

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455538	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/17/2026
NAME OF PROVIDER OR SUPPLIER Magnolia Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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** Based on interview and record review the facility failed to provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing and administering of all drugs and biologicals, to meet the needs of each resident for 1 of 8 residents (Resident #1) reviewed for pharmacy services. The facility failed to accurately reconcile and transcribe Resident #1's hospital discharge medication on facility admission which resulted in Resident #1 not receiving 66 doses of levothyroxine (thyroid) medication. The facility failed to complete a secondary reconciliation of Resident #1's admission orders from the hospital to ensure all orders were transcribed, ordered, and administered. The facility failed to review and complete the pharmacy recommendation of clarifying Resident #1's order for levothyroxine. This failure could place residents at risk of not receiving medication and decline of health. Findings include: Record review of Resident #1's face sheet, dated 06/16/26, indicated a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included hypothyroidism (underactive thyroid disease), diabetes (body cannot use blood sugar properly), acquired absence of right leg below knee, and major depressive disorder (serious mental health condition). Record review of Resident #1's admission MDS assessment, dated 04/03/26, indicated she was admitted to the facility on [DATE]. She was usually able to make herself understood and usually understood others. She was cognitive (BIMS-13). Her active diagnosis included diabetes, acquired absence of right leg below knee, and thyroid disorder, depression, and hypothyroidism. Record review of Resident #1's comprehensive care plan printed on 06/16/26 indicated her diagnosis included hypothyroidism. There was no specific care plan related to the diagnosis of hypothyroidism. Record review of Resident #1's hospital Discharge summary, dated [DATE] (obtained from the hospital on [DATE]), indicated her diagnosis included chronic hypothyroidism. Continue Synthroid 200 mcg if within normal reference levels. Patient Instructions and Medications list included levothyroxine 200 mcg-take 200 mcg by mouth daily. She was administered levothyroxine 200 mcg in hospital on [DATE], prior to discharge to facility. The facility was unable to locate the original document. Record review of Resident #1's physician orders, printed on 06/16/26, for the period of 04/01/26 through 06/05/26 included a diagnoses of hypothyroidism. There was no order for medication to treat hypothyroidism. Record review of Resident #1's MAR for 04/2026 indicated there was no medication administered to treat hypothyroidism. Record review of Resident #1's MAR for 05/2026 indicated there was no medication administered to treat hypothyroidism. Record review of Resident #1's MAR for 06/01/2026 through 06/05/2026 indicated there was no medication administered to treat hypothyroidism. Record review of progress note, dated 04/01/26 at 5:40 p.m., completed by LVN A, indicated Resident #1 was admitted to the facility at 2:30 p.m. MD B and NP C notified of Resident #1's admission. There was no documentation of medication review. Record review of Resident #1's pharmacy review, dated 04/03/26 completed by Pharmacist E, indicated to ensure levothyroxine was discontinued on admission. Record review of Resident #1s progress note, dated 04/09/26 at 8:55 a.m., completed by LVN G indicated CMP, TSH, and CBC results received and sent to NP C. No new orders. Record review of Resident #1's new admission (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	note, dated 04/02/26, signed by MD B and NP C on 04/16/26, indicated her diagnosis included hypothyroidism: check TSH and continue Synthroid 200 mcg daily. Medication list included levothyroxine (Synthroid) 200 mcg PO daily. Medication reconciliation list did not include levothyroxine (Synthroid) 200 mcg PO daily. Assessment indicated hypothyroidism. Plan included: chronic hypothyroidism, not on thyroid medication, TSH 3.26 (4/2026). Record review Resident #1's follow-up by NP C, dated 04/09/26 (signed by NP C on 04/16/26), indicated her diagnosis included hypothyroidism: check TSH and continue Synthroid 200 mcg daily. Medication list included levothyroxine (Synthroid) 200 mcg PO daily. Medication reconciliation list did not include levothyroxine (Synthroid) 200 mcg PO daily. Lab done at facility on 04/07/26 indicated TSH level at 3.260 (A TSH level of 3.2 mIU/L (is a unit used in laboratory tests to quantify the concentration of substances such as hormones in the blood) is generally considered within the standard normal range, but it may be slightly above the optimal range for thyroid function). Labs reviewed did not indicate discontinuation of Synthroid. Assessment indicated hypothyroidism. Plan included: chronic hypothyroidism, not on thyroid medication, TSH 3.26 (4/2026). Record review Resident #1's follow-up by NP C, dated 04/16/26 (signed by NP C on 04/16/26), indicated her diagnosis included hypothyroidism: check TSH and continue Synthroid 200 mcg daily. Medication list included levothyroxine (Synthroid) 200 mcg PO daily. Medication reconciliation list did not include levothyroxine (Synthroid) 200 mcg PO daily. Lab done at facility on 04/07/26 indicated TSH level at 3.260. Labs reviewed did not indicate discontinuation of Synthroid. Assessment indicated hypothyroidism. Plan included: chronic hypothyroidism, not on thyroid medication, TSH 3.26 (4/2026). Record review Resident #1's follow-up by NP C dated 05/05/26 (signed by NP C on 05/05/26) indicated her diagnosis included hypothyroidism: check TSH and continue Synthroid 200 mcg daily. Medication list included levothyroxine (Synthroid) 200 mcg PO daily. Medication reconciliation list did not include levothyroxine (Synthroid) 200 mcg PO daily. Lab done at facility on 04/07/26 indicated TSH level at 3.260. Labs reviewed did not indicate discontinuation of Synthroid. Assessment indicated hypothyroidism. Plan included: chronic hypothyroidism, not on thyroid medication, TSH 3.26 (4/2026). Record review of Resident #1's hospital records, dated 06/06/26 through 06/15/26, indicated Resident #1 was admitted from home after she tripped and fell onto her couch. She complained of back pain. She reported she had not had her thyroid medication for over two months. Lab results dated 06/06/26 (included with Resident #1's hospital record dated 06/06/26-06/15/26) indicated TSH level of 155.000-high. Resident #1's diagnoses included hypothyroidism (uncontrolled), elevated TSH with low T4, continue levothyroxine and monitor thyroid function. During an interview on 06/16/26 at 8:57 a.m., Resident #1 said she was discharged from one facility on 03/22/26. She said she had a fall the day she was discharged and was subsequently admitted again to the hospital. She said she was discharged to a second facility on 04/01/26. She said she was discharged from the facility on 06/05/26. She said the second facility never gave her thyroid medications for the entire time of her stay. She said her diagnosis included Hashimoto's (autoimmune disorder that affects the thyroid gland and causes hypothyroidism) and hypothyroidism. She said she asked a nurse if she was getting the medication and the nurse said she was not, but she could not recall the name of the nurse or when she asked about the medication. She said she did not feel any different and did not have any symptoms or complications because she did not receive her levothyroxine. During an interview on 06/16/26 at 1:37 p.m., LVN A said she utilized Resident #1's discharge medication list that was provided by the hospital for her admission to the facility on [DATE]. She said she reviewed the medications and entered the medications in the electronic record. She said she recalled clarification of a narcotic pain medication but did not recall clarification of other medications. She said she placed the discharge summary in a drawer for medical records to upload to Resident #1's electronic record. She said she did not recall any medication issues. During an interview on 06/16/26 at 2:00 p.m., ADON D said she did not review Resident #1's admission medications on 04/02/26 for accuracy as she was on vacation. During an interview on (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	06/16/26 at 2:36 p.m., NP C said she usually reviewed resident medications that were uploaded in the electronic record for accuracy. She said she did not know and could not recall reviewing Resident #1's medication list. She said she could not locate the medication list in the electronic record. She said she documented in her notes on 04/26/26 that Resident #1 was not on thyroid medication. She said the risk of not being administered thyroid medication as ordered could cause fatigue, weight gain, and hair loss. She said Resident #1's thyroid levels reported on 04/08/26 indicated her levels were within normal limits. She could not say why Resident #1's levothyroxine was not started upon admission to the facility. During an interview on 06/16/26 at 2:40 p.m., the DON said Pharmacist E's recommendation, dated 04/03/26, was intended to ensure the levothyroxine was discontinued. She said Pharmacist D must have noted the levothyroxine was discontinued in the hospital discharge summary. She said since it was not started, it did not require a discontinue order. She said medications entered upon admission to the facility were reviewed at the next morning meeting. She said she could not locate any documentation the medication list was reviewed. She said Resident #1's medications should have been reviewed on 04/02/26, but there was no written documentation to confirm the review. She said she could not locate Resident #1's original discharge medication list. She said the list was usually uploaded to the resident's electronic record after admission to the facility, after the admitting nurse entered the medication into the electronic record. She said the risk of not receiving the medication as ordered could lead to medical decline. During an interview on 06/16/26 at 2:45 p.m., Pharmacist E said Resident #1's record indicated the levothyroxine was not activated. She said she could not locate a discontinued order in the electronic record. She said the recommendation to ensure the levothyroxine was discontinued indicated the nursing staff needed to clarify the order. During an interview on 06/17/26 at 9:57 a.m., the Medical Director indicated he had spoken with the DON and was understanding there might have been a confusion related to Resident #1's medication orders. He said he believed the thyroid medication was not ordered because Resident #1's thyroid levels were within normal limits. He said it was not normal practice to discontinue thyroid medication if the thyroid levels were within normal limits and there was a diagnosis of hypothyroidism. He said he would have continued the levothyroxine as listed in the discharge summary. He said the risk of not taking thyroid medication could manifest symptoms of hypothyroidism. He said thyroid medication had a long half-life (estimation of time it takes for the drug's initial concentration in the body to decrease by half) and there would not necessarily be life threatening complications. He said there could be weight gain, fatigue, and hair loss. MD B (primary physician) was out of the country as of the date of the investigation and not available for interview. Record review of a blank, undated, New Admission/re-admission Nurse check off list provided by the facility on 06/16/26 indicated . verify all orders with primary physicians .		