

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 09/27/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676463	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Crimson Heights Health & Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41654 FACILITY Environment 46708 Based on observations, interviews, and record review, the facility failed to accommodate the needs and preferences for four (Resident #50, Resident #56, Resident #57 and Resident 66) of 10 residents reviewed for accommodation of needs, in that: The facility failed to ensure Resident #56, Resident #57, and Resident #66 had their call lights within reach. This deficient practice could place residents at risk for falls, not receiving care and nursing interventions in a timely manner, and subject them to skin breakdown. Findings included: Review of Resident #56's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including dementia, cognitive communication deficit, symbolic dysfunctions (a language disorder), abnormalities of gait and mobility, and need for assistance with personal care. Review of Resident #56's MDS, dated [DATE], reflected a BIMS score of 00, indicating severe cognitive impairment. It further reflected she utilized a wheelchair and required extensive assistance with eating, transferring, bed mobility, and toileting. Review of Resident #56's care plan start date10/03/2022, reflected she was a fall risk and to keep call light in reach at all times. (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: 676463	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Crimson Heights Health & Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #57's undated face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including senile degeneration of brain, zoster (a viral infection that causes an outbreak of a painful rash or blisters on the skin), bipolar disorder, acute upper respiratory infection, symptoms and signs involving the circulatory and respiratory systems, nonsurgical wound dressing-monitor wound, pain, unspecified, restlessness and agitation, anxiety disorder due to known physiological condition, dementia, Parkinson's disease, Alzheimer's disease, chronic pain due to trauma, and essential hypertension. Review of Resident #57's MDS, dated [DATE], reflected a BIMS score of 06, indicating severe cognitive impairment. It further reflected she utilized a wheelchair and was dependent with toileting and transfers. Review of Resident #57's care plan start date 08/07/2023, reflected she was a fall risk and to keep call light in reach at all times. Review of Resident #66's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] last admission 05/28/2024 with diagnoses including unsteadiness on feet, Type 2 diabetes, hyperosmolality (the blood has a high concentration of salt (sodium), glucose, and other substances) and hypernatremia (high sodium concentration, muscle weakness, need for assistance with personal care, abnormalities of gait and mobility, cognitive communication deficit, dehydration, Alzheimer's disease, and chronic obstructive pulmonary disease. Review of Resident #66's MDS, dated [DATE], reflected a BIMS score of 03, indicating severe cognitive impairment. It further reflected she utilized a wheelchair and required extensive assistance with bed mobility and transferring and total dependence with toileting. Review of Resident #66's care plan start date 12/14/2023, reflected she was a fall risk and to keep call light in reach at all times. Observation on 06/11/2023 at 10:35 am revealed Resident #56's call light was not in reach. Surveyor attempted to interview Resident #56, but she was not interviewable. Observation on 06/11/2024 at 1:25 pm revealed Resident #57's door open and heard Resident #57 calling out, help me several times. Observation on 06/11/2024 at 1:30 pm revealed Resident #57's call light located between the wall and the back of her bed side table, out of Resident #57's reach. When surveyor entered the room Resident #57 said, I feel so stupid. Surveyor attempted to interview Resident #57, but she was not interviewable. Observation on 06/11/2024 at 1:35 pm revealed CNA C entered Resident #57's room. When CNA C exited Resident #57's room, surveyor entered the room and observed Resident #57's call light located between the wall and the back of her bedside table, out of Resident #57's reach. Observation on 06/12/2024 at 9:05 am of Resident #66's call light revealed it was in the trashcan located next to Resident #66's bed, out of Resident #66's reach. Review of facility policy titled Facility Call Lights, Responding To dated 05/05/2023 reflected: (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676463	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Crimson Heights Health & Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy - The staff will respond to call lights or other requests for assistance to meet the patient's/resident's needs. When leaving the patient or resident room, ensure the call light is placed within the patient's/resident's reach.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676463	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Crimson Heights Health & Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41654 Based on interview and record review, the facility failed to ensure assessments accurately reflected the resident's status for 1 of 4 residents (Residents #97) reviewed for resident assessments. The facility failed to ensure Resident #97's most recent admission MDS reflected that Resident #97 received dialysis services. This deficient practice could place residents at-risk for inadequate care due to inaccurate assessments. Findings include: A record review of Resident #97's face sheet dated 06/13/24 reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #97's diagnosis included end stage renal disease (a terminal illness that occurs when the kidneys can no longer function properly and support the body's needs; people with ESRD must receive dialysis or a kidney transplant to survive more than a few weeks), hypertension (high blood pressure), Bell's palsy (type of facial paralysis that results in a temporary inability to control the facial muscles on the affected side of the face), and legal blindness (having a central vision acuity of 20/200 or less in your best eye). A record review of Resident #97's Admission MDS assessment, dated 03/29/24, reflected the resident had a BIMS score of 10, which indicated cognition was moderately impaired. Resident #97's Admission MDS reflected Resident #97 had an active diagnosis of renal insufficiency, renal failure, or end stage renal disease (ESRD), and that resident did not receive dialysis services. A record review of Resident #97's care plan, dated 04/10/2024, reflected Resident #97 was care planned for receiving Hemodialysis Due to End Stage Renal Disease. Goal Will not develop complications from dialysis. Approaches: Maintain and encourage resident to go to dialysis. Do not take BP on the arm with shunt. Monitor patency of the shunt by assessing the presence of thrill and bruit, document findings. Weigh resident as ordered. Diet and fluid as ordered. Maintain fluid restriction as indicated. In an interview on 06/12/24 at 11:46 AM, Resident #97 stated she attended dialysis three times a week on Tuesday's, Thursday's, and Saturday's. She stated she had a dialysis port to right arm. She stated the best place to find her if she was not at dialysis would be activities. She stated staff took good care of her and she got to and from dialysis with no problems. She stated she had not had any problems with dialysis. She stated staff checked on her frequently and responded to her quickly when she called for them. She stated she did not have any concerns. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676463	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Crimson Heights Health & Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the DON on 06/13/24 at 12:51 pm, she stated that the MDS nurses were responsible for completing and ensuring the accuracy of the MDS assessments. She stated both of the MDS nurses had been doing the MDS assessments for a long time and she was sure they had been trained on completion and accuracy of MDS assessments. She stated an MDS report should reflect if a resident was receiving dialysis services. She stated she was aware that Resident #97 received dialysis services. She stated she was not aware that Resident #97's MDS assessment did not reflect that resident received dialysis services. She stated if a MDS assessment had not been completed correctly it could affect the care plan because the care plan was triggered by the MDS assessment. She stated if the plan of care was not completed correctly it could have affected the residents care. In an interview with the MDS A on 06/13/24 at 1:17 pm, she stated she and another staff member were responsible for completing the MDS assessments. She stated she was responsible for completing the Medicaid and private pay residents MDS assessments and her partner was responsible for completing the Medicare and skilled care residents MDS assessments. She stated her partner helped her out at times because she had so many. She stated she had been trained on completing and ensuring the accuracy of the MDS assessments. She stated if a resident was receiving dialysis services, the MDS assessment should have reflected it. She stated if a resident admitted to the facility and was receiving dialysis services, it should have been reflected in the admission MDS assessment. She stated if a MDS assessment was completed inaccurately, it could affect the billing and the accuracy, but she felt that it would not have affected the resident because there were many other ways to care for the residents. In an interview with the MDS B on 06/13/24 at 1:27pm, she stated she was responsible for completing the MDS assessments for residents that were on Medicare and skilled services. She stated she and her partner worked together as well. She stated she had been trained on completing and ensuring the accuracy of the MDS assessments. She stated if a resident was receiving dialysis services, the MDS assessment should have reflected it. She stated she knew Resident #97 but did not know if Resident #97 received dialysis services. She stated she had not completed a MDS assessment for Resident #97. She stated she was not aware that Resident #97's MDS assessment did not reflect resident received dialysis. She stated if a MDS assessment was completed it could have affected the triggers on the resident matrix, but she did not feel like it could have necessarily affected residents. A record review of the facility's Minimum Data Set (MDS) Nursing Policies and Procedures, dated 2023, complete revision: 5/5/2023, email revision: 09/28/2023 reflected Policy: A licensed nurse will conduct or coordinate each assessment with the interdisciplinary team. An MDS, which is a comprehensive, accurate, standardized reproducible assessment will be completed for each resident, using the RAI process. Facility staff complete a comprehensive assessment of each resident's needs, strengths, goals, life history, and preferences, and offer guidance for further assessment once problems have been identified. The comprehensive assessment is completed initially and periodically.Procedures: 1. Review the resident's medical record. This review may include pre-admission activities. Identify resident's status, care and services rendered during the Observation Period for the current assessment. Review is to include but not be limited to pre-admission, admission, and transfer notes; current plan of care, physicians' orders, progress notes, history and physical; nursing, dietary, activity, social service, and therapy notes and assessments; monthly summaries, lab and x-ray reports, consultations, medication administration records, treatment administration records, and resident, staff and family interviews .		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676463	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Crimson Heights Health & Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47795 Based on observations, interviews, and record review, the facility failed to ensure each resident's person-centered comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment for 1 (Resident #3) of 16 residents reviewed for care plans. The facility failed to ensure Resident #3 comprehensive care plan was updated when her IV medication was discontinued. This failure could place residents at risk of receiving inadequate or unnecessary interventions not individualized to their health care needs. The Findings included: Review of Resident # 3's face sheet revealed an [AGE] year-old female admitted to the facility on [DATE] with a readmission on 4/3/2024, with Diagnosis that included Acute kidney failure (A condition in which the kidneys suddenly can't filter waste from the blood), Alzheimer's disease(a progressive disease that destroys memory and other important mental functions) and Dysphagia, oral phase (Difficulty swallowing, oral phase involves using the mouth to prepare food or liquids for swallowing) Review of Resident # 3's quarterly MDS assessment dated [DATE] revealed a BIMS score of 11 which could indicate Moderate cognitive impairment. Review of Resident # 3's care plan updated 6/11/2024 revealed a problem of Resident #3 requires IV medication. With a goal of resident will not exhibit signs of complication from IV (localized infection, systemic infection, electrolyte imbalance etc.) Review of Resident # 3's physician orders dated 6/13/2024 revealed no current orders for IV medication, with an ordered stop date of 05/31/2024 for Zosyn (Antibiotic) IV every 6 hours. Order on 6/3/2024 to remove Midline IV. Observation of Resident # 3 on 6/11/2024 at 11:00 am revealed the resident was alert, clean, dry, and well groomed. No iv-access was observed. In an interview of Resident # 3 on 6/11/2024 at 11:00 am, she stated that she likes it here; they treat her well. She thinks she was in the hospital but cannot remember why. When asked about the dressing to her arm she was not sure what happened. Interview with the DON on 6/11/2024 at 12:30 pm revealed her expectations were that the care plan reflects an accurate picture of the resident and are updated in real time. She was not aware of Resident #3's care plan not being updated and stated they have several ways to communicate with the staff for resident updates, including record review and morning meeting. She stated that the MDS nurse is responsible for the care plan, but that any member of the Interdisciplinary team can update them. She stated that care plans not being updated can cause potential harm to the resident by them not receiving the care they need. