STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676400	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mrc the Crossings	255 N Egret Bay Blvd League City, TX 77573

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, and record review, the facility failed to store and label drugs and biologicals used in the facility in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable for 1 of 5 residents (Resident #14) reviewed for medication storage and labeling. RN A failed to remove Resident #14's expired insulin from the nursing cart. This failure could place residents at risk of receiving expired and ineffective medications.Findings include: Record review of Resident #14's admission Record dated 3/12/26 revealed an [AGE] year old female who admitted to the facility on 0114/2026 with diagnoses including acute diastolic congestive heart failure (occurs when the left chamber of the heart becomes stiff and cannot relax to fill with blood properly leading to sudden and severe congestion and symptoms like breathlessness), type II diabetes mellitus (a chronic metabolic disorder characterized by high blood sugar levels in the blood as a result of the body's inability to use insulin properly), acute kidney failure (the sudden loss of kidney function, causing waste to build up in the blood), and dependence on renal dialysis (artificial life-sustaining treatment and is required to replace failed kidney function by removing toxins and excess fluid). Record review of Resident's #14's Annual MDS dated [DATE] revealed she had a BIMS score of 15 out of 15 which indicated her cognitive function was intact. Record review of Resident #14's Order Summary Report dated 03/12/2026 revealed a discontinued order for Lantus SoloStar subcutaneous Solution Pen Injector 100 Unit per ml insulin glargine inject 24 unit subcutaneously in the morning for DM II with an end date of 2/27/26. Record review of facility staffing sheet dated March 11, 2026, revealed RN A worked the 06:30 am to 06:30 pm shift. Observation and interview on 03/11/2026 10:15 am of nurse cart for 1500 with RN A and in the top drawer of the cart observed Insulin pen Basaglar (insulin glargine) injection pen dated 2/5/26 in black ink for Resident #14 also written on the side of insulin pen in black ink. The insulin dial was at zero indicating the injector pen was empty and contained no remaining doses. RN A said that Resident #14 was no longer on the medication, and she did not know why she had not removed the insulin pen from the cart. She said the date was 02/09/2026 and had just expired. When surveyor showed her the pen again, she said the date was 02/05/2026. When asked how long the insulin should be kept on the cart, RN A repeated that Resident #14 was no longer taking the medication and she removed the insulin pen. When asked why she was removing it, RN A said because it had expired and Resident #14 did not take the medication anymore because it had been discontinued. RN A said she was responsible for ensuring the medication cart was appropriately cleaned and stocked and for removing any outdated or expired medications. In a follow up interview with RN A on 03/12/2026 at 09:37 am who said that a possible adverse reaction of Resident #14 receiving expired insulin could be ineffective glucose control and worsening diabetes signs/symptoms. RN A repeated that Resident #14 never received the expired medication as the injector pen was empty. In an interview with the DON on 03/12/2026 at 3:17 pm who said Resident #14's expired Basaglar (insulin glargine) injection pen should not have been on the cart. The DON said that insulin was only good for 28 days and if the insulin pen was dated 02/05/2026 on 03/11/2026 (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676400	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mrc the Crossings	255 N Egret Bay Blvd League City, TX 77573

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	then the pen was expired. The DON said a possible adverse reaction of Resident #14 receiving expired insulin could be ineffective glucose control and worsening diabetes signs/symptoms. The DON said RN A was responsible for ensuring the nurse cart was stocked and all expired or outdated medications were removed. The DON said the pharmacist also conducted monthly cart checks for expired and outdated medications and that Resident #14 had not received the expired insulin because RN A explained the pen was zero with no doses and she completed her own record review of the order for the insulin medication and confirmed it had been discontinued on 02/27/2026. Telephone interview with Pharmacist on 03/13/2026 at 3:36 pm who said that she had not completed the 30-day pharmacy review for the facility yet for the month of March and that any expired and discontinued medication/s should be discarded and removed from the cart. The Pharmacist said most insulins expire 28 days from open date. Record Review of policy Medication Monitoring and Management dated 2006 revealed in part: In order to optimize the therapeutic benefit of medication therapy and minimize or prevent potential adverse consequences, facility staff, the attending physician/prescriber, and the consultant pharmacist, perform on-going monitoring for appropriate, effective and safe medication use.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676400	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mrc the Crossings	255 N Egret Bay Blvd League City, TX 77573

