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	10/23/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported 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, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result 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 for one of five residents (Resident #1) reviewed for abuse and neglect . The facility failed to report to Health and Human Services an incident of potential neglect for Resident #1 within 24 hours, when Resident #1 was left unattended with a hot cup of liquid which resulted in Resident #1 sustaining second degree burns to her right leg and pain.This failure could place residents at risk of abuse, neglect, pain, and diminished quality of life.Record review of Resident #1's face sheet, dated 10/21/2025 reflected a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of anxiety disorder (feeling of worry, fear), Proteus mirabilis (bacterial infection), rheumatoid arthritis (autoimmune disease that cause pain and stiffness in joints), muscle wasting and atrophy (loss of muscle mass and strength), hypertension (elevated blood pressure), and heart failure.Review of Resident #1's Significant change MDS assessment dated [DATE] reflected Resident #1 was assessed to have a BIMS score of 15 which indicated she was cognitively intact. Further review of the MDS reflected that Resident #1 had impairment in her upper extremity.Record review of Resident #1's care plan, dated 10/21/2025, revealed that it was updated to identify a skin concern of non-pressure wound to right shin with the initiated date of 04/03/2025 and the care plan also identified a focus area of ADL self-care deficit noted resident required total staff assistance with eating initiated 06/24/2025.Record Review of the facility's Incidents By Incident Type on 10/21/2025 for the months of 01/01/2025-10/21/2025 did not reflect Resident #1's burn incident. Record review of TULIP (online system for intakes regarding facility reported incidents and complaints in nursing facilities) for dates 4/02/25 through 10/21/25 indicated the facility had not reported to the state agency Resident #1's burn with injury on 04/02/25.Record Review of Resident #1 progress notes dated 04/02/2025 at around 7:33 PM, reflected LVN B was notified by a CNA that Resident #1 poured warmed broth on her body, LVN B noted Resident #1 in supine position crying with burn to leg. LVN B provided Resident #1 with PRN Acetaminophen - Codeine 300-30 mg x 1 tablet, notified DON and MD. The notes further noted that the area formed with blisters, cream applied.Record Review of Resident #1's physician orders reflected an order dated 04/03/2025 Silver Sulfadiazine Cream 1 % Apply to Right shin topically every day shift for Wound Care Apply to wound on right shin.An observation and interview conducted on 10/21/2025 at 3:47 PM, Resident #1 stated she did have an incident on 04/02/2025 where hot soup accidentally fell on her leg causing her a burn and pain. Resident was noted to have significant area of discolored skin to her right shin, that resulted from the burn. Resident #1 stated she was in pain and asked to go to the hospital emergency room, but the nurse did not respond to her request. Resident #1 stated the doctor did not see her until almost a week later. An observation / review of photos dated 04/03/2025 and 04/07/2025 conducted on 10/21/2025 at 4:23 PM, revealed Resident #1's burn on her right leg showed full thickness burn through two layers of skin to indicate a second-degree burn.An interview was attempted with CNA A on 10/21/2025 at 5:14 PM, received voicemail and a message left to return call.An interview was attempted with LVN B on 10/21/2025 at 5:15 PM, received voicemail and a message was left to return call.In an interview conducted with CNA A on 10/22/2025 at 11: 24 AM, CNA A stated the burn incident in April 2025 with Resident #1 was a simple accident. CNA A explained that Resident #1 had asked for either tea, coffee, or soup; however, the CNA could not recall which one. She stated Resident #1 normally ate soup a lot. CNA A stated she obtained hot water from the dispenser in the coffee room next to the nurses' station and advised Resident #1 to let the water cool. CNA A reported she left the room to provide care for another resident and when she returned, Resident #1 had knocked over the cup and the liquid had spilled through the covers. CNA A stated she removed the covers and noted Resdent#1's leg was wet, and Resident #1 was hurting. CNA A stated she notified the LVN B charge nurse, who came to assess Resident #1. CNA A stated Resident #1 did not have any visible marks that day, however the following day, some marks were noted. An interview was attempted two more times with LVN B on 10/22/2025 at 12:29 and 12:40 PM, a voicemail was