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676463	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Crimson Heights Health & Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview of MDS nurse A on 6/11/2024 1:18 pm revealed that she and the other MDS share duties. They are responsible for the MDS and the care plan. She stated that a change in the resident's orders and medical condition should be updated as it happens, and they review the orders and attend a daily meeting to gather information to information needed to update the care plan. She stated that is not sure why the care plan was not updated when the IV medication was discontinued. She stated there was no potential harm to the resident as the staff do not look at the care plans. Interview of MDS nurse B on 6/11/2024 at 1:33 pm revealed that she and another nurse share the MDS and care plan duties. She stated they have orders that they review and have a stand up meeting every morning addressing any issues with residents in the last 24 hours. She stated those are the two sources she uses to update the care plans. She was not aware that Resident #3's care plan was not updated and does not know why it was not. She stated that more of the staff go by the physician's orders and not the care plan, so she did not see any potential harm to the resident. Interview with the ADM on 6/11/2024 at 6:00 pm revealed his expectation was that care plans be current and updated timely. He stated they had several methods to communicate the needs of the residents to the Interdisciplinary team such as morning meeting and order review. He stated that the MDS nurses were responsible for the care plans but that he understood any member of the team had access to update them. He stated that he was not sure what could happen, but he did think it could interfere with the care. Review of Policy Care Plan Process, Person-centered care Revision May 5, 2023, revealed 9. Thru ongoing assessment, the facility will initiate person-centered care plans when the resident's clinical status or change of condition dictate the need such as but not limited to falls and pressure ulcer/development.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676463	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Crimson Heights Health & Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0677 Level of Harm - Actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46708 47772 Based on observations, interviews, and record reviews, the facility failed to assist with activities of daily life, for 2 of 8 residents (Resident #50 and Resident #98) who was observed for assistance with ADLs. The facility failed to: - Provide supervision, or touching assistance, for Resident #98 during food service. - Answer Resident #50's call light for 50 minutes after repeated verbalizations/request for help as he was soiled with urine and bowel movement subsequently making him feel helpless and neglected. This failure placed residents at risk of poor nutrition, dehydration, skin breakdown, and unintended weight loss. Findings included: Resident #98 Record review of Resident #98's face sheet, dated 6/12/2024, reflected Resident #68 was a [AGE] year-old-male, who admitted to the facility on [DATE]. He was diagnosed with Acquired Absence of Left Leg Above Knee (which was an amputated extremity,) Type 2 Diabetes (which was a problem of the body's ability to use sugar for fuel,) Moderate Protein Calorie Malnutrition (which was a diagnostic code for nutritional metabolic disease,) and Other Symptoms and Signs Concerning Food and Fluid Intake (which was a diagnostic code nutrition deficiency.) Record review of Resident #98's Admission MDS assessment, dated 5/28/2024, reflected Section C., Cognitive Patterns; Indicated Resident #98 had a BIMS Score of 5. A BIMS Score of 5 indicated Resident #98 had severe cognitive impairment. Section GG., Functional Abilities: Indicated Resident #98 required supervision or touching assistance while eating. Supervision or touching assistance meant the helper provided verbal cues and/or touching, steadying and/or contact guard assistance as the resident completed the activity. Assistance may have been provided throughout the activity, or intermittently. Resident #98 required partial/moderate assistance rolling left to right; sitting to lying; and lying to sitting on bed. Partial/moderate assistance meant the helper did less than half of the work completing the task. Record review of Resident #98' CP indicated a problem area, created 6/10/2024, for ADLs evidenced by the need for required assistance. The goal, created on 6/10/2024, indicated Resident #98 would improve ADL independence. The intervention for nursing staff, created 6/10/2024, indicated Resident #98 would require 1 staff member with bed mobility and 1 staff member with eating. Record review of Resident #98's general nursing order, dated 5/24/2024 and written by ADON B, indicated Resident #98 would receive assistance of 1 person while eating. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676463	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Crimson Heights Health & Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0677 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #98's weights indicated on 05/24/2024, the resident weighed 95.1 lbs. On 06/12/2024, the resident weighed 94.6 pounds which is a -0.53 % Loss. Interview on 6/11/2024 at 10:54 AM with Resident #98 revealed he had not been able to eat like he wanted. He took his meals in his room and stated the CNAs, who served him his meals, did not take time to feed him. He stated they brought him his meals, set up his tray, and then went on to the next person. Observation on 6/12/2024 at 12:04 PM reflected CNA D entering Resident #98's room to deliver his lunch. Observation on 6/12/2024 at 12:08 PM reflected CNA D exiting Resident #98's room after delivering his lunch. Observation and interview on 6/12/2024 at 12:08 PM reflected Resident #98 in his bed with this bed raised between 30 to 45 degrees. His lunch was on a bed side table positioned across his mid-section. His milk was opened, soup was uncovered and in front of him, his main dish was at the back of the tray still covered. His beverage still had the lid. Interview with Resident #98 revealed CNA B brought him the tray, set it up a little, and she said she would be back later to see if he needed any help. Observation on 6/12/2024 at 12:14 PM reflected the CNA D had not returned to the room. Observation on 6/12/2024 at 12:26 PM reflected the CNA D had not returned to the room. Observation and interview on 6/12/2024 at 12:36 PM of Resident #98's food tray reflected a small percentage of his lunch had been