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that the medication error rate was not five percent or greater. The facility had a medication error rate of 7% based on 2 out of 26 opportunities, which involved 1 of 5 residents (Resident #44) and 1 of 3 staff (LVN A) observed during medication administration reviewed for medication error. LVN A failed to ensure Resident #44's medications were crushed individually and within professional standards. LVN A failed to ensure Resident #44's Levaquin (antibiotic) and Ferrous Sulfate (Iron) were not crushed and mixed together. LVN A failed to ensure Resident #44's Levaquin (antibiotic) and Ferrous Sulfate (Iron) were not given at the same time. These failures could place residents at risk of receiving ineffective medications and increased risk of severe stomach irritation, continued infections, possible overdose, and medication toxicity. Findings include: Record Review of Resident #44's admission record dated 03/12/2026, revealed the resident was an [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including acute on chronic congestive heart failure (a life-threatening sudden worsening or pre-existing long-term heart failure that includes rapid fluid accumulation in the lungs and body, usually triggered by infections), anemia (a blood disorder characterized by a lack of healthy red blood cells), and pneumonia (an infection that inflames the air sacs in one or both of the lungs, causing them to fill with fluid or pus). Record review of Resident's #44's Annual MDS dated [DATE] revealed she had a BIMS score of 14 out of 15 which indicated normal thinking and memory with no or very little impairment. Record review of Resident #44's Order Summary Report dated 03/12/2026 revealed and active order with a start date of 02/22/2026 for Ferrous Sulfate Oral Tablet 325 (65 Fe [Iron]) MG (Ferrous Sulfate) Give 1 tablet by mouth one time a day for supplement on hold from 03/11/2026 at 5:02pm until 03/14/2026 at 5:01 pm. Record review of Resident #44's Order Summary Report dated 03/12/2026 revealed an active order with a start date of 03/11/2026 for Levaquin 500 mg Give 1 tablet by mouth one time a day for pneumonia until 03/14/2026. Continued record review revealed the following order: May crush medication or open capsules as needed unless contraindicated. Record review of Resident #44's MAR printed 03/12/2026 revealed Ferrous Sulfate Oral Tablet 325 (65 Fe [Iron]) MG (Ferrous Sulfate) Give 1 tablet by mouth one time a day for supplement and Levaquin tablet 500 mg Give 1 tablet by mouth one time a day for pneumonia until 03/14/2026 and were documented as administered by LVN A on 03/11/2026 at 09:00 am. Record review of facility staffing sheet dated March 11, 2026, revealed LVN A worked the 06:30 am to 06:30 pm shift. Observation and interview on 03/11/2026 at 09:52 am of medication administration pass for Resident #44 with resident consent. LVN A prepared Resident #44's medications by placing each pill in a small clear 30 ml sized cup. LVN A placed all of the pills that included Levaquin 500 mg 1 tablet and Ferrous Sulfate Oral tablet 325 (65 Fe [Iron]) 1 tablet into a translucent plastic pouch and crushed them all together. LVN A then poured the pulverized medications which were all deep brown in color, back into the small clear 30 ml medicine cup and mixed a plastic spoonful of applesauce into the pulverized medications creating a paste-like, dark colored mixture. When asked if she always crushed iron tablets, LVN A said she had before and when asked if she should crush iron tablets, she said she crushed Resident #44's medications because of her swallowing difficulty and when asked if she should crush all the medications together, LVN A said there was an order to crush medications as needed. LVN A said she usually mixed Resident #44's medications in applesauce and that Resident #44 liked applesauce. LVN A proceeded to Resident #44's bedside with the paste-like, dark colored mixture inside the 30 ml medication cup. Resident #44 was seated in her wheelchair at the bedside and was appropriately dressed and groomed in a teal-colored matching top and bottom lounge wear set. LVN A explained to Resident #44 that she was receiving her medications and Resident #44 frowned up her face as LVN A administered the first spoonful of the dark colored past-like mixture. Resident #44 swallowed and then made a wrenching (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676400	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mrc the Crossings	255 N Egret Bay Blvd League City, TX 77573

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sound like she was going to vomit. When surveyor asked if LVN A had ever taken iron tablets as a supplement, LVN A said she heard iron can taste terrible. When asked if Resident #44 usually wrenched when she was given her iron and other medications crushed with applesauce, LVN A said not all of the time. LVN A provided Resident #44 with sips of water in between approximately 4 spoonfuls of the dark colored paste-like mixture of medications with Resident #44 frowning after each bite and shaking her head back and forth between spoonfuls. Resident #44 said that she did not understand why medication had to taste so bad and then said she wanted to rinse out her mouth in the bathroom and brush her teeth. LVN A assisted Resident #44 to the bathroom where the resident was assisted with rinsing out her mouth and brushing her teeth. In an interview with LVN A on 03/11/2026 at 4:36pm who said she was not sure which medications could be crushed together and which ones could not, LVN A said she would need to check. LVN A said she had a list of medications that could be crushed and list of medications that could not be crushed that were kept on