STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676323	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Crescent	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)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to ensure residents were free from abuse, neglect, misappropriation of resident property, and exploitation for 1 of 9 residents (CR#1) reviewed for abuse and neglect. 1. The facility failed to prevent CNA A from having access to CR#1 and other residents after an allegation of abuse was made. 2. The facility failed to ensure CR#1 was free from physical/mental abuse and neglect when CR#1 reported he was abused and threatened by CNA A. CR#1 sustained an injury on the left arm on 6/21/25. An Immediate Jeopardy (IJ) situation was identified on 06/25/2025. While the IJ was removed on 6/26/2025., the facility remained out of compliance at a scope of isolated with the potential for more than minimal harm due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk of being subjected to continued abuse. Findings include: Record review of CR#1's undated face sheet reflected a [AGE] year-old male who was initially admitted to the facility on [DATE] and re-admitted on [DATE]. CR#1 had diagnoses which included toxic encephalopathy (a neurological disorder that occurs with brain is exposed to toxic substances, such as heavy metals or neurotoxic solvents over a period of time) and had a cystostomy catheter (tube inserted through the abdomen into the bladder).Record review of CR#1's Orders revealed, Wound Treatment-Xeroform (dressing) everyday shift cleanse wound to left hand with Normal Saline or skin cleanser. Pat dry. Apply Xeroform to wound. Cover with dry dressing. Start Date-06/22/2025. Record review of CR#1's care plan, dated 6/17/2025, revealed the following:Focus: [CR#1] has an ADL self-care performance deficit r/t. Date initiated 5/2/2025Goal: [CR#1] will maintain currently level of function in through the review date.Interventions: [CR#1] Transfer: Resident is totally dependent of staff for transferring. Date initiated: 5/27/2025 Record review of WCD notes, dated 6/24/2025, revealed a skin tear wound of the left forearm. Wound size 2.2x1x0.3. Primary dressing Xeroform gauze apply once daily and as needed: if saturated, soiled, or dislodged. For 30 days. Record review of CR#1's admission MDS dated [DATE], revealed CR#1 has a BIMS Score of 12, which indicated moderate cognitive impairment. CR#1 used a wheelchair as a mobility device; required 2 or more helpers to complete to assist with transferring from wheelchair or bed. Record review of Phone Order, by WCD, dated 6/22/25 at 12:42 AM, titled, Wound Orders - [wound] for Wound Treatment). It was an order for Xeroform (wound dressing) Record review of nursing notes, revealed there were no notes documented on 6/21/2025 regarding CR#1's injuries. Record review of text message received from LVN A from her telephone revealed, she telephoned 911 in reference to CR#1's abuse incident on 6/22/25 at 4:21PM. Record review of nursing notes, by WCN A, dated 6/22/25 at 6:38 PM, revealed Received report resident has skin tear to left hand. Assessment done verbally denied pain and discomfort. Physician informed, order in place. Wound care done at this time, tolerated well. Offloads reposition and safety noted. RP updated remain stable. Will continue plan of care. Record review of nursing notes, by RN A, dated 6/22/25 at 6:58 PM, for effective date 6/21/25 at 3:30 PM revealed the following note: Received report from the outgoing nurse that patient voiced concern regarding a CNA's approach during care. Patient reported that the assigned CNA was not gentle and continued to insist that he perform tasks independently, despite the patient stating he felt too weak and required two-person assistance. CNA reportedly attempted care initially alone, but eventually called for a second staff member to assist. During assessment, patient was noted with an existing bruise to the left upper arm that appeared to have reopened, resulting in a small amount of blood observed on the bedsheet. It remains unclear when the original injury occurred. Patient continued to express that the CNA was rough during care. Writer obtained statements from the involved CNA and requested the primary nurse to initiate an incident report for documentation and follow-up. Patient was repositioned and made comfortable in bed. The DON was notified of the incident and ongoing concerns. Will continue to monitor patient closely and follow up as needed. Record review of documentation supplied by ED that revealed, handwritten dated and time of employees termination on top of the Texas Board of Nursing records for each employee involved in the incident. The Director of Nursing (6/25/2025 at 7:29pm), LVN A (6/25/2025 at 8:29pm), RN A (6/25/2025 at 7:31pm), and CNA A (6/25/2025 at 7:36pm), were all terminated on 06/25/2025 for failure to immediately report abuse to the Abuse Coordinator. During an observation and interview on 6/24/25 at 9:15 AM, CR#1 was seated in his wheelchair at the entrance of his room and was observed with a bandage on his left forearm that had a small amount of blood on it. It had a written date of 6/24/2025. CR#1 was alert, orientated to person, place and event. CR#1 stated the injury occurred when

