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	11/18/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**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 incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 8 residents (Resident #1) reviewed for Foley catheter care The facility failed to ensure Resident #1's Foley catheter had a leg strap to prevent being pulled or tugged on. This failure could place residents at risk for unwanted pain, discomfort, and risk of dislodgement or injury. Findings include: Record review of Resident #1's face sheet, dated 11/13/25, reflected a [AGE] year-old female who was admitted to the facility originally on 11/29/24 and readmitted on [DATE]. Resident #1 had diagnoses which included the following: paraplegia (loss of movement typically in the legs, caused by a spinal injury or another condition), ileus (temporary absence of the intestinal muscle contraction that prevents the normal flow of intestinal contents and cause short term blockage), muscle wasting and atrophy (shrinking of muscle due to lack of use of the muscle), intraspinal abscess (serious infection where pus builds up cause by a bacteria) and granuloma (forming of cells that forms in a response to long time injury or infection, identified by redness, swelling, heat, pain, and loss of function), osteomyelitis (bone infection) of the vertebra lumbar region (bones of the lower back), type 2 diabetes mellitus (when the body does not produce enough insulin or does not use it properly to keep blood sugar levels normal), and depression. Record review of Resident #1's Comprehensive Care Plan, dated 08/27/25 and revised 09/04/25, reflected Resident #1 was being care planned for Foley catheter: Dx of neuromuscular dysfunction (of bladder (when there is nerve damage to the brain, spinal cord that prevents the bladder from functioning properly). The interventions included the following: -Monitor/document for pain/ discomfort due to catheter-Check tubing for kinks each shift Record review of Resident #1's admission MDS, dated [DATE], reflected a BIMS score of 13, which indicated the resident's cognition was intact. Section H (Bladder and Bowel) of the MDS was coded 9, which indicated Resident #1 had a catheter. Record review of Resident #1's Physician Order Summary Report for the month of November 2025 reflected the following order: -Dated 08/28/25 Foley catheter 16F/10cc bulb Observation on 11/13/25 at 4:38 PM of Foley catheter care for Resident #1 by the ADON with the assistance of CNA B revealed Resident #1 was not wearing a Foley catheter secured strap. Resident #1's Foley catheter tubing was draining yellow urine. Interview on 11/13/25 at 5:30 PM, RN A said he was Resident #1's nurse. RN A said Resident #1 was supposed to have a secured Foley leg strap to prevent tubing from pulling which could cause injury to the resident that could lead to bleeding. RN A said he was responsible for making sure Resident #1 had a Foley catheter secured strap intact. RN A said the secured strap must have come off. Interview on 11/13/25 at 5:30 PM, Resident #1 said the staff never attached a secure strap to her Foley catheter tubing. Interview on 11/13/25 at 5:35 PM, CNA B said Resident #1's Foley catheter should have had a secure strap to prevent pulling of the Foley catheter tubing and dislodging the Foley catheter. CNA B said she was not assigned to Resident #1 and was just assisting with her care. Interview on 11/13/25 at 5:40 PM, the DON said all residents with Foley catheters should have a leg strap to prevent dislodging the Foley catheter. Record review of the NF policy on Catheter Care, Urinary, revised September 2014, reflected in part: .Ensure that the catheter remains secure with a leg strap to reduce friction and movement at the insertion site. (Note: catheter tubing should be strapped to the resident's inner thigh).

