

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 02/13/2026
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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practices, to promote healing, prevent infection and prevent new ulcers from developing for 1 (CR #1) of 5 residents reviewed for pressure ulcers. -LVN A failed to transcribe CR #1's new wound treatment order given on 01/29/26 until 02/03/26. This failure could place residents at risk for delay wound healing. Findings: Record review of CR #1's face sheet dated 02/11/26 revealed a [AGE] year-old female admitted to the facility on [DATE] and discharged on 02/10/26. CR #1 diagnoses included: hypoxic encephalopathy (serious brain injury caused by reduced oxygen and blood flow to the brain), cerebral infarction (when blood flow to the brain is blocked), emphysema (group of lung diseases), acute respiratory failure with hypoxia (lack of oxygen), pulmonary edema (excess fluids accumulates in the lungs, making it difficult to breathe), type 2 diabetes mellitus (when the body cannot produce enough insulin {a hormone that regulates blood sugar} to control blood sugars), morbid obesity, dysphagia (difficulty swallowing), hemiplegia (paralysis on one side of the body) and hemiparesis (one sided muscle weakness), seizures, intracranial hemorrhage (type of stroke or trauma where blood leaks into or around the brain), anemia, elevated white blood cell count, myocardial infarction (heart attack), heart failure, pneumonitis (lung infection) due to inhalation of food and vomit, rhabdomyolysis (muscle breakdown) , hyponatremia (low sodium), and gastrostomy (surgical creation of an open into the stomach to insert a feeding tube for direct nutrition, medication, and hydration) , and hypothermia (low body temperature). Record review of CR #1's admission MDS dated [DATE] reflected a BIMS score of 3 indicating that CR #1's cognition was severely impaired. Section GG-Functional Abilities reflected CR #1 was impaired on one side of body to the upper extremity and both sides to the lower extremities. Further review revealed that CR#1 was dependent of toileting and personal hygiene Section M-Skin Condition revealed that CR #1 had no pressure ulcers or injuries but was at risk for developing pressure ulcers/injuries. Record review of CR #1's Care Plan dated 01/21/26 revealed that CR #1 was being care planned for pressure ulcer prevention with interventions that included barrier cream, turn and reposition every 2 hours and PRN, use suspension devices (supporting device to elevate a limb of the body to lift off a surface to prevent direct pressure)to reduce pressure on heels and bony prominences (area of the body where a bone lies close to the skin surface). Record review of Clinically Unavoidable Pressure Injury form signed by the NP on 01/25/26 of stage 2 (two) coccyx (small triangular bone at the base of the spine)/ blister. Record review of Wound Care Specialist NP wound treatment order form dated 01/29/26 sacral pressure stage 3 zinc plus collagen powder. Record review of CR #1's Completed Order Summary report dated 02/11/26 reflected the following orders: -Dated 01/28/26 wound treatment: Calcium Alginate every day shift for wound care cleanse wound to sacrum with normal saline or skin cleanser. Pat dry, apply calcium alginate with TRIAD cream (zinc based) to wound bed. Cover with dry dressing. Discontinued 02/03/26 -Dated</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 676323
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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>02/03/26 wound treatment: every day shift for wound care cleanse wound to sacrum with normal saline or skin cleanser. Pat dry, apply collagen with TRIAD cream (brand name for a sterile, zinc based) to wound bed. Cover with dry dressing. Record reviews of CR #1's MAR & TAR for the month of January 2026 revealed that the facility was following Physician Orders. Record review of CR #1's MAR& TAR for the month of February 2026 reflected the order for zinc plus collagen powder was not initiated until 02/04/26. Interview on 02/11/26 at 12:23PM with the wound care nurse LVN A said CR#1 developed a wound to her sacrum at the NF that was discovered on 01/28/26 measuring 10 x 10cm in redness. LVN A said he done weekly skin assessments on residents every week. LVN A said he notified the family of CR #1, and Wound Care Specialist NP. LVN A said the Wound Care Specialist NP gave an order to treat the wound with calcium alginate. LVN A said he was the nurse that noticed the redness to CR #1's sacrum. Further interview with LVN A said the reason the new wound care treatment order was not transcribed on the day