the nursing medication cart and surveyor provided with copies of the lists. LVN A then said she looked it up and Resident #44's iron should not have been crushed with her Levaquin and that Resident #44's iron should not have been taken with her Levaquin because it could decrease the efficacy of the Levaquin antibiotic. LVN A said that after she looked it up the medications should be given at least 2-4 hours apart and she would notify Resident #44's physician. LVN A said that the resident could be at risk for her infection worsening or not improving from receiving the iron and antibiotic together. Record review of Resident #44's EMR on 03/12/2026 at 8:32 am revealed Resident #44's Ferrous Sulfate 325 (65 Fe [Iron]) MG (Ferrous Sulfate) Give 1 tablet by mouth one time a day for supplement was placed on hold at 5:07pm on 03/11/2026. Interview with DON on 03/12/2026 at 3:17pm who said that Resident #44's iron and Levaquin should not have been crushed together and should not have been administered together. The DON said that iron should not be crushed and iron taken with Levaquin could decrease the efficacy of the antibiotic Levaquin. The DON said that there was a list of medications that should not be crushed on each nursing cart for the nursing staff to reference and that each medication should have been crushed separately. The DON said she did not know why LVN A crushed all of Resident #44's medications or why they were all crushed together. The DON said she started staff in-service training and Resident #44's Ferrous Sulfate order had been placed on hold until her Levaquin antibiotic was completed. The DON said that the resident could be at risk of continued infection from her antibiotic being rendered ineffective by the iron. Telephone interview with Pharmacist on 03/13/2026 at 3:36 pm who said that she had not completed the 30-day pharmacy review for Resident #44 yet because the resident had not been at the facility for 30-days yet. The Pharmacist said that Resident #44's Ferrous Sulfate (Iron) should not have been crushed. The Pharmacist said that Resident #44's Levaquin should not have been crushed with the iron and the Pharmacist said they should not have been taken all together. The Pharmacist said iron can decrease the efficacy of antibiotics and other medications and she would have recommended that the iron be stopped or held until the course of antibiotic treatment was completed. The Pharmacist said that Ferrous Sulfate (iron) should not be crushed because they are often developed with special coatings or as extended release, ensuring more steady absorption and reducing side effects like nausea and stomach upset/discomfort. The Pharmacist said she would have recommended to administer the Levaquin at other times away from other medications, for example, she would have recommended to administer the Levaquin at 10 am and 10 pm. Record review of facility provided list of Medications Not to Be Crushed dated as revised 12/19 revealed in part: Iron Salts* (time released) [NAME] Grad 500, [NAME]-Sequels, Slow Fe. Record Review of policy Medication Monitoring and Management dated 2006 revealed in part: The consultant pharmacist reviews written records to determine that: 5). Alteration of dosage forms, such as pill crushing, has not impaired therapeutic response.C. The interdisciplinary team reviews the resident's medication regime for efficacy and actual or potential medication-related problems (on and on-going basis/quarterly. 17. The resident is not taking other medications, nutritional supplements, including herbal products, or foods that would be incompatible (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676400	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mrc the Crossings	255 N Egret Bay Blvd League City, TX 77573

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with the prescribed medication. Record review of policy Crushing Medications dated revised October 2024 revealed: Medications shall be crushed only when it is appropriate and safe to do so, consistent with physician orders.1. The medical director and director of nursing services, in conjunction with the consultant pharmacist, shall identify appropriate indications and procedures for crushing medications.d. Crushing each medication separately and administering each with food is considered best practice. However, separating and administering crushed medication is not appropriate for all residents. Issues related to safety, needs, preferences, medication schedule, and functional ability will determine the most resident-centered approach.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676400	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mrc the Crossings	255 N Egret Bay Blvd League City, TX 77573

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for food procurement. The facility failed to ensure foods were covered and sealed appropriately.These failures could place residents at risk of food borne illness and disease.Findings included: Observation and interview on 3/10/26 at 8:56 am with the Dining Service Director of one large plastic bin with clear closable lids was open and had sugar in it.An observation at 8:59 am of one 3- gallon tub of chocolate chip ice cream in the walk-in freezer, the lid was not on the ice cream. Interview with DM he said that a staff member left the sugar bin open and forgot to close it. He did not know who because they all used the sugar. He said that the ice cream should have been closed. The sugar and ice cream being opened could cause cross contamination. The ice cream could have frost bite and could ruin the quality