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	07/02/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to permit residents to return to the facility after they were placed on therapeutic leave and failed to develop and implement an effective discharge planning process that focuses on the resident's discharge goals for 1 of 8 residents (Resident #11) reviewed for discharge process. The facility failed to ensure Resident #11 was allowed to return to the facility on 7/1/26 after she went out on pass on 6/30/26 resulting in the resident leaving the facility with nowhere to go. The facility failed to develop an effective discharge plan for Resident #11.This failure could place residents at risk of emotional distress, fearfulness and disorientation to discharge. Findings include: Record review of Resident #11's admission Record generated on 7/1/26 revealed she was admitted to the facility on [DATE] with diagnoses of right femur fracture, bipolar disorder (a mental health condition that causes extreme mood swings) and anxiety disorder (mental health conditions characterized by excessive, persistent, and uncontrollable fear or worry that is out of proportion to the actual situation). Resident #11's primary payor source was listed as private pay. (paying for goods or services directly out-of-pocket using personal funds rather than relying on government assistance like Medicare or Medicaid or third-party health insurance). She was [AGE] years old. Record review of Resident #11's Baseline Care Plan dated 4/23/26 revealed Resident #11's initial goal was to discharge to the community with assistance as needed. Record review of Resident #11's Order Summary Report generated on 7/2/26 revealed a physician's order that indicated Resident #11 required nursing home care for 180 days with an order date of 4/23/26. Further review of Resident #11's physician orders revealed an order allowing Resident #11 to go on therapeutic pass (non-medical visit outside of the facility) with medications. Record review of Resident #11's Nursing Facility admission Agreement dated 4/24/26 revealed it was signed by Resident #11 who acknowledged the following information: PASSES. Resident may leave Facility for therapeutic home visits on passes with permission of Resident's Attending Physician and Resident/Resident Representative. Facility administration shall be notified of all passes in advance and Resident shall be signed out at the nurse's station when leaving and upon return.BEDHOLD (a guaranteed reservation for a resident's specific bed when they temporarily leave) POLICY. Upon request, Facility shall hold Resident's bed when Resident is away from Facility for hospitalization or therapeutic home visit, as long as the applicable bedhold fee is paid. The daily bedhold fee is the current daily charge for the Resident bed. If Resident is transferred from Facility, or is on a therapeutic home leave without arranging for a bedhold, Facility shall process the discharge of Resident. If Resident desires to be readmitted after discharge, Resident shall be treated as a new applicant for purposes of admission. Except in an emergency, Resident shall not be transferred or discharged without prior consultation with Resident, Resident's Attending Physician. and written notification describing the reason (s) for the transfer or discharge and Resident right to appeal the transfer or discharge. Record review of Resident #11's admission MDS assessment dated [DATE] revealed Resident #11 had a BIMS score (a short, standardized cognitive screening test used to assess a person's attention, memory, and orientation) of 15, indicating she had no cognitive impairment. She had a PHQ-9 (a standardized, (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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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9-item self-report questionnaire used by healthcare providers to screen for depression, establish provisional diagnoses, and measure the severity of depressive symptoms) score of 7, indicating she had mild depressive symptoms. She used a walker and a wheelchair for mobility and had functional impairment in reach of motion on one side of her lower extremities. She required partial/moderate assistance with bathing, lower body dressing, walking 10 feet, and transfers from chair/bed-to-chair. The assessment indicated she had occasional urinary incontinence and frequent bowel incontinence. Record review of Resident #11's Care Plan Report dated 5/19/26 and revised on 6/5/26 revealed she had a right femur fracture. The goal was listed as, [Resident #11]'s surgical incision will heal without s/sx of infection or breakdown by review date. Interventions included following the physician orders for weight bearing status and review the physical therapy treatment plan. Record review of Resident #11's Nursing Home Transfer and Discharge Notice dated 6/12/26 revealed Resident #11 would be discharged from the facility for not paying her bill for services provided by the facility after reasonable and appropriate notice to pay. The effective date of transfer was 7/30/26. The notice was signed by Resident #11 and the Administrator. Record review of Resident #11's After Visit Summary from a local hospital dated 6/25/26 revealed instructions following posterior hip replacement (a traditional, muscle-sparing surgical technique where a surgeon accesses