consumed. Interview revealed he was unable to eat his entire lunch because of his limited mobility and not being able to re-position his body. Interview and observation on 6/13/2024 at 1:53 PM with CNA D revealed there were residents on the hallway that required the assistance of 1 person while eating. She stated those residents were identified through shift change or by looking on the kiosk, which was a computer monitor mounted on the wall, which indicated the ADL care required. CNA D was observed having logged on the kiosk and having searched residents who required X 1, an additional, person for eating assistance. CNA D stated that residents, who required X 1 person for eating assistance, were supposed to receive plate set up and actual feeding. Interview and record review on 6/13/2024 at 2:12 PM with LVN G revealed the information which pertained to residents, and the required level of assistance for eating, was determined in the resident assessment, added to the CP, and found on the resident profile. The resident profile was available to the CNAs through the kiosk. LVN G stated that assistance X 1 person assistance for eating required set up, but a requirement to be fed was annotated with a comment, such as the resident needed to be fed. LVN G reviewed Resident #98's resident profile, which indicate eating assistance X 1. She stated there was no annotation having required the resident to be fed. LVN G reviewed Resident #98's assessments. LVN G noted the requirement for required supervision or touching assistance while eating. LVN G stated a resident who did not get their required level of assistance while eating risked weight loss and dehydration. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676463	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Crimson Heights Health & Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0677 Level of Harm - Actual harm Residents Affected - Few	Interview on 06/13/24 at 2:34 PM with the ADON A revealed nursing staff were trained to use the resident profile found in the kiosk to determine their required level of care. There were residents on skilled nursing that needed assistance x 1 for eating. Assistance X 1 person meant the resident needed 1 person in the room while eating for assistance. Safeguards in place to make sure a resident was receiving the required assistance would be thorough chart review, stop, and watch observations, and one-on-one visits. If a resident was not receiving the level of assistance while eating, the resident risked weight loss, dehydration, problems with wound healing, and frustration. Interview on 06/13/24 at 3:48 PM with the ADM revealed he expected his staff to follow facility policy in having aided in ADL care to residents. Residents who required the assistance of 1 person for eating were supposed to have a staff with them to assist set up and provide assistance during the meal. The system in place, to learn of such requirements, was the resident profile. Staff were supposed to refer the resident profile to learn of the required care. Residents who did not get the meal assistance they required were placed at risk of weight loss, thirst, isolation, and frustration. A failure to provide proper assistance for ADL care fell on nursing staff having failed to check the resident profile for required assistance. Record review of the facility's Activities of Daily Living Policy, dated 5-5-2023, indicated ADLs were related to personal care having included grooming, dressing, oral hygiene, transfer, bed mobility, eating, bathing, and communication system. Staff were expected to recognize and assess their resident's inability to perform an ADL and review the most current comprehensive or most recent quarterly assessment. Facility staff were supposed to provide assistance to maximize independence including, but not limited to, grooming, dressing, transfer, ambulation, eating, and communication. Resident #50 Review of Resident #50's Quarterly MDS assessment dated [DATE] reflected a [AGE] year-old male who was admitted to the facility on [DATE] with a BIMS score of 03, indicating severe cognitive impairment. The resident utilized a wheelchair, required supervision with eating, and was totally dependent in the areas of toileting and all transferring. He had diagnoses of dementia, cerebrovascular accident (stroke), hemiparalysis (a common after-effect of stroke that causes weakness on one side of the body), hypertension (when the pressure in your blood vessels is too high (140/90 mmHg or higher) and diabetes. Bowel and bladder care reflected always incontinent. Observation and interview with Resident #50 on 06/12/2024 at 12:45 pm revealed Resident 50's call light was turned on and his door was open. At 1:23 pm Resident #50 yelled out loudly, from his bed, 3 times, I need a change! At 1:28 pm Resident #50 again yelled out loudly, from his bed, 3 times, I need a change! At this time, the surveyor entered Resident #50's room observed him in his bed and asked him if he needed a brief change and if he was both wet and had a bowel movement and Resident #50 said, yes, both. At 1:35 pm, CNA A entered Resident #50's room. After CNA A exited Resident #50's room, surveyor entered his room and asked Resident 50 if his brief had been changed and he said it had been and he was clean. When asked how it made him feel that he was left in a wet dirty brief for 50 minutes he said it made him feel, real bad in a lot of ways and said they could be better. He said it, made me feel like crap and he felt like no one was there to help him and made him feel alone. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676463	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Crimson Heights Health & Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0677 Level of Harm - Actual harm Residents Affected - Few	Interview on 06/11/2024 at 2:25 pm with CNA B revealed staff should respond to call lights as soon as possible and if someone was calling from their room, they should be checked on because something could have happened to the resident. CNA B revealed it is not good resident care for the call light not to be in reach of the resident and a call light should not be located between the back of a bedside table and the wall. CNA B revealed that 50 minutes is too long for a resident to wait for someone to respond to their call light. Interview on 06/11/2024 2:05 pm with CNA A revealed that 50 minutes was too long for a resident to wait for their call light to be answer and residents would feel like their needs were not being meet if they were left in a wet and dirty brief. Interview on 06/13/2024 at 12:18 pm with the DON revealed that call lights should be answered as quickly as possible. She revealed it was not good care for a resident to wait 50 minutes in a wet and soiled brief for it to be changed. The DON revealed it was not good resident care for the resident's call light to be out of reach. She revealed it would not make a resident feel good to sit in a wet soiled brief for 50 minutes and call out for help more than once and for no one to come and help them. It would make the resident feel like no one is listening to them or coming to care