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	03/11/2025

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 0580 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** 47879 Based on interview and record review, the facility failed to consult with the resident's physician when there was a need to alter treatment for 1 of 5 residents (Resident #7) reviewed for physician notification with changes in condition. 1. The facility failed to notify the physician of Resident #7 not having pain medications available at the facility when he was admitted on [DATE] with diagnoses of pain and orders for oxycodone for pain. 2. The facility failed to notify Resident #7's physician on [DATE] when he had a change in condition with unmanageable pain when he complained of excruciating pain (scaled 10 out of 10). The facility failed to notify Resident #7's physician on [DATE] when he had break through pain, scale of 8 out of 10, after returning from the hospital with a fentanyl patch. This failure could place residents at risk of not receiving appropriate medical treatments, which could result in a decline in health. Findings included: Record review of the face sheet dated [DATE] indicated Resident #7 was admitted on [DATE], he was [AGE] years old with diagnoses including end stage renal disease (a condition where the kidneys have permanently lost their ability to function properly), dialysis encounter, failed kidney transplant, liver transplant status, congestive heart failure (a condition where the heart muscle is weakened and cannot pump blood effectively), lower back pain, and pain in lower limbs. Resident #7 expired on [DATE] Record review of a discharge MDS assessment, dated [DATE], indicated Resident #7's pain assessment interview was not conducted. Resident #7 had a fall with major injury (bone fractures, joint dislocations, closed head injuries with alternated consciousness, subdural hematoma) since admission/entry to the nursing facility. Resident #7 used an opioid high-risk drug during the last seven days during the lookback period. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Record Review of Resident #7's Brief Interview of Mental Status dated [DATE] indicated Resident #7 had a BIMS score of 14 and was cognitively intact. He was able to make daily decisions regarding task of daily life. Record review of Resident #7's baseline care plan, dated [DATE], indicated he received high risk/black box pain medications (narcotics) and had skin impairment of pressure and non-pressure ulcers. Review of Resident #7's physician orders for [DATE] indicated there was a prescription for pain medication oxycodone 5 mg tablet, one tablet, by mouth, as needed every four hours for unspecified pain for ten days starting [DATE], discontinued [DATE]. Resident #7 had an additional pain medication order for acetaminophen (Tylenol) 325 mg tablet, 2 tablets, by mouth, as needed every six hours starting [DATE] for unspecified pain. Resident #7 had another order for pain medication Hydrocodone 5 mg- acetaminophen 325 mg tablet (Norco), one tablet, by mouth, as needed every six hours starting [DATE] for unspecified open wound of lower back and pelvis. Resident #7 had an order for Fentanyl 50 mcg/hour transdermal patch one as needed every seventy-two-hours starting [DATE]. Review of Resident #7's MAR for [DATE] indicated Resident #7 could be administered PRN Tylenol 325mg (2 tablets) by mouth, as needed every six hours starting [DATE] for unspecified pain, and hydrocodone 5 mg-acetaminophen 325 mg tablet (Norco) one tablet, by mouth, as needed every six hours starting [DATE] for unspecified pain for open wound of his lower back and pelvis. The resident was administered one hydrocodone 5 mg- acetaminophen 325 mg tablet (Norco) tablet on [DATE] at 5:44 p.m. with effectiveness. Resident #7 was not administered any pain medication on [DATE]. Record review of Resident #7's TAR for [DATE] indicated LVN II documented on [DATE] at 5:54 p.m. Resident #7's pain level an 8 out of 10 on the pain scale. Record review of Resident #7's clinical note, dated [DATE] at 6:53 a.m., authored by LVN T indicated Resident #7 had multiple wounds on his body including open areas to his left hip, left leg, below his knee, under his knee, bilateral heels, left elbow, and an open wound to his sacrum. Resident #7 had limited bed mobility and required assistance for repositioning. Record review of Resident #7's clinical note, dated [DATE] at 5:44 p.m., authored by LVN H indicated Resident #7 was awake and complaining of pain all over and was medicated with one Norco ,d+[DATE]mg pulled from the emergency kit. Record review of Resident #7's clinical note, dated [DATE] at 8:25 a.m., authored by the SW indicated Resident #7 was moaning while in bed reporting high level pain. Resident #7 had pain in his back, butt, legs, everywhere. During an interview on [DATE] at 12:20 p.m., the SW said she was completing Psychosocial wellbeing paperwork for Resident #7 on [DATE] at 8:25 a.m., and he was in bed moaning, reporting high level pain. She said Resident #7 had pain in his back, butt, legs, everywhere and had labored uneven breathing. She said she immediately notified the CN of his complaints of pain and spoke with Resident #7's family member. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of Resident #7's clinical note, dated [DATE] at 9:00 a.m., authored by LVN II indicated Resident #7 complained of excruciating pain generalized reporting pain on a scale of 10 out of 10. Resident #7 had labored breathing pattern and unmanageable pain. The note did not indicate the physician was notified of the resident complaining of excruciating pain with labored breathing patterns. Record review of Resident #7's SBAR form, dated [DATE] untimed and unsigned, indicated mental status change of decreased level of consciousness, labored or rapid breathing, and pain evaluation of a pain intensity of a 10 out of 10. Resident #7 transferred to the hospital. No indication that the primary care clinician was notified. Record review of Resident #7's hospital emergency department records dated [DATE] at 9:00 a.m. indicated Resident #7 was transferred to the ER from the nursing facility for uncontrolled pain and he was noted with multiple wounds to his body. Resident #7 was administered Fentanyl 80 mcg IVP for pain. The hospital notes indicated the resident was recently admitted to the nursing home from an acute care hospital and the nursing facility did not have his Fentanyl patch or hydrocodone in stock. Record review of Resident #7's clinical note, dated [DATE] at 2:24 p.m., authored by LVN I indicated Resident #7 returned to the facility and had a Fentanyl patch on his right shoulder for pain management. Resident #7 received a new order for cefuroxime axetil 500 mg tablet that was sent to pharmacy. There was no indication that the physician was notified that Resident #7 returned to the facility. Unable to interview LVN I, no return calls, or messages, attempted on [DATE] at 12:06 p.m. During an interview on [DATE] at 3:10 PM, LVN II said Resident #7 had chronic pain. LVN II said she knew the facility did not have Resident #7's pain medication in the building on [DATE]. LVN II said she did not notify the DON, ADON, or the physician of the resident complaining of pain when he returned from the ER. LVN II said I didn't think to call the doctor about his pain or give him anything because I knew he was sent to the hospital on the previous shift for his pain and received a Fentanyl pain patch. During an interview on [DATE] at 12:18 p.m., MD MM said he was the facility's medical director and Resident #7's attending physician. He said that him and his staff communicated with the nursing facility via a communication system. He stated he was unable to identify, in the communication system, any records regarding Resident #7s nursing facility admission, medication list, general admission assessment, pain assessment, the change in condition on [DATE], sending Resident #7 to the ER for unmanageable pain, nor on [DATE] when Resident #7 continued to have pain of an 8 after receiving Fentanyl patch at the ER. The Physician said if he was aware that Resident #7 required oxycodone for pain control upon admission to the nursing facility, he would have submitted the triple script, required, to the pharmacy, because he would have continued the resident current pain management regimen as ordered from the acute care facility. The Physician said he should have been notified immediately of Resident #7's uncontrolled or unmanageable pain so that he could have ordered medications for breakthrough pain, or an anti-inflammatory medication if not contraindicated with his transplant status. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on [DATE] at 2:00 p.m., the ADON said the admitting charge nurse should have notified the attending physician of Resident #7's admission, need for a triple script for his oxycodone, general and pain assessment. The ADON said that if the triple script was obtained that Resident #7's oxycodone could have been ordered and emergent delivery by pharmacy to be available within 3 hours. The ADON said a pain assessment should have been completed and documented in the EMR on admission and during episodes of pain. The ADON said she was unable to provide or obtain documentation of admission pain assessment or pain assessment for [DATE] when episode of pain of 10 out of 10 or [DATE] when episode of pain of 8 out of 10. The ADON said pain should be assessed every shift, and as needed and unmanageable pain should be reported to physician immediately. The ADON said attending physician should be notified of resident admissions and changes in condition. During an interview on [DATE] at 2:12 p.m., the DON said she expected the nurses to notify the MD immediately for any changes in the residents, including increased pain, unavailable pain medications and/or ineffective pain medications. She said if a resident was having pain or if pain medication was unavailable, the staff could pull meds from emergency kits when it was not available and/or notify the MD of the pain medications available in the CMEK to administer immediately for pain relief until pain medications were available from pharmacy. She stated the MD needed to be part of the medical decision-making process. She stated a negative outcome of the MD not being involved could be untreated pain putting resident at risk of not receiving appropriate medical treatments, which could result in a decline in health. During an interview on [DATE] at 3:30 p.m., the Administrator said she expected the nurses to notify the MD immediately for any changes in the residents, including increased pain, unavailable pain medications and/or ineffective pain medications. She stated the nurses should follow the facility's policy regarding notifying MD of changes in condition, pain management, and the MD needed to be part of the medical decision-making process. She stated a negative outcome of the MD not being involved could be untreated pain putting resident at risk of not receiving appropriate medical treatments, which could result in a decline in health. Record review of the Change in a Resident's Condition or Status dated February 2021, 1. The nurse will notify the resident's attending physician or physician on call when there has been a(an): e. need to alter the resident's medical treatment significantly; g. need to transfer the resident to a hospital/treatment center . 2. A significant change of condition is a major decline or improvement in the resident's status that: a. will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self-limiting); b. impacts more than one area of the resident's health status . 3.Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR Communication Form.