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (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 0880 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 observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program to provide a safe, sanitary and comfortable environment to help prevent the transmission of communicable diseases and infections for 1 of 8 Residents (Resident # 1) reviewed for infection control. 1. The ADON and CNA B failed to wear full PPE (disposable gown) when providing Foley catheter care for Resident #1. 2. RN A failed to wear full PPE (disposable gown) when performing Resident #1's wound dressing changes to the sacrum (large bone triangular positioned at the very base of the spine) and RL ischium (the bone that supports the upper body's weight and balance that is located near the pelvis [bone at the base of the spine]). These failures could place residents at the risk of acquiring and spreading multidrug-resistant organisms through contact with staff and other residents that could lead to unwanted infections. Findings include: Record review of Resident #1's face sheet, dated 11/13/25, reflected a [AGE] year-old female who was admitted to the facility originally on 11/29/24 and readmitted on [DATE]. Resident #1 had diagnoses which included the following: paraplegia (loss of movement typically in the legs, caused by a spinal injury or another condition), ileus (temporary absence of the intestinal muscle contraction that prevents the normal flow of intestinal contents and cause short term blockage), muscle wasting and atrophy (shrinking of muscle due to lack of use of the muscle), intraspinal abscess (serious infection where pus builds up cause by a bacteria) and granuloma (forming of cells that forms in a response to long time injury or infection, identified by redness, swelling, heat, pain, and loss of function), osteomyelitis (bone infection)of the vertebra lumbar region (bones of the lower back), type 2 diabetes mellitus (when the body does not produce enough insulin or does not use it properly to keep blood sugar levels normal), and depression. Record review of Resident #1's Comprehensive Care Plan, dated 08/27/25 and revised 09/04/25, reflected Resident #1 was care planned for EBP as evidence by chronic wound-sacrum & RL ischium with interventions that included the following: -Post EBP on the door to room -Provide Protective Equipment at entrance to door. Record review of Resident #1's admission MDS, dated [DATE], reflected a BIMS score of 13, which indicated the resident's cognition was intact. Record review of Resident #1's Physician Order Summary Report for the month of November 2025 reflected the following orders: -Dated 08/28/25 Foley Catheter 16 F/10 cc bulb -Dated 09/24/25 Wound Treatment to right buttock cleanse with 1/4 Dakins solution, pat dry, apply santyl (medicated ointment used to remove dead tissue from chronic wounds to promote wound healing) and cover with border dressing every day shift. -Dated 10/07/25 Wound Treatment: Sacral stage 4 pressure: cleanse with Dakins (wound cleanser made from diluted household bleach, baking soda, and water use to treat and prevent infections in various wounds) 1/4 strength pat dry and apply NPWT @ 125 mmhg continuous pressure. As needed if dislodge apply Dakins soaked gauze and apply border dressing. Observation on 11/13/25 at 4:11 PM revealed Resident #1 resting in bed on an air mattress awake looking at her cell phone. There was an Enhanced Barrier Precaution on the outside of the resident's door informing the staff to put on gowns and gloves. There was a PPE storage cart outside of resident doorway with PPE inside that consisted of gown and gloves. Resident #1 had an indwelling Foley catheter hanging on the left side of the bed inside of a privacy bag. Observation on 11/13/25 at 4:38 PM revealed RN A, ADON, and CNA B entered Resident #1's room without placing on a disposable gown and washed their hands with soap and water and donned gloves. The ADON and CNA B proceeded to provide Foley catheter care for Resident #1. When the ADON and CNA B were done providing care, RN A began to change Resident #1's dressings to her wounds which consisted of the sacrum and the right lower ischium/buttock area. Observation of the wound bed to the sacrum being red in color, no odor but a small amount of red drainage was observed. RN A cleaned the wound bed with Dakins solution 1/4 strength cleaning the wound bed from the inside out one wipe at a time. When RN A was done cleaning the sacral wound, he packed the sacral wound with a sponge material, covered it with a translucent tape and attached the wound vac tubing in the center of the dressing. RN A proceeded to clean the right ischium/buttock area with the same solution and in the same fashion, pat dry and applied santyl ointment to the wound bed. The wound bed to the right ischium/buttock area was observed with some black discolored areas in the wound bed with a small amount of red drainage. When RN A was done, he discarded all soiled materials inside of a red biohazard bag, washed hands along with the ADON and CNA B. Interview on 11/13/25 at 5:22 PM, the ADON said the reason she did not place on full PPE when assisting with Foley catheter care and wound care for Resident #1 was due to her being