| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455538 | A. Building<br>B. Wing | 07/02/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Magnolia Manor | 4400 Gulf St<br>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 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the assessments accurately reflected the resident's status for 2 of 20 residents reviewed for accuracy of assessments. (Residents #73 and #86) 1. The facility failed to ensure Resident #73's most recent quarterly assessment captured the resident's range of motion (ROM) limitations to her left lower extremity. 2. The facility failed to ensure Resident # 86's most recent quarterly assessment captured the resident's range of motion limitations to her right lower extremity. These failures could place the residents at risk for not receiving the appropriate care and services.<br><br>Findings included:<br><br>1. Record review of a face sheet dated 07/02/25 indicated Resident #73 was a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnosis included chronic embolism (a blockage in a blood vessel caused by a substance like a blood clot that traveled from elsewhere in the body) and thrombosis (blood clot forming in a vein or artery, which can obstruct blood flow), pain in leg, and resistant hypertension (a type of high blood pressure that remains uncontrolled when taking five or move different types of antihypertensive medications at maximum or near-maximum dosage).<br><br>Record review of a quarterly MDS assessment dated [DATE] indicated Resident ##73 had a BIMS score of 9 indicating she had moderately impaired cognition, required substantial/maximal assistance with most ADLs, and had no functional limitation to her upper and lower extremities.<br><br>Record review of a care plan dated 04/29/25 indicated Resident #73 had a contracture (a structural change in the body’s soft tissue, like muscles, tendons, and ligaments, or skin that causes them to stiffen and shorten) to her left knee. Goals indicated contractures would not increase. Interventions included providing pressure relieving devices on bed and chair.<br><br>During an observation and interview on 06/30/25 at 10:30 a.m., Resident #73 was lying in bed with her left leg positioned with a pillow and bent at the knee. She said she had not been able to straighten her left knee for years. She said she had received physical therapy several times at the facility, and it had not helped her knee.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a telephone interview on 07/02/25 at 9:38 a.m., the former MDS Nurse said that Resident #73 had a contracture of her left knee. She said she always assessed a resident before completing their MDS assessment. She said Resident#73 was admitted to the facility with a contracture of her left knee and she coded her MDS as having no functional limitations because her contracture was her baseline normal. She said she followed RAI instructions when coding an MDS. She said the DON had final approval on all MDS assessments and was her direct supervisor at the facility. She said she had worked at the facility for one year as the MDS Nurse before she left her position on 05/29/25. She said she was not able to answer anymore questions and hung up the phone.<br><br>During an interview on 07/02/25 at 12:19 p.m., LVN B said she had worked at the facility for 1 year and regularly took care of Resident #73. She said her left knee was permanently contracted and nursing interventions included positioning for comfort and to prevent further contracture of her knee. She said if she assessed Resident #73 to have increased pain or decreased ROM she would report the change to her physician.<br><br>During an interview on07/02/25 at 1:35 p.m., the DON said she expected MDS assessments to be correctly coded to reflect the resident’s status. She said Resident #73’s functional limitations were not coded correctly in her MDS and did not reflect her limited ROM of her left knee. She said the possible negative outcome of an inaccurately coded MDS could be the resident’s needs not being addressed in their care plan. She said she was the direct supervisor of the former MDS Nurse.<br><br>2. Record review of a face sheet dated 07/01/25 indicated Resident #86 was a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnosis included cerebral infarction (a condition where blood flow to the brain is blocked leading to brain tissue damage or death due to oxygen deprivation) hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body) following cerebrovascular disease (a group of conditions that impact the brain’s blood vessels and blood flow), and contracture of muscle of unspecified lower leg.<br><br>Record review of a significant change MDS dated [DATE] indicated resident #86 had a BIMS score of 6 indicating she had severe cognitive impairment, required substantial/maximal assistance with most ADLs, and had no impairment in range of motion or functional limitation of her upper or lower extremities.<br><br>Record review of a care plan dated 04/15/25 indicated Resident #86 was at risk for skin breakdown and increased pain related to her contracture of her right elbow. The care plan did not address her contracture of her right hip and knee.