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 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 observations, interviews, and record reviews, the facility failed to ensure that each resident received adequate supervision and assistance devices to prevent accidents for 1 of 5 (Residents #1) reviewed for accidents hazards and supervision.The facility failed to ensure CNA A provided Resident #1 adequate supervision after she provided her with hot water for soup on 04/02/25, in which Resident #1 suffered 2nd/3rd degree burns on her right leg.The facility failed to have appropriate interventions in place to ensure hot water was tested for safe temperatures before being served to residents.These failures resulted in an Immediate Jeopardy (IJ) situation on 10/22/2025. The IJ template was provided to the facility on [DATE] at 6:53PM. While the IJ was removed on 10/23/2025, the facility remained out of compliance at a scope of pattern and a severity level of potential harm with the potential for more than minimal harm that is not an Immediate Jeopardy, due to facility's need of more time to monitor the plan of removal for effectiveness. These failures could place residents at risk of physical harm.Record review of Resident #1's face sheet, dated 10/21/2025 reflected a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of anxiety disorder (feeling of worry, fear), Proteus mirabilis (bacterial infection), rheumatoid arthritis (autoimmune disease that cause pain and stiffness in joints), muscle wasting and atrophy (loss of muscle mass and strength), hypertension (elevated blood pressure), and heart failure.Record Review of Resident #1's Significant change MDS assessment dated [DATE] reflected Resident #1 was assessed to have a BIMS score of 15 which indicated she was cognitively intact. Further review of the MDS reflected that Resident #1 had impairment in her upper extremity.Record review of Resident #1's comprehensive care plan, dated 10/21/2025, revealed that it was updated to identify a skin concern of non-pressure wound to right shin with the initiated date of 04/03/2025 and the care plan also identified a focus area of ADL self-care deficit noted resident required total staff assistance with eating initiated 06/24/2025. The care plan did not include interventions for being served hot liquids.Record Review of Resident #1 progress notes dated 04/02/2025 at around 7:33 PM, reflected LVN B was notified by a CNA that Resident #1 poured warmed broth on her body, LVN B noted Resident #1 in supine position crying with burn to leg. LVN B provided Resident #1 with PRN Acetaminophen - Codeine 300-30 mg x 1 tablet, notified DON and MD.Review of Resident #1's skin assessment dated [DATE] reflected non-pressure wound of the right shin undetermined thickness, size of 10 cm length by 17 cm width, area 170 cm2 undermining. Record Review of Resident #1's physician orders reflected an order dated 04/03/2025 Silver Sulfadiazine Cream 1 % Apply to Right shin topically every day shift for Wound Care Apply to wound on right shin.Record Review of Resident #1's progress noted dated 04/04/2025 reflected Resident #1 was assessed by wound nurse practitioner and facility TN. Resident was noted to have cluster of fluid filled blisters to right shin, new order noted for xeroform (wound dressing). Record Review of the facility's Incidents By Incident Type provided on 10/21/2025 for the months of 01/01/2025-10/21/2025 did not reflect Resident #1's burn incident.Record Review of staff in-services reflected on 04/03/2025 was completed with direct care staff on Safety of Hot Liquids by LVN /Nurse Unit Manager. The In-service reflected to Never give a resident any liquid hot enough to cause a burn. If a resident requests a liquid (drink or soup) to be warmed up, then WARMED is all it should be. If you can't hold the container of liquid, then it is too HOT to give to residents. Place on counter out of reach of resident until it cools to warm/room temperature.In an interview conducted on 10/21/2025 at 3:47 PM, Resident #1 stated she wanted her soup hot. She stated CNA A came and brought her some hot water from the coffee pot. She stated CNA A told her This is the water for your soup it is hot and do not waste it. Resident #1 stated it was a 16-ounce cup. She stated she reached for her remote and the water accidentally fell on her leg. Resident #1 stated CNA A came back to check on her and noticed she had wasted the water and started removing the blanket. Resident #1 stated CNA A notified the nurse. Resident #1 stated she was in pain and asked to go to the hospital emergency room, but the nurse did not respond to her request. Resident #1 stated the doctor did not see her until almost a week later. In an interview conducted on 10/21/2025 at 4:15 PM with RP, RP stated Resident #1 received the burn on her right leg. He reported that he was called late in the evening on 04/02/2025 which was much later after the incident had occurred. RP stated he came on April 3rd and took pictures of the burns. He reported that the facility did not send Resident #1 out to the emergency room, stated they would provide treatment for Resident #1 at the facility and that there was no need to send resident out for treatment. RP stated in his opinion the burns were real bad and he sought legal advice. RP