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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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to implement the abuse protocol that prohibit and prevent abuse, neglect, and exploitation of residents 1 (CR#1) of 9 residents reviewed for abuse. The facility failed to prevent abuse, report the abuse allegation immediately to the Abuse Coordinator, and failed to protect the residents as the alleged perpetrator was allowed to continue to work. CR#1 reported he was physically abused on his arm by CNA A on 6/21/2025 around 2:30pm, which was the time CNA A started her afternoon shift. An Immediate Jeopardy (IJ) situation was identified on 06/26/2025. While the IJ was removed on 6/27/2025., the facility remained out of compliance at a scope of pattern with the potential for more than minimal harm due to the facility's need to evaluate the effectiveness of the corrective systems. These failures placed residents at risk of physical harm, emotional distress, mental anguish and death from possible abuse and neglect.Findings Include: Record review of the facility's Abuse Protocol policy, dated April 2019, revealed the following:7. The following definitions are provided to assist our Facility's staff members in recognizing incidents of Patient Abuse:a. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish, or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all Patient/Resident, irrespective of any physical or mental condition, cause physical harm, pain, or mental anguish. Willful as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.b. Taking or using photographs or recordings in any manner that would demean or humiliate a Patient. This includes using any type of equipment (e.g., cameras, smart phones, and other electronic devices) to take, keep or distribute photographs and recordings on social media. c. Misappropriation of Patient property means the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a Patient's belongings or money without the Patient's consent.d. Verbal abuse is defined as any use of oral, written or gestured language that includes disparaging and derogatory terms to Patient or their families, or within their hearing distance, to describe Patient, regardless of their age, ability to comprehend, or disability.e. Sexual abuse is defined as, but is not limited to, sexual harassment, sexual coercion, or sexual assault, or any nonconsensual sexual contact of any type with the Patient.f. Physical abuse is defined as hitting, slapping, pinching, kicking, etc. It also includes controlling behavior through corporal punishment.g. Involuntary seclusion is defined as separation of a Patient from other Patient's or from his or her room against the Patient will, or the will of the Patient's legal guardian or representative. (Note: temporary monitored separation from other Patient's will not be considered involuntary seclusion and may be permitted when used as a therapeutic intervention to reduce agitation as determined by the Medical Director, and/or the Director of Nursing, and such action is consistent with the Patient's Care Plan).h. Mental abuse is defined as, but not limited to, humiliation, harassment, threats of punishment, or withholding of treatment or services. (Identifying)i. Adverse event is an untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof.j. Exploitation means taking advantage of a Patient for personal gain through the use of manipulation, intimidation, threats, or coercion.k. Mistreatment means inappropriate treatment or exploitation of a Patient.l. Neglect is the failure of the facility, it's employees or service providers to provide goods and services to a Patient that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.m. Person-centered-care means to focus on the Patient as the locus of control and support the Patient in making their own choices and having control over the daily lives.8. Any person observing an incident of Patient Abuse or suspecting Patient Abuse must immediately report such incidents to the Charge Nurse. The following information should be reported to the Charge Nurse:a. The name of the Patient involved;b. The date and time that the incident occurred;c. Where the incident took place;d. The name(s) of the person(s) committing the incident, if known;e. The name(s) of any witnesses to the incident;f. The type of abuse that was committed (i.e., verbal, physical,sexual, etc.); andg. Other information that may be requested by the Charge Nurse.9. The Charge Nurse will immediately examine the Patient and notifythe Abuse Prevention Coordinator upon receiving reports of mental,physical or sexual abuse. Findings of the examination will berecorded in the Patient's medical record. (Protection)Record review of CR#1's undated face sheet reflected a [AGE] year-old male who was initially admitted to the facility on [DATE] and re-admitted on [DATE]. CR#1 had diagnoses which included toxic