<br><br>During an observation on 06/30/25 at 10:30 a.m., Resident #86 was lying in bed in her room with her right side completely covered. Resident pulled back the bed covers to show her right leg which was bent at her hip and knee and contracted on top of her right arm. She had a right below the knee amputation (BKA). She used her left hand to open her right knee approximately 2 inches but was unable to move her right hip or arm.<br><br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 07/01/25 at 1:30 p.m., LVN A said she had worked at the facility for 7 months. She said she regularly took care of Resident #86. She said Resident #86 was admitted to the facility with her right BKA and contractures to her right elbow, hip and knee. She said the resident was lifted and turned using the bed pad to protect her contractures. She said nursing used pillows and positioning for comfort and to prevent any increase in her contractures.<br><br>During a telephone interview on 07/02/25 at 9:38 a.m., the Former MDS Nurse said Resident #86 had contractures to her right elbow, right knee, and right hip. She said she also had a BKA of her right leg. She said Resident #86 was admitted to the facility with the contractures on her right side and her right BKA, so she coded her ROM on her MDS as having no impairment because the hemiparesis and contractures were her normal. She said she followed RAI instructions when coding an MDS. She said the DON had final approval on the care plan and was her direct supervisor at the facility. She said she worked at the facility for one year as the MDS nurse and left on 5/29/25. She said she was not able to answer any more questions.<br><br>During an interview on 07/02/25 at 9:56 a.m., the Regional Director of Clinical Operations said Resident #86’s MDS was inaccurately coded by the Former MDS Nurse. She said the MDS showed Resident #86 to have no impairment in her ROM and did not reflect impairment to her right side due to her hemiplegia, contractures, and right BKA. She said her expectation was for all resident MDS assessments to be coded according to RAI instructions and Resident #86’s MDS was not coded accurately which could lead to her plan of care not being accurate and complete.<br><br>During an interview on 07/02/25 at 10:21 a.m., the DON said Resident #86’s MDS did not accurately document her right sided range of motion limitations. She said inaccurate coding of the MDS could lead to an incomplete or inaccurate care plan for the resident. She said the facility did not have an MDS policy and followed the RAI (resident Assessment Instrument) for coding MDS assessments.<br><br>During an interview on 07/02/25 at 2:21 p.m., the Administrator said she expected resident’s MDS to be coded correctly to reflect the resident’s care needs.<br><br>Record review of the Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual last updated May 2025 indicated …”1. Review the medical record for references to functional range-of-motion limitations during the 7-day observation period. 2. Talk with staff members who work with the resident as well as family/significant others about any impairment in functional ROM. … 4. Assess the resident’s ROM bilaterally … 6. Although this item codes for the presence or absence of functional limitation related to ROM, thorough assessment ought to be comprehensive and follow standards of practice for evaluating ROM impairment.” … |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality of care for 1 of 13 residents (Resident #244) reviewed for new admissions. The facility to develop and accurately complete a baseline care plan within 48 hours of admission for Resident #244.This failure could lead to residents not receiving necessary care and decreased quality of life. Record review of Resident #244's face sheet, dated 07/02/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included chronic gout (characterized by repeated episodes of joint pain and inflammation due to uric acid in the blood), emphysema (chronic lung disease that progressively damages the tiny air sacs in the lung, making it difficult to breathe), and adjustment disorder with anxiety. Record review of the 5-day MDS showed in progress in Resident #244's clinical record due to admission date of 06/28/2025.Record review of Resident #244's July 2025 MAR he was administered tramadol HCL 50 mg twice on 07/01/2025. Resident #244 had rated his pain as an 8 out of 10. Resident #244 also received allopurinol 100 mg once daily for gout. The baseline care plan dated 06/28/2025 for Resident #244 did not contain the following CMS guideline required information:*Precautionary plan for fall risk;*Dietary instructions for No Added Salt diet;*Prescribed PRN (as needed) pain medications;*Prescribed routine medications; *Physician treatment orders related to MASD (moisture associated skin damage) to scrotum *Prescribed therapy services; and*Failed to provide Resident #244 and his representative with a summary of the baseline care plan. During an interview on 07/02/2025 at 12:45 p.m., after reviewing Resident #244's baseline care plan together, the DON and the Regional Director of Clinical Services said the document should have contained fall risk, dietary instructions, physician treatment orders, prescribed therapy services, etc. The DON and Regional Director of Clinical Services said all fields of a baseline care plan should be completed, a copy reviewed, signed by resident and his representative, and a copy provided to them. They each acknowledged the baseline care plan was incomplete with accurate information regarding