STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676463	A. Building B. Wing	07/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crimson Heights Health & Wellness	19279 McKay Dr. Humble, TX 77338

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan which included measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs for Resident #1. The facility failed to update Resident #1's care plan to reflect she was a two plus person physical assist that resulted in an improper transfer on 07/15/2025. This led to Resident #1's, left shoulder fracture. An immediate jeopardy (IJ) was identified on 07/20/2025. The IJ template was provided to the facility on [DATE] at 10:39 am by the Investigator. While the IJ was removed on 07/21/2025, the facility remained out of compliance at a scope of isolated with a severity level of potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place. This failure placed dependent residents at risk of being injured, bruised, or have fractured limbs. Findings include: Record review of Resident #1's face sheet revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. The resident's diagnoses included: Personal history of traumatic brain injury (Primary, Admission), Pain disorder with related psychological factors, Acute pain due to trauma, Pain disorder exclusively related to unsteadiness on feet, Cognitive communication deficit, need for assistance with personal care, other abnormalities of gait and mobility, Idiopathic gout, (a digestive disease-herat-burn) right ankle and foot, Muscle weakness (generalized), Conversion disorder with seizures or convulsions. Record review of Resident # 1's nurses notes, dated 07/15/2025, revealed Nurse A notified Resident # 1 primary Physician of the popping sound. The Dr. ordered a STAT x-ray to the left shoulder and upper arm. Nurse # 1 said she ordered the STAT x-ray with a local X-ray company. The x-ray revealed a left shoulder mild displaced fracture of the proximal humerus (a break in the upper arm bone near the shoulder joint) surgical neck. The Dr. gave orders for the Resident# 1 to be sent out to the hospital for further evaluation and a higher level of care. Resident was sent out by the night nurse. The Hospital x-ray revealed the same proximal humerus fracture. Record review of Resident #1's care plan, effective date 12/06/2024, revealed the resident the Resident requires a Hoyer lift with 2 staff for transfer. Further review revealed resident was at risk for falls related to unsteady gait. Revised on 7/17/2025 Record review of Resident # 1's MDS dated , 06/06/2025, revealed section C0500-BIMS coded as an 11 which indicated moderate cognition impairment. Section G-transfer revealed Resident # 1 depended totally on staff to move to or from between surfaces; bed, chair, wheelchair and standing, with two plus persons' physical assist. Record review of Resident #1's care plan with effective date of 12/6/24 revealed Resident #1 required 1-2 person(s) assist with transfers. Last revised on 5/5/25. During an interview with Nurse A on 07/18/2025 at 11:07 am, she stated she was at the nursing station documenting around shift change when CNA D came and asked her to come with him. Resident # 1 was still sitting in her wheelchair. CNA D said during the transfer, he attempted to pivot Resident #1 back into her bed when he heard a popping sound on Resident # 1's left shoulder, and the Resident was crying. Nurse A stated she did not review the care plan to know how many staff were required currently to assist Resident # 1 during transfers. Nurse A stated she assessed Resident #1 and gave her pain medication. During an interview with CNA D on via telephone on 07/18/2025 at 11:47 am, he stated he walked into Resident # 1's room and remembered she was a 1 person assist from the last time he checked the POC. He stated, he did not check the portion of the POC that would have showed if she was a one or two person assist, so he did not request for assistance. CNA D said, Resident # 1 was begging to be put back into bed. CNA D told the Resident; the mechanical lift was not working because the battery was not charged. CNA D in attempting to pivot Resident #1 back to her bed, he heard a popping sound from the resident's left shoulder. During an interview with Resident #1 on 07/18/2025 at 3:23 pm over the phone, she stated CNA D was trying to put her in bed by himself without using a mechanical lift. She stated CNA D did not tell her that, the mechanical lift was not working because the battery was not charged. Resident #1 said, she asked CNA D; Would you please use the Hoyer Lift, he said no. I can pick you up by myself. Resident #1 said, when CNA D picked her up from under her arms, she heard a popping sound from her left shoulder and started crying. Resident # 1 said when the nurse arrived at her room about 20 minutes later, she told the nurse CNA D picked her up in the wrong way, and her left arm popped. Resident #1 said, the nurse gave her pain medication on that day. Resident # 1 said In the past, it's been two staff helping to transfer me. This one decided not to use the Hoyer lift on Tuesday night.During an interview with the ADON on 07/21/2025 at 10:11 am, she stated updating the care plan to reflect the needs