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47879 Based on interview and record review, the facility failed to implement the written abuse policy to ensure an allegation of sexual abuse was reported immediately to the Abuse Coordinator, State Agency, and implement measures to ensure residents were protected from further abuse after an allegation of abuse for 1 of 20 residents (Resident #10) reviewed for allegations of abuse. 1. The facility failed to ensure CNA K was suspended/terminated or removed from working with all residents after a sexual abuse allegation was reported on 01/11/2025. 2. The facility failed to immediately report the sexual abuse allegation to the Abuse Coordinator. The non-compliance was identified as past non-compliance. The Immediate Jeopardy began on 01/11/2025 and ended on 01/18/2025. The facility had corrected the non-compliance before the survey began. This failure could place residents at risk of abuse, physical harm, mental anguish, and emotional distress. Findings included: Record review of the facility's policy Abuse Prohibition Protocol, date revised April 2019, indicated 8. Any person observing an incident of Patient Abuse or suspecting Patient Abuse must immediately report such incidents to the Charge Nurse. 9. The Charge Nurse will immediately examine the Patient and notify the Abuse Prevention Coordinator upon receiving reports of mental, physical, or sexual abuse. Findings of the examination will be recorded in the Patient's medical record. (Protection) 10. The Abuse Prevention Coordinator will: a. 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. Report events that cause reasonable suspicion of serious bodily injury immediately (within 2 hours) after forming the suspicion to The Department of Aging and Disability Services (DADS) and other appropriate authorities as required under applicable regulations and regulatory guidance. b. Immediately suspend the employee for an abuse allegation until an investigation is completed. c. Conduct and document on a Patient Abuse Investigation a thorough investigation of each incident of Patient Abuse, neglect, exploitation or mistreatment to include observations, interviews and reviews of all Patient's involved; interviews of all witnesses, including Patients, staff and family members; notifying physicians; notifying families and responsible parties of the involved patient's; and recording all relevant physical findings. d. Complete an appropriate assessment of all Patient's involved e. Take all steps necessary to protect the Facility's Patients from further incidents of Patient Abuse, neglect, exploitation, or mistreatment while the investigation is in progress (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of the face sheet dated 03/04/2025 indicated Resident #10 was admitted on [DATE], she was [AGE] years old with diagnoses of 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), Vascular Dementia (a type of loss of cognitive functioning caused by conditions that damage blood vessels and block blood flow to your brain), bipolar disorder (mental disorder associated with episodes of mood swings ranging from depressive lows to manic highs) and schizoaffective disorder (mental health condition with a combination of symptoms of schizophrenia and mood disorder). Record review of admission MDS assessment dated [DATE] indicated Resident #10 had a BIMS score of 6indicating she was cognitively impaired. She was able to make herself understood and understood others. No behaviors were noted. Resident #10 had bipolar disorder and anxiety disorder. Resident #10 had received medication last 7 days of antipsychotic, antianxiety, and antidepressant. Record review of Resident #10's care plan, dated 11/01/2024, indicated she had verbal behavior symptoms towards other; openly expressing anger with others and called staff inappropriate names; disarrayed room by unmaking bed, spreading clothes and other items all over room and floor; and verbally accused male staff member of raping her on 01/11/2025. Had a history, prior to facility admission, of rape allegations. Interventions included redirecting resident, provide medications as ordered, send to ER for further evaluation, treatment and rape kit, staff are to partner while in room with resident; no male CNA's to be assigned to this resident; record behavior on the tracking form and monitor for patterns of behaviors; respond in a calm voice and maintain eye contact; remove resident if verbal abusive to others, and report to MD if indicated. Record Review of Resident #10's clinical note, dated 01/11/2025 at 8:00 p.m., indicated LVN E and LPC J was in Resident #10's room reapplying her wander guard. LVN E offered for CNA K to assist Resident #10 with personal care. Resident #10 stated I don't want him in here. LPC J notified LVN E that Resident #10 alleged that CNA K was in her bed on top of her. Record Review of Resident #10's psychological service progress note, dated 01/11/2025 at 7:49 p.m., authored by LCP J, indicated Resident #10 reported to her that her safety was compromised, and staff member (CNA K) had got into her bed, and she did not like it. Facility staff (LVN E) was notified of the allegation. Record Review of Resident #10's clinical note, dated 01/12/2025 at 12:57 p.m., late entry, authored by LVN F, indicated Resident #10 was in the hallway saying that she had been raped by CNA K. LVN F immediately notified DON, Administrator, and hospice. Resident #10 refused a head-to-toe assessment by LVN F. Resident #10 refused assessment by hospice nurse. Resident #10 was transported to local ER for evaluation. Record Review of Resident #10's clinical note, dated 01/12/2025 at 4:16 p.m., authored by LVN E, indicated report was received on Resident #10 from local ER. Resident #10 was seen by forensic nurse and report was clear (no indications of rape). Resident #10 was transported back to the facility. Record review of Resident #10 clinical notes, date 2/10/2025 at 6:16 p.m., Resident #10 was transferred to behavioral hospital for admission. Unable to interview Resident #10 during investigation survey (03/03/2025, 03/4/2025, 03/05/2025. 03/06/2025. 03/10/2025 and 03/11/2025) Resident #10 remains hospitalized at behavioral hospital. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 03/05/2025 at 5:00 p.m., LPC J said on 01/11/2025 around 8:00 p.m., LVN E and UM H requested her assistance on redirecting Resident #10 and assisting with reapplying her wander guard she had removed off her leg and resisting the reapplication. LPC J said she was able to intervene and assist facility staff with reapplying Resident #10's wander guard. LPC J said during interventions the resident requested to be changed and placed back to bed. LVN E told Resident #10 her CNA would assist her and Resident #10 denied assistance from the CNA and alleged she did not feel safe. Resident #10 alleged CNA K had got into her bed, and she did not like it. LPC J said LVN E was notified of the allegation and LVN E assisted Resident #10 back to bed and requested care. LPC J said UM H was not present when Resident #10 made the allegations. LPC J said she notified LVN E of the allegations made by Resident #10 not feeling safe and staff getting into her bed because they were concerning to her. LPC J said she visited with Resident #10 for approximately 1 hour that evening and she was experiencing some delusions and paranoia, but it was resolved, and her mood had calmed prior to her departure. LPC J said she had a 1:1 training provided by the facility EDO/Abuse Coordinator regarding reporting all allegations of abuse to her immediately and was provided abuse training, examples, and EDO/Abuse Coordinators personal cell phone for reporting abuse allegations in the future. During an interview on 03/04/2025 at 5:11 p.m., LVN E said Resident #10 was having behaviors on 01/11/2025 around 8:00 p.m. was refusing to reapply the wander guard she had removed. UM H requested LPC J to assist with the redirection and intervention. LVN E said Resident #10 requested to be changed and when she said CNA K would come change her, Resident #10 stated I don't want him in here. LVN E said LPC J whispered to her that Resident #10 said CNA K got in her bed and on top of her. LVN E said LPC J asked her who she could speak to about the allegation/situation, and she told LPC J the administrator was not her on weekends and she would need to tell the unit manager. LVN E said she notified UM H about the situation/ allegation. LVN E said she was terminated for not reporting the alleged sexual abuse to EDO/Abuse Coordinator immediately. LVN E said the incident was reported to the UM H (her chain of command) who was on duty that day but was not reported to the EDO/Abuse Coordinator. LVN E said she was trained regarding abuse and neglect and reporting the incident but did not recall specific training on reporting to the EDO/Abuse Coordinator until after the incident occurred with Resident #10. During an interview on 03/04/2025 at 4:30 p.m., UM H denied that LVN E reported the allegation of CNA K sexually abusing Resident #10 to her. UM E said she recalled working 01/11/2025 as a charge nurse and assisting LVN E with attempting to reapply Resident #10's wander guard because the resident was refusing. UM H said once LPC J entered Resident #10's room and assisted LVN E with redirecting the resident and reapplying the wander guard, she returned to her hall and continued providing care to her assigned residents. UM H said LVN E did not report a sexual abuse allegation to her, or she would have called the EDO/Administrator immediately. UM H said she was not made aware of the sexual allegation of CNA K sexually abusing Resident #10 until 01/12/2025. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 03/04/2025 at 10:30 a.m., CNA K said on 01/11/2025 around 7:30 p.m., he and CNA G provided personal care to Resident #10 and Resident #10 had kicked him in the stomach twice while providing her care. He said he reported the incident to the CN/LVN E. CNA K said that he did not provide care to Resident #10 without another staff member in the room because she had a history of make allegations against staff. CNA K denied the alleged sexual abuse allegation made by Resident #10. CNA K said that he was made aware by LVN E that Resident #10 had made sexual allegations against him prior to him leaving his shift on 01/11/2025. He said he but was not reprimanded, suspended, or ask to leave at that time. CNA K said he had not provided care to Resident #10 since the sexual abuse allegation on 01/11/2025. CNA K said on 01/12/2025 he reported to facility to work his 6:00 a.m. to 2:00 p.m. shift and around 9:30 a. m. he was interviewed and suspended by EDO regarding a sexual allegation made by Resident #10. CNA K said he was allowed to return to work after the facility investigated and found the allegation to be untrue. Unable to interview Resident #10, she was hospitalized at a behavioral hospital. Record review of CNA K's time sheet indicated he was on duty on 01/11/2025 at 6:05 a.m. to 10:16 p.m. and was on duty on 01/12/2025 from 6:21 a.m. to 9:45 a.m. Record review of CNA K's employee coaching and counseling record indicated he was suspended pending investigation of an allegation of abuse of resident on 1/12/2025. Record review on LVN E's employee coaching and counseling record indicated she was terminated on 01/17/2025 for failure to report abuse allegation in a timely manner. During an interview on 03/04/2025 at 2:00 p.m., LVN F said Resident #10 rolled up to her medication cart on 01/12/2025 around 9:30 a.m. and told her CNA K had raped her the previous evening/night. LVN F said she escorted Resident #10 to her room to complete an assessment, but Resident #10 refused the assessment. LVN F said she immediately notified the EDO, ADON, hospice, the RP and MD. LVN F said Resident #10 was transferred to the local ER for evaluation, a SANE exam, and rape kit per orders. During an interview on 03/06/2025 at 10:05 a.m., the ADON said she was notified of the allegation of CNA K sexually abusing Resident #10 on 01/12/2025 at 9:30 a.m. and she immediately notified the EDO/Abuse Coordinator and assisted with investigating the allegation. During an interview on 03/06/2025 at 11:25 a.m., the Administrator said the allegation of CNA K sexually abusing Resident #10 was not reported to her until 01/12/2025 by LVN F around 9:30 a.m. and she reported it to the state thereafter. She said when she was made aware of the sexual abuse allegation, CNA K was immediately suspended pending the investigation. She said that during the investigation she identified that Resident #10 had made a similar allegation to staff and vendor on the evening of 01/11/2025. She said during Resident #10's interview she identified the allegation on 01/11/2025 and 01/12/2025 as the same allegation and alleged CNA K got in her bed, got on top of her and raped her. She said all staff were provided an in-service on abuse and neglect including reporting allegations of abuse to EDO/Abuse coordinator immediately. She said all abuse allegations must be reported to her immediately and reported to the state within 2 hours of the allegation. She said residents were at risk of continued abuse if allegations of abuse were not reported as required. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of an In-Service Attendance Record with subject of Abuse, Neglect, Exploitation, and timely reporting, dated 01/13/2025, indicated that 29 staff members signed the in-service record, and 66 staff members were notified by phone regarding all allegations of abuse must be reported to the abuse coordinator/EDO immediately and EDO/Abuse Coordinator's phone number provided to report abuse allegations. Record review of facility reported abuse allegations incidents from 01/12/2025 through 03/11/2025 indicated the abuse coordinator was notified immediately of abuse allegations. Record Review of Safe Surveys dated week of 01/12/2025 - 01/18/2025 indicated there no residents expressing concerns regarding their safety or abusive staff. Record Review of multiple employee Abuse/Neglect and Compliance Questionnaire's dated between 01/12/2025 - 01/18/2025 indicated staff answered questions based on the in-services provided. During interviews on 03/03/2025 from 08:30 a.m. - 03/06/2025 to 2:30 p.m., 2 RNs (RN EE & RN FF), 2 Unit Mangers (UM/LVN H & UM/LVN Y) and 10 LVN's (LVN E, LVN F, LVN I, LVN O, LVN T, LVN U, LVN V, LVN W, LVN X, and LVN Z) were able to identify types of abuse, all were knowledgeable of the abuse policy and procedures for reporting abuse, and all were aware of the new expectations to notify the EDO/Abuse Coordinator immediately of any allegations of abuse. During interviews on 03/03/2025 from 08:30 a.m. - 03/06/2025 to 2:30 p.m., 9 CNAs (CNA B, CNA D, CNA G, CNA K, CNA L, CNA AA, CNA BB, CNA CC, and CNA DD), and 1 CNA/MA (CNA/MA A) were able to identify types of abuse, all were knowledgeable of the abuse policy and procedure for reporting abuse, all were aware of the new expectations to notify the EDO/Abuse Coordinator immediately of any allegations of abuse. During interviews on 03/03/2025 from 08:30 a.m. - 03/06/2025 to 2:30 p.m., 1 Human Resource staff (HR C), 1 MDS Nurse (MDS N), 2 - Community Relations Coordinator (CRC P & CRC M), 1 Housekeeping staff (HSK Q), Business office manager (BOM R), Van Driver (VD GG) and maintenance staff (MT S) were able to identify types of abuse, all were knowledgeable of the abuse policy and procedure for reporting abuse, all were aware of the new expectations to notify the EDO/Abuse Coordinator immediately of any allegations of abuse. On 03/06/2025 at 05:40 p.m., the Administrator was informed of the Immediate Jeopardy. The non-compliance was identified as past non-compliance. The Immediate Jeopardy began on 01/11/2025 and ended on 01/18/2025. The facility had corrected the noncompliance before survey began.