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to report an alleged violation involving abuse or resulting in serious bodily injury immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury to the administrator of the facility and to other officials including to the State Survey Agency in accordance with State law through established procedures; that 1(CR#1) of 9 residents had been abused by CNA A, which resulted in injury. The facility staff failed to immediately report abuse to the Abuse Coordinator, the State Survey Agency and Law Enforcement. An Immediate Jeopardy (IJ) situation was identified on 06/26/2025. While the IJ was removed on 6/27/2025., the facility remained out of compliance at a scope of pattern with the potential for more than minimal harm due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk of continued abuse. Findings include:Record review of CR#1's undated face sheet reflected a [AGE] year-old male who was initially admitted to the facility on [DATE] and re-admitted on [DATE]. CR#1 had diagnoses which included toxic encephalopathy (a neurological disorder that occurs with brain is exposed to toxic substances, such as heavy metals or neurotoxic solvents over a period of time) and had a cystostomy catheter (tube inserted through the abdomen into the bladder).Record review of CR#1's Orders revealed, Wound Treatment-Xeroform (dressing) everyday shift cleanse wound to left hand with Normal Saline or skin cleanser. Pat dry. Apply Xeroform to wound. Cover with dry dressing. Start Date-06/22/2025. Record review of CR#1's care plan, dated 6/17/2025, revealed the following:Focus: [CR#1] has an ADL self-care performance deficit r/t. Date initiated 5/2/2025Goal: [CR#1] will maintain currently level of function in through the review date.Interventions: [CR#1] Transfer: Resident is totally dependent of staff for transferring. Date initiated: 5/27/2025Record review of WCD notes, dated 6/24/2025, revealed a skin tear wound of the left forearm. Wound size 2.2x1x0.3. Primary dressing Xeroform gauze apply once daily and as needed: if saturated, soiled, or dislodged. For 30 days. Record Review of the Nursing Board certificates received from ED for the current staff: DON, RN A, LVN A and CNA A. Each document contained a handwritten termination date and time on the upper righthand corner of each document.Record review of CR#1's admission MDS dated [DATE], revealed CR#1 has a BIMS Score of 12, which indicated moderate cognitive impairment. CR#1 used a wheelchair as a mobility device; required 2 or more helpers to complete to assist with transferring from wheelchair or bed.Record review of nursing notes, revealed there were no notes documented on 6/21/2025 regarding CR#1's injuries. During an observation and interview on 6/24/25 at 9:15 AM, CR#1 was seated in his wheelchair at the entrance of his room and was observed with a bandage on his left forearm that had a small amount of blood on it. It had a written date of 6/24/2025. CR#1 was alert, orientated to person, place and event. CR#1 stated the injury occurred when CNA A tried putting him in bed by herself by pulling his arms to lift him out of the wheelchair. CR#1 stated he told CNA A he did not want to go to bed, but she insisted anyway and continued to pull on his arms. CR#1 stated CNA A told him she could put him in bed by herself and he told her it would take two people, but he was not ready to go to bed. He stated CNA A told him if she didn't put him in bed then he would be there all night even if he pooped on himself, and she would not bring him any food. He stated CNA A insisted on putting him in bed by herself and he told her he was unable to assist her due to how he was feeling. CR#1 stated during her pulling on his arms by herself, CNA A injured his left arm. CR#1 continued to tell CNA A not to pick him up by herself because it took two people. He stated she did not listen, but when she realized she couldn't she went and got CNA B. CR#1 stated he told LVN what occurred when she came to his room. He stated CNA A was rough with him.Record review of text received from LVN A from her telephone reveals that the 911 call was made on 6/22/25 at 4:21pm. Record review of nursing notes, by WCN A, dated 6/22/25 at 6:38 PM, revealed Received report resident has skin tear to left hand. Assessment done verbally denied pain and discomfort. Physician informed, order in place. Wound care done at this time, tolerated well. Offloads reposition and safety noted. RP updated remain stable. Will continue plan of care. Record review of nursing notes, by RN A, dated 6/22/25 at 6:58 PM, for effective date 6/21/25 at 3:30 PM revealed the following note: Received report from the outgoing nurse that patient voiced concern regarding a CNA's approach during care. Patient reported that the assigned CNA was not gentle and continued to insist that he perform tasks independently, despite the patient stating he felt too weak and required two-person assistance. CNA reportedly attempted care initially alone, but eventually called for a second staff member to assist. During

