

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  12/04/2025
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</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

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  12/04/2025
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to 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 one resident (CR #1) of four residents reviewed for infection control. The facility failed to implement enhanced barrier precautions when LVN A entered CR #1's room and administered IV medications without donning appropriate Personal Protective Equipment (PPE). The facility failed to implement infection control prevention when LVN A did not wash or sanitize his hands after entering CR#1's room. The facility failed to implement infection control prevention when LVN A did not sanitize the resident's overbed table. The failure placed CR #1 at risk for infection at the IV site as well as for sepsis, and placed other residents at risk for infection by cross-contamination. Findings include: Record review of CR #1's admission Record (copied 12/04/2025) revealed he was [AGE] years old and was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, osteomyelitis (infection of the bone) of his left foot and ankle, Type 2 diabetes, and muscle weakness. CR #1 was discharged to an acute care hospital on [DATE]. Record review of CR #1's Physician Order dated 10/29/2025 revealed he was to receive Cefepime HCl (antibiotic) intravenous solution, 1 gm/50 ml, three times daily until 12/03/2025. Record review of CR #1's November 2025 MAR revealed the IV antibiotic was scheduled, and was administered on 11/05/2025, within one hour before or after 1:00 a.m. The initials were those of LVN A. Record review of the MDS dated [DATE] revealed CR #1 scored 13/15 on the BIMS, indicative of intact cognition. He did not exhibit any behavioral symptoms or resist care during the look-back period (minimum 6 days). CR #1 had limited range-of-motion to both upper and both lower extremities. Record review of CR #1's Care Plan dated 11/23/2025 revealed the resident was on EBP related to wounds and for having a feeding tube. The Care Plan dated 10/25/2025 reflected CR #1 had an infection. Interventions read, in part, . Maintain universal precautions when providing resident (sic) care. The Care Plan dated 10/25/2025 reflected CR #1 required isolation due to MRSA in his wound. The Care Plan read, in part, .Hand washing to prevent the spread of infection. Provide protective equipment at entrance to room. Review of a video dated 11/05/2025 at 00:42 a.m. revealed CR #1 lying in his bed. A male staff, later identified as LVN A, entered the room. LVN A was wearing a mask. He was not wearing a gown or gloves when he entered the room, and he did not sanitize or wash his hands after entry. He was carrying the bag of intravenous medication. LVN A hung the bag on the IV pole and dropped the tubing onto a chair. LVN A did not sanitize the overbed table before he removed the cap from a syringe of flush, which he then set on the overbed table. Although LVN A was blocking the view of the camera, it appeared that he cleaned the connector, flushed, then connected the medication tubing to the IV connector hub. LVN A then started the flow. He collected the syringe and other discarded items from the overbed table. He moved the overbed table to bedside. He did not sanitize the overbed table. LVN A then exited the room without washing his hands. In an interview on 11/22/2025 at 1:05 p.m., LVN C said when preparing to administer IV medications, the nurse was to check the order, collect the supplies, then confirm the order in the system. The nurse washes hands, don (put on) gloves, then mix the IV medication and prime the tubing. She said the nurse would then check the IV site for any signs of infection. The nurse would then flush the port and administer the medication. In an interview on 11/22/2025 at 4:23 p.m., RN B, the Weekend Supervisor, said if staff did not wear gloves when administering IV medication, it would be an infection control issue. Bacteria could be introduced into the IV tubing. Bacteria in the tubing could cause sepsis and infection in the vein, as well as cellulitis (bacterial infection of the skin's deeper layers). In an interview on 12/04/2025 at 3:44 p.m., LVN C, the facility Infection Preventionist, said residents receiving IV antibiotics would be on EBP. The staff should wash their hands and don a gown and gloves. The overbed table should be sanitized before and after the procedure. Potential problems that could arise could be contamination. She said she could not recall any in-services for IVs, but has conducted in-services regarding isolation. In an interview on 12/04/2025 at 4:33 p.m., the DON said a resident receiving IV antibiotics would be on EBP. She said the staff should wash their hands, then put on a gown and gloves prior to entering the room. The overbed table should be sanitized prior to placing items on it. A complication of not following the guidelines could result in infection. The facility policy Nursing Policy and Procedure Intravenous Therapy - Section 6 (updated 05/2024) read, in part, The delivery of IV therapy provides no margin for error, and one mistake may cause irreparable damage to the Patient. The Policy did not address</p>		