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident received supervision and assistive devices to prevent accident for Resident #1. On 07/15/2025, CNA D transferred Resident #1 unassisted using a stand and pivot method instead of a mechanical lift (a device used to aid in the transfer and movement of individuals especially those with mobility limitation) device as required by her care plan dated 12/06/2024. During the transfer there was audible pop from Resident #1's left shoulder. Resident #1 had pain and sustained a fracture. An immediate jeopardy (IJ) was identified on 07/18/2025. The IJ template was provided to the facility on [DATE] at 05:34 pm. While the IJ was removed on 07/20/2025, the facility remained out of compliance at a scope of isolated with a severity level of potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place. This failure placed dependent residents at risk of experiencing pain, injuries, bruises, and fractures from possible accidents which could result in a diminished quality of life and hospitalization. Findings include: Record review of Resident #1's face sheet revealed, a [AGE] year-old female who was admitted to the facility on [DATE]. The resident's diagnoses included: Personal history of traumatic brain injury (Primary, Admission), Pain disorder with related psychological factors, Acute pain due to trauma, Pain disorder exclusively related to unsteadiness on feet, Cognitive communication deficit, Need for assistance with personal care, other abnormalities of gait and mobility, Idiopathic gout (A digestive disease-heart burn), right ankle and foot, Muscle weakness (generalized), Conversion disorder with seizures or convulsions (Violent , uncontrollable shaking of the body). Record review of Resident # 1's MDS dated , 06/06/2025, revealed section C0500-BIMS codes as an 11 which indicated moderate cognition impairment. Section G-transfer revealed Resident # 1 depended totally on staff to move to or from between surfaces; bed, chair, wheelchair and standing, with two plus persons' physical assist. Record review of Resident #1's care plan, dated 12/06/2024, revealed the Resident required a mechanical lift with 2 staff for transfer. Further review revealed resident was at risk for falls related to unsteady gait. Record review of Resident # 1's nurses notes, dated 07/15/2025, revealed Nurse A notified Resident # 1 primary Physician of the popping sound. The Dr. ordered a STAT x-ray to the left shoulder and upper arm. Nurse # 1 said she ordered the STAT x-ray with a local X-ray company. The x-ray revealed a left shoulder mild displaced fracture of the proximal humerus (a break in the upper arm bone near the shoulder joint) surgical neck. Nurse A stated, the Dr. gave orders for Resident# 1 to be sent out to the hospital for further evaluation and a higher level of care. Resident was sent out by the night nurse. The Hospital x-ray revealed the same proximal humerus fracture. Observation of the mechanical lift storage room on 07/18/2025, at 10:25 am revealed there were three mechanical lifts and a battery charging unit that could hold three mechanical lift batteries. Two of the mechanical lifts had fully charged batteries while the third battery was on the battery charging unit. During an interview with Nurse A on 07/18/2025 at 11:07 am , said, she was at the nursing station documenting around shift change when CNA D came and asked her to come with him. Resident # 1 was still sitting in her wheelchair. CNA D said during the transfer, he attempted to pivot Resident #1 back into her bed when he heard a popping sound on Resident # 1's left shoulder, and the Resident was crying. Nurse A stated she did not review the care plan to know how many staff were required currently to assist Resident # 1 during transfers. Nurse A stated she assessed Resident #1 and gave her pain medication. During an interview with CNA D via telephone on 07/18/2025 at 11:47 am, he stated he walked into Resident # 1's room and remembered Resident #1 was a 1 person assist from the last time he looked at the POC. He did not check the portion of the POC on the day of the incident that would have showed if she was a one or two person assist, so he did not request for assistance. CNA D said, Resident # 1 was begging to be put back into bed. CNA D told the resident the mechanical lift was not working because the battery was not charged. CNA D in attempting to pivot Resident #1 back to bed, he heard a popping sound from Resident #1's left shoulder. During an interview with Resident #1 on 07/18/2025 at 3:23 pm over the phone, she stated CNA D was trying to put her in bed by himself without using a mechanical lift. She stated CNA D did not tell her that, the Mechanical lift was not working because the battery was not charged. Resident #1 said, she asked CNA D, Would you please use the mechanical Lift, he said, no. I can pick you up by myself. Resident #1 said, when CNA D picked her up from under her arms, she heard a popping sound from her left shoulder and started crying. Resident # 1 said when the nurse arrived at her room about 20 minutes later, she told the nurse CNA