

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 07/30/2026
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)		
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **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 fed by enteral means received the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers for 1 of 6 residents (Resident #1) reviewed for enteral feedings. 1. LVN A failed to ensure Resident #1 was wearing their abdominal binder (a special belt that is used to secure the feeding tube against the body, preventing the tube from dangling, snagging on clothing, or being accidentally pulled out) on 07/30/26. 2. LVN A failed to stop Resident #1's enteral feeding (tube feeding that deliver liquid nutrition directly into the stomach or small intestines) at 7AM on 07/30/26. These failures could place residents at risk for aspiration, stomach bloating, diarrhea, nausea, vomiting, tube dislodgment (accidental shifting, removal, displacement of a medical device-such as feeding tube), and unwanted hospitalization. Findings include: Record review of Resident #1's face sheet, dated 07/30/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included the following: encephalopathy (malfunction of the brain that causes altered mental status, confusion, and memory loss), type 2 diabetes mellitus (when the body has trouble using sugar from the food eaten, leading to too much sugar in the blood), dysphagia (difficulty swallowing), dementia (severe decline in memory, thinking, and reasoning interfering with a person's daily life), dermatitis (skin condition causing redness and itching), benign neoplasm of left breast (non- cancer but abnormal growth of cells in the breast tissue), and mixed receptive-expressive language disorder (a communication condition where a person has trouble understanding what others say and using language to share their own thoughts). Record review of Resident #1's quarterly MDS, dated [DATE], Section C-Cognitive Patterns reflected the resident mental status was a 3, which indicated the resident cognition was severely impaired. Section K-Swallowing/Nutritional status revealed Resident #1 proportion of total calories was received through parenteral or tube feeding was 51%. Record review of Resident #1's Physician Order Summary Report for the month of July 2026 reflected the following orders: -Dated 04/03/26, abdominal binder on each shift to protect peg tube (feeding tube) from dislodging every shift. -Dated 04/03/26, LCS (Low Concentrated Sweets) NAS (No Added Salt) diet pureed texture (smooth, lump-free food with a pudding-like consistency, made by blending or mashing cooked ingredients with added liquids with broth, milk, or juice), regular/thin consistency. -Dated 06/26/26, Enteral feed every shift Isosource 1.5 at 70 ml/hr via feeding tube. To run from 7PM to 7AM daily (may substitute with Jevity [a brand of liquid medical food and tube-feeding formula]). Record review of Resident #1's MAR & TAR for the month of July 2026 revealed the facility was following Physician orders. Record review of Resident #1's Comprehensive (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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Care Plan, dated 04/08/26, reflected resident being care planned for enteral feeding via G-tube (flexible medical device placed through the skin of the abdomen directly into the stomach to deliver nutrition, fluids, and medications) with an intervention to serve diet as ordered. Resident was also being care planned for tube feedings due to dysphagia with an intervention to monitor/document/report any s/sx of: aspiration (foreign material such as formula, stomach acid, or saliva is accidentally inhaled into the airway and lungs instead of down the esophagus [a tube that carries food and liquid from the throat to the stomach]), fever, SOB, and tube dislodgement (accidental shifting, removal, or displacement of a medical device-such as feeding tube). Observation on 07/30/26 at 9:43 AM of medication pass for Resident #1 by LVN A revealed Resident #1 was resting in bed receiving Isosource 1.5 cal (high calorie, nationally complete liquid medical food containing fiber, protein, and fats, designed for tube feeding) at 70 ml/hr via G-tube (flexible medical device placed through the skin of the abdomen directly into the stomach to deliver nutrition, fluids, and medications) . Resident #1 did not have an abdominal binder on. Interview on 07/30/26 at 12:30 PM, LVN A said she had been working at the facility for almost a year on a PRN basis on the morning and evening shifts. LVN A said she forgot to disconnect Resident #1 from her enteral feedings at 7:00 AM. LVN A said although she documented on Resident #1's TAR the resident abdominal binder was intact she failed to assess resident to ensure the abdominal binder was intact and was sorry. LVN A said by not disconnecting Resident #1 from her feedings at 7:00 AM placed the resident at risk of being over fed, bloating, nausea and vomiting. LVN A said if Resident #1's abdominal binder was not in place; this placed the resident at risk of her G-tube being dislodged and the resident would have to go to the hospital to have the tube reinserted. Interview on 07/30/26 at 1:55PM, the DON said by LVN A not disconnecting Resident #1's enteral feeding as ordered by the physician it could place the resident at risk for weight gain. The DON said if the abdominal binder was not