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	03/11/2025

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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	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 observation, interview, and record review the facility failed to ensure allegations of abuse to the abuse coordinator, allegations of abuse were reported to the state agency within the required 2 hour timeframe, and allegations of misappropriation were reported to the state agency within the required 24 hour timeframe for 6 of 20 residents reviewed for freedom from abuse, neglect, and exploitation/ misappropriation. (Residents #1, #2, #3, #4, #5, and #10) 1. The facility failed to report a sexual abuse allegation immediately to the Abuse Coordinator. LPC J and LVN E did not immediately report, to the Abuse Coordinator, when Resident #10 reported a sexual abuse allegation on CNA K. This non-compliance was identified as past non-compliance. The Immediate Jeopardy began on 01/11/2025 and ended on 01/18/2025. The facility had corrected the non-compliance before the survey began. 2. The facility failed to report an allegation of abuse to the State Agency within 2 hours when it was reported on 01/19/2025 that Resident #1 was verbally abused by LVN HH. 3. The facility failed to report allegations of misappropriation of property to the State Agency within 24 hours when it was reported Resident #5 was missing money. 4. The facility did not report alleged sexual abuse involving Resident #2 and Resident #3 within the two-hour timeframe as required by HHSC on 07/24/24. 5. The facility did not report alleged sexual abuse involving Resident #3 and Resident #4 within the two-hour timeframe as required by HHSC on 09/19/24. The failures could place residents at risk of abuse, physical harm, mental anguish, and emotional distress. Findings included: 1. Record review of the face sheet dated 03/04/2025 indicated Resident #10 was admitted on [DATE], she was [AGE] years old with diagnoses of 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), Vascular Dementia (a type of loss of cognitive functioning caused by conditions that damage blood vessels and block blood flow to your brain), bipolar disorder (mental disorder associated with episodes of mood swings ranging from depressive lows to manic highs) and schizoaffective disorder (mental health condition with a combination of symptoms of schizophrenia and mood disorder). Record review of admission MDS assessment dated [DATE] indicated Resident #10 had a BIMS score of 6indicating she was cognitively impaired. She was able to make herself understood and understood others. No behaviors were noted. Resident #10 had bipolar disorder and anxiety disorder. Resident #10 had received medication last 7 days of antipsychotic, antianxiety, and antidepressant. (continued on next page)

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	03/11/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of Resident #10's care plan, dated 11/01/2024, indicated she had verbal behavior symptoms towards other; openly expressing anger with others and called staff inappropriate names; disarrayed room by unmaking bed, spreading clothes and other items all over room and floor; and verbally accused male staff member of raping her on 01/11/2025. Had a history, prior to facility admission, of rape allegations. Interventions included redirecting resident, provide medications as ordered, send to ER for further evaluation, treatment and rape kit, staff are to partner while in room with resident; no male CNA's to be assigned to this resident; record behavior on the tracking form and monitor for patterns of behaviors; respond in a calm voice and maintain eye contact; remove resident if verbal abusive to others, and report to MD if indicated. Record Review of Resident #10's clinical note, dated 01/11/2025 at 8:00 p.m., indicated LVN E and LPC J was in Resident #10's room reapplying her wander guard. LVN E offered for CNA K to assist Resident #10 with personal care. Resident #10 stated I don't want him in here. LPC J notified LVN E that Resident #10 alleged that CNA K was in her bed on top of her. Record Review of Resident #10's psychological service progress note, dated 01/11/2025 at 7:49 p.m., authored by LCP J, indicated Resident #10 reported to her that her safety was compromised, and staff member (CNA K) had got into her bed, and she did not like it. Facility staff (LVN E) was notified of the allegation. Record Review of Resident #10's clinical note, dated 01/12/2025 at 12:57 p.m., late entry, authored by LVN F, indicated Resident #10 was in the hallway saying that she had been raped by CNA K. LVN F immediately notified DON, Administrator, and hospice. Resident #10 refused a head-to-toe assessment by LVN F. Resident #10 refused assessment by hospice nurse. Resident #10 was transported to local ER for evaluation. Record Review of Resident #10's clinical note, dated 01/12/2025 at 4:16 p.m., authored by LVN E, indicated report was received on Resident #10 from local ER. Resident #10 was seen by forensic nurse and report was clear (no indications of rape). Resident #10 was transported back to the facility. Record review of Resident #10 clinical notes, date 2/10/2025 at 6:16 p.m., Resident #10 was transferred to behavioral hospital for admission. Unable to interview Resident #10 during investigation survey (03/03/2025, 03/4/2025, 03/05/2025. 03/06/2025. 03/10/2025 and 03/11/2025) Resident #10 remains hospitalized at behavioral hospital. During an interview on 03/04/2025 at 10:30 a.m., CNA K said on 01/11/2025 around 7:30 p.m., he and CNA G had provided personal care to Resident #10. He said Resident #10 had kicked him in the stomach twice while providing her care and he reported the incident to the CN/LVN E. CNA K said that he did not provide care to Resident #10 without another staff member in the room because she had a history of making allegations against staff. CNA K denied the sexual abuse allegation made by Resident #10. CNA K said that he was made aware by LVN E that Resident #10 had made sexual allegations against him prior to him leaving his shift on 01/11/2025 but he was not reprimanded, suspended, or asked to leave at that time. CNA K said he had not provided care to Resident #10 since the sexual abuse allegation on 01/11/2025. CNA K said on 01/12/2025, he reported to facility to work his 6:00 a.m. - 2:00 p.m. shift and around 9:30 a.m. he was interviewed and suspended by EDO regarding a sexual allegation made by Resident #10. CNA K said he was allowed to return to work after the facility investigated and found the allegation to be untrue. (continued on next page)

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	455538	A. Building B. Wing	03/11/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 03/04/2025 at 2:00 p.m., LVN F said Resident #10 rolled up to her medication cart on 01/12/2025 around 9:30 a.m. and told her CNA K had raped her the previous evening/night. LVN F said she escorted Resident #10 to her room to complete assessment but Resident #10 refused the assessment. LVN F said she immediately notified EDO, ADON, hospice, RP, and MD. LVN F said Resident #10 was transferred to a local ER for evaluation, SANE exam, and rape kit per orders. During an interview on 03/04/2025 at 5:11 p.m., LVN E said Resident #10 was having behaviors on 01/11/2025 around 8:00 p.m. and she requested the other CN/UM H to assist with redirecting Resident #10 and reapplying her wander guard she had previously removed. LVN E said Resident #10 was refusing to reapply the wander guard and UM H had requested LPC J to assist with the redirection and intervention. LVN E said Resident #10 requested to be changed and when she said CNA K would come change her, Resident #10 stated I don't want him in here. LVN E said LPC J whispered to her that Resident #10 said CNA K got in her bed and on top of her. LVN E said LPC J asked her who she could speak to about the allegation/situation and told her the administrator was not there on weekends and she would need to tell the unit manager. LVN E said she notified UM H about the situation/ allegation. LVN E said she was terminated for not reporting the alleged sexual abuse to EDO/Abuse Coordinator immediately. LVN E said that the incident was reported to the UM that was on duty that day but was not reported to the EDO/Abuse Coordinator. LVN E said she was trained regarding abuse and neglect and reporting the incident but does not recall specific training on reporting to the EDO/Abuse Coordinator until after the incident occurred with Resident #10. LVN E said she reported the incident to the UM (chain of command), but the UM was working as the floor charge nurse that day covering for staff call in. During an interview on 03/04/2025 at 4:30 p.m., UM H denied that LVN E reported the allegation of CNA K sexually abusing Resident #10 to her. UM E said she recalls working 01/11/2025 as a charge nurse and assisting LVN E with attempting to reapply Resident #10's wander guard because resident was refusing. UM H said once LPC J entered Resident #10's room and assisted LVN E with redirecting resident and reapplying the wander guard, she returned to her hall and continued providing care to her assigned residents. UM H said LVN E did not report sexual abuse allegation to her, or she would have called the EDO/Administrator immediately. UM H said she was not made aware of CNA K sexually abusing Resident #10 until 01/12/2025. During an interview on 03/04/2025 at 4:58 p.m., CNA G said she assisted CNA K to provide personal care to Resident #10 on 1/11/2025 around 7:30 p.m. and was in the room the entire time while care was being provided and no sexual abuse occurred. CNA G said that she assisted CNA K and other staff often with providing care to Resident #10 because she had a history of making allegations against staff. (continued on next page)