care for Resident #244 and a copy had not been presented to Resident #244 or his representative and should have been. During an interview on 07/02/2025 at 03:00 p.m., the administrator said her expectations were for all baseline care plans to be complete and accurate. She said the DON was responsible to ensure. All staff have been trained and retrained. The administrator said the Admissions Nurse had previously been responsible for completing baseline care plans, however due to performance issues, she was no longer employed at facility and a new employee had started within the past week. The administrator added if baseline care plans were not done properly, it was considered incomplete. The administrator said the risk of an incomplete baseline care plan was facility staff to fail to provide person-centered care. Record review of a policy titled Care Plans - Baseline dated March 2022, indicated the following. A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission. Policy Interpretation and Implementation.1. The baseline care plan includes instructions needed to provide effective person-centered care of the resident that meet professional standards of quality care and must include the minimum health care information necessary to properly care for the resident including but not limited to the following:initial goals based on admission orders in discussion with the representative, physician's orders, dietary orders, therapy services.#4 the resident and or representative are provided a written summary of the baseline care plan in a language that the resident representative can understand that includes but is not limited to the following did the stated goals and objectives a summary of the resident's medications and dietary instructions any services and treatments to be administered by the facility in personnel acting on behalf of the facility any updated information provision of the summary to the resident in Oregon resident representative is documented in the medical record. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan to meet each resident's medical, nursing, mental and psychosocial needs for 2 of 20 residents reviewed for care plans. (Residents #45 & #86) 1. The facility did not have a care plan to address Resident #45's Risperidone (antipsychotic medication). 2. The facility did not have a care plan to address Resident #86's contractures (a structural change in the body's soft tissues, like muscles, tendons, ligaments, or skin, that causes them to stiffen and shorten causing limited range of motion (ROM) and pain in the affected areas) Resident's right lower extremity. These failures could place residents at risk of not having their individual needs met and not receiving needed services.<br><br>Findings included:<br><br>1. Record review of the face sheet dated 07/02/25 indicated Resident #45 was an [AGE] year-old male admitted on [DATE]. His diagnoses included anxiety disorder, major depressive disorder, and bipolar disorder.<br><br>Record review of the physician orders dated July 2025 indicated Resident #45 had an order dated 02/17/25 for Risperidone (Risperidal) tablet 0.5 mg orally two times a day.<br><br>Record review of the current care plan printed 07/02/25 indicated Resident #45 was currently taking psychotropic medication(s) as evidenced by: _X__Depression _X__Anxiety _X__Cognitive impairment and he currently takes:__Risperidal (was left blank) and _X__Other (specify): Buspar/ Hydroxyzine PRN/Remeron/ Depakote.<br><br>During an interview on 07/02/25 at 10:25 a.m. the DON said she did not realize Resident #45’s care plan did not include the Risperidone. She said she expected the care plans to be accurate. She said inaccurate care plans could lead to all a resident's needs not being addressed in the care plan.<br><br>2. Record review of a face sheet dated 07/01/25 indicated Resident #86 was a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnosis included cerebral infarction (a condition where blood flow to the brain is blocked leading to brain tissue damage or death due to oxygen deprivation) hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body) following cerebrovascular disease (a group of conditions that impact the brain’s blood vessels and blood flow), and contracture of muscle of unspecified lower leg.<br><br>Record review of a significant change MDS dated [DATE] indicated resident #86 had a BIMS score of 6 indicating she had severe cognitive impairment, required substantial/maximal assistance with most ADLs, and had no impairment in range of motion or functional limitation of her upper or lower extremities.<br><br>Record review of a care plan dated 04/15/25 indicated Resident #86 was at risk for skin breakdown and increased pain related to her contracture of her right elbow. The care plan did not address her contracture of her right hip and knee.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an observation on 06/30/25 at 10:30 a.m., Resident #86 was lying in bed in her room with her right side completely covered. Resident pulled back the bed covers to show her right leg which was bent at her hip and knee and contracted on top of her right arm. She had a right below the knee amputation (BKA). She used her left hand to open her right knee approximately 2 inches but was unable to move her right hip or arm.