the hip joint from the back of the body. The damaged ball-and-socket joint is removed and replaced with artificial components) that stated to follow the instructions provided by the hospital physical therapist regarding range of motion and to be careful bending the hip more than 90 degrees for the first 6 weeks. She had a wound incision on her right hip. The After Visit Summary included an X-ray of the right hip dated 6/25/26 which stated the impression as, Status post conversion to total right hip arthroplasty (a surgical procedure where an orthopedic surgeon replaces a diseased or damaged right hip joint with an artificial prosthesis) with expected postoperative findings. Record review of Resident #11's Progress Note dated 6/30/26 at 9:55am written by LVN T stated Resident #11 went out on pass and would return at approximately 4:00pm. Record review of Resident #11's Progress Note dated 7/1/26 at 5:08am revealed Resident #11 had not returned and the resident's responsible party and the DON were notified. Record review of Resident #11's Transfer/Discharge Report dated 7/1/26 revealed Resident #11 had a date of transfer/discharge of 6/30/26 at 9:55am. The report provided a list Resident #11's medications, when the medication was last administered, and the count of medications that were given to the resident on discharge. The document was signed by Resident #11 and an unknown staff member. Record review of Resident #11's Progress Note dated 7/1/26 at 12:36pm written by the Unit Manager stated Resident #11 returned to the facility in stable condition and was notified of discharge. Discharge instructions and medications given and discharge paperwork signed. Pt then left the facility and verbalized she would be back to get her personal belongings. Record review of Resident #11's Progress note dated 7/1/26 at 12:37pm written by the Unit Manager stated Resident #11's nurse practitioner was notified of the resident leaving and an order was given to release the medications excluding narcotics. The Unit Manager reported that an APS case was submitted. In an interview on 7/1/26 at 3:15pm, The BOM said Resident #11 left around lunch time on 6/30/26. She said she saw her get in a bus. She said she did not return and thought she left against-medical-advice. She said they issued her a 30-day notice a few weeks ago and she had until the end of July 2026 to move out. In an interview on 7/1/26 at 3:47pm, LVN O said Resident #11 liked to go out on pass and visit with friends. He said Resident #11 left on 6/30/26. He said he called Resident #11's family member when she did not return to the facility last night during his shift. He said Resident #11 could not be reached by phone. In an interview on 7/1/26 at 4:17pm, the Social Worker stated Resident #11 lived in a homeless shelter prior to her admission. She said her discharge plan included transitional housing. She said she had not seen Resident #11 this week. She said Resident #11 was alert and oriented, could make her own decisions and leave the facility to go out on pass. Surveyor attempted to call Resident #11 by phone with the phone number found in her medical record on 7/1/26 at 4:30pm. The phone number was not in service. In a telephone interview on 7/1/26 at 4:37pm, Resident #11's (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Family Member stated Resident #11 was at the facility today and the staff kicked her out. She said on 6/30/26, she went to a nearby church. The Family Member stated the bus did not pick her up from the church so she could not make it back to the facility. The Family Member stated she received a call from Resident #11 around 1:00pm on 7/1/26 stating she was at the facility and needed to be picked up. The Family Member stated she refused. The Family Member stated Resident #11 had a recent hip surgery. The Family Member gave the surveyor Resident #11's phone number. In an interview on 7/1/26 at 4:42pm, the Regional Director of Clinical Services stated Resident #11 visited with the DON earlier today and took her medications. He said Resident #11 went out on pass on 6/30/26 and returned around 10:00am on 7/1/26. He said Resident #11 left the facility against-medical-advice. He said Resident #11 packed up her items and left them at the front of the facility in the lobby. He said they made a report to adult protective services because they were worried about her safety in the community. He said she would be allowed to stay if she chose to. He said she had an outstanding balance of about $18,000. In a telephone interview on 7/1/26 at 4:52pm, Resident #11 stated she left the faciity on 6/30/26 to go to a charity shop and visit friends. She said she planned to return to the facility around 4pm but the bus did not pick her up. She said she tried to call the facility but did not get through. She said when she arrived to the facility earlier today on 7/1/26, her belongings were placed in a big box on a dolly in her room. She said a woman came into her room and said she had been discharged . She said she could not believe that they made her leave for something that was outside of her control. She said she met with the Administrator and he asked about a local group home that she previously expressed she was not interested in. She said she pleaded with them to stay at the facility, and they told her she could not stay. She said she told them she had nowhere to go. She said she