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	455538	A. Building B. Wing	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 03/05/2025 at 5:00 p.m., LPC J said on 01/11/2025 around 8:00 p.m., LVN E and UM H had requested her assistance on redirecting Resident #10 and assisting with reapplying her wander guard she had removed off her leg and resisting the reapplication. LPC J said she was able to intervene and assist facility staff with reapplying Resident #10's wander guard. LPC J said during interventions resident requested to be changed and placed back to bed, LVN E told Resident #10 her CNA would assist her and Resident #10 denied assistance from CNA and alleged she did not feel safe and that CNA K had got into her bed, and she did not like it. LPC J said LVN E was notified of the allegation and LVN E assisted Resident #10 back to bed and assisted with requested care. LPC J said UM H was not present when Resident #10 made the allegations. LPC J said she notified LVN E of the allegations made by Resident #10 not feeling safe and staff getting into her bed because they were concerning to her. LPC J said that she visited with Resident #10 for approximately 1 hour that evening and she was experiencing some delusions and paranoia, but it was resolved, and her mood had calmed prior to her departure. LPC J said that she had a 1:1 training provided by the facility EDO/Abuse Coordinator regarding reporting all allegations of abuse to her immediately and was provided abuse training, examples, and EDO/Abuse Coordinator's personal cell phone for reporting abuse allegations in the future. During an interview on 03/06/2025 at 10:05 a.m., the ADON said she was notified of the allegation of CNA K sexually abusing Resident #10 on 01/12/2025 at 9:30 a.m. and she immediately notified the EDO/Abuse Coordinator and assisted with investigating the allegation. During an interview on 03/06/2025 at 11:25 a.m., the Administrator said the allegation of CNA K sexually abusing Resident #10 was not reported to her until 01/12/2025 by LVN F around 9:30 a.m. and reported to the state thereafter. She said when she was made aware of the sexual abuse allegation, CNA K was immediately suspended pending the investigation. She said that during the investigation, she identified that Resident #10 had made a similar allegation to staff and vendor on the evening of 1/11/2025. She said during Resident #10's interview, she identified the allegation on 01/11/2025 and 01/12/2025 as the same allegation and alleged CNA K got in her bed, got on top of her, and raped her. She said all staff were provided an in-service on abuse and neglect including reporting allegations of abuse to EDO/Abuse Coordinator immediately. She said all abuse allegations must be reported to her immediately and reported to the state within 2 hours of the allegation. She said residents were at risk of continued abuse if allegations of abuse were not reported as required. Record review of CNA K's time sheet indicated he was on duty on 01/11/2025 at 6:05 a.m. to 10:16 p.m. and was on duty on 01/12/2025 from 6:21 a.m. to 9:45 a.m. Record review of CNA K's employee coaching and counseling record indicated he was suspended pending investigation of an allegation of abuse of resident on 1/12/2025. Record review on LVN E's employee coaching and counseling record indicated she was terminated on 01/17/2025 for failure to report abuse allegation in a timely manner. Record review of an In-Service Attendance Record with subject of Abuse, Neglect, Exploitation, and timely reporting, dated 1/13/2025, indicated that 29 staff members signed the in-service record, and 66 staff members were notified by phone regarding all allegations of abuse being reported to the Abuse Coordinator/EDO immediately and the EDO/Abuse Coordinator's phone number was provided to report abuse allegations. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of facility's reported abuse allegations incidents from 01/12/2025 through 03/11/2025 indicated that the abuse coordinator was notified immediately of abuse allegations. Record Review of Safe Surveys dated week of 01/12/2025 - 01/18/2025 revealed no residents expressing concerns regarding their safety or abusive staff. Record Review of multiple employee Abuse/Neglect and Compliance Questionnaire's dated between 01/12/2025 - 01/18/2025 revealed staff answered questions based on the in-services provided. During interviews on 03/03/2025 from 08:30 a.m. - 03/06/2025 to 2:30 p.m., 2 RN (RN EE & RN FF), 2 Unit Mangers (UM/LVN H & UM/LVN Y) and 10 LVN's (LVN E, LVN F, LVN I, LVN O, LVN T, LVN U, LVN V, LVN W, LVN X, and LVN Z) were able to identify types of abuse, all were knowledgeable of the abuse policy and procedure for reporting abuse, all were aware of the new expectations to notify the EDO/Abuse Coordinator immediately of any allegations of abuse. During interviews on 03/03/2025 from 08:30 a.m. - 03/06/2025 to 2:30 p.m., 9 CNA's (CNA B, CNA D, CNA G, CNA K, CNA L, CNA AA, CNA BB, CNA CC, and CNA DD), and 1 CNA/MA (CNA/MA A) were able to identify types of abuse, all were knowledgeable of the abuse policy and procedure for reporting abuse, all were aware of the new expectations to notify the EDO/Abuse Coordinator immediately of any allegations of abuse. During interviews on 03/03/2025 from 08:30 a.m. - 03/06/2025 to 2:30 p.m., 1 Human Resource staff (HR C), 1 MDS Nurse (MDS N), 2 - Community Relations Coordinator (CRC P & CRC M), 1 Housekeeping staff (HSK Q), Business office manager (BOM R), Van Driver (VD GG) and maintenance staff (MT S) were able to identify types of abuse, all were knowledgeable of the abuse policy and procedure for reporting abuse, all were aware of the new expectations to notify the EDO/Abuse Coordinator immediately of any allegations of abuse. On 03/06/2025 at 05:40 p.m., the Administrator was informed of the Immediate Jeopardy. The non-compliance was identified as past non-compliance. The Immediate Jeopardy began on 01/11/2025 and ended on 01/18/2025. The facility had corrected the noncompliance before survey began. 2. Record review of the face sheet dated 03/04/2025 indicated Resident #1 was admitted on [DATE], she was [AGE] years old with diagnoses of 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), dementia (a type of loss of cognitive functioning), aphasia (inability to understand or produce speech, as a result of brain disease or damage), dysphagia (difficulty swallowing), muscle weakness, abnormal gait and mobility, and depression (mental illness that negatively affects how you feel, the way you think and how you act). Resident #1 resided on the memory care unit. Record review of Resident #1's quarterly MDS assessment, dated 01/20/2025, indicated a BIMS score of 03 which indicated her cognition was severely impaired, and she was usually able to make herself understood and usually understood others. No behaviors were noted. Resident #1 had anxiety disorder, depression, stroke affecting speech and vision, non-Alzheimer's dementia. bipolar disorder and anxiety disorder. Resident #1 had received medication last 7 days of antiplatelet, anticonvulsant and antidepressant. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of Resident #1's care plan, dated 04/04/2024, indicated she had impaired short-term memory and was unable to recall after 5 minutes, behaviors of spitting out medications, and impaired judgement and agitation secondary to dementia. Interventions included redirecting resident, re-orient to time, location, events, and activities as needed, use cues to enhance participation in self-care and report decline, ensuring safe environment, offer diverse activities to redirect attention during periods of agitation, involve resident in activities, assess for reasons of decline in behaviors, document behaviors and notify MD of decline. During an observation on 03/05/2025 at 11:00 a.m., Resident #1 was lying in bed in her room. She appeared well groomed with no foul odors and no signs of abuse or neglect were identified. Resident #1 interacted with facility staff with no indication of fear or discomfort. Unable to interview Resident #1 due to her severely impaired cognition. Record review of the Provider Investigation Report dated 01/22/2025 indicated on 01/19/2025 at 3:00 p.m., Resident's #1's family members reported to weekend supervisor, RN EE, that LVN HH was lecturing, scolding, and exhibiting unprofessional behaviors towards Resident #1 who had memory and cognitive impairments. RN EE notified the DON and ADON of the incident immediately. RN EE was directed to send LVN HH home until the incident was investigated. The Investigation Findings indicated it was unconfirmed after talking with the Resident #1's family members and completing the investigation process. It was determined LVN HH did not verbally abuse Resident #1. The Agency Action Post-Investigation included in-service performed on all staff on abuse and neglect, 1:1 in-service with LVN HH on abuse and neglect; 1:1 in-service with RN EE on abuse and neglect and reporting abuse to EDO/Abuse coordinator immediately. The date and time reported to HHSC was on 01/22/2025 at 1:45 p.m. (3 days after the incident was initially reported). During an interview on 03/05/2025 at 4:15 p.m., the Administrator said the allegation of LVN HH verbally abusing Resident #1 was unconfirmed. The Administrator said the incident happened on the weekend of 01/19/2025. The Administrator said RN EE, the weekend supervising nurse, was approached by Resident #1's family members reporting that they did not like the way LVN HH was speaking to Resident #1 and it was inappropriate because Resident #1 had memory and cognitive impairments. She said RN EE reported the incident to DON and ADON and was directed to send LVN HH home until the allegation could be investigated. She said during a review of the grievances on 01/22/2025, she contacted Resident #1's family members to investigate the grievance and found no concerns of verbal abuse of Resident #1, and identified LVN HH with unprofessional behavioral. She said she consulted with the corporate support team, and it was decided it would be best practice to report the incident to HHSC and it was submitted on 01/22/2025. The Administrator said the allegation should have been reported within 2 hours of the allegation and then investigated. The Administrator said not reporting and investigating the alleged abuse could place residents at risk for further abuse. 3. Record review of the face sheet dated 03/06/2025 indicated Resident #5 was admitted on [DATE], he was [AGE] years old with diagnoses of dementia (group of symptoms that affects memory, thinking and interferes with daily life), COPD (an ongoing lung condition caused by damage to the lung), anxiety (emotion characterized by an unpleasant state of inner turmoil and includes feelings of dread over anticipated events) and Parkinson's disease (a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves). Resident #5 was discharged on [DATE] to an acute care hospital. (continued on next page)