given was because the facility was having some internet issues. LVN A was asked if he could have transcribed the order on paper? LVN A said he did not see the new wound order given on 01/29/26 until 02/03/26. LVN A said he had other obligations one being calling the families about new orders. LVN A said calcium alginate absorbs wound secretions, and zinc was used for moisture- associated along with sweat or urine to protect the skin. LVN A said the surveyor would have to speak with the Wound Care Specialist NP to see what risk it placed CR #1 for regarding delay in new wound treatment. Interview on 02/11/26 at 1:47PM with the Wound Care Specialist NP said she came to the NF once a week on Thursday's. She said she first saw CR #1 on 01/29/26. She said CR #1 had a wound to the sacral area (tailbone). She said she gave an order for zinc plus collagen powder. She said this treatment would not allow the brief to stick to the skin. She said this treatment was a protectant/ barrier like petroleum oil base type of dressing. She said when she documented the treatment wound care form and provided it to the facility, it was an order to be transcribed and carried out. She said she gave the initial order for calcium alginate and this was a basic dressing that could be used until the wound could be further assessed by the clinician. She said calcium alginate was good for drainage and to rebuild the skin. She said she was not aware that the new order she gave on 01/29/26 for zinc plus collagen powder had not been initiated until 02/04/26. She said although there was a delay in initiating the order for zinc plus collagen, it did not place CR #1 at risk for harm and that using calcium alginate would not necessarily make the wound worse but maybe slow the healing process. She said whenever she wrote an order for wound treatment it did not mean she would continue with that same order during the course of treating a wound. The Wound Care Specialist NP said she would give it approximately 2-3 weeks and may have to change the treatment plan pending the wound and how it was healing. Interview on 02/11/26 at 2:25PM with the DON said LVN A was responsible for transcribing treatment orders. The DON said LVN A worked at the facility Monday through Friday and that the facility had another wound care nurse to cover the weekends. The DON said when LVN A received wound care orders from the Wound Care Specialist NP he was supposed to communicate this in the morning meetings. The DON said the ADON shared an office with LVN A. The DON said the ADON was responsible in making sure that all orders including wound care orders were transcribed. The DON said it was both ADON and her that were responsible for ensuring that all orders were being transcribed in a timely manner. The DON said she had designated this task to the ADON because she could not do everything. The DON said she spoke with LVN A after learning there was a delay in transcribing CR #1's treatment order given on 01/29/26. The DON said she had initiated on 02/11/26 a 100% skin audit sweep on residents at the facility with skin breakdown with no further concerns identified. Interview on 02/13/26 at 9:50AM with ADON said she was not aware that LVN A did not transcribe CR #1's new wound care orders</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>given on 01/29/26. The ADON said she tried to help wherever she was needed including verifying orders daily and checking to see if there were any pending orders. The ADON said this was done to avoid any delay in care. The ADON said to be completely honest, the task of overseeing wound care orders was not assigned to her. The ADON said it was important to carry out orders when received to enhance the quality of care. The ADON said she observed CR #1's wound to the sacrum on 02/09/26 and that the wound bed was pink, moist, no odor, or signs and symptoms of infection. Record review of the NF policy on Provision of Quality of Care dated 10/01/25 reflected in part: .Based on comprehensive assessments, the facility will ensure that residents receive treatment and care by qualified persons in accordance with professional standards of practice, the comprehensive person-centered care plans, and the resident's choices. Record review of the NF policy on Consulting Physician/Practitioner Orders dated 10/01/25 reflected in part: .For consulting physician/practitioner orders received in writing or via fax, the nurse in a timely manner will: call the attending physician to verify the order.follow facility procedures for verbal or telephone orders including: noting the order, submitting to pharmacy and transcribing to the medication or treatment administration record.</p>		