12 indicating he was cognitively aware for decision making. He was coded as not exhibiting any behaviors. For ADL care he was coded as needing supervision for eating, toileting and oral hygiene, upper body dressing and shower/bathe, putting on and taking off footwear and for personal hygiene. For lower body dressing he coded as needing partial/moderate assist. For bowel and bladder, he was coded as frequently incontinent.</p> <p>Record review of CR#4's recapitulated physician's orders for March 2025 revealed the following active medications:</p> <p>Order date 12/01/2024 for Midodrine 5mg, give 1 tablet by orally three times a day for hypotension. Hold . for Systolic Blood Pressure greater than 100.</p> <p>Order date 12/01/2024 for Metoprolol 25mg tartrate tablet, give 0.5mg tablet two time a day. Hold if Systolic blood pressure was less than 110 and Diastolic blood pressure was less than 60 and pulse was less than 60.</p> <p>Record review of CR#4's medication administration record for March 2025 revealed the following:</p> <p>Midodrine 0.5 mg was not held on the following dates 03/03/2025 b/p was 128/60, 03/05/2025 b/p was 122/61, 03/06/2025 b/p 130/90, 03/10/2025 b/p was 125/62.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Metoprolol 0.5 was not held on 3/02/2025 b/p was 101/63, 3/10/2025 b/p was 101/67 and 3/21/2025 b/p was 109/65.</p> <p>Record review of Resident #4's nurse's progress notes dated March 2025 revealed no documentation as to why the medications was given when it was to be held.</p> <p>Interview on 04/11/2025 at 1:24 pm. with RN A she said when there was an order, they confirm the order and follow the order. She said medications with parameters also deals with the timing, it can be stop or continue. If there are concerns, they should call the doctor. For example, blood pressure medications and insulin with parameters the doctor would be call for confirmation. She said CR#2's blood pressure was always low. His medication was to help increase his blood pressure. RN A said she did not administer the medication on the following dates: 03/03/2025 blood pressure was 128/60, 03/05/2025 blood pressure was 122/61, 03/06/2025 blood pressure was 130/90 and on 03/10/2025 blood pressure was 125/62, she said it was an error. When she was asked why there were check marks indicating blood pressure medication was administered, she responded she documented in error. She said the order for Midodrine 5 mg was to be held for Systolic blood pressure greater than 100 and she would not give if it was greater than 100 and if Metoprolol was to be held if systolic was less than 110 she would have held it. She said moving forward she will ensure that she does not make that error again. She said, she should document with a check mark and a number indicating it was not given and the reason why it was not given. A check only would indicate it was given and it would be difficult to know if the medication was given or not given.</p> <p>In an interview on 4/11/2025 at 1:55 pm, with RN B, she said when doctor's orders were not followed, you get written up, if you do it again, then you will be reported. She said not following doctor's orders It might cause harm to the resident such as elevated or decrease blood pressure. Medications with parameters were metoprolol, lisinopril, diabetic medications with sliding scales. She said I don't know how I signed that the MAR as given. I cannot give that medication with parameters. Symptom of Ventricular fibrillation-flushed, chest pain and decreased oxygen saturation could be the result of not holding medications when it was to be held.</p> <p>In an interview on 4/11/2025 at 2:15 pm. with Director of Nursing she said all blood pressure medications should have parameters. She said some blood pressure medications with parameters were carvedilol, amlodipine, losartan and metoprolol. She said the consequences of not following the parameters the doctor order for blood pressure medications could cause harm, making blood pressure to be too high or it can drop too low. She said she knew the CR#4 was a dialysis and cardiac patient. She said her expectations were that the nurses were to follow the parameters ordered for medications and document. She said if medication was not given it should be documentation as to why it was held. She said she was responsible for monitoring the nurses and she will be in-servicing all nursing staff on medication administration.</p> <p>In an interview at 3:09 pm. with LVN D he said medications with parameters, was to determine when to administer and when not to administer medication. He said some medications with parameters were, blood pressure medication, pain medications and diabetes medications. He said if a blood pressure medication has parameters, it should be held as per orders. He said if there was concerns about an order the doctor should be called for clarification. He said some consequences of not following doctor's orders were the blood pressure might drop too low or might be too high.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the facility policy and procedures on Administering Medication dated April 2019 read in part .</p> <p>Policy heading:</p> <p>Medications are administered in a safe and timely manner, and as prescribed.</p> <p>Policy Interpretation and Implementation</p> <p>1. Only persons licensed or permitted by this state to prepare, administer, and document the administration of medication may do so.</p> <p>2. The Director of Nursing services supervises and directs all personnel who administer medications and/or have related functions.</p> <p>4. Medications are administered in accordance with prescriber's orders, including required time frame.</p> <p>6. Medication errors are documented, reported, and reviewed by the QAPI committee to inform process or the need for additional staff training.</p> <p>21. If a drug is withheld, refused or given at another time other than the schedule time the individual administering the medication shall initial and circle the MAR space provided for that drug and dose.</p>		