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	455538	A. Building B. Wing	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of admission MDS assessment dated [DATE] indicated Resident #5 had delusions, inattention, and disorganized thinking. No behaviors were noted. Resident #5 had and anxiety disorder. Resident #5 had received medication last 7 days of antipsychotic, antianxiety and antidepressant. Record review of Resident #5's care plan, dated 10/09/2024, indicated he had trauma informed care: displayed behavior concerns, displayed flashbacks; self-destruction behaviors, poor impulse control, hyper-aerosol, and feeling of guilt (accused his wife of having an affair, removes wound dressings, constantly gets out of bed, and gets on the floor, yells and screams out). Interventions included redirecting resident, provide medications as ordered, record behavior on the tracking form and monitor for patterns of behaviors; respond in a calm voice and maintain eye contact; remove resident if verbal abusive to others, and report to MD if indicated. Record review of Resident #5's witness statement dated 10/15/2024, authored by AD JJ, indicated Resident #5 recalled over $100 was missing from his wallet, last time money was physically seen was at the hospital prior to transferring to the nursing facility. Unable to interview Resident #5 he was no longer a resident of the facility. During interview on 03/04/2025 at 8:20 a.m., AD JJ said Resident #5 reported to her he was missing money, and she wrote a witness statement for the missing money as advised by the Administrator. She said she immediately notified the ADON, DON, and Administrator of Resident #5's complaint of missing money. During interview on 03/04/2025 at 10:08 a.m., the Administrator said that she did not recall receiving the misappropriation of property allegation for Resident #5. The Administrator said that allegations of misappropriation of property must be reported the State Agency and investigated. The Administrator said that it must have got missed with the statement being in the wrong provider investigation report folder. The Administrator said allegations of misappropriation of property should be reported to her and reported to the state agency within 24 hours and an investigation should be completed and reported to the state agency within 5 working days of the incident. 4. Record review of the face sheet dated 03/06/2025 indicated Resident #2 was a [AGE] year-old female admitted on [DATE]. Her diagnoses included anxiety (persistent and excessive worry that interferes with daily activities) and hypertensive heart disorder (hypertensive heart disorder). During an observation and interview on 03/06/25 at 02:25 p.m. Resident #2 was up in her wheelchair propelling self in the hallway. Interactions with other residents were appropriate. She was alert and oriented times three. She answered questions appropriately. She said she had an issue with a male resident touching her in her private area. She said she thought she may have given him the wrong impression at the time. She said he was no longer at the facility. Record review of the face sheet dated 03/06/2025 indicated Resident #3 was an [AGE] year-old male admitted on [DATE]. His diagnoses included hypotension (a condition in which the blood pressure is abnormally low), type 2 diabetes (a chronic condition that affects the way the body processes blood sugar), alcohol dependence (physically or psychologically dependent on alcohol), and alcohol induced dementia (long-term excessive alcohol consumption, leading to brain damage and cognitive impairment). The face sheet indicated he was discharged on [DATE]. (continued on next page)

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	455538	A. Building B. Wing	03/11/2025

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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Resident #3 was not observed as he had been discharged . Record review of a self-report submission form indicated Incident Details: Date/time you first learned of the incident: 07/24/24 at 04:00 p.m Brief narrative summary of the reportable incident: [Resident #2] reported that on an unknown date, another resident, [Resident #3] was in the hallway as was she. When they got near each other [Resident #3] placed his hand on her thigh and then inched it upwards near her private area. She told him to stop and he did. She did not initially say anything because she said she had been nice to him and felt she may have given him the wrong impression. Review of the TULIP (Texas Unified Licensure Information Portal) website indicated the incident was received on 07/24/24 at 06:06 p.m. (6 minutes after the required 2-hour timeframe). 5. Record review of the face sheet dated 03/06/2025 indicated Resident #4 was a [AGE] year-old female admitted on [DATE]. Her diagnoses included Alzheimer's disease (progressive disease that destroys memory and other important mental functions) and dementia (loss of cognitive functioning). The face sheet indicated she had discharged on [DATE]. Resident #4 was not observed as she had been discharged . Record review of a self-report submission form indicated Incident Details: Date/time you first learned of the incident: 09/19/24 at 02:30 p.m Brief narrative summary of the reportable incident: [Resident #4] and [Resident #3] were in the main dining room filled with residents in preparation for mass when the maintenance director, [name] came upon them sitting in the front of the room and [Resident #3] was sitting in his wheelchair with his hand on the outside of [Resident #4]'s clothing on her private area. He appeared to be moving his hand in an up and down motion. She was sitting in her wheelchair smiling. Record review of an email from the Administrator to the HHSC Complaint and Incident Intake dated 09/19/24 indicated it was sent at 04:42 p.m. (12 minutes after the required 2-hour timeframe). (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of the facility's policy Abuse Prohibition Protocol, date revised April 2019, indicated 8. Any person observing an incident of Patient Abuse or suspecting Patient Abuse must immediately report such incidents to the Charge Nurse. 9. The Charge Nurse will immediately examine the Patient and notify the Abuse Prevention Coordinator upon receiving reports of mental, physical, or sexual abuse. Findings of the examination will be recorded in the Patient's medical record. (Protection) 10. The Abuse Prevention Coordinator will: a. 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. Report events that cause reasonable suspicion of serious bodily injury immediately (within 2 hours) after forming the suspicion to The Department of Aging and Disability Services (DADS) and other appropriate authorities as required under applicable regulations and regulatory guidance. b. Immediately suspend the employee for an abuse allegation until an investigation is completed. c. Conduct and document on a Patient Abuse Investigation a thorough investigation of each incident of Patient Abuse, neglect, exploitation, or mistreatment to include observations, interviews and reviews of all Patient's involved; interviews of all witnesses, including Patients, staff and family members; notifying physicians; notifying families and responsible parties of the involved patient's; and recording all relevant physical findings. d. Complete an appropriate assessment of all Patient's involved e. Take all steps necessary to protect the Facility's Patients from further incidents of Patient Abuse, neglect, exploitation, or mistreatment while the investigation is in progress Record review of the Provider Letter PL 2024-14 dated August 29, 2024 indicated: 2.4 Reportable Incidents and Timeframes Type of Incident: an incident that results in serious bodily injury and that involves any of the following: -neglect -exploitation -mistreatment -injuries of unknown source -misappropriation of resident property When to Report: *Immediately, but not later than two hours after the incident occurs or is suspected