was sitting at a local store to charge her phone. She said she was unsure where she would go and may go to a local shelter. She said she could take care of her personal care needs. In an interview on 7/1/26 at 5:5pm, the Administrator stated he met with Resident #11 earlier on 7/1/26. He said Resident #11 did not specify whether she wanted to stay at the facility or not. He said they gave her medications and then she left. He said when residents leave out on pass, they were allowed to return to the facility. In an interview on 7/2/26 at 12:10pm, the Receptionist said Resident #11 was allowed to leave the facility out on pass. She said the Housekeeping Supervisor placed Resident #11's belongings in the front lobby. She said Resident #11 returned to the facility in the morning of 7/1/26. She said Resident #11 was upset and mad. She said the Administrator reported that Resident #11 would be discharged . In an interview on 7/2/26 at 12:44pm, the Housekeeping Supervisor said the BOM reported that since Resident #11 had left on 6/30/26 and did not return, she would be discharged . She said she was told to pack Resident #11's belongings. She said Resident #11 returned around 10:00 am on 7/1/26 when they were packing her items. She said she reported Resident #11's return to the BOM and the BOM and DON spoke to the resident. In interviews on 7/2/26 between 1:25pm and 1:45pm, CNA V and CNA N said Resident #11 could independently perform activities of daily living tasks. Surveyor attempted to interview Resident #11's NP on 7/2/26 at 1:22pm but was unsuccessful. In an interview on 7/2/26 at 2:20pm, the DON said Resident #11 admitted to the facility after a fall with a hip fracture. She said was independent with ADL care. She said she went out-on-pass often and could handle her own medical care, including making her own appointments. She said she was not aware Resident #11 had a hip replacement. She said the BOM told her Resident #11 could not stay out overnight. She said when Resident #11 returned to the facility on 7/1/26, they met with her and discussed discharge process. She said they offered to let her stay in a personal care home. She said Resident #11 did not want to hear anything else they had to say and left. She said Resident #11 had a history of homelessness. She said Resident #11 did not qualify for long-term care. In an interview on 7/2/26 at 4:00pm, the BOM said Resident #11 was not on Medicare or Medicaid. She said if a resident had Medicaid, they were allowed to leave the facility for 72 hours while out on pass. She said if residents were at the facility for skilled care then they could not leave for 24 hours because if they leave then that would indicate they could care for themselves. She said the same rule (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would apply to a private-pay resident. She said they did not know where Resident #11 was and they assumed she would not come back. She said the decision was made to discharge her. She said she could not continue to go out on pass because they did not know what could happen to her and it was putting the resident and the facility in jeopardy. In an interview on 7/2/26 at 4:21pm, the Administrator stated on 7/1/26 in the facility's morning meeting with the IDT, they discussed Resident #11's discharge because she was not at the facility at midnight. He said if she returned then she would have to pay her balance. He said they explained the situation to the resident on 7/1/26. He said Resident #11 was unhoused prior to admission. He said they tried to assist Resident #11 with finding a place to live. Record review of the facility's Therapeutic Leave policy dated 10/2025 read, It is the policy of this facility to allow residents to leave the facility for a non-medical visit, therapy known as therapeutic leave, in accordance with Federal and State guidelines. Each resident will be permitted to return to the facility after therapeutic leave, regardless of payment source. Residents who seek to return to the facility within the bed hold period defined in the state specific plan are allowed to return to their previous room, if available.Not permitting a resident to return following therapeutic leave constitutes a discharge. Because the facility was able to care for the resident prior to therapeutic leave, documentation related to the basis for discharge must clearly show why the facility can no longer care for the resident.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure incontinent care was provided in accordance with appropriate treatment and service practices to prevent urinary tract infections and to restore continence to the extent possible for 1 of 3 residents (Resident #1) reviewed for incontinent care and catheter care, in that:While providing incontinent care to Resident #1 on 07/01/2026, CNA A did not spread the resident's labia. This failure could place residents at-risk for infection and skin breakdown due to improper care practices. Findings included:Record review of Resident #1's face sheet dated 01/02/2026 revealed she was a [AGE] year-old female admitted with the following diagnoses: cardiomyopathy (a disease of the heart muscles that makes if harder for the heart to pump blood to the rest of the body), muscle weakness and abnormalities of gait and mobility.Record review of Resident #1's MDS dated [DATE] revealed her BIMS score was coded 13-indicating