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Form Approved OMB
No. 0938-0391

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	03/09/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to treat each resident with respect and dignity and provided care in a manner that promoted maintenance or enhancement of his for 3 of 3 residents (Resident #1, Resident #2, Resident 5) reviewed for resident rights.The facility failed to ensure staff assisted Resident #1, Resident #2, Resident 5 by failing to answer call lights in a timely manner to provide assistance. This failure could place residents at risk for decreased quality of life, decreased self-esteem and increased anxiety.The Findings include:Record review of Resident1's Face Sheet revealed a [AGE] year-old female who was originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses of Chronic obstructive pulmonary disease (air flow is restricted during breathing), Hypothyroidism (thyroid gland doesn't make enough hormone), Hyperlipidemia (plaque buildup in arteries), Schizophrenia (brain disorder), hypertension (blood flowed through the vessels with high force), Type 2 diabetes mellitus with hyperglycemia (Insulin resistant), Paraplegia (paralysis affecting the lower half of body).Record Review of Resident1's Care plan dated 3/6/2026 revealed the following:Problem: Resident1 requires assistance with ADLs (start dated 3/28/25 and edited 12/16/25)Goal: Resident1 will improve/maintain current ADL independence (start dated 3/28/25 and edited 12/16/25).Approach: Resident1 requires supervision x 1 with eating (8/19/25); assist resident as need with personal hygiene (3/28/25).Problem: Resident1 has a diagnosis of seizures and is at risk of injury (12/16/25)Goal: Resident1 will not injure self-secondary to seizure disorder (edited 12/16/25 and long-term goal target date 3/16/26).Approach: Keep call light within reach (3/28/25)Problem: Resident1 is at risk for falling r/t muscle weakness and impaired mobility, contractures (12/16/25).Goal: Resident1 will remain free from injury through the next 90 days (12/16/25).Resident was totally dependent on staff for all her ADLs and staff was to ensure the call light is within reach.Approach: Keep call light in reach at all times (3/28/25).In an interview on 3/5/26 at 10:15 am with Resident1 she stated it takes staff at least 30 minutes or more to answer call buttons. She stated on a few occasions she needed to be changed, and it took more than 30 minutes for her call light to be answered. She stated sitting in soiled diaper creates a feeling of helplessness. She stated she deals with depression and not being independent and having to depend on staff who let you down increases her level of depression. She stated the call light issues are on going and have been taken to the resident council for grievance.Record review of Resident 2's undated Face Sheet revealed an [AGE] year-old female who was originally admitted to the facility 11/9/25 and readmitted on [DATE] with a diagnoses of Chronic obstructive pulmonary disease with (acute) exacerbation (Admission), Immunodeficiency (your body's ability to fight diseases is reduced), Type 2 diabetes mellitus with diabetic polyneuropathy (high blood sugar causes nerve damage), Upper respiratory infection (bacteria illness affecting nose, throat, and sinuses), Anxiety disorder (uncontrollable fear), and Hypertensive heart disease with heart failure (chronic high blood pressure).Record review of Resident 2's baseline MDS dated [DATE] revealed a BIMS score of 12 (resident has moderate cognitive impairment). Resident 2 required supervision or touching assistance for all of her ADLs.Record Review of Resident #2's Care plan dated 2/12/26 revealed the (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	following:Problem: Resident 2 is at risk for falling R/T COPD, impaired cognition and ambulatory status [02/24/2026]Goal: Resident 2 will remain free from injury through next 90 days [3/2/26]Approach: Keep call light in reach at all times [11/24/25]; Observe frequently and place in supervised area when out of bed [11/24/25]Problem: At risk for S&A of hyper/hypoglycemia (blood sugar drop) r/t diagnosis of diabetes mellitus [2/24/26]Goal: Blood sugar will remain within acceptable range set per MD orders [2/24/26Approach: Provide diabetic snacks between meals and at bedtime [11/10/25].In an interview on 3/5/26 at 9:30am with Resident 2 she stated she is on hospice. She stated she is supposed to get a snack in the evening due to her diabetes; however, when she pushes her call light it takes approximately 45 minutes or more to get answered. Sometimes the call is not answered. She stated that her not getting her evening snack makes her feel nauseated and sick to the stomach.Record Review of Resident 5 undated face sheet revealed an [AGE] year-old female who was admitted to the facility on [DATE] with diagnosis of Type 2 diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (a