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	02/26/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 1 of 1 resident (Resident #1) reviewed for dietary intake.-The facility incorrectly documented the meal percentage intake for Resident #1. This failure could place all residents at risk for unwanted weight loss and hospitalization. Findings included:Record review of Resident # 1's admission face sheet dated 02/22/2026 revealed she was an [AGE] year-old female who was admitted into the facility on [DATE]. Her diagnoses included: High blood pressure. Hyperlipidemia (high levels of fat in your blood stream), generalized body weakness and abnormality of gait and mobility.Record review of Resident # 1's admission MDS dated [DATE] revealed for section C0500 the resident's BIMS score was uncoded because the MDS was not completed as this was day two of her admission.Record review of Resident # 1's medical providers' notes dated 02/26/2026 written at 09: 48 a.m., that was retrieved at 12:23 p.m., stated proactive health check- evaluate the resident for abdominal pain, headache, loss of taste and sore throat.In an interview with CNA A on 02/24/2026 at 10:12 a.m., she stated Resident #1 ate 76 to 100 percent of her breakfast. She said if a resident does not eat, she would notify the nurse. CNA A stated she did not notify the nurse that Resident # 1 did not eat her breakfast. CNA A said falsification of documentation was when you lie.Record review of the Nutrition - Amount Eaten In an interview with LVN A on 02/24/2026 at 12:34 p.m., she stated CNA A told her Resident # 1 did not eat her breakfast only after the paramedics who came to assess Resident # 1 had left the building. LVN A said, inaccurate documentation of records was writing something in a resident's chart that was not true. She said the consequences of inaccurately documenting Resident # 1's breakfast meal percentage could affect her health in that, she had medication without eating, which could cause her stomach to be upset. She said breakfast was served at 7:30 a.m. LVN A said inaccurate documentation of Resident # 1's meal percentage could affect her weight. In an interview with RN A on 02/24/2026 at 12 :48 p.m., she said inaccurate documentation was writing or saying something that did not happen. If a resident missed a meal, she expected the CNA to notify her. That way she would assess why a resident did not eat. RN A said she would notify the Doctor. RN A said consequences of inaccurately documenting a resident's meal consumption percentage might result in the following: the resident might become weak; the blood sugar might drop. It might also affect certain medications such as those that should not be taken on an empty stomach. There might be failure to thrive.In an interview with LVN B, on 02/24/2026 at 03:26 p.m., she said inaccurately documenting was when someone writes or says something that never happened. LVN B said if a resident's meal percentage was inaccurately documented it would affect the nutritional status, and that would compromise the health's' health. The weight would be affected and the staff involved might be fired.In an interview with RN B on 02/25/2026 at 07:00 a.m., she said inaccurate documentation of records was anything that was inaccurate that was documented on a resident's medical records. If meals documentation was inaccurately documented the nurse would not know how to assess and identify why the resident did not eat. If she knew that the resident did not eat, she would have assessed, (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	offered alternatives and then notify the Doctor. If the primary nurse for Resident # 1 was not notified, the nurse would not assess for failure to eat. RN A said consequences of inaccurate documentation of meal percentage to the Resident # 1's health could be: the residents would become weak, not being able to participate in PT. Resident # 1 might also have weight loss, and they would not know what to tell the Dietician, who might be ordering double portion for the wrong reason. Resident # 1's health might be declining. She said she always asks the nurse aides to tell her which residents ate less than fifty percent of their meals, so she could assess them.In an interview with the ADON on 02/26/2026 at 08:51 a.m., she said inaccurate documentation records was when you document something that you did not perform. The ADON said the consequences would be unexplained weight loss and declining health, malnutrition, medications might not be effective, residents would be weak and thereby unable to attend PT and OT and might have unwanted or returned hospitalization for those that were recently hospitalized . If a resident did not eat a meal, she expects the nurse aide to notify the primary nurse, who would assess and escalate the concern to the Doctor and the Dietician who would assess the resident's appetite. The Dietician might recommend supplements. The staff who recorded the inaccurate meal percentage would be re-educated on falsification of records, and the nurse aide would have to explain why he or she did not report to the primary nurse. In an interview with the DON on 02/26/2026 at 09: 10 a.m., she said inaccurate documentation of record was when you document incorrect information. The DON said, CNA A told her, she documented that Resident # 1 ate sixty-five to one hundred because the resident always ate good. The DON said the inaccurate documentation of Resident # 1's meal could result to weight loss if it continues. She said, she expects the CNAs to notify the charge nurse each time a resident does not eat, so the nurse can offer substitutes.Record review of CNA A's time sheet retrieved on 02/26/2026 revealed that this was the very first time CNA A had ever worked with Resident # 1.In an interview with the ADM on 02/26/2026 at 09:26 a.m., he said inaccurate documentation of records was inappropriately documenting information. He said if meals percentages were falsified indicating that Resident # 1 ate when she did not, this could result to weight loss. He said the staff was re-educated and there were ongoing in-services. Record review of facility's policy of: Documentation in Medical Record Policy Statement: -Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation.- Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred.- False information shall not be documented.