memory and thinking. Section GG-Functional abilities indicated she was totally dependent on staff for on her ability to maintain perineal and personal hygiene.Record review of Resident #1's care plan dated 06/19/2026 revealed: Bladder incontinent. Goal: will remain free from skin breakdown due to incontinence. Intervention: clean peri-area with each incontinence episode, monitor and document any possible causes of incontinence bladder infection.In an observation on 07/01/2026 at 11:49 a.m. revealed while providing incontinent care for Resident #1, CNA A did not separate Resident #1's labia. CNA A did not clean either side of the labia separately. In an interview with CNA A on 07/01/2026 at 12: 03 p.m., she said she was trained to wipe both sides of the labia and throw away the wipes and then wipe the middle of the labia with a clean wipe. CNA A said the risk of not following the proper technique was that Resident # 1 could have bacteria infection which could lead to UTI (infection in any part of the urinary tract, which includes the kidneys and bladder). She said if the resident had UTI, that could lead to confusion and hallucinations. She said the resident would be uncomfortable with pain. CNA A said she did not follow the proper steps because she thought she had already separated the labia. In an interview with RN A on 07/01/2026 at 1:12 p.m., she said it was the responsibility of the nursing staff to perform peri care. She said peri care was performed to prevent infection, cross contamination and improve personal hygiene. RN A said if the steps were not correct, the resident might not be clean. She said the risk of not going through all the steps was that there could be infection. She said the most common infections of the peri area were UTI and bladder infection. In an interview with the ADON on 07/01/2026 at 1:26 p.m., she said it was the responsibility of the CNAs' and nurses to assist and perform peri care. She said if the steps were not completed correctly, there was a risk of UTI. She said the resident would be confused. The ADON said she resident would have dark colored urine, pain during urination and frequently wanting to urinate. She said she was not aware that CNA A did not follow the correct incontinent care procedure. She said, she would go through the correct steps with CNA A. In an interview with the DON on 07/01/2026 at 1:38 p.m., she said incontinent care was the responsibility of all nursing staff. She said incontinent care training and check-off was done by DON, ADON and UM. She said if CNA A did not follow the proper steps, there was of UTI and skin breakdown. She said if the UTI was not detected quickly, the resident might be hospitalized .In an interview with the ADM on 07/01/2026 at 1:45 p.m., he said, peri care was done because the resident was incontinent (being unable to voluntary control bodily discharges like urine or feces). He said if the steps were not done correctly, there was a risk of UTI and yeast infection. Record review of the facility's policy titled: Peroneal Care, revised on 12/01/2025 reveals: perineal care refers to the care of the external genitalia and anal area. Section C under: Policy Explanation and Compliance Guidelines stated: Separate the residents' labia with one hand and cleanse perineum with the other hand by wiping in direction from front to back.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that residents were free of any significant medication errors for 1 of 11 residents (CR #2) reviewed for pharmacy services. -The facility failed to ensure CR #2 received his Hydroxyurea medication (prescription medication used to treat certain cancers) upon admission to the facility and missed 3 doses on 4/24/26, 4/26/26 and 4/28/26. This failure could place residents at risk of not receiving necessary medications and decline in health. Findings include: Record review of CR #2's admission Record generated on 5/14/26 revealed he was admitted to the facility on [DATE] with diagnoses of thrombocytopenia (a medical condition characterized by an abnormally low count of platelets in the blood), chronic myeloproliferative disease (a group of slow-growing blood cancers) and chronic myeloid leukemia (a slow-growing cancer of the bone marrow that causes an overgrowth of white blood cells). He was [AGE] years old. Record review of CR #2's Discharge Instructions from the local hospital dated 4/23/26 revealed an order for CR #2 to start taking Hydroxyurea 500mg on 4/24/26. The order was for 1 capsule by mouth every other day for 30 days. Record review of CR #2's Physician Progress Note completed by MD A on 4/24/26 revealed CR #2 was admitted to the facility with thrombocytopenia and was taking Hydroxyurea. MD A documented that CR #2 was taking Hydroxyurea 500mg, 1 capsule once a day and stated that the medication list was reviewed and reconciled with the patient. Record review of CR #2's Order Summary Report generated on 5/14/26 revealed a physician's order for Hydroxyurea 500mg dated 4/27/26 with instructions for one capsule by mouth every 48 hours related to Thrombocytopenia. Record review of CR #2's Progress Note dated 4/27/26 at 7:45pm written by RN E stated the Oncologist called with an order for Hydroxyurea 500mg every 48 hours. The note read, the order already in place. Pharmacy called to deliver med, also patient's [family member] said that she could go to her pharmacy to get med, she