severe life-threating complication of type 2 diabetes (extremely high blood glucose levels),Type 1 diabetes mellitus with diabetic nephropathy (nerve damage in hands, feet, and legs). Diverticulitis ofIntestine (inflammation of small, bulging pouches in the colon).Record Review of Resident 5's MDS dated [DATE] revealed a BIMS score of 8 (moderate cognitive impairment). Resident 5 required partial/moderate assistance in the areas of eating, oral hygiene, upper body dressing, and personal hygiene. Resident 5 required substantial/maximum assistance in toileting hygiene, shower/bathe self, and lower body dressing, putting on/taking off footwear, sit to lying on side of bed, sit to stand, and chair transfer.Record Review of Resident #5's Care plan dated 1/22/26 revealed the following:Problem: Resident 5 is at risk for dehydration due to presence of feeding tube related to diagnosis of anorexia (edited 2/27/26).Goal: Resident 5 will have a stable weight as evidenced by no significant weight loss of 5% or more in 30 days; or 10% or more in 180 days (edited 2/27/26).Approach: administer feeding via gtube per orders. Monitor hydration status and electrolytes (edited 9/7/25); Placement verification-check residual (if 150ml or less reinsert volume into stomach and continue feeding. If greater than 150ml, hold feeding and notify physician_created 6/17/25).Problem: Resident 5 is at risk for pressure injury related to immobility, incontinence, poor nutrition, decreased cognition, diabetes, and fragile skin (edited 2/27/26)Goal: resident's skin will remain intact over the next 90 days (edited 2/27/26)Approach: CNA to inspect skin, especially over bony prominences, during bathing and personal care and report fining to licensed nurse (edited 3/4/25); reposition resident as needed per tolerance (3/4/25);Problem: Resident 5 is at risk for falling r/t use of antianxiety medications, muscle weakness and arthritis (2/27/26)Goal: Resident 5 will remain free from injury through next 90 days (edited 2/27/26)Approach: Keep call light in reach at all times (3/4/25)On 3/9/26 at 7:50am during an observation in Resident 5's room where she was sitting on the side of her bed. She activated the call light at 7:50 am. At 8:10am RN A arrived in the room, walked past Resident, looked behind the curtain of residents' roommate who was not present, then proceeded to walk out of the room without addressing the activated call light.In an interview on 3/9/26 at 7:50am with Resident 5 she stated she very seldom uses the call light system; however, on one occasion she was extremely sick and pushed her call light and it was more than 30 minutes before it was answered. Resident 5 stated, I'm afraid that if I was dying I'd probably be dead before staff responds. Resident 5 stated this is an on-going problem on all shifts.In an interview on 3/5/26 at 10:00am Resident 3 stated she knows that it takes a long time for staff to answer call lights as she has heard the complaints from other residents. She stated it takes staff 30 minutes to 1 1/2 hours to answer call lights. In an interview on 3/5/26 at 10:30am Resident 4 stated she is the resident council secretary. She stated call lights are an on-going issue. She stated it takes more than 30 minutes for call lights to be answered. She stated these issues are in the resident council meeting minutes because she is the secretary.In a Telephone Interview on 3/5/26 at 4:45pm with Ombudsman- he stated call lights being answered in acceptable times have been an on-going issue and he has received multiple complaints. He stated night shift (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	barely answers their call lights.In an interview on 3/9/26 at 7:43am with the ADON she stated in the matter of call lights, she believed there is a perception issue with residents. She stated there are enough CNAs and if need be, the MAs will and can assume the position of a CNA. In an interview on 3/9/26 at 8:10am with RN A he stated he was the WC nurse for the facility. RN A initially stated he was unaware of the call light being on. He was asked to step out of the room to see if the call light was on, which he stated was on. RN A stated he did not address the resident's needs, and he should have since she was the only resident in the room and the call light was on. RN A stated the failure to address the resident who activated the call light could have resulted in the resident being in some type of distress, which could have been bad for residents. He stated being a WC Nurse did not prevent him from answering a call light. He stated he should have. He stated this was an error on his behalf.In an interview on 3/9/26 at 8:15am with Resident 6 he stated he has an issue with night shift answering his call light. He stated he needs to be changed, and it takes more than 30 minutes for a response. He stated he has been left in soiled diaper because his light had not been answered. He