in place, it placed Resident #1's G-tube at risk for being dislodged. Record review of the facility policy on Appropriate Use of Feeding Tubes revised December 01/25 reflected in part: .A resident who is fed by enteral means receives the appropriate treatment and services to restore, it possible, oral eating skills and to prevent complications of enteral feeding include but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Feeding tubes (nasogastric, gastrostomy, jejunostomy) will be utilized in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **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 designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 6 residents (Resident #1) reviewed for infection control. LVN A failed to practice Enhanced Barrier Precautions when administering direct care for Resident #1 on 07/30/26. This failure could place residents at risk for acquiring and spreading infections. Findings include: Record review of Resident #1's face sheet, dated 07/30/26, revealed reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1's diagnoses included the following: encephalopathy (malfunction of the brain that causes altered mental status, confusion, and memory loss), type 2 diabetes mellitus (when the body has trouble using sugar from the food eaten, leading to too much sugar in the blood), dysphagia (difficulty swallowing), dementia (severe decline in memory, thinking, and reasoning interfering with a person's daily life), dermatitis (skin condition causing redness and itching), benign neoplasm of left breast (non- cancer but abnormal growth of cells in the breast tissue), and mixed receptive-expressive language disorder (a communication condition where a person has trouble understanding what others say and using language to share their own thoughts). Record review of Resident #1's quarterly MDS, dated [DATE], Section C-Cognitive Patterns reflected that the resident mental status was a 3, indicating which indicated the resident cognition was severely impaired. Record review of Resident #1's Physician Order Summary Report for the month of July 2026 reflected the following orders: -Dated 04/22/26, Enhanced Barrier Precautions (enteral feedings [{tube feeding}] every shift, follow facility policy. -Dated 06/26/26, Isosource (high calorie, nationally complete liquid medical food containing fiber, protein, and fats, designed for tube feeding) 1.5 at 70 ml/hr from 7PM-7AM daily. Record review of Resident #1's Comprehensive Care Plan, dated 04/22/26, reflected the resident being was care planned for Enhanced barrier Precautions with the intervention to implement Enhanced Barrier Precautions. Observation on 07/30/26 at 9:43 AM of medication pass for Resident #1 by LVN A revealed. there was an EBP signage on the door entrance. Inside of the room at the door entrance was a plastic 3 bins storage container with PPE inside that consisted of gloves sitting on top of the container with disposable gowns inside. Resident #1 was resting in bed receiving Isosource 1.5 cal (high calorie, nationally complete liquid medical food containing fiber, protein, and fats, designed for tube feeding) at 70ml/hr via G-tube (flexible medical device placed through the skin of the abdomen directly into the stomach to deliver nutrition, fluids, and medications). LVN A entered Resident #1's room washed her hands and placed on a pair of gloves but not a disposable gown. LVN A proceeded to administer Resident #1's medications via G-tube. Interview on 07/30/26 at 12:30 PM, with LVN A said she had been working at the facility for almost a year on a PRN basis on the morning and evening shifts. LVN A said she was familiar with EBP. LVN A said EBP should be practiced when providing direct care for residents that who had a G-tube by wearing gown and gloves to prevent the spread of infections to Resident #1. LVN A said she forgot to wear a gown while providing care for Resident #1. Interview on 07/30/26 at 1:50 PM with the Infection Control Nurse Preventionist said residents that who were on EBP consisted of residents with the following: G-tubes, intravenous (into the vein) lines, indwelling Foley catheters, and wounds. The Infection Control Prevention said staff had to wear gowns and gloves when providing direct care for residents with these devices to protect the residents from infections as well as the staff members. Interview on 07/30/26 at 1:55 PM, Interview with the DON said if staff did not practice EBP (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on residents with artificial devices on their body, it placed the residents at risk for infections. Record review of the facility's policy on Enhanced Barrier Precautions dated December 01, 2025 reflected in part: .It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms.Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (a germ that has developed a resistant to many common antibiotic medications) that employs targeted gown and gloves use during high contact resident care activities.An order for Enhanced Barrier Precautions will be obtained for residents with any of the following: wounds.and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes.even if the resident is not know to be infected or colonized (bacteria living on or in the body without causing an active infection) with MDRO.Implementation of Enhanced Barrier Precautions: make gowns and gloves available immediately near or outside of the resident's room.		