of food for residents. An observation and interview at 10:20 am on 3/11/26 with the Dining Service Director of a total of 3, 3-gallon tubs, a 3-gallon tub of strawberry sorbet and 3- gallon tubs of strawberry ice cream and cherry vanilla ice cream with lids partially open and one dark colored hair on the partially opened 3-gallon tub of strawberry sorbet, located in the stand-alone freezer in kitchen across from prep station. Interview with the Dining Service Director, he said that lids being opened could cause cross contamination, affect the value of the food, and could make someone sick. An interview on 3/11/26 at 12:06 pm with the Administrator regarding additional opened sorbet and ice cream, she said she was aware and that the ordered plastic lids to all ice cream containers. An interview on 3/11/26 at 2:20 pm and with the Administrator she said that food items left open could cause rodents, bugs and cross contamination, the ice cream could be off tasting for residents. An interview with the DON on 3/11/24 at 2:24 pm, she agreed with the Administrator that food items left open could cause rodents, bugs and cross contamination, the ice cream could be off tasting for residents.Interview on 3/13/26 at 1:40 pm with the Director of Dining , he said that they provided in-services to the dining team which were responsible for food storage. He said that they also disposed of ice cream and closed the lid to the sugar container and that the negative outcome could be airborne contamination could make residents sick. Record review of the In-service sheet dated 3/10/26 for the dining team, read in part.all items need to be closed.keep bins closed. Record review of the facility policy and procedure entitled, Food and Supply Storage, dated revised 1/24 read in part.All food shall be stored in such a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption.Cover unused portions.Frozen storage: Store bulk materials in NSF approved containers that have tight fitting lids.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676400	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mrc the Crossings	255 N Egret Bay Blvd League City, TX 77573

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure rooms were adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area for 1 of 6 residents (Resident #5) reviewed for call systems.The facility failed to install a functioning call light system for Resident #5's room located on the 1500 hall.This failure could place residents at risk for a delay in care and services, increased falls, excessive wait times, pain, and a decreased quality of life.Finding included:Record review of the face sheet for Resident #5 dated 03/13/2026 revealed an [AGE] year-old female admitted to the facility on [DATE] in room [ROOM NUMBER] with diagnoses of unspecified dementia unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (memory loss/cognitive decline where the specific type is not identified, the severity is not defined, and no significant psychological or behavioral symptoms are present).Record review of Resident #5's undated care plan revealed the following:Focus: The Elder is risk for falls r/t (related to) unsteady gait.Goal: The Elder will be free of serious injury from falls through the review date.Intervention: Be sure the Elder's call light is within reach and encourage the Elder to use it for assistance as needed. The elder needs a safe environment such as even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night; Side rails as ordered, handrails on walls, personal items within reach. Record Review of Resident # 5's Quarterly MDS (minimum data set) assessment dated [DATE] revealed a BIMS (Brief Interview for Mental Status) score 14 out of 15; indicating Resident # 5's cognition was intact. In an interview and observation on 03/10/2026 at 10:28 am with Resident #5 in room [ROOM NUMBER], she said that her call light had not worked for months, caused staff to respond to care slowly, and she had to wait between 15 to 20 minutes for care. She said that she had reported to staff that the call light did not work, but she could not remember the date, time, or which staff she reported the repair to. Observation at this time of Resident #5 to have pressed the call light, the indicator light did not flash on the wall at the bedside, and the indicator light did not come on in the hallway outside of the room. In an interview and observation on 03/10/2026 at 10:30am with MA D, who said that Resident #5's call light was functioning on 03/09/2026, and Resident #5 had not reported to her that the call light was not functioning. MA D said that residents had a right to a functioning call light at all times. She said that residents without a functioning call light were not able to alert staff of care needs, incidents, accidents, or changes in conditions. Observation at this time of MA D to enter the room of Resident #5 to test the call light for functioning. Observation of MA D to press the call light, the indicator light did not flash on the wall at the bedside, the indicator light did not come on in the hallway outside of the room, and the indicator light did not come on at the nurses' station. Observation of MA D to report that the call light in the room of Resident #5 did not function to LVN E. In an interview and observation on 03/10/2026 at 10:38am with LVN E, who said that Resident #5's call light was functioning on 03/09/2026, and Resident #5 had not reported to her that the call light was not functioning. She said that repair requests are reported to the Maintenance Director and requests are maintained in an electronic