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F 0697 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47879 Based on interview and record review, the facility failed to ensure that pain management was provided to residents who required such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 5 (Resident #7) residents reviewed for pain. The facility failed to administer Resident #7 pain medication for a complaint of pain intensity level of 10 (worst pain possible) out of 10 on [DATE] and pain intensity level of 8 (severe pain) out of 10 on [DATE] due to facility did not have Resdient #7's ordered pain medication available. This failure could place residents at risk for increased pain and decreased quality of life. Findings included: Record review of the face sheet dated [DATE] indicated Resident #7 was admitted on [DATE], he was [AGE] years old with diagnoses including end stage renal disease (a condition where the kidneys have permanently lost their ability to function properly), dialysis encounter, failed kidney transplant, liver transplant status, congestive heart failure (a condition where the heart muscle is weakened and cannot pump blood effectively), lower back pain, and pain in lower limbs. Resident #7 expired on [DATE]. Record review of a discharge MDS assessment, dated [DATE], indicated Resident #7's pain assessment interview was not conducted. Resident #7 had a fall with major injury (bone fractures, joint dislocations, closed head injuries with alternated consciousness, subdural hematoma) since admission/entry to the nursing facility. Resident #7 used an opioid high-risk drug during the last seven days during the lookback period. Record Review of Resident #7's Brief Interview of Mental Status dated [DATE] indicated Resident #7 had a BIMS score of 14 and was cognitively intact. He was able to make daily decisions regarding task of daily life. Record review of Resident #7's baseline care plan, dated [DATE], indicated he received high risk/black box pain medications (narcotics) and had skin impairment of pressure and non-pressure ulcers. Review of Resident #7's physician orders for [DATE] indicated there was a prescription for pain medication oxycodone 5 mg tablet, one tablet, by mouth, as needed every four hours for unspecified pain for ten days starting [DATE], discontinued [DATE]. Resident #7 had an additional pain medication order for acetaminophen (Tylenol) 325 mg tablet, 2 tablets, by mouth, as needed every six hours starting [DATE] for unspecified pain. Resident #7 had another order for pain medication Hydrocodone 5 mg- acetaminophen 325 mg tablet (Norco), one tablet, by mouth, as needed every six hours starting [DATE] for unspecified open wound of lower back and pelvis. Resident #7 had an order for Fentanyl 50 mcg/hour transdermal patch one as needed every seventy-two-hours starting [DATE]. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of Resident #7's MAR for [DATE] indicated Resident #7 could be administered PRN Tylenol 325mg (2 tablets) by mouth, as needed every six hours starting [DATE] for unspecified pain, and hydrocodone 5 mg-acetaminophen 325 mg tablet (Norco) one tablet, by mouth, as needed every six hours starting [DATE] for unspecified pain for open wound of his lower back and pelvis. The resident was administered one hydrocodone 5 mg- acetaminophen 325 mg tablet (Norco) tablet on [DATE] at 5:44 p.m. with effectiveness. Resident #7 was not administered any pain medication on [DATE]. Record review of Resident #7's clinical note, dated [DATE] at 5:44 p.m., authored by LVN H indicated Resident #7 was awake and complaining of pain all over and was medicated with one Norco ,d+[DATE]mg pulled from the emergency kit. Record review of Resident #7's clinical note, dated [DATE] at 8:25 a.m., authored by the SW indicated Resident #7 was moaning while in bed reporting high level pain. Resident #7 had pain in his back, butt, legs, everywhere. During an interview on [DATE] at 12:20 p.m., the SW said she was completing Psychosocial wellbeing paperwork for Resident #7 on [DATE] at 8:25 a.m., and he was in bed moaning, reporting high level pain. She said Resident #7 had pain in his back, butt, legs, everywhere and had labored uneven breathing. She said she immediately notified the CN of his complaints of pain and spoke with Resident #7's family member. Record review of Resident #7's clinical note, dated [DATE] at 9:00 a.m., authored by LVN II indicated Resident #7 complained of excruciating pain generalized reporting pain on a scale of 10 out of 10. Resident #7 had labored breathing pattern and unmanageable pain. The note did not indicate the physician was notified of the resident complaining of excruciating pain with labored breathing patterns. Record review of Resident #7's SBAR form, dated [DATE] untimed and unsigned, indicated mental status change of decreased level of consciousness, labored or rapid breathing, and pain evaluation of a pain intensity of a 10 out of 10. Resident #7 transferred to the hospital. No indication that the primary care clinician was notified. Record review of Resident #7's hospital emergency department records dated [DATE] at 9:00 a.m. indicated Resident #7 was transferred to the ER from the nursing facility for uncontrolled pain and he was noted with multiple wounds to his body. Resident #7 was administered Fentanyl 80 mcg IVP for pain. The hospital notes indicated the resident was recently admitted to the nursing home from an acute care hospital and the nursing facility did not have his Fentanyl patch or hydrocodone in stock. Record review of Resident #7's clinical note, dated [DATE] at 2:24 p.m., authored by LVN I indicated Resident #7 returned to the facility and had a Fentanyl patch on his right shoulder for pain management. Resident #7 received a new order for cefuroxime axetil 500 mg tablet that was sent to pharmacy. There was no indication that the physician was notified that Resident #7 returned to the facility. Unable to interview LVN I, no return calls, or messages, attempted on [DATE] at 12:06 p.m. Record review of Resident #7's TAR for [DATE] indicated LVN II documented on [DATE] at 5:54 p.m. Resident #7's pain level an 8 out of 10 on the pain scale. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on [DATE] at 3:10 PM, LVN II said Resident #7 had chronic pain. LVN II said she knew the facility did not have Resident #7's pain medication in the building on [DATE]. LVN II said she did not notify the DON, ADON, or the physician of the resident complaining of pain when he returned from the ER. LVN II said I didn't think to call the doctor about his pain or give him anything because I knew he was sent to the hospital on the previous shift for his pain and received a Fentanyl pain patch. During an interview on [DATE] at 12:18 p.m., MD MM said he was the facility's medical director and Resident #7's attending physician. He said that him and his staff communicated with the nursing facility via a communication system. He stated he was unable to identify, in the communication system, any records regarding Resident #7s nursing facility admission, medication list, general admission assessment, pain assessment, the change in condition on [DATE], sending Resident #7 to the ER for unmanageable pain, nor on [DATE] when Resident #7 continued to have pain of an 8 after receiving Fentanyl patch at the ER. The Physician said if he was aware that Resident #7 required oxycodone for pain control upon admission to the nursing facility, he would have submitted the triple script, required, to the pharmacy, because he would have continued the resident current pain management regimen as ordered from the acute care facility. The Physician said he should have been notified immediately of Resident #7's uncontrolled or unmanageable pain so that he could have ordered medications for breakthrough pain, or an anti-inflammatory medication if not contraindicated with his transplant status. During an interview on [DATE] at 2:00 p.m., the ADON said the admitting charge nurse should have notified the attending physician of Resident #7's admission, need for a triple script for his oxycodone, general and pain assessment. The ADON said that if the triple script was obtained that Resident #7's oxycodone could have been ordered and emergent delivery by pharmacy to be available within 3 hours. The ADON said a pain assessment should have been completed and documented in the EMR on admission and during episodes of pain. The ADON said she was unable to provide or obtain documentation of admission pain assessment or pain assessment for [DATE] when episode of pain of 10 out of 10 or [DATE] when episode of pain of 8 out of 10. The ADON said pain should be assessed every shift, and as needed and unmanageable pain should be reported to physician immediately. The ADON said attending physician should be notified of resident admissions and changes in condition. During an interview on [DATE] at 2:12 p.m., the DON said she expected the nurses to notify the MD immediately for any changes in the residents, including increased pain, unavailable pain medications and/or ineffective pain medications. She said if a resident was having pain or if pain medication was unavailable, the staff could pull meds from emergency kits when it was not available and/or notify the MD of the pain medications available in the CMEK to administer immediately for pain relief until pain medications were available from pharmacy. She stated the MD needed to be part of the medical decision-making process. She stated a negative outcome of the MD not being involved could be untreated pain putting resident at risk of not receiving appropriate medical treatments, which could result in a decline in health. During an interview on [DATE] at 3:30 p.m., the Administrator said she expected the nurses to notify the MD immediately for any changes in the residents, including increased pain, unavailable pain medications and/or ineffective pain medications. She stated the nurses should follow the facility's policy regarding notifying MD of changes in condition, pain management, and the MD needed to be part of the medical decision-making process. She stated a negative outcome of the MD not being involved could be untreated pain putting resident at risk of not receiving appropriate medical treatments, which could result in a decline in health. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of the Change in a Resident's Condition or Status dated February 2021, 1. The nurse will notify the resident's attending physician or physician on call when there has been a(an): e. need to alter the resident's medical treatment significantly; g. need to transfer the resident to a hospital/treatment center . 2. A significant change of condition is a major decline or improvement in the resident's status that: a. will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self-limiting); b. impacts more than one area of the resident's health status . 3.Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR Communication Form.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47879 Based on observation, interview, and record review, the facility failed to ensure that licensed nursing staff were able to demonstrate the specific competencies and skill sets pain assessments, pain management, accessing CMEK, notifying physician of change in condition and arranging urgently needed medication order and delivery from pharmacy. The facility failed to ensure LVN II was competent in pain assessments, pain management, accessing CMEK, notifying physician of change in condition and both LVN II and UM/LVN H were competent in arranging urgently needed medication order and the delivery from pharmacy for 2 of 8 residents (Resident #7 and Resident #8) assessed for staff competency. The failure could place residents at risk for prolonged and unnecessary pain and suffering and a decreased quality of life. Findings included: Record review of the face sheet dated [DATE] indicated Resident #7 was admitted on [DATE], he was [AGE] years old with diagnoses including end stage renal disease (a condition where the kidneys have permanently lost their ability to function properly), dialysis encounter, failed kidney transplant, liver transplant status, congestive heart failure (a condition where the heart muscle is weakened and cannot pump blood effectively), lower back pain, and pain in lower limbs. Resident #7 expired on [DATE]. Record review of a discharge MDS assessment, dated [DATE], indicated Resident #7's pain assessment interview was not conducted. Resident #7 had a fall with major injury (bone fractures, joint dislocations, closed head injuries with alternated consciousness, subdural hematoma) since admission/entry to the nursing facility. Resident #7 used an opioid high-risk drug during the last seven days during the lookback period. Record Review of Resident #7's Brief Interview of Mental Status dated [DATE] indicated Resident #7 had a BIMS score of 14 and was cognitively intact. He was able to make daily decisions regarding task of daily life. Record review of Resident #7's baseline care plan, dated [DATE], indicated he received high risk/black box pain medications (narcotics) and had skin impairment of pressure and non-pressure ulcers. Review of Resident #7's physician orders for [DATE] indicated there was a prescription for pain medication oxycodone 5 mg tablet, one tablet, by mouth, as needed every four hours for unspecified pain for ten days starting [DATE], discontinued [DATE]. Resident #7 had an additional pain medication order for acetaminophen (Tylenol) 325 mg tablet, 2 tablets, by mouth, as needed every six hours starting [DATE] for unspecified pain. Resident #7 had another order for pain medication Hydrocodone 5 mg- acetaminophen 325 mg tablet (Norco), one tablet, by mouth, as needed every six hours starting [DATE] for unspecified open wound of lower back and pelvis. Resident #7 had an order for Fentanyl 50 mcg/hour transdermal patch one as needed every seventy-two-hours starting [DATE]. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #7's MAR for [DATE] indicated Resident #7 could be administered PRN Tylenol 325mg (2 tablets) by mouth, as needed every six hours starting [DATE] for unspecified pain, and hydrocodone 5 mg-acetaminophen 325 mg tablet (Norco) one tablet, by mouth, as needed every six hours starting [DATE] for unspecified pain for open wound of his lower back and pelvis. The resident was administered one hydrocodone 5 mg- acetaminophen 325 mg tablet (Norco) tablet on [DATE] at 5:44 p.m. with effectiveness. Resident #7 was not administered any pain medication on [DATE]. Record review of Resident #7's TAR for [DATE] indicated LVN II documented on [DATE] at 5:54 p.m. Resident #7's pain level an 8 out of 10 on the pain scale. Record review of the face sheet dated [DATE] indicated Resident #8 was admitted on [DATE], she was [AGE] years old with diagnoses including dementia (loss of cognitive functioning), chronic obstructive pulmonary disease (chronic obstructive pulmonary disease-a lung disease that blocks airflow making it difficult to breathe), and arthritis (painful inflamation and stiffness of the joints) Record review of a quarterly MDS assessment, dated [DATE], indicated Resident #8's received prn pain medication in the last 5 days. Pain assessment interview indicated Resident #8 did not have pain in the last 5 days. Record Review of Resident #8's Brief Interview of Mental Status dated [DATE] indicated Resident #8 had a BIMS score of 9 and was moderately impaired cognitively. She was able to make daily decisions regarding task of daily life. Record review of Resident #8's care plan, dated [DATE], indicated she will participate actively in making choices/decisions for care regarding pain management. Review of Resident #8's physician orders for [DATE] indicated there was a prescription for pain medication acetaminophen 300mg-codeine 30 mg tablet, one tablet, by mouth, as needed every twelve hours for unspecified pain starting [DATE] for pain of ,d+[DATE]. Resident #8 had an additional pain medication order for Tylenol Extra Strength 500 mg tablet, 2 tablets, by mouth, as needed every six hours for unspecified pain starting [DATE] for pain ,d+[DATE]. Record review of in-service dated [DATE], [DATE], and [DATE] indicated staff were in-serviced over change in condition and notifying physician. Record review of in-service dated [DATE] and [DATE] indicated staff were in-serviced over medication ordering and availability. Contents or summary of training for [DATE] authored by DON LL: We cannot run out of medications for anyone, for no reason. Please check you medication daily to ensure this. Evaluation, comments, or suggestions: Does not happen, we will non-compliant with MD orders delaying residents care with possible adverse reaction which could result in an immediate jeopardy. Please see me if you do not understand. Zero tolerance. Contents or summary of training for [DATE] authored by DON: Charge nurse must send all medication orders immediately to resident's pharmacy following medication ordering procedure, if medication dose is needed prior to the next scheduled pharmacy delivery, check emergency kit for the medication. If the medication is available in CMEK, remove only the dose that is needed. Fill out a CMEK charge slip and send it to pharmacy immediately, leaving one copy of the CMEK charge slip in the emergency kit. If medication is not in the emergency kit, call pharmacy to arrange for the immediate dose to be delivered from back-up pharmacy. DON and MD also must be notified immediately of any medication not available. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on [DATE] at 1:36 p.m., DON reported to CN/LVN NN and ADON that Resident #8 was on the call light for pain. CN/LVN NN told DON and ADON I just gave her pain medication the regular Tylenol 2 hours ago. DON and ADON replied to CN/LVN NN give her something for pain. CN/LVN NN goes to Resident #8's room to verify pain and stated to Resident #8 that she had received regular Tylenol for pain two hours ago. Resident #8 said I though I had Tylenol #3 available if needed. CN/LVN NN told Resident #8 that the MD had discontinued her Tylenol #3. Resident #8 asked why didn't the MD make me aware of the Tylenol #3 being discontinued, I was not aware. CN/LVN NN replied to Resident #8 I don't know. CN/LVN NN returns to the nurses' station and reports to ADON assessment and findings. CN/LVN NN and ADON look in the narcotic book and Resident #8 did not have a narcotic count sheet or narcotic medications in cart. ADON contacted MD's office for medication orders for Resident #8 pain. ADON and LVN W accessed the CMEK to get Acetaminophen 300mcg-codeine 30mg 1 tablet as ordered by MD. ADON gave the CN/LVN NN Acetaminophen 300mcg-codeine 30mg 1 tablet to be administered to Resident #8 for pain. During an interview on [DATE] at 3:15 p.m., LVN II said she was not aware that pain assessment was to be documented on a pain assessment form on admission or when pain level is greater than or equal to 1 on pain scale. LVN II said she knew the facility did not have Resident #7's pain medication in the building on [DATE]. LVN II said she did not notify the DON, ADON, or the physician of the resident complaining of pain when he returned from the ER. LVN II said I didn't think to call the doctor about his pain or give him anything because I knew he was sent to the hospital on the previous shift for his pain and received a Fentanyl pain patch. LVN II was not able to identify the procedure for accessing the CMEK and said she would have to call someone else for guidance because she was prn staff and was unaware of that medication could be ordered with an urgent delivery method (less than 3 hours). During an interview on [DATE] at 11:39 a.m., UM/LVN H said she was not aware of the procedures for ordering urgent delivery medications from the pharmacy and would have to call someone else for guidance. During an interview on [DATE] at 2:12 p.m., the DON said the nursing staff was trained on hire, annually and as required. The DON said she expected the nurses to be competent in notifying the MD immediately for any changes in the residents, including increased pain, unavailable pain medications and/or ineffective pain medications. She said she expected the nurses to be competent in pain assessment, pain management and accessing needed medications from the emergency kits when it was not available and getting urgent medications from the pharmacy. She stated lack of staff competencies could result in negative outcome of the MD not being involved could be untreated pain putting resident at risk of not receiving appropriate medical treatments, which could result in a decline in health. During an interview on [DATE] at 3:30 p.m., the Administrator said she expected the nurses to be competent with assessments, pain management, accessing emergency kit, notifying pharmacy of urgent needed medications, and notifying the MD immediately for any changes in the residents. She stated lack of staff competencies could put resident at risk of not receiving appropriate medical treatments, which could result in a decline in health. She said with notify the MD immediately for any changes in the residents, including increased pain, unavailable pain medications and/or ineffective pain medications. She stated the nurses should follow the facility's policy regarding notifying MD of changes in condition, pain management, and the MD needed to be part of the medical decision-making process. She stated a negative outcome of the MD not being involved could be untreated pain putting resident at risk of not receiving appropriate medical treatments, which could result in a decline in health. (continued on next page)