for them. Interview on 06/13/2024 at 5:45 pm with the ADM revealed that 50 minutes is not timely for answering a resident call light. He revealed that for a resident to wait that long they could feel isolated, and his call light should have been answered. The ADM revealed a call light should be available and within reach of the resident and each time staff go into a resident's room, they should make sure the call light is in reach. Residents could have had an injury and not be able to get help from the staff if the call light is not in reach. Review of the facility's complaint/grievance report dated 10/26/2023 reflected a grievance that it took too long for staff to respond to the resident's call light. The facility responded to the grievance by stating they would education the staff in answering call lights within a timely manner. Review of facility complaint/grievance report dated 04/19/2024 reflected a grievance that a resident waited 45 minutes to have their call light answered. The administrative staff investigated the grievance and found that it did take 45 minutes for the resident's call light to be answered. Review of facility policy titled Facility Call Lights, Responding To dated 05/05/2023 reflected: Policy - The staff will respond to call lights or other requests for assistance to meet the patient's/resident's needs. Procedures: Respond to call lights and requests for assistance as quickly as practicable.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676463	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Crimson Heights Health & Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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. 47795 Based on observation, interview, and record review, the facility failed to ensure that all drugs and biologicals were stored in locked compartments and inaccessible to unauthorized staff, visitors, and residents for 1 (Crash cart #1) of 8 medication/treatment carts reviewed for medication storage in that: The facility failed to ensure Crash Cart #1 was not left unattended and unlocked. This failure could allow residents, unsupervised access to medical equipment including sharps. Findings Include: Observation on 6/11/2024 at 2:20 pm of Crash cart # 1 revealed the handle was in the unlocked position and unattended on hallway three hundred not in view of the nursing station. Cart # 1 was in a frequently used hallway used by Staff, residents and visitor. Drawers were labeled drawer #1 IV started kit, needles, flashlight, Drawer # 2 Misc. supplies, Drawer # 3 Tubing o2 mask, Drawer # 4 Suction Supplies, Drawer # 5 BP Cup, sterile water, trach kit, Drawer #6 PPE, Cannister, Ambu bag, Bandages. Cart # 1 was secured with the handle placed in the locked position and secured with a numbered plastic tag. Interview with LVN A on 6/12/2024 at 1:00 pm revealed that the crash cart was supposed to be locked and it if is unlocked that means it was used and the nurse that used it is responsible to restock and lock it. She stated she thought the night supervisor was responsible for ensuring it is checked daily, but she is not sure of the process. She stated that she does have residents that wander, and they could be a risk if they were to get access to some of the items in the crash cart and that the crash cart is stored out of sight of the nurse's station. Interview with the DON on 6/14/2024 at 12:30 pm revealed the crash cart was considered a medication cart because it has medical supplies, and her expectation was that all medication carts be secured when not in use. She was made aware of the crash cart being in the unlocked position, it was secured and a plastic tag with a number was secure to the cart. She stated that the night supervisor is responsible to check the crash cart and ensure it is secured. An in-service was given to all licensed nursing staff about the crash cart, and they are responsible if they find it unlocked they are to secure it. She stated that a resident might be harmed with the sharps or other items on the cart. Interview with the ADM on 6/14/2024 at 6:00 pm revealed his expectation was that all medication carts or supply carts be secured per policy. He stated that he was not sure what is on the crash cart, but any medical equipment can be potential harmful to a resident if they were to get access to it. Review on 6/12/2024 at 2:00 pm of Inservice Crash Cart revealed all nursing staff were educated on the securing the crash cart after use on 6/11/2024 and 6/12/2024. Confirmed with staffing sheets all staff signed. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676463	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Crimson Heights Health & Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review on 6/14/2024 at 5:00 pm of policy Medication Storage dated 4/17/2024 In accordance with state and federal laws, the facility will store all drugs and biologicals in locked compartments under the proper temperature and other appropriate environmental controls to preserve their integrity.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676463	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Crimson Heights Health & Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47772 Based on observation, interview, and record review, the facility failed to provide sufficient staff to effectively conduct food and nutrition services for the facility's main dining room. The facility failed to serve meals, at the specific times posted, in the main dining room. This failure placed residents at risk of increased hunger, thirst, frustration, and decreased feelings of self-worth. Findings included: Record review of Resident #66's face sheet, dated 6/12/2024, reflected a [AGE] year-old female who admitted to the facility on [DATE]. Record review of Resident #45's face sheet, dated 6/12/2024, reflected an [AGE] year-old male who admitted to the facility on [DATE]. Record review of Resident #68's face sheet, dated 6/12/2024, reflected a [AGE] year-old male who admitted to the facility on [DATE]. Record review of Resident #75's face sheet, dated 6/12/2024, reflected a [AGE] year-old female who admitted to the facility on [DATE]. Record review of Resident #80's face sheet, dated 6/12/2024, reflected a [AGE] year-old male who admitted to the facility on [DATE]. Record review of Resident #254's face sheet, dated 6/12/2024, reflected a [AGE] year-old male who admitted to the facility on [DATE]. Record review of the facility's posted meal service reflected breakfast mealtime was 7:00 AM; lunch mealtime was 11:30 AM; and dinner mealtime was 5:00 PM. Observation and record review on 06/11/24 at 11:30 AM, in the facility's dining room, revealed residents beginning to congregate for the lunch meal service. Residents were arriving on their own and residents were being assisted by staff. The meal hours posted on the wall just outside the dining room, indicated lunch service began at 11:30 AM. Observations on 06/11/24 at 12:07 PM, in the facility's dining room, revealed meal service had not begun and the residents had not begun to eat lunch. Interview and observation on 06/11/24 at 12:08 PM with Resident #66 revealed her sitting at a dining room table. Interview with Resident #66 revealed she had been waiting for a long time to be served lunch and she had not been provided with any food. She was very hungry and having to wait for 38 minutes to be served made her feel like she was not thought of as worthy. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676463	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Crimson Heights Health & Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and observation on 06/11/24 at 12:10 PM with Resident #75 revealed her sitting at a dining room table. Interview with Resident #75 revealed she had been waiting for a long time to be served lunch and she had not been provided with any food. She was very hungry and having to wait for 40 minutes to be served made her feel like she was not valued. Interview and observation on 06/11/24 at 12:12 PM with Resident #80 revealed him sitting at a dining room table. Interview with Resident #80 revealed he had been waiting for a long time to be served lunch and he had not been provided with any food. He was hungry and having to wait for 42 minutes to be served made him feel bad. Observations on 06/11/24 at 12:15 PM, in the facility's dining room, revealed meal service had started to begin. Residents began receiving their meals. The delivery of the meal service was completed at 12:27 PM. Observations and record review on 06/12/24 at 8:14 AM, in the facility's dining room, revealed residents congregated for the breakfast meal service. Residents were seated in the dining room at the tables. Record review of the posted meal hours, posted on the wall just outside the dining room, indicated breakfast service began at 7:00 AM. At the time of the observation, staff were serving residents, but 14 residents had not been provided with their breakfast meal. Interview and observation on 06/12/24 at 8:21AM with Resident #68 revealed him sitting at a dining room table. He had just been approached by staff and served his breakfast meal. Interview with Resident #68 revealed he had been waiting for about an hour to eat. He felt annoyed he had to wait for such a long time. Interview and observation on 06/12/24 at 8:25 AM with Resident #254 revealed him sitting at a dining room table. He had just been approached by staff and served his breakfast meal. Interview with Resident #254 revealed he had been waiting for about an hour to eat. He was angry he had to wait for such a long time. Observation on 6/12/2024 at 8:28 AM of Resident #45 revealed him sitting in his wheelchair at a dining room table. He was observed scooting to the edge of his wheelchair inching towards to the breakfast meal of the resident to his immediate right. There was no breakfast meal in front of him at the time. Both his arms were slightly extended, parallel to the ground, and his hands were moving up and down, at the wrists, like someone would say hello or goodbye. A staff member, CNA C, was observed having re-directed Resident #45 to stay in his seat; Resident #45 received his breakfast meal. Interview on 6/12/2024 at 8:31 AM with CNA C revealed she knew Resident #45 very well. She described his body movements as his way of saying that he was hungry and wanted to eat. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676463	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Crimson Heights Health & Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/12/24 at 10:27 AM with the DM revealed the facility started serving breakfast at 7:00 AM. The first residents served breakfast were the residents who ate in their rooms on the halls; then, the dining room was served last. The hall trays were sent to the halls beginning at 7:00 AM, where a nursing staff member met the carts and checked the tickets prior to service for the residents. The meals served to the residents on the hallways were completed by 7:30 AM to 7:45 AM. The kitchen, however, would not be able to start serving the residents in the dining hall until a nurse came to check the tickets and trays for accuracy. The expected time of the nurse's arrival at the dining room was between 7:30 AM and 7:45 AM. The estimated time it took for nursing staff to check the tickets and serve residents in the dining hall was 15 minutes. If the nurse arrived at 7:30 AM, and it took 15 minutes to check tickets and serve the trays, the residents in the dining hall would have waited at their table for 45 minutes for breakfast. If the nurse arrived at 7:45 AM, and it took 15 minutes to check tickets and serve the trays, the residents in the dining hall would have waited at their table for 1 hour for breakfast. The DM stated that the nursing staff did not report to the dining hall between 7:30 AM to 7:45 AM. Furthermore, the kitchen staff would often have to wait an additional 15 minutes for the nurse to arrive to check the tickets and trays. When the nursing staff did not arrive until 8:00 AM, and it took 15 minutes to check tickets and serve the trays, the residents in the dining hall would have waited at their table up to 1 hour and 15 minutes for breakfast. The DM stated the lunch service, which began at 11:30 AM, and how the same method and times were congruent. The DM stated the residents in the dining room had to wait a long time to be served their breakfast and lunch. The DM stated she had addressed the late arrival of the nurse to the dining room, with the ADONs, DON, and the ADM. A schedule was created to address the consistency of the nurse's arrival times, but that schedule had not been effective. At times, the DM stated she utilized the audible paging system for a nurse to report to the dining hall, but that had been ineffective as well. For dinner, all residents were served in their rooms, where the delays did not occur. Interview on 06/12/24 at 10:47 AM with the [NAME] revealed that residents had to wait way too long in the dining hall before they got the chance to eat. The kitchen staff had to wait for a nurse to check trays, which was supposed to happen between 7:30 AM to 7:45 AM, but they were rarely on time. One time, the kitchen staff had to wait so long, that she had called the DM on her day off for help. The call to her DM was ineffective, meaning the wait was not shortened. She stated that residents had complained, and even described residents as mad. She had observed ambulatory residents (those who could have moved on their own) had gotten up and left before meal service had even begun. Observations on 06/12/24 at 11:29 AM reflected 26 residents waiting in dining hall for lunch. Interview on 06/12/24 at 11:54 AM with LVN E revealed she had reported to the dining hall on occasion to check the tickets and trays for residents who ate in the dining hall. She stated there was not a written schedule, but she would usually report to the dining hall about 11:45 AM for the lunch meal. When she would arrive, the dining hall was usually full of residents waiting for their meal. Interview and observation on 06/13/24 at 1:10 PM with LVN F revealed nursing staff reported to the dining hall to check tickets and trays before the meals were served to the residents. She stated the schedule was posted at one time in the staffing folder, but it was not there anymore. LVN F was observed, at the nursing station, looking through the staffing book, but the observation reflected the schedule was not there. Nursing staff had a mutual understanding of who was assigned on which days and which meals. The nurse, who was checking tickets, was supposed to be at the dining hall at 7:00 AM for breakfast and 11:30 for lunch. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676463	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Crimson Heights Health & Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 6/13/2024 at 1:22 PM with LVN G revealed she was a nursing staff member who reported to the dining room at times to check tickets for resident's trays. She stated she reported to the dining hall between 7:00 AM and 7:30 AM. The meal service usually took about 15 minutes. If a resident had to wait long to eat, risks they might have faced were being hungry, thirsty, and sometimes angry. Diabetic residents had their blood sugars checked at 6:30 AM. If residents were at risk of low blood sugar, they would have received a small snack, usually orange juice, to combat low blood sugar to tide them over until breakfast. LVN G stated she had been as late as 8:00 AM in reporting the dining hall to check tickets, but those times were rare. Interview on 06/13/24 at 3:08 PM with KA revealed kitchen staff had been instructed to wait for the nurse to come to the dining hall and check tickets before they could start serving the residents. She worked 4 days a week and stated it was quite frequent kitchen staff would have to wait for a nurse, up to 30 minutes past the expected time, to come to the kitchen to proceed feeding the residents in the dining hall. She had observed residents at their tables looking bored, had heard residents calling out for food, had seen residents come to kitchen door to look in the kitchen, and one occasion heard a resident having pounded on the door. Interview on 06/13/24 at 3:23 PM with the ADON B revealed staff started transporting residents to the dining hall for breakfast around 6:45 AM for breakfast at 7:00 AM. Nursing staff usually reported to the dining hall between 7:30 AM to 7:45 AM to check the tickets and the trays before having served the to the residents. According to the times the meals started, and the times nursing staff arrived, residents were having to have waited 45 minutes to 1 hour to have their breakfast. If a resident was placed in a situation to wait at their table for 45 minutes to 1 hour before being served, they risked aggravation for having to wait and confusion as to why they were waiting. Interview on 06/13/24 at 4:07 PM with the ADM revealed he expected his staff to follow facility policy begin serving meals on time. A failsafe in place to identify and correct late meal services was management staff performing observations and ensuring mealtimes were being followed. Risks a resident might face for extended waiting times with meals were general dissatisfactions with the meal service. The failure for residents experiencing delayed meal services would have fallen on the nursing staff reporting to the dining hall on time to perform their duties. Record review of the facility's Meal Service in the Dining Room Policy, dated 6/20/2023, indicated the facility was supposed to serve meals at the times specified/posted.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676463	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Crimson Heights Health & Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46708 Based on observation, interview and record review the facility failed to ensure residents received the diet ordered per physician order for 1 of 3 residents (Resident #2) reviewed for therapeutic diets. The facility failed to provide Resident #2 with 1 Cream Soup at all meals as ordered by a physician. This failure could affect residents who had physician orders for 1 cream Soup at all meals and could put the residents at risk for weight loss and a decline in health. Findings: Review of Resident #2's face sheet, undated revealed an admitted [DATE] with a readmitted [DATE] with diagnoses which included Alzheimer's disease, Parkinson's disease, xerosis cutis (prevalent condition resulting from inadequate hydrolipids in the skin), cerebellar stroke syndrome happens when blood supply to the cerebellum is stopped, anxiety disorder due to known physiological condition, vitamin deficiency, functional intestinal disorder (disorders characterized by chronic gastrointestinal symptoms), and hyperlipidemia (an of cholesterol and triglycerides in your blood). Review of Resident #2's MDS assessment dated [DATE] revealed a BIMS score of 10, suggesting moderately impaired cognition. Review of Resident #2's Care Plan Problem Start Date 07/06/2023 category: Nutritional Status, Resident #2 received a bite sized diet and was at risk for malnutrition and weight fluctuations due to difficulty chewing serve diet as ordered per medical doctor. Review of Resident #2 General Physician Orders dated 01/08/2024 revealed an order for 1 cream Soup at all meals date open ended. Observation of lunch on 06/12/2024 at 12:09 pm revealed a meal ticket for Resident #2 that listed cream soup and no cream soup was served with Resident #2's lunch. Interview on 06/12/2024 at 12:09 pm with the Dietary Manager confirmed that Resident #2 was not served cream soup with her meal and had never been served cream soup with any of her meals as part of a dietary order. She said she never received any notice that Resident #2 was supposed to receive cream soup with her meals. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676463	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Crimson Heights Health & Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of the facility Policy Nutritional Policies and Procedures dated 06/20/2023 reflected facility policy is to obtain a physician's order for all therapeutic and mechanically altered diets. Those patients or residents who require therapeutic diets are assessed by the dietitian for appropriate individualized modifications. Use of a therapeutic and chemically altered diet is continually monitored to ensure they continue to be medically indicated. Prepare and serve all therapeutic and mechanically altered diets as planned. Check all trays for accuracy before they are served to the patient/ resident.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676463	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Crimson Heights Health & Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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** 46708 Based on interview and record review, the facility failed to ensure that medical records were accurately documented for 1 of 13 residents (Resident #44) reviewed for accurate medical records, in that: 1. The facility failed to ensure Resident #44's vitals documentation accurately reflected her mealtimes and food intake. This deficient practice could result in errors in care and treatment and place residents at risk for low blood sugar, malnutrition, and potential inaccurate treatment for weight gain or loss. The findings were: Record review of Resident #44's face sheet (undated) revealed a [AGE] year old femail admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of dementia, hypo-osmolality (a condition where the levels of electrolytes, proteins, and nutrients in the blood are lower than normal and hyponatremia (serum sodium concentration of less than 135 units of measure used for electrolytes), epistaxis (nosebleed), type 2 diabetes mellitus with hypoglycemia (a condition in which your blood sugar level is lower than the standard range with coma), diabetes mellitus due to underlying condition with other diabetic kidney complication, diabetes mellitus due to underlying condition with diabetic chronic kidney disease, end stage renal disease, long term use of anticoagulants, acquired absence of right upper limb below elbow, presence of cardiac pacemaker and edema. Review of annual minimum data set (MDS) assessment for Resident #44 dated 03/30/2024 reflected a brief interview for mental status (BIMS) score of 2, indicating severe cognitive impairment. MDS reflected a helper did all the effort involved in Resident #44's eating, resident did none of the effort to complete the eating activity. Review of Resident #44's care plan problem start date 05/20/2024 reflected Resident #44 had experienced an 8.3% weigh loss in 90 days related to decreased appetite and calorie intake. Approach start date 05/20/2024 - monitor and record intake of food. Approach start date 05/20/2024 - monitor/record weight as ordered by physician. A review of facility's mealtimes reflected breakfast 7:00 am, lunch 11:30 am, and dinner 5:00 pm A review of Resident #44's vitals reflect the following mealtimes and food intake: 05/13/2024 10:44 am Breakfast 76-100% 12:48 pm Lunch 76-100% 12:48 pm PM Snack - None 12:48 pm Dinner - None (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 09/27/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676463	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Crimson Heights Health & Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/14/2024 1:33 pm Lunch 76-100% 1:33 pm PM Snack - None 1:33 pm Dinner - None 05/15/2024 12:59 pm Lunch 76-100% 12:59 pm PM Snack 76-100% 12:59 pm Lunch 76-100% 12:59 pm Dinner - None 05/16/2024 12:58 pm Breakfast 76-100% 12:58 pm PM Snack - None 12:58 pm Dinner - None 05/17/2024 1:39 pm Lunch 76-100% 1:39 pm PM Snack 76-100% 1:39 pm Dinner None 05/18/2024 1:14 pm Breakfast 51-75% 1:14 pm Lunch 76-100% 1:14 pm PM Snack 26-50% 1:22 pm Dinner 76-100% 05/19/2024 1:11 pm PM Snack 76-100% 1:11 pm Lunch 76-100% 1:11 pm Dinner76-100% 1:22 pm Lunch 76-100% 05/20/2024 12:54 pm Breakfast 26-50% 12:54 pm Lunch 1 - 25% 12:54 pm PM Snack 26-50% (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 09/27/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676463	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Crimson Heights Health & Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12:54 pm Dinner 05/21/2024 1:24 pm Breakfast 76-100% 1:24 pm Lunch 76-100% 1:24 pm PM Snack 76-100% 1:24 pm Dinner None 05/22/2024 1:28 pm PM Snack 76-100% 1:28 pm Dinner None 1:28 pm PM Snack 76-100% 05/23/2024 1:54 pm Lunch 76-100% 1:54 pm PM Snack None 1:54 pm Diner None 05/24/2024 11:39 am Breakfast 76-100% 11:40 am AM Snack 76-100% 11:40 am Lunch 76-100% 11:40 am Dinner None 05/25/2024 1:46 pm Breakfast 76-100% 1:46 pm Lunch 76-100% 1:46 pm PM Snack 76-100% 05/26/2024 11:32 am Breakfast 76-100% 11:33 am AM Snack None 11:33 am Lunch 51-75% 11:37 am Dinner 51-75% 05/27/2023 9:25 am Breakfast 76-100% 9:25 am AM Snack 76-100% (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 09/27/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676463	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Crimson Heights Health & Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1:19 pm Lunch 76-100% 1:19 pm PM Snack None 1:19 pm Dinner None 05/28/2024 1:11 pm Breakfast 76-100% 1:11 pm PM Snack 76-100% 1:11 pm Dinner None 05/29/2024 12:50 pm Dinner 76-100% 12:50 pm Lunch 76-100% 12:50 pm PM Snack 76-100% 12:50 pm Dinner None 05/30/2024 1:43 pm Breakfast 76-100% 1:43 pm Lunch 76-100% 1:43 pm PM Snack None 1:43 pm Dinner None 05/31/2024 1:24 pm Lunch 76-100% 1:24 pm PM Snack None 1:24 pm Dinner None 06/01/2024 1:04 pm PM Snack 76-100% 1:04 pm Lunch 76-100% 1:04 pm Breakfast 76-100% 1:04 pm Dinner 76-100% 06/02/2024 11:18 am Breakfast 1 - 25% 11:18 am AM Snack None 12:38 pm PM Snack None (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 09/27/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676463	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Crimson Heights Health & Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12:38 pm Lunch 51-75% 12:38 pm Dinner 76-100% 06/03/2024 1:31 pm Lunch 76-100% 1:31 pm PM Snack None 1:31 pm Dinner None 06/04/2024 12:51 pm Breakfast 76-100% 12:51 pm Lunch None 12:51 pm PM Snack None 12:51 pm Dinner None 06/05/2024 12:59 pm Lunch 76-100% 12:59 pm PM Snack 76-100% 12:59 pm Dinner 76-100% 06/06/2024 1:12 pm Breakfast 76-100% 1:12 pm Lunch 76-100% 1:12 pm PM Snack None 1:12 pm Dinner None 06/07/2024 1:24 pm Breakfast 76-100% 1:24 pm Lunch 76-100% 1:24 pm PM Snack 76-100% 1:24 pm Dinner 76-100% 06/08/2024 1:43 pm Lunch 76-100% 1:43 pm PM Snack 76-100% 1:43 pm Dinner 76-100% 06/09/2024 9:19 am Dinner None (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 09/27/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676463	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Crimson Heights Health & Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	06/10/2024 1:07 pm Lunch 76-100% 1:08 pm PM Snack None 1:08 pm Dinner None 06/11/2024 1:37 pm Breakfast 76-100% 1:37 pm Lunch 51 - 75% 1:37 pm PM Snack None 1:37 pm Dinner None 06/12/2024 1:16 pm Lunch 51 - 75% 1:16 pm PM Snack 26 - 50% 1:32 pm Dinner None 06/13/2024 12:42 Breakfast 76-100% 12:42 Lunch None 12:42 PM Snack None 12:42 Dinner None An interview on 06/13/2024 with the DON at 4:15 pm revealed, when shown that the entries in Resident #44's electronic medical record were not accurate because several of them occurred at the same time and the entries for dinner and the amount recorded eaten for dinner occurred before dinner was served. The DON said that there was a facility policy for staff to have 100% documentation for tasks and if the task did not occur on that staff member's shift, but the electronic medical record required an entry, the staff made an entry for that event to comply with the 100% documentation requirement. The DON revealed that this was not good practice because inaccurate recording of a resident's food can affect a resident's blood sugar, dialysis, and nutrition status. Interview on 06/13/2024 with the ADM at 5:45 pm revealed resident care information and food intake should be accurately documented in their electronic medical record because it could affect the interventions that are needed by residents. Review of the facility's policy Documentation - Licensed Nursing dated 05/05/2023 reflected: The nursing staff will be responsible for recording care and treatment, observations and assessment and other appropriate entries in the patient/resident clinical record.		