stated the feeling of being left unattended makes him sad and feel worthless. He stated he does not have any wounds.In an interview on 3/9/26 at 8:30am with CMA B she stated some residents have complained about call lights not being answered; however, she stated she will assist CNAs whenever she can. She stated answering a call light after 30 minutes is not acceptable because the resident could be in a dangerous situation.In an interview on 3/9/26 at 10:10am with CNA A she stated she believed there is enough staff. She stated call lights should be answered within 2-5 minutes. She stated 30 minutes is too long. She stated an emergency could happen and the residents' needs would not be met. In an interview on 3/9/26 at 4:27pm DON stated she gets complaints about call lights rarely and when she does, she looks at the circumstances. She stated call lights should be answered as soon as possible. She stated everybody can answer a call light because if a call light is on it may be an emergency. She stated a call light on for 30 minutes or more is excessive.Record Review of Resident Council Meeting Minutes dated 1/7/26 revealed, There are long wait times to answer call lights.Record Review of Facility's Policy on Call Lights dated May 5, 2023 revealed the following:Respond to call lights and request for assistance as quickly as practicableStaff respond to emergency lights immediately

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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 interview and record review, the facility failed to provide pharmaceutical services including procedures to accurately administer medications to meet the needs of each resident for 1 of 1 resident (Resident 1) reviewed for pharmacy services.The LVN A failed to properly administer a narcotic medication to Resident 1 and documented that the medication was wasted.The LVN A failed to properly dispose of the unused narcotic medication by leaving the medication on the resident's side table without supervision.The LVN A failed to properly document a controlled drug in the narcotic record or receipt and disposition established for Resdent 1. These failures could impact residents who receive medications based on pharmaceutical recommendations. Findings include:Record review of Resident1's Face Sheet revealed a [AGE] year-old female who was originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses of Chronic obstructive pulmonary disease (air flow is restricted during breathing), Hypothyroidism (thyroid gland doesn't make enough hormone), Hyperlipidemia (plaque buildup in arteries), Schizophrenia (brain disorder), hypertension (blood flowed through the vessels with high force), Type 2 diabetes mellitus with hyperglycemia (Insulin resistant), Paraplegia (paralysis affecting the lower half of body).Record Review of Resident1's Care plan dated 3/6/2026 revealed the following:Problem: Resident1 requires assistance with ADLs (start dated 3/28/25 and edited 12/16/25)Goal: Resident1 will improve/maintain current ADL independence (start dated 3/28/25 and edited 12/16/25).Approach: Resident1 requires supervision x 1 with eating (8/19/25); assist resident as need with personal hygiene (3/28/25).Problem: Resident1 has a diagnosis of seizures and is at risk of injury (12/16/25)Goal: Resident1 will not injure self-secondary to seizure disorder (edited 12/16/25 and long-term goal target date 3/16/26).Approach: Keep call light within reach (3/28/25) Problem: Resident1 is at risk for falling r/t muscle weakness and impaired mobility, contractures (12/16/25).Goal: Resident1 will remain free from injury through the next 90 days (12/16/25).Resident was totally dependent on staff for all her ADLs and staff was to ensure the call light is within reach.Approach: Keep call light in reach at all times (3/28/25).Record review of Resident 1's physician orders revealed an order for Nucynta ER (tapentadol) 150 mg give one tablet once a day for a history of Pain.In an interview on 3/9/26 at 10:20am with Resident 1 she stated this weekend (3/7/26) a nurse put a narcotic pill in a cup and placed it on her side table. She stated she was informed that she has a pill on her desk by CNA B who had awakened her on 3/8/26 between 5:45-6:00am when she woke her up to provide care. Resident stated she informed RN B and showed him the pill, but he did not do anything. Resident 1 stated the pill is a narcotic (tapentadol). In a telephone interview on 3/9/26 at 10:30am with CNA B she stated she worked this weekend (3/7/26 & 3/8/26) from 6:00am - 10:0pm. She stated she went to Resident 1's room around 6:00am on 3/8/26 to give care. She stated she noticed a blue pill in a cup on Resident 1's side table. She stated she asked Resident 1 about the pill and Resident 1 told her that she did not know how that pill got there. She stated the nurse must have sat it there last (Saturday) night while she was asleep. She stated the resident told her she