system. LVN E said that residents had a right to a functioning call light at all times. She said that residents without a functioning call light were not able to alert staff of care needs, incidents, accidents, or changes in conditions. Observation at this time of LVN E to report that the call light in the room of Resident #5 did not function to the Maintenance Director. In an interview and observation on 03/10/2026 at 10:49am with MA D, who said that Resident #5's call light was repaired and functioning. Observation of MA D to test the call light of Resident #5, and the indicator light did flash on the wall at the bedside, in the hallway outside of the room, and at the nurse's station. In an interview on 03/10/2026 at 11:29am with both the DON and ADON, they were informed that Resident #5 was observed without a functioning call light. In an (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676400	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mrc the Crossings	255 N Egret Bay Blvd League City, TX 77573

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 03/10/2026 at 11:35 am with the Administrator, she was informed that Resident #5 was observed without a functioning call light. In an interview on 03/13/2026 at 10:13am with the DON, who said that clinical staff should check for call light placement and functioning when entering a resident's room, but they are not required to document that the task is completed. She said that repair requests are reported to the Maintenance Director immediately and requests are maintained in an electronic system. She said that the Maintenance Director should ensure that call systems are functioning in each resident's room, she was unsure of how often the Maintenance Director checked the call lights for functioning, or how the Maintenance Director documented that the task was completed. She said that residents had a right to a functioning call light at all times. She said that residents without a functioning call light were not able to alert staff of care needs, incidents, accidents, or changes in conditions. In an interview on 03/13/2026 at 12:14pm with the Maintenance Director, who said that he should ensure that each resident has a functioning call light at all times. He said that monthly checks are completed to ensure that each resident has a functioning call light. He said that there was no documentation that the monthly checks were being completed. He said that repair requests are reported to the Maintenance Director immediately and requests are maintained in an electronic system. He said that there were no outstanding repair requests for call lights, and requests to repair call lights are addressed immediately. He said that routine checks of the call light systems are designed to catch when residents call lights are not functioning. He said that if the checks are not documented there was no way to show that they had been completed. He said that residents had a right to a functioning call light at all times. He said that residents without a functioning call light were not able to alert staff of care needs, incidents, accidents, or changes in conditions. He said that he received a repair request for the call light in the room of Resident #5 on 03/10/2026, and the repair was completed the same day. In an interview on 03/13/2026 at 12:37pm with the Administrator, who said that any staff that entered a resident's room should check for call light placement and functioning, but they are not required to document that the task is completed. She said that repair requests are reported to the Maintenance Director immediately and requests are maintained in an electronic system. She said that the Maintenance Director should ensure that call systems are functioning in each resident's room, she was unsure of how often the Maintenance Director checked the call lights for functioning, or how the Maintenance Director documented that the task was completed. She said that it was her expectation that the Maintenance Director completed the task, documented the task was completed, and she could only assume that the Maintenance Director had completed the task. She said that if the Maintenance Director was completing the task it would catch that residents were having issues with call light functioning. She said that residents had a right to a functioning call light at all times. She said that residents without a functioning call light were not able to alert staff of care needs, incidents, accidents, or changes in conditions. Record review of electronic work orders from 01/01/2026-03/13/2026 with no outstanding repair request for call light malfunction for Resident #5 prior to 03/10/2026. Record review of the policy titled, Call System, Resident, and dated September 2022 read in part, . Policy Heading.Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized work station. Policy Interpretation and Implementation. 1.Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor.3.The resident call system remains functional at all times. If audible communication is used, the volume is maintained at an audible level that can be easily heard. If visual communication is used, the lights remain functional.5.The resident call system is routinely maintained and tested by the maintenance department. Record review of the policy titled, Answering the call light, and dated 2001 read in part, The purpose of this procedure is to ensure timely responses to the resident's request and needs. General Guidelines.4. Be sure that the call light is plugged in and functioning at all times. 5. Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor.