STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455538	A. Building B. Wing	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Manor	4400 Gulf St Groves, TX 77619

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33460 Based on observation, interview, and record review the facility failed to ensure residents had the right to be treated with respect and dignity including the right to retain and use personal possessions including furnishings, and clothing, as space permitted, unless to do so would infringe upon the right or health and safety of other residents for 4 (Residents #9, #13, #47, and #268) of 18 residents reviewed for the right to retain and use personal possessions. The facility failed to return all their personal clothes from the laundry for Residents #9,#13, #47 and #268 from 04/17/24 to 04/22/24. This failure could place residents at risk of having their rights infringed upon and could lead to the residents not being able to use their personal clothes. Findings Included: 1. Record review of Resident #9's admission record dated 04/24/24 indicated an [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, Alzheimer's Disease (progressive disease that destroys memory), anxiety (a feeling of worry, nervousness and unease) and chronic kidney disease (kidneys not working normally). Record review of Resident #9's quarterly MDS assessment dated [DATE] indicated his BIM score of 07 which indicated moderately impaired cognition. He was independent with dressing and required limited assistance with bathing and grooming. Record review of Resident #9's care plan dated 04/24/24 indicated he required limited assistance with dressing. The goal was for Resident #9 to dress self over the next 90 days. Interventions included assisting Resident #9 to select clothing that is clean, in good repair, fits, and is appropriate for the season. During an interview on 04/22/24 at 3:15 p.m., Resident # 9 stated we are missing our clothes (all my pants and 4 shirts) and was because the laundry lady had a vacation. During an observation on 04/22/24 at 3:30 p.m., the laundry supervisor was putting clothes in the resident's closets. (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: 455538	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2024
NAME OF PROVIDER OR SUPPLIER Magnolia Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 4400 Gulf St Groves, TX 77619	

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/23/24 at 2:30 p.m., Resident #9 said my clothes are back in my closet now. 2. Record review of Resident #13's admission record dated 04/23/24 indicated an [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, left sided weakness, stroke, anxiety, and depression. Record review of Resident #13's quarterly MDS assessment dated [DATE] indicated his BIMS was 14 which was cognitive intact. Record review of Resident #13 care plan dated 4/23/24 indicated he required extensive to total assistance to bathing and grooming. During an interview on 04/22/24 at 9:00 a.m., Resident #13 said in a loud voice he was not getting his clothes back from the laundry and he had been waiting days for his clothes to return. During an interview on 04/23/24 at 09:04 a.m., Resident #13 stated I got back three shirts but some of my shorts are still missing. 3. Record review of Resident #47s admission record dated 04/24/24 indicated a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, heart disease and senile degeneration of the brain. Record review of Resident #47's quarterly MDS assessment completed on 02/20/24 indicated his BIMS was 06 and he required supervision with bathing and grooming. Record review of Resident #47's care plan indicated he required supervision with grooming and bathing. The interventions included set up assistance to complete bathing and grooming. During an interview on 4/22/24 at 12:35 p.m. Resident # 47 said I can't find my clothes. He said this was the second time my clothes had been lost and he did not know the date the clothes were lost before. 4. Record review of Resident #268' s admission record dated 04/17/24 indicated a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, dementia and high blood pressure. Record review of Resident #268's admission MDS was not completed. Record review of Resident #268's care plan indicated ineffective individual coping related to depression. During an interview on 4/22/24 at 9:40 a.m., Resident #268 was wandering on the secure unit saying he was not going to change his clothes because they were not bringing clothes back to him. During an observation on 4/22/24 at 942 a.m., there was no clothes in Resident #268's closet. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/22/24 at 9:45 a.m., LVN G said they have been going to the laundry and get clothes for the residents. She said she did not have time this morning to go get the clothes for the resident. She said normally the laundry brings the clothes to each room and said but last few days the laundry supervisor had taken some time off. During an interview on 4/23/24 at 11:45 a.m. with the Administrator and laundry supervisor in the Administrator's office. The administrator said she was notified on Sunday the nursing was having to get resident's clothes out of laundry. The Laundry Supervisor said while she was on vacation her relief kept calling in and not coming into work. The Administrator looked at the computer and said the last day her relief worked was on Tuesday 4/16/24. The laundry Supervisor said no one was passing out the resident personal clothes until she got back on Monday 4/22/24. The Administrator said her expectation was for resident personal clothes to be washed and dried and returned by next morning. During an observation on 4/24/24 at 9:00 a.m., the Administrator was in Resident #47's room helping the resident locating his clothes.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30664 Based on observations, interviews, and record reviews, the facility failed to ensure the right to formulate an advance directive was provided for 2 of 6 residents reviewed for resident rights. (Resident #27 and #62) * The facility did not have a valid Out of Hospital-Do Not Resuscitate (OOH-DNR) for Residents #27 and #62. This failure could place residents at risk of lifesaving procedures being performed against their wishes resulting in bruising, broken ribs, electrical shocking of the heart, having a tube placed in the throat and provided artificial breathing methods, and possibly being brought back to life in an unaware and unresponsive state. Findings included: Record review of a face sheet dated 04/24/24 indicated Resident #27 was an [AGE] year-old female admitted on [DATE]. Her diagnoses included chronic obstructive pulmonary disease (a lung disease that blocks airflow making it difficult to breathe), hypertension (condition in which the force of the blood against the artery walls is too high), and congestive heart failure (a condition in which the heart's main pumping chamber (left ventricle) is weak, becomes stiff, and unable to fill properly). She was designated Do Not Resuscitate. Record review of the current MDS assessment with an ARD of 02/25/24 indicated Resident #27 had minimal difficulty hearing, had unclear speech, she was rarely/never understood, sometimes understood others, and had moderately impaired cognitive skills for daily decision making. Record review of the EMR on 04/23/24 indicated Resident #27 had a scanned OOH-DNR dated 04/11/22 with no printed name of physician signature, printed name, date signed, and no license number of physician under the Physician's Statement section. Record review of the care plan on 04/24/24 indicated Resident #27 requested a code status of DNR with interventions of inform staff of code status per facility policy, monitor for decrease in change of condition, report to M.D. and responsible party, and monitor for any changes in resident's code status. During an observation and interview on 04/23/24 at 08:10 a.m. Resident #27 was up in her wheelchair propelling herself on the secured unit. She was not able to answer questions appropriately. During an interview and record review on 04/24/24 at 10:27 a.m. the DON said DNRs were to be completely filled out including the physician statement section unless they have 2 physicians signing. She confirmed Resident #27's DNR's Physician Statement section was left blank. She said the outcome would be the DNR would not be valid, and procedures would have to be started. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of a face sheet dated 04/24/24 indicated Resident #62 was a [AGE] year-old female admitted on [DATE]. Her diagnoses included myocardial infarction (blood flow decreases or stops in one of the blood vessels of the heart causing tissue death), cerebral infarction (lack of adequate blood supply to brain cells deprives them of oxygen and vital nutrients which can cause parts of the brain to die off), diabetes mellitus type 2 (chronic condition that affects the way the body processes blood sugar), hypertension (condition in which the force of the blood against the artery walls is too high), respiratory failure (a serious condition that makes it difficult to breathe on your own), and tracheostomy (surgical opening that is made through the front of the neck into the windpipe). Record review of the current MDS assessment with an ARD of 02/21/24 indicated Resident #62 had adequate hearing, had no speech, she was rarely/never understood, she rarely/never understood others, and had severely impaired cognitive skills for daily decision making. Record review of the EMR on 04/23/24 indicated Resident #62 had a scanned OOH-DNR dated 02/14/24 with telephone consent in Section C Declaration by a qualified relative of the adult person who is incompetent or otherwise incapable of communication and in the bottom section All persons who have signed above must sign below, acknowledging that this document has been properly completed and there were 2 witness signatures in the Witness section. During an observation and interview on 04/22/24 at 09:43 a.m. Resident #62 was up in bed with a tracheostomy with continuous oxygen. She had limited speech. During an interview on 04/24/24 at 10:27 a.m. the DON said DNRs were to be filled out by the person who was initiating the DNR. She said a telephone consent instead of signature on Resident #62's DNR was not acceptable. She said the outcome would be the DNR would not be valid and procedures would have to be started. During an interview on 04/24/24 at 10:04 a.m. the MR staff said when she received DNRs she would check them and if they did not look right she would give them to nursing or SW. During an interview on 04/24/24 at 12:20 p.m. the SW said she just started 3 days ago but it would be her responsibility to do audits on DNRs to ensure they were complete and filled out correctly. Record review of an Advanced Directive policy dated June 2016 had no information about the accuracy and completeness of an OOH-DNR. According to Completing the Texas Out of Hospital Do Not Resuscitate Form accessed on 04/23/24 at https://www.dshs.texas.gov/dshs-ems-trauma-systems/out-hospital-do-not-resuscitate-program indicated Section C: The relative acting on behalf of the patient must check the appropriate box in this section, sign and date the form, and then print or type his/her name Section D: The physician must check the appropriate box in this section, sign and date the form, print or type his/her name, and provide his/her license number Witnesses Two witnesses or a notary public must sign that they have witnessed the patient's signature or the signature of a person(s) acting on the patient's behalf in sections A-E

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25779 Based on interview and record review, the facility failed to provide services as outlined by the comprehensive care plan, to meet professional standards of quality for consultation with the resident's physician when there was a significant change in the resident's condition or a need to alter treatment significantly for one (Resident #39) of 18 residents reviewed for following physician's orders. The facility failed to implement Resident #39's care plan when his blood pressure and/or heart rate fell below prescribed parameters and did not notify his physician in April 2024. (04/03/24, 04/08/24, 04/11/24, 04/12/24, 04/13/24, 04/20/24, 04/21/24, 04/22/24, and 04/23/24). The failure placed residents, who required blood pressure and heart rate monitoring, at risk for complications due to delayed physician intervention. Findings included: Record review of Resident #39's clinical record indicated he was admitted on [DATE], was [AGE] years old with diagnoses which included hypertension (high blood pressure). Record review of the annual MDS assessment dated [DATE] indicated Resident #39 had a BIMS score of 14 which indicated cognition was cognitively intact. He was diagnosed with hypertension. Review of Resident #39's care plan dated 12/28/21 to present, indicated the resident had diagnosis of hypertension and takes hypertensive medication. The interventions included administering medications per order, monitor labs, and reporting abnormalities to MD (medical doctor). Record review of physician orders dated April 2024 indicated Resident #39 was prescribed Coreg 3.125 mg (used to lower blood pressure) twice daily for hypertension. Hold if systolic blood pressure below 110, diastolic blood pressure below 60, or heart rate below 60. Record review of the MAR dated April 1 - 24, 2024 indicated on the following dates and times, Resident #39's Coreg 3.125 mg was held due to blood pressure and/or heart rate outside the prescribed parameters and there was no indication in the clinical record the physician had been notified: *04/03/24 at 8:00 a.m., *04/08/24 at 8:00 a.m., *04/11/24 at 8:00 p.m., *04/12/24 at 8:00 a.m., *04/13/24 at 8:00 a.m., (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*04/20/24 at 8:00 a.m., *04/21/24 at 8:00 p.m., *04/22/24 at 8:00 p.m., and *04/23/24 at 8:00 a.m. Record review of nurses' notes for Resident #39 dated 03/29/24, through 04/18/24 (last entry), gave no indication of notifying the physician of the blood pressure medication being held for 9 of 47 opportunities. During joint interview and record review on 04/24/24 at 11:30 AM, UM D and LVN E said anytime a resident has vital signs out of prescribed parameters, and medication was withheld, the physician should be notified, especially if there was a pattern of medications being withheld. LVN E said the physician for Resident #39 should have been notified and made aware of withholding of the blood pressure medications. UM D said if any medication that was held or refused three times in a row, the physician should be notified and documented in the resident's clinical record. UM D and LVN E sais Resident #39's clinical record lacked documentation of physician notification. Both said they had received training on when to notify physicians on residents' behalf. During an interview and record review on 04/24/24 at 11:45 a.m., the ADON reviewed Resident #39's current electronic MAR and progress notes and confirmed the absence of documentation of physician notification when medications were held. The ADON said if residents have any parameters with medications, and medication was withheld, the physician must be made aware immediately. The ADON said physicians needed to know of residents' vital signs being outside prescribed parameters. She added if vital signs were consistently out of range, negative outcomes could include falls, dizziness, among other signs or symptoms. During an interview and record review on 04/24/24 at 9:08 a.m., the DON said her expectations were for residents to have documentation in clinical record including physician notification of any medication being withheld. She said she would expect staff to notify physician for each occurrence of being withheld. She confirmed there was no documentation the physician was notified when Resident #39's medications were withheld and should have been. The policy Physician Notification dated revised January 2024 indicated . The types of conditions which arise frequently are listed. vital signs .It is the responsibility of the nursing staff to observe the change, make an assessment, and notify the physician as indicated.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47879 Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse were reported, but not later than 2 hours after the allegation is made, if the events that cause the allegation involves abuse or result in serious bodily injury, to the State Survey Agency, for 1 (Resident #2) of 16 residents reviewed for reporting allegations of abuse. The facility failed to report an allegation of physical abuse within 2 hours to the State Agency when Resident #2 reported to facility staff that Resident #1 hit/slapped her in the head. This failure could place residents at risk of abuse, physical harm, mental anguish, and emotional distress. Findings included: 1. Record review of a face sheet dated 4/22/2024 indicated Resident #1 was a 68-years-old, admitted to the facility on [DATE]. Her diagnoses included unspecified intellectual disabilities (a condition that affects a person's ability to learn and function at an expected level), Down Syndrome (genetic disorder caused when abnormal cell division results in extra genetic material from chromosome 21), benign lipomatous neoplasm (benign tumors of fat cells that present as soft, painless masses most commonly seen on the trunk, but can be located anywhere on the body), malignant neoplasm of connective and soft tissue (type of cancer that affect the connective tissues in our bodies: muscle, nerves, blood vessels and fats), morbid (severe) obesity (being more than 10 pounds overweight), hypertension (condition in which the force of the blood against the artery walls is too high), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). Record review of a MDS assessment dated [DATE] indicated Resident #1 was usually able to make herself understood and usually understand others. She had a BIMS of 02 (severely impaired cognitively). She has behaviors of inattention and disorganized thinking. She required maximum assistance for most ADLs. She was always incontinent of bowel and bladder. Record review of Resident #1's care plan dated 4/23/2024 indicated Resident #1 had behavioral symptoms: Resident #1 has physical behavioral symptoms directed at others (hit another resident). Interventions included to refer to psych services; provide medication as ordered; record behaviors, monitor pattern of behavior (time of day, precipitating factors, specific staff or situations), notify MD; remind resident that behavior is not appropriate; and remove from situation; allow time to calm down. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's progress note dated 3/29/2024 at 2:24 p.m. authored by the ADON indicated she was notified by staff that Resident #1 slapped another resident. ADON went to the front sitting area and Resident #1 was noted sitting in her wheelchair, behind the couch. The ADON asked Resident #1 what happened, and she stated, I was trying to watch the TV but this lady was in the way, so I hit her. ADON asked Resident #1 to please come with her to do a face-to-face video call with facility NP. NP did not feel resident was a threat to harm herself nor harm others. Resident #1 was reminded that it was not ok to hit people and if she needs assistance to please call staff for help. The PCP was notified of the incident, new orders received to continue Levaquin for UTI and to start Depakote 125mg bid dx mood stabilizer and Ativan 0.5mg q 6hrs prn agitation. Family and NP notified of new orders. Record review of Resident #1's progress notes dated 3/29/204 at 2:00 p.m. authored by the NP indicated she received a face time call from ADON at facility, Resident #1 was present for the call, Resident #1 hit another resident in the common area while watching TV. When NP asked Resident #1 why she hit the other resident, she replied, She was in front of the TV. Discussion continued and Resident #1 verbalized understanding that it was not ok to hit other residents. She could move away from the situation or have a nurse assist her with any issues. Resident #1 agreed that it was not ok to hit people and she would not touch other residents. Further review revealed the NP documents at this time, I do not feel patient is a threat or harm to herself or others. Patient is on day three of Levaquin being treated for a Urinary Tract Infection. and ordered patient to start Depakote 125mg BID and Alprazolam 0.5mg q 6 hours as needed. Patient is pleasant and stable at the end of call. ADON or facility to call NP back with any changes in condition or additional issues. During an observation and interview on 4/22/2024 at 11:09 a.m., Resident #1 sitting up in wheelchair in room, she said she did not recall the incident involving her and Resident #2 that happened on 3/29/2024. Resident #1 said that she knew that she was not supposed to hit other residents or staff. 2.Record review of a face sheet dated 4/22/2024 indicated Resident #2 was [AGE] years old, initially admitted to the facility on [DATE]. Her diagnoses Alzheimer's disease (a progressive disease beginning with mild memory loss and possibly leading to loss of the ability to carry on a conversation and respond to the environment), disorder of lipoprotein metabolism (condition that your body may not have enough enzymes to break down lipids) osteoarthritis of right hand (swelling and irritation that causes pain and stiffness in the hand joints), anxiety disorder (persistent and excessive worry that interferes with daily activities) and depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). Record review of a MDS assessment dated [DATE] indicated Resident #2 was able to make herself understood and understand others. She had a BIMS of 12 (moderately impaired cognitively). No behaviors identified. She was independent with most ADLs but required supervision with shower/bathing and toileting hygiene. She was occasionally incontinent of bladder and bowel. Record review of Resident #2's care plan dated 4/23/2024 indicated Resident #2 has diagnosis of anxiety disorder with physical manifestations of anxiety as evidence by outbursts. Interventions included refer to deer oaks psych services; assess changes in mental status; assess and record behaviors, determine pattern of behavior (time of day, precipitating factors/situations; discuss with physician and team a trial period of (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	antianxiety medication therapy; and touch hands/shoulder to show caring or provide comfort. provide 1-1 interaction read a story/talk about events (weather/etc.). Record review of Resident #2's progress notes dated 3/29/204 at 2:33 p.m. authored by UM D indicated that resident came to nurse and stated another resident hit her on top of head. when asked what happened resident stated I was setting on the couch watching tv, and she just hit me. She told me to quit telling people what to do. head to toe assessment initiated, no visible injuries noted. resident stated the back of her head hurt. 4 out of a 0 to 10 pain level prn Tylenol given. RP notified RP stated, I was afraid this was coming; she is such a busy body. No concerns from RP, MD and DON notified. During an observation and interview on 4/22/2024 at 11:30 a.m., Resident #2 was sitting in TV room visiting with other residents, she said she did not recall the incident involving her and Resident #2 that happened on 3/29/2024. Resident #2 said she got along with everyone at the facility, she denied having an altercation with another resident. During an interview on 4/23/2024 at 2:15 p.m., with CNA B said on 3/29/2024 around 1:30 p.m., she was returning to facility from lunch and when she entered the facility from TV sitting area door, she observed Resident #1 hit/slap Resident #2 on the head, she said Resident #2 was sitting on the end of couch with other residents watching TV, Resident #1 wheeled up behind couch and slapped/hit Resident #2 on the head. CNA B said she immediately separated the two residents and reported the incident to the charge nurses. CNA B said Resident #1 said she could not see the TV and wanted Resident #2 to move her head. She said she has been trained on abuse and neglect and was aware to report any allegations of abuse to the charge nurse and/or ADON/DON immediately. During an interview on 4/24/2024 at 9:10 a.m., LVN C said she recalled the incident between Resident #1 and Resident #2 on 3/29/2024. She said she did not witness the altercation but was the charge nurse for Resident #2 and was notified by CNA B and Resident #2 regarding the incident as soon as it occurred around 1:30 p.m. LVN C said she immediately notified ADON, DON, RP, and MD of the incident. She said she has been trained on abuse and neglect and was aware to report any allegations of abuse to the administrator/Abuse Prevention Coordinator immediately, the day of incident Abuse Prevention Coordinator not working, so she notified ADON & DON. During an interview on 4/24/2024 at 10:10 a.m., ADON said she recalled the incident between Resident #1 and Resident #2 on 3/29/2024. She said she did not witness the altercation but was the charge nurse for Resident #1 and was notified by CNA B regarding the incident as soon as it occurred around 1:30 p.m. The ADON said she notified Abuse Prevention Coordinator immediately by phone/text, and then notified Psych services, facility NP, PCP and RP. Record review of TULIP intake for Resident #1 and Resident #2 indicated information date received on 3/29/2024 at 6:39 p.m., read that the allegation of abuse occurred on 3/29/2024 at 1:30 p.m. and the facility first learned of the incident on 3/29/2024 at 1:30 p.m. Caller information indicated the reporter of the allegation was the Abuse Prevention Coordinator. Record review of Provider Investigation report dated 4/5/2024 indicated that the alleged allegation of abuse occurred on 3/29/2024 at 1:30 p.m. and was reported to HHSC on 3/29/2024 at 6:00 p.m. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455538	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2024
NAME OF PROVIDER OR SUPPLIER: Magnolia Manor		STREET ADDRESS, CITY, STATE, ZIP CODE: 4400 Gulf St Groves, TX 77619	

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/24/2024 at 11:45 a.m., the Executive Director/Abuse Prevention Coordinator said she was notified of the abuse allegation on 3/29/2024, she recalled being notified of the incident while attending church services on holiday on 3/29/2024. Executive Director/Abuse Prevention Coordinator said she reported the abuse allegation as soon as she could get access to a computer and acknowledged it was greater than 2 hours from the alleged abuse allegation. The Executive Director/Abuse Prevention Coordinator said the expectations was for the facility staff to report all suspicions or allegations of abuse immediately to her, as the abuse prevention coordinator. She said the timeframe for reporting allegations of abuse to the state agency was to report within 2 hours of the allegation. The Executive Director said she should have reported allegations of abuse to the state agency within 2 hours of the allegation. Record review of the facility's Abuse and Neglect policy dated April 2019 indicated . The Abuse Prevention Coordinator will: immediately (within 2 hours) report to The Department of Aging and Disability Services (DADS) and other appropriate authorities' incidents of patient abuse as required under applicable regulations and regulatory guidance.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25779 The facility failed to ensure that a resident who needs respiratory care, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences for 1 of 18 residents reviewed for respiratory care. (Resident #29) The facility failed to follow physician orders for Resident #29's oxygen. This failure could place the residents at risk of not receiving the care and services to maintain their highest level of well-being. Findings included: Record review of physician orders dated April 2024 indicated Resident #29, admitted [DATE], was [AGE] years old with diagnoses of congestive heart failure (a chronic condition in which the heart does not pump blood as well as it should) and chronic obstructive pulmonary disease (a group of lung diseases that block air flow and make it difficult to breathe). The orders indicated the resident received oxygen 2 liters via nasal cannula beginning 1/24/24. Record review of the most recent quarterly MDS assessment dated [DATE] indicated Resident #29 received oxygen therapy. Record review of a care plan dated 2/12/24 indicated Resident #29 was unable to maintain O2 Saturation. Receives oxygen at 2 L/min. Record review of the TAR dated 4/1/24 to 4/30/24 indicated Resident #29 was to receive oxygen at 2 liters/minute nasal cannula. During the following observations, Resident #29's oxygen was in progress and was set at 3 liters via nasal cannula: *on 04/22/24 at 9:39 a.m., *on 03/22/24 at 2:16 p.m., *on 04/23/24 at 9:38 a.m., *on 04/23/24 at 12:36 p.m., and *on 04/23/24 at 2:57 p.m. During interview and record review on 04/23/24 at 2:51 p.m., LVN A, upon review of the clinical record, said Resident #29's oxygen was ordered at 2 liters via nasal cannula. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Magnolia Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 4400 Gulf St Groves, TX 77619	

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation of Resident #29 and interview on 04/23/24 at 2:57 p.m., LVN A said the resident's oxygen was set at 3 liter and should be set at 2 liters. She said the resident did not receive the correct dose of oxygen. She said the possible negative outcome would be the resident's lungs could be affected. When asked how the lungs would be affected, she did not respond. During an observation of Resident #29 and interview on 04/23/24 at 3:00 p.m., the DON said the resident did not receive the oxygen at 2 liters as ordered. She said the possible negative outcome could be damage to the lungs. She said her expectations were for the staff to administer the oxygen as ordered. Record review of a Oxygen Administration policy revised October 2010 indicated: Purpose: The purpose of this procedure is to provide guidelines for safe oxygen administration. Procedure: 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 2. Review the resident's care plan to assess for any special needs of the resident. 3. Assemble the equipment and supplies as needed.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Manor	4400 Gulf St Groves, TX 77619

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 33460 Based on interview and record review, the facility failed to maintain the daily nurse staffing data for at least 18 months of last 18 months. The facility to ensure the records for the posted daily nurse staffing data were maintained from October 2022 to April 23,2024. This failure could place residents, families and visitors at risk of not being able to request the daily nurse staffing data record for the last 18 months. Findings included: During an interview on 04/23/24 at 9:00 a.m., the secretary said she was responsible for printing the daily nurse staffing data sheet. Then she would post it in the frame at the front entrance of the facility. She said she did not retain staffing reports and said she disposed of them each day when she would post the new one. She said no one had told her to keep them. During an interview on 04/23/24 at 2:00 p.m., the administrator said she wanted the posting for staffing to be maintained in a binder after each day. She said if not the documents would not be available for viewing or review as required. Record review of the staff posting dated 04/23/24 indicated .The records must be maintained for 18 months.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 30664 Based on observation, interview, and record review, the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition for 1 of 1 stove in the kitchen reviewed for essential equipment. The facility did not ensure the gas stove was in safe operating condition. Three burners on the back of the stove and the 2 ovens would not ignite when the knobs were turned. This failure could place the residents at risk of a fire and not having safe operating equipment. Findings included: During an observation and interview on 04/22/24 at 09:15 a.m. during initial tour of kitchen the stove's 3 rear burners were not lighting when the knobs were turned on. The DM said the stove will do that at times. During an observation and interviews on 04/23/24 at 11:25 a.m. during lunch preparation the stove's 3 rear burners were not lighting when the knobs were turned on. The 2 stoves were not lighting when the knobs were turned on. Cook F said she had issues at times and would light it with a lighter when it happened. The DM said the ovens at times would not light either. He said he kept a lighter for when the burners and the ovens would not light. He said he had not reported the stove to the MS. During an interview on 04/23/24 at 12:32 p.m. the MS said she was not informed about the stove burners and ovens not lighting when turned on. She said if staff used a lighter to light them it could cause an explosion and injuries to residents and staff. According to the FDA Food Code 2022 accessed at https://www.fda.gov/food/retail-food-protection/fda-food-code 4-5 Maintenance and Operation 4-501 Equipment 4-501.11 Good Repair and Proper Adjustment. (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2