informed RN B at which time she exited Resident 1's room. Afterward, CNA B stated she returned to Resident 1's room and Resident 1 still had the pill in her possession.In a Telephone Interview on 3/9/26 at 11:14am with RN B he stated he worked this weekend (3/7/26 & 3/8/26) from 6am-6pm. He stated he spoke with Resident 1 about a pill. He stated he asked her why the pill was left. He stated Resident 1 had shown him the pill and at this time he took the pill in his possession. He stated he spoke with the night nurse, LVN A, who told him that she gave Resident 1 a PRN narcotic, then he stated LVN A signed it off in the narcotic book as being wasted because Resident 1 did not take it. RN B stated the pill should never have been left. RN B stated Resident 1 always takes her medication. RN B stated the negative effect with this issue is Resident 1 could have been overmedicated because it was a scheduled narcotic medication.In a Telephone Interview on (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/9/26 at 11:24am with LVN A she stated she worked at the facility Saturday and Sunday (3/7/26 & 3/8/26). She stated she was informed by CNA B regarding the narcotic pill in Resident 1's room. She stated she did administer medication. (3/7/26 & 3/8/26) She stated MA A signed out the pill and left it on Resident 1's table. She stated the pill was already signed out of the book when she looked at it. LVN A stated MA A was new and was supposed to be trained by a nurse. LVN A stated all medications administered to Residents are to be observed while the resident is taking the medication. LVN A stated Resident 1 could have been over-medicated or missed a dose all together.In a telephone interview on 3/9/26 at 12:00pm with LVN B she stated she did work this weekend from 6:00 AM to 6:00 PM (3/7/26 & 3/8/26). LVN B stated she trained MA A. She stated she was familiar with Resident 1's medication and observed MA A administering her narcotics (medication) in the morning. LVN B stated that at no time would she or her trainee ever place a pill in a cup and put it by any resident's desk. LVN B stated MAs are trained to administer medication to residents and observe them take the medication. She stated the negative effect to this issue is Resident 1 could have been heavily medicated or there are patients with dementia walking through the hall and going into peoples' rooms. One of them could have taken the medication.In an interview on 3/9/26 at 4:27pm with DON she stated the pill found in Resident 1's room was not appropriate. The resident could have been in pain or over-medicated.In a telephone interview on 3/9/26 at 4:45pm with CMA A she stated she completed orientation and training with LVN B. She stated she remembers administering scheduled medications only that morning. She stated she observed Resident 1 take the medication. She never administered in the evening. She stated the pill (Tapentadol) in the cup in question is PRN (given as needed) and only nurses can administer.Record Review of facility medication management program dated [complete revision: 5/5/23: revealed the following:10. the authorized staff member or licensed nurse must remain with the resident while the medication is swallowed. Never leave medication in a resident room without order to do so.Record Review of Narcotic book titled, Controlled Drug Receipt/Record/Disposition Form for Resident. The name of the medication was NUCYNTA (tapentadol) (a strong narcotic pain reliever) ER TAB 150MG (Scheduled II). On 3/7/26 at 7p LVN A put amount given 1, amount left 10 her signature CBrown/wasted (missed dose)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that controlled medications, were properly secured, as evidenced by medications being left unattended and unsecured for 1 of 1 resident (Resident 1) reviewed for accurate labeling of drugs.The LVN A left a pill in Resident 1's room, on a side table unsecuredThis failure could place Resident 1 and other residents at risk of being overmedicated and possible of overdoseFindings include:Record review of Resident1's Face Sheet revealed a [AGE] year-old female who was originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses of Chronic obstructive pulmonary disease (air flow is restricted during breathing), Hypothyroidism (thyroid gland doesn't make enough hormone), Hyperlipidemia (plaque buildup in arteries), Schizophrenia (brain disorder), hypertension (blood flowed through the vessels with high force), Type 2 diabetes mellitus with hyperglycemia (Insulin resistant), Paraplegia (paralysis affecting the lower half of body).Record Review of Resident1's Care plan dated 3/6/2026 revealed the following:Problem: Resident1 requires assistance with ADLs (start dated 3/28/25 and edited 12/16/25)Goal: Resident1 will improve/maintain current ADL independence (start dated 3/28/25 and edited 12/16/25).Approach: Resident1 requires supervision x 1 with eating (8/19/25); assist resident as need