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	03/11/2025

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

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Pain Management Policy dated [DATE]. A Pain Assessment must be completed for a Patient upon admission, including re-admission, the onset or an increase in Pain, quarterly and with any significant change in the Patient's condition. 2. Every Patient must be assessed for pain utilizing the Pain Intensity Scale (Faces/ ,d+[DATE]) or PAINAD for the non-verbal, cognitively impaired patient. a) Every shift. b) Prior to and one hour following the administration of as needed Pain medication. c) Prior to and immediately following any invasive procedure, including dressing changes. 3. If a Patient's Pain intensity score is greater than or equal to 1 or has been assessed with non-verbal/non-cognitive signs of Pain; the Pain must be addressed through pharmacological and/or non-pharmacological Pain interventions and documented. 4. If a Patient is assessed with Pain that limits function, the Patient must be screened by appropriate therapy disciplines. 5. If a Patient is assessed for unrelieved Pain, the nurse must notify the attending physician to obtain an order for appropriate Pain management. 6. A care plan must be completed and/ or updated for any changes to Pain Management interventions. 7. The Monthly Quality Assurance & Performance Improvement Meeting (PCMS 19) must include a review of appropriate and timely usage of the Pain Assessment, the intensity score, and the use of appropriate Pain-relieving measures. Record review of the Medication Ordering Procedures dated [DATE], Purpose: To ensure that medications are ordered appropriately and to assist both the Facility and Pharmacy in maintaining a timely medication re-ordering schedule. Procedure: . 5. If a medication dose is needed prior to the next scheduled pharmacy delivery, check the emergency kit for the medication. If the medication is available in the emergency kit, remove only the dose that is needed. Fill out a CMEK charge slip and fax/scan immediately to Pharmacare. Leave one copy of the CMEK charge slip in the emergency kit. If the medication is not in the emergency kit, call Pharmacare. The pharmacist will try to arrange for the needed doses to be delivered from a back-up pharmacy. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Controlled Medication Emergency Kit Policy dated [DATE], it is the policy of the facility to provide appropriate pain management therapy through the utilization of a Controlled Medication Emergency Kit (CMEK) for initial dose(s) of pain medication. Pharmacy is registered with the Drug Enforcement Agency (DEA) and the Texas Department of Public Safety (DPS) to maintain controlled substances. Pharmacy will provide the DPS-registered nursing facility with a Controlled Medication Emergency Kit (CMEK). Medications provided in the CMEK are as follows: Diazepam injection (generic name) Valium (brand name) 5mQ/ml (strength) IM/IV (route) 10 ml (quantity); Diphenoxylate/atropine (generic name) Lomotil (brand name) 2XXX,d+[DATE].025 (strength) po (route) 6 (quantity); hydrocodone/APAP (generic name) Norco (brand name) ,d+[DATE] (strength) po (route) 20 (quantity); hydrocodone/APAP (generic name) Norco (brand name) 7XXX,d+[DATE] (strength) po (route) 20 (quantity); hydrocodone/APAP (generic name) Norco (brand name) ,d+[DATE] (strength) po (route) 20 (quantity); lorazepam (generic name) Ativan (brand name) 0.5 (strength) po (route) 20 (quantity); Propoxyphene-N/APAP (generic name) Darvocet N-100 (brand name) ,d+[DATE] (strength) po (route) 20 (quantity); Alprazolam (generic name) Xanax(brand name) 0.25mg (strength) po (route) 20 (quantity); and Zolpidem (generic name) Ambien (brand name) 5mg (strength) po (route) 12 (quantity). Procedure: 1. The facility will maintain the CMEK controlled medications in a sealed container with a serial numbered lock that will be stored in a designated medication cart. 2. Upon receipt of the CMEK, a narcotic count will be conducted by a licensed nurse and recorded on the CMEK Use Log and the serial numbered lock verified on the sealed container. The CMEK must be a part of the change-of-shift narcotic count of the designated medication cart. This is to be documented on the Shift-to-Shift Count Verification Form. 3. Medications dispensed from the CMEK require a physician's order. 4. Medications removed from the CMEK are to be recorded on the Controlled Medication Emergency Kit (CMEK) Usage Log. 5. After the appropriate medication is removed from the CMEK, a new serial numbered lock is to be placed on the sealed container and recorded on the CMEK Use Log. 6. After recording the removal of medication on the CMEK Usage Log, a copy of the CMEK Usage Log must be faxed to pharmacy as notification that medication was removed from the CMEK. 7. Pharmacy will replace the Controlled Medication Emergency Kit (CMEK) once weekly or as needed. A copy of the CMEK Usage Log should be returned with the CMEK to the pharmacy. Special Note: If a patient requires an emergency dose of Valium injection, the appropriate dose should be withdrawn from the vial contained in the CMEK. Once the appropriate dose has been administered, medication remaining in the multi-dose vial shall be discarded per facility policy for wasting controlled substance medication (i.e., wasting shall be witnessed by two nurses).