<br><br>During a telephone interview on 07/02/25 9:38 a.m., the Former MDS Nurse said Resident #86 had contractures to her right elbow, right knee, and right hip. She said she also had a below the knee amputation (BKA) of her right leg. She said she always assessed a resident before competing their care plan. She said Resident #86 was admitted to the facility with the contractures on her right side and her right BKA, but she was not sure if they were all addressed in her care plan. She said she was responsible for initiating comprehensive care plans during her employment at the facility. She said she completed care plans based on the admission MDS, physician orders, resident diagnosis and functional abilities. She said the DON had final approval on the care plan and was her direct supervisor at the facility. She said she did not remember what was in Resident #86's care plan and no longer had access to the records. She said she worked at the facility for one year as the MDS nurse and left on 5/29/25. She said she was not able to answer any more questions, and she hung up.<br><br>During an interview on 07/02/25 at 9:56 a.m., the Regional Director of Clinical Services said the facility had a performance improvement plan (PIP) in place for care plans. She said the plan did not address inaccurate coding of an MDS resulting in an incomplete care plan. She said Resident #86’s care plan only addressed her contracture of her right elbow and did not address her contractures of her right knee and right hip. She said the inaccurate MDS led to Resident #86’s care plan being inaccurate.<br><br>During an interview on 07/02/25 10:21 a.m., the DON said the quarterly MDS coding for ROM were inaccurate for Resident #86. She said the inaccurate MDS coding led to an incomplete care plan. She said the facility’s PIP in place for care plans did not address inaccurate MDS coding resulting in incomplete care plans. The DON said the former MDS Nurse was responsible for completing Resident #86’s care plan. She said her expectation was for care plans to be completed accurately. She said inaccurate care plans could lead to all a resident's needs not being addressed in the care plan.<br><br>During an interview on 07/02/25 2:21 p.m., the Administrator said she expected resident care plans were to be complete and address all needs, goals, and interventions for each resident. She said the former MDS Nurse was responsible for completing Resident #86’s care plan. She said the DON was the direct supervisor for the former MDS Nurse.<br><br>Record review of the facility’s Care Plans-Comprehensive policy revised September 2010 indicated An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental, and psychological needs is developed for each resident. The comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS. |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident’s drug regimen must be free from unnecessary drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident's drug regimen was free from unnecessary medications (is a medication used: without adequate indication for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued) for 2 of 5 residents (Residents #45 and #77) reviewed for unnecessary medications. 1. The facility failed to ensure Resident #45 had an appropriate diagnosis entered for order for his Risperidone (antipsychotic) and Divalproex (an anticonvulsant used to treat seizures, migraine, and bipolar disorder). 2. The facility failed to ensure Resident #77 had an appropriate monitoring for his Oxcarbazepine (anticonvulsant used to treat depression). This failure could place residents at risk for unintended, harmful events attributed to the use of a medication without the appropriate indication or side effect monitoring. Findings included:<br><br>1. Record review of the face sheet dated 07/02/25 indicated Resident #45 was an [AGE] year-old male admitted on [DATE]. His diagnoses included anxiety disorder (persistent and excessive worry that interferes with daily activities), major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and bipolar disorder (mental disorder associated with episodes of mood swings ranging from depressive lows to manic highs).<br><br>Record review of the physician orders dated July 2025 indicated Resident #45 had orders dated 02/17/25 for Risperidone (Risperidal) tablet 0.5 mg 1 table orally two times a day for anxiety and Divalproex capsule 125 mg 3 tablets orally three times a day for dementia.<br><br>Record review of a pharmacy consultant Note to Attending Physician/Prescriber dated 06/19/25 indicated they requested a decrease and discontinue of Risperidone for anxiety due to flag as unnecessary use.<br><br>During an interview on 07/02/25 at 10:25 a.m. the DON said during the transition on 06/01/25 from one EMR to the other EMR the diagnoses were supposed to transition over, but some did not, so they were being inputted into the system. She said Resident #45 Risperidone was for his bipolar disorder and the Divalproex was for major depressive disorder.<br><br>2. Record review of a face sheet dated 07/02/25 indicated Resident #77 was an [AGE] year-old male admitted on [DATE]. His diagnoses included dementia (loss of cognitive functioning), anxiety disorder (persistent and excessive worry that interferes with daily activities), depression (mental illness that negatively affects how you feel, the way you think and how you act), and delusional disorder (a mental health condition that causes unshakable beliefs in something that’s untrue).