with personal hygiene (3/28/25).Problem: Resident1 has a diagnosis of seizures and is at risk of injury (12/16/25)Goal: Resident1 will not injure self-secondary to seizure disorder (edited 12/16/25 and long-term goal target date 3/16/26).Approach: Keep call light within reach (3/28/25)Problem: Resident1 is at risk for falling r/t muscle weakness and impaired mobility, contractures (12/16/25).Goal: Resident1 will remain free from injury through the next 90 days (12/16/25).Resident was totally dependent on staff for all her ADLs and staff was to ensure the call light is within reach.Approach: Keep call light in reach at all times (3/28/25).Record review of Resident 1's physician orders revealed an order for Nucynta ER (tapentadol) 150 mg give one tablet once a day for a history of Pain.In an interview on 3/9/26 at 10:20am with Resident 1 she stated this weekend (3/7/26) a nurse put a narcotic pill in a cup and placed it on her side table. She stated she was informed that she has a pill on her desk by CNA B who had awakened her on 3/8/26 between 5:45-6:00am when she woke her up to provide care. Resident stated she informed RN B and showed him the pill, but he did not do anything. Resident 1 stated the pill is a narcotic (tapentadol).In a telephone interview on 3/9/26 at 10:30am with CNA B she stated she worked this weekend (3/7/26 & 3/8/26) from 6:00am - 10:0pm. She stated she went to Resident 1's room around 6:00am on 3/8/26 to give care. She stated she noticed a blue pill in a cup on Resident 1's side table. She stated she asked Resident 1 about the pill and Resident 1 told her that she did not know how that pill got there. She stated the nurse must have sat it there last (Saturday) night while she was asleep. She stated the resident told her she informed RN B at which time she exited Resident 1's room. Afterward, CNA B stated she returned to Resident 1's room and Resident 1 still had the pill in her possession. In a Telephone Interview on 3/9/26 at 11:14am with RN B he stated he worked this weekend (3/7/26 & 3/8/26) from 6am-6pm. He stated he spoke with Resident 1 about a pill. He stated he asked her why the pill was left. He stated Resident 1 had shown him the pill and at this time he took the pill in his possession. He stated he spoke with the night nurse, LVN A, who told him that she gave Resident 1 a PRN narcotic, then he stated LVN A signed it off in the narcotic book as being wasted because Resident 1 did not take it. RN B stated the pill should never have been left. RN B stated Resident 1 always takes her medication. RN B stated the negative effect with this issue is Resident 1 could have been overmedicated because it was a scheduled narcotic medication.In a Telephone Interview on 3/9/26 at 11:24am with LVN A she stated she worked at the facility Saturday and Sunday (3/7/26 & 3/8/26). She stated she was informed by CNA B regarding the narcotic pill in Resident 1's room. She (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she did administer medication. (3/7/26 & 3/8/26) She stated MA A signed out the pill and left it on Resident 1's table. She stated the pill was already signed out of the book when she looked at it. LVN A stated MA A was new and was supposed to be trained by a nurse. LVN A stated all medications administered to Residents are to be observed while the resident is taking the medication. LVN A stated Resident 1 could have been over-medicated or missed a dose all together.In a telephone interview on 3/9/26 at 12:00pm with LVN B she stated she did work this weekend from 6:00 AM to 6:00 PM (3/7/26 & 3/8/26). LVN B stated she trained MA A. She stated she was familiar with Resident 1's medication and observed MA A administering her narcotics (medication) in the morning. LVN B stated that at no time would she or her trainee ever place a pill in a cup and put it by any resident's desk. LVN B stated MAs are trained to administer medication to residents and observe them take the medication. She stated the negative effect to this issue is Resident 1 could have been heavily medicated or there are patients with dementia walking through the hall and going into peoples' rooms. One of them could have taken the medication.In an interview on 3/9/26 at 4:27pm with DON she stated the pill found in Resident 1's room was not appropriate. The resident could have been in pain or over-medicated.Record Review of facility medication management program dated [complete revision: 5/5/23: revealed the following:10. the authorized staff member or licensed nurse must remain with the resident while the medication is swallowed. Never leave medication in a resident room without order to do so.Record Review of Narcotic book titled, Controlled Drug Receipt/Record/Disposition Form for Resident. The name of the medication was NUCYNTA (tapentadol) (a strong narcotic pain reliever) ER TAB 150MG (Scheduled II). On 3/7/26 at 7p LVN A put amount given 1, amount left 10 her signature CBrown/wasted