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30664 Based on observation, interview and record review, the facility failed to establish a system of receipt and disposition of all controlled drugs in sufficient detail to enable accurate reconciliation and determine that drug records were in order and that an account of all controlled drugs were maintained and periodically reconciled for 2 of 2 residents (Resident #6 and Resident #7) reviewed for controlled medications. 1. Resident #6's hydrocodone 7.5 mg /acetaminophen 325 mg (narcotic pain medication for moderate or severe pain) were not accounted for at the time of discharge [DATE] and remained unaccounted for after his discharge. 2. The facility did not have pain medication for Resident #7 for a complaint of pain intensity level of 10 (worst pain possible) out of 10 on [DATE] and pain intensity level of 8 (severe pain) out of 10 on [DATE]. This failure could place residents at risk for medication overdose, medication under-dose, ineffective therapeutic outcomes, and drug diversion. Findings included: 1. Record review of the face sheet dated [DATE] indicated Resident #6 was a [AGE] year-old male admitted on [DATE]. His diagnoses included malignant neoplasm of pancreas (cancer of the part of the digestive system and produces insulin and other important enzymes and hormones that help break down foods) , intestinal obstruction (a blockage that prevents food or liquid from passing through the small or large intestine), and pain. Record review of the MDS dated [DATE] indicated he was able to hear without difficulty, he could able to be understood and could understand others, he had clear speech, he was cognitively intact, he received no routine or PRN pain medications, he had no pain, and he received no opioid medications. Record review of the July and [DATE] physician orders indicated Resident #6 had no order for hydrocodone 7.5 mg /acetaminophen 325 mg. Record review of the July and [DATE] MARs indicated Resident #6 had not received any hydrocodone 7. 5mg /acetaminophen 325 mg. Record review of the discharge paperwork indicated Patient Medication Profile sheets for Resident #6 listing the following medications: * furosemide (fluid pill) 20 mg-28 tablets; * telmisartan (blood pressure medication) 40 mg-28 tablets; * hydrochlorothiazide (fluid pill) 12.5 mg-28 tablets; (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* potassium chloride (mineral supplement) ER 20 mEq-58 tablets; * Creon (digestive enzymes) 12,,d+[DATE],000- 60,000 unit capsule-78 capsules; and * insulin glargine-yfgn (U-100) 100 unit mL-1 vial. The forms were signed by the resident as receiving the medication to discharge. There was no hydrocodone 7.5 mg /acetaminophen 325 mg listed. Record review of a Provider Investigation Report dated [DATE] indicated a Drug Diversion of Resident #6's hydrocodone 7.5 mg /acetaminophen 325 mg. It was reported by a family member that Resident #6 discharged to another facility and his hydrocodone 7.5 mg /acetaminophen 325 mg was not sent with him. The facility searched all medication carts, medication rooms, and drug destruction bins. During an interview on [DATE] at 01:45 p.m. LVN X said Resident #6's family brought in a bottle of hydrocodone 7.5 mg /acetaminophen 325 mg a couple of days after he had admitted . She said she did not see an order for the medication when she checked the orders. She said she and another nurse counted the medication and made a count sheet for it then she placed it on the medication cart. During an interview on [DATE] at 03:32 p.m. the ADON said Resident #6's family member called the facility looking for his hydrocodone 7.5 mg /acetaminophen 325 mg. She said they thought it might still be located on the medication cart. She said it was not on the medication cart so they thought since he discharged it may have been put in the medication destruction to be destroyed but it was not on list of medications, and they could not locate the narcotic count sheet that was with the bottle. Drug tests were conducted on all staff that had access to the medication with all results being negative. The report indicated the facility was not able to determine if the medication was inappropriately taken by a staff member, if it was not appropriately disposed of, or what definitively happen to it. During an interview on [DATE] at 04:25 p.m. the Administrator said she expected staff to follow policy regarding narcotic medications to prevent drug diversions. Record review of a Transfer or Discharge, Facility-Initiated policy dated [DATE] indicated Documentation of Facility-Initiated Transfer or Discharge 1. When a resident is transferred or discharged from the facility, the following information is documented in the medical record: a. The basis for the transfer or discharge; (1) If the resident is being transferred or discharged because his or her needs cannot be met at the facility, documentation will include: a) the specific resident needs that cannot be met; b) this facility's attempt to meet those needs; and (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c) the receiving facility's service(s) that are available to meet those needs; b. That an appropriate notice was provided to the resident and/or legal representative; c. The date and time of the transfer or discharge; d. The new location of the resident; e. The mode of transportation; f. A summary of the resident's overall medical, physical, and mental condition; g. Disposition of personal effects; h. Disposition of medications; i. Others as appropriate or as necessary; and j. The signature of the person recording the data in the medical record 2. Record review of the face sheet dated [DATE] indicated Resident #7 was admitted on [DATE], he was [AGE] years old with diagnoses including end stage renal disease (a condition where the kidneys have permanently lost their ability to function properly), dialysis encounter, failed kidney transplant, liver transplant status, congestive heart failure (a condition where the heart muscle is weakened and cannot pump blood effectively), lower back pain, and pain in lower limbs. Resident #7 expired on [DATE]. Record review of a discharge MDS assessment, dated [DATE], indicated Resident #7's pain assessment interview was not conducted. Resident #7 had a fall with major injury (bone fractures, joint dislocations, closed head injuries with alternated consciousness, subdural hematoma) since admission/entry to the nursing facility. Resident #7 used an opioid high-risk drug during the last seven days during the lookback period. Record Review of Resident #7's Brief Interview of Mental Status dated [DATE] indicated Resident #7 had a BIMS score of 14 and was cognitively intact. He was able to make daily decisions regarding task of daily life. Record review of Resident #7's baseline care plan, dated [DATE], indicated he received high risk/black box pain medications (narcotics) and had skin impairment of pressure and non-pressure ulcers. Review of Resident #7's physician orders for [DATE] indicated there was a prescription for pain medication oxycodone 5 mg tablet, one tablet, by mouth, as needed every four hours for unspecified pain for ten days starting [DATE], discontinued [DATE]. Resident #7 had an additional pain medication order for acetaminophen (Tylenol) 325 mg tablet, 2 tablets, by mouth, as needed every six hours starting [DATE] for unspecified pain. Resident #7 had another order for pain medication Hydrocodone 5 mg- acetaminophen 325 mg tablet (Norco), one tablet, by mouth, as needed every six hours starting [DATE] for unspecified open wound of lower back and pelvis. Resident #7 had an order for Fentanyl 50 mcg/hour transdermal patch one as needed every seventy-two-hours starting [DATE]. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #7's MAR for [DATE] indicated Resident #7 could be administered PRN Tylenol 325mg (2 tablets) by mouth, as needed every six hours starting [DATE] for unspecified pain, and hydrocodone 5 mg-acetaminophen 325 mg tablet (Norco) one tablet, by mouth, as needed every six hours starting [DATE] for unspecified pain for open wound of his lower back and pelvis. The resident was administered one hydrocodone 5 mg- acetaminophen 325 mg tablet (Norco) tablet on [DATE] at 5:44 p.m. with effectiveness. Resident #7 was not administered any pain medication on [DATE]. Record review of Resident #7's TAR for [DATE] indicated LVN II documented on [DATE] at 5:54 p.m. Resident #7's pain level an 8 out of 10 on the pain scale. Record review of Resident #7's clinical note, dated [DATE] at 6:53 a.m., authored by LVN T indicated Resident #7 had multiple wounds on his body including open areas to his left hip, left leg, below his knee, under his knee, bilateral heels, left elbow, and an open wound to his sacrum. Resident #7 had limited bed mobility and required assistance for repositioning. Record review of Resident #7's clinical note, dated [DATE] at 5:44 p.m., authored by LVN H indicated Resident #7 was awake and complaining of pain all over and was medicated with one Norco ,d+[DATE]mg pulled from the emergency kit. Record review of Resident #7's clinical note, dated [DATE] at 8:25 a.m., authored by the SW indicated Resident #7 was moaning while in bed reporting high level pain. Resident #7 had pain in his back, butt, legs, everywhere. During an interview on [DATE] at 12:20 p.m., the SW said she was completing Psychosocial wellbeing paperwork for Resident #7 on [DATE] at 8:25 a.m., and he was in bed moaning, reporting high level pain. She said Resident #7 had pain in his back, butt, legs, everywhere and had labored uneven breathing. She said she immediately notified the CN of his complaints of pain and spoke with Resident #7's family member. Record review of Resident #7's clinical note, dated [DATE] at 9:00 a.m., authored by LVN II indicated Resident #7 complained of excruciating pain generalized reporting pain on a scale of 10 out of 10. Resident #7 had labored breathing pattern and unmanageable pain. The note did not indicate the physician was notified of the resident complaining of excruciating pain with labored breathing patterns. Record review of Resident #7's SBAR form, dated [DATE] untimed and unsigned, indicated mental status change of decreased level of consciousness, labored or rapid breathing, and pain evaluation of a pain intensity of a 10 out of 10. Resident #7 transferred to the hospital. No indication that the primary care clinician was notified. Record review of Resident #7's hospital emergency department records dated [DATE] at 9:00 a.m. indicated Resident #7 was transferred to the ER from the nursing facility for uncontrolled pain and he was noted with multiple wounds to his body. Resident #7 was administered Fentanyl 80 mcg IVP for pain. The hospital notes indicated the resident was recently admitted to the nursing home from an acute care hospital and the nursing facility did not have his Fentanyl patch or hydrocodone in stock. During an interview on [DATE] at 3:10 PM, LVN II said Resident #7 had chronic pain. LVN II said she knew the facility did not have Resident #7's pain medication in the building on [DATE]. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 2:00 p.m., the ADON said the admitting charge nurse should have notified the attending physician of Resident #7's admission, need for a triple script for his oxycodone, general and pain assessment. The ADON said that if the triple script was obtained that Resident #7's oxycodone could have been ordered and emergent delivery by pharmacy to be available within 3 hours. During an interview on [DATE] at 2:12 p.m., the DON said she expected the nurses to notify the MD immediately for any changes in the residents, including increased pain, unavailable pain medications and/or ineffective pain medications. She said if a resident was having pain or if pain medication was unavailable, the staff could pull meds from emergency kits when it was not available and/or notify the MD of the pain medications available in the CMEK to administer immediately for pain relief until pain medications were available from pharmacy. She stated the MD needed to be part of the medical decision-making process. She stated a negative outcome of the MD not being involved could be untreated pain putting resident at risk of not receiving appropriate medical treatments, which could result in a decline in health. During an interview on [DATE] at 3:30 p.m., the Administrator said she expected the nurses to notify the MD immediately for any changes in the residents, including increased pain, unavailable pain medications and/or ineffective pain medications. She stated the nurses should follow the facility's policy regarding notifying MD of changes in condition, pain management, and the MD needed to be part of the medical decision-making process. She stated a negative outcome of the MD not being involved could be untreated pain putting resident at risk of not receiving appropriate medical treatments, which could result in a decline in health.