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to have evidence that all alleged violations of abuse were thoroughly investigated, to prevent further potential abuse or mistreatment while the investigation was in progress, and report the result of all investigations to other officials in accordance with State law, including to the State Survey Agency within 5 working days of the incident for 1 (CR#1) of 9 residents reviewed for abuse.The facility failed to ensure resident(s) was/were free from physical/mental abuse and neglect when CR#1 reported he was abused by CNA A and received an injury. The facility staff failed to immediately report the incident to the Abuse Coordinator (ED), suspend staff, and being an investigation of the incident promptly.The facility failed to prevent CNA A from having access to CR#1 and other residents after an allegation of abuse was reported.An Immediate Jeopardy (IJ) situation was identified on 06/26/2025. While the IJ was removed on 6/27/2025., the facility remained out of compliance at a scope of pattern with the potential for more than minimal harm due to the facility's need to evaluate the effectiveness of the corrective systems. These failures placed resident(s) involved in abuse incidents at risk of continued abuse, mistreatment, further injury, pain and physical and emotional distress contributing to further serious injuries. The findings include:Record review of CR#1's undated face sheet reflected a [AGE] year-old male who was initially admitted to the facility on [DATE] and re-admitted on [DATE]. CR#1 had diagnoses which included toxic encephalopathy (a neurological disorder that occurs with brain is exposed to toxic substances, such as heavy metals or neurotoxic solvents over a period of time) and had a cystostomy catheter (tube inserted through the abdomen into the bladder).Record review of CR#1's Orders revealed, Wound Treatment-Xeroform (dressing) everyday shift cleanse wound to left hand with Normal Saline or skin cleanser. Pat dry. Apply Xeroform to wound. Cover with dry dressing. Start Date-06/22/2025.Record review of CR#1's care plan, dated 6/17/2025, revealed the following:Focus: [CR#1] has an ADL self-care performance deficit r/t. Date initiated 5/2/2025Goal: [CR#1] will maintain currently level of function in through the review date.Interventions: [CR#1] Transfer: Resident is totally dependent of staff for transferring. Date initiated: 5/27/2025Record review of WCD notes, dated 6/24/2025, revealed a skin tear wound of the left forearm. Wound size 2.2x1x0.3. Primary dressing Xeroform gauze apply once daily and as needed: if saturated, soiled, or dislodged. For 30 days.Record Review of the Nursing Board certificates received from ED for the current staff: DON, RN A, LVN A and CNA A. Each document contained a handwritten termination date and time on the upper righthand corner of each document.Record review of CR#1's admission MDS dated [DATE], revealed CR#1 has a BIMS Score of 12, which indicated moderate cognitive impairment. CR#1 used a wheelchair as a mobility device; required 2 or more helpers to complete to assist with transferring from wheelchair or bed. Record review of nursing notes, revealed there were no notes documented on 6/21/2025 regarding CR#1's injuries. During an observation and interview on 6/24/25 at 9:15 AM, CR#1 was seated in his wheelchair at the entrance of his room and was observed with a bandage on his left forearm that had a small amount of blood on it. It had a written date of 6/24/2025. CR#1 was alert, orientated to person, place and event. CR#1 stated the injury occurred when CNA A tried putting him in bed by herself by pulling his arms to lift him out of the wheelchair. CR#1 stated he told CNA A he did not want to go to bed, but she insisted anyway and continued to pull on his arms. CR#1 stated CNA A told him she could put him in bed by herself and he told her it would take two people, but he was not ready to go to bed. He stated CNA A told him if she didn't put him in bed then he would be there all night even if he pooped on himself, and she would not bring him any food. He stated CNA A insisted on putting him in bed by herself and he told her he was unable to assist her due to how he was feeling. CR#1 stated during her pulling on his arms by herself, CNA A injured his left arm. CR#1 continued to tell CNA A not to pick him up by herself because it took two people. He stated she did not listen, but when she realized she couldn't she went and got CNA B. CR#1 stated he told LVN what occurred when she came to his room. He stated CNA A was rough with him.Record review of text received from LVN A from her telephone reveals that the 911 call was made on 6/22/25 at 4:21pm.Record review of nursing notes, by WCN A, dated 6/22/25 at 6:38 PM, revealed Received report resident has skin tear to left hand. Assessment done verbally denied pain and discomfort. Physician informed, order in place. Wound care done at this time, tolerated well. Offloads reposition and safety noted. RP updated remain stable. Will continue plan of care.Record review of nursing notes, by RN A, dated 6/22/25 at 6:58 PM, for effective date 6/21/25 at 3:30 PM revealed the following note: Received report