left here to pharmacy. Record review of CR #2's Progress Note dated 4/27/26 at 8:45pm written by RN E stated the pharmacy reported the Hydroxyurea medication would be delivered on the same night (4/27/26). RN E wrote that CR #2's family member could not obtain the medication from the pharmacy. Record review of CR #2's Medication Administration Record dated April 2026 indicated he received one capsule of Hydroxyurea 500mg by mouth on 4/29/26. On 4/27/26, RN C documented that the medication was not administered and referred to a nurse progress note. In a telephone interview on 5/14/26 at 2:16pm, CR #2's family member stated that while in the nursing facility, CR #2 missed his chemotherapy medication for three days. The family member stated they gave him the medication after she brought it to their attention. In an interview on 7/1/26 at 1:33pm, LVN W said she completed CR #2's admission assessment when he arrived to the facility. She said she did not complete the medication review and thought another nurse completed it but could not say who. In an interview on 7/1/26 at 1:52pm, RN C stated she could not remember CR #2. In an interview on 7/1/26 at 4:00pm, the ADON stated if a resident admitted to the facility with an order for chemotherapy medications a family member would bring the medications with them. She said it could take a while for the pharmacy to fill expensive medications. She said she started working at the facility at the end of April 2026 when CR #2 was admitted . In an interview on 7/1/26 at 5:02pm, the ADON said she reviewed CR #2's medical record. She said someone at the facility should have asked for the family member to bring the Hydroxyurea medication to the facility when he was admitted . She said they spoke to the Oncologist on 4/27/26 who gave a new order for the Hydroxyurea to start the medication. She said that was when the facility ordered the medication from the pharmacy. In an interview on 7/2/26 at 11:29am, The Regional Director of Clinical Services said they reviewed clinical information prior to admission and flagged any high-cost medications. Said they usually check with the family members prior to admission to see if they could bring the medication from home. In regard to CR #2, the Regional Nurse Consultant said RN C called the Oncologist after the family member raised the concern that she could not provide the medication to (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility. Surveyor attempted to interview CR #2's NP on 7/2/26 at 1:22pm but was unsuccessful. In an interview on 7/2/26 at 2:20pm, the DON stated she attended CR #2's Circle of excellence meeting, which was a meeting they had with the resident and family member within 48 to 72 hours of admission. She said she could not remember talking about his medications. She said when someone was taking chemotherapy medication they coordinated with the family member before they accept for admission because their insurance would not cover it if it had already been filled. Record review of the facility's policy regarding Medication Administration dated 11/1/25 read, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice. Record review of the facility's policy regarding admission of a Resident dated 11/14/25 read, The admission process is intended to obtain all possible information regarding the resident for the development of the comprehensive plan of care, and to assist the resident in becoming comfortable in the facility. Residents are admitted to the facility under orders of the attending physician. Once the resident/family has selected the facility, pre-admission information should be gathered. Preadmission information may include, but is not limited to: History and physical, Discharge summary, Physician's orders, Medication and/or Treatment records. Upon admission, the designated facility staff will obtain information and perform assessments as per their respective departments and as per facility protocol. Information gathered will be placed into the resident's medical record via the facility's means of recordkeeping. Record review of Hydroxyurea Information Sheet on 7/16/16 at 8:58am located at https://medlineplus.gov/druginfo/meds/a682004.html#why read, Hydroxyurea (Hydrea) is used alone or with other medications or radiation therapy to treat a certain type of chronic myelogenous leukemia (CML; a type of cancer of the white blood cells). Hydroxyurea is in a class of medications called antimetabolites. Hydroxyurea treats cancer by slowing or stopping the growth of cancer cells in your body. Take hydroxyurea at around the same time every day. Follow the directions on your prescription label carefully, and ask your doctor or pharmacist to explain any part you do not understand. Take hydroxyurea exactly as directed. Do not take more or less of it or take it more often than prescribed by your doctor. Your doctor may need to delay your treatment or adjust your dose of hydroxyurea depending on your response to treatment and any side effects that you may experience. Talk to your doctor about how you are feeling during your treatment. Do not stop taking hydroxyurea without talking to your doctor. What should I do if I forget a dose? Take the missed dose as soon as you remember it. However, if it is almost time for the next dose, skip the missed dose and continue your regular dosing schedule. Do not take a double dose to make up for a missed one.