<br><br>Record review of physician orders indicated an order dated 04/29/25 Resident #77 was to receive Oxcarbazepine 300 mg give 1 tablet by mouth two times a day for dementia.<br><br>Record review of the pharmacy consultant request dated 05/15/25 for Resident #77 indicated a request for side effect monitoring of Oxcarbazepine.<br><br>Record review of physician orders indicated an order dated 05/30/25 for Resident #77 to have side effect monitoring of an anti-depressant for Oxcarbazepine<br><br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 07/02/25 at 01:25 p.m. the ADON said Resident #77’s Oxcarbazepine had side effect monitoring for antidepressant because the medication was being used for depression and not as an anticonvulsant.<br><br>During an interview on 07/02/25 at 04:30 p.m. the DON said she expected the correct diagnoses to be with the medications. She said she also expected the correct side effect monitoring to be done. She said the nurses did the monitoring.<br><br>Record review of a Medications policy and procedure dated November 2017 indicated the following:<br><br>“1. Upon admission (including readmission) of each Patient/Resident, the physician’s orders for the Patient/Resident must be reviewed and reconciled by the Charge Nurse and the Director of Nursing or his/her designee for accuracy in the Electronic Medical Record….5. The Patient who hasn’t used psychotropic medications must not be given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record….8. Behaviors and side effects of the use of medication must be monitored and documented for Patient/Residents receiving psychotropic medication and monitoring for side effects only for Patient/Residents receiving antidepressants….12. The Monthly Quality Assurance & Performance Improvement Meeting must include a review of the appropriate and timely entering of physician orders, documentation of Anticoagulant medication side effects, timely auditing of medication carts and re-ordering of medications, the appropriate administration of medications by licensed staff and/or medication aide, the obtaining of Informed Consent for Psychotropic Medication, monitoring Behaviors, appropriate and timely follow-up to the Consultant Pharmacist’s Report, appropriate and timely drug destruction.” |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview, and record review, the facility failed to properly store, prepare, distribute, and serve food in accordance with the professional standards for food service safety 1 of 1 kitchen reviewed for safety requirements. 1. The facility failed to ensure foods were sealed and/or labeled properly in freezer and dry storage. 2. The facility failed to ensure food items in the dry pantry were labeled, dated, sealed, and not expired. 3. The facility failed to ensure dented cans in the dry pantry were not stored and co-mingled with non-dented food cans ready for use. These failures could place residents, who received food and beverages from the kitchen, at risk for health complications, foodborne illnesses, and decreased quality of life.Findings included:<br><br>During initial observation and interview in the kitchen on 06/30/25 with the DM at 9:04 a.m. of the commercial storage can rack indicated the following canned food items were stored co-mingled with non-dented food cans:<br><br>- One #10 can of Great Northern Beans with a large dent in the middle of the can<br><br>- One #10 can of Fruit Cocktail with a dent along the bottom seam.<br><br>- One #10 can of Banana Pudding with a dent along the top seam.<br><br>Interview with the DM on 06/30/25 at 9:10 a.m. confirmed the cans of great northern beans, fruit cocktail and banana pudding contained dents and should have been stored separate from non-dented cans.<br><br>During an observation and interview on 06/30/25 at 9:15 a.m. of the #1 freezer with the DM indicated there were:<br><br>- an open, undated, original cardboard box containing a clear plastic bag of frozen breakfast sausage patties that was ripped open, not properly sealed and exposed to the elements.<br><br>The DM said it was breakfast sausage patties. When asked about the frozen breakfast sausage patties, the DM tied the plastic bag and said it should be sealed.<br><br>During an observation and interview on 06/30/25 at 9:30 a.m. of the dry storage/pantry with the DM indicated there were:<br><br>- One, thick & easy 32 oz carton opened and used not dated when opened and manufacture label read discard within 4 days of opening.<br><br>The DM said he did not know when or who opened the carton of thick & easy and would discard it, can cause decreased quality and taste. DM said there were no residents receiving thickened liquids at this time.<br><br>- One, 1-pound bag of strawberry gelatin mix in their original container, opened and used in a sealed Ziploc bag; not dated when opened.<br><br>(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<br>B. Wing | 07/02/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Magnolia Manor | 4400 Gulf St<br>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.

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | The DM removed the gelatin mix from the shelf and discarded it. The DM said he was not able to tell if the gelatin was still usable or not. The DM said if used, residents could get sick.<br><br>During an observation and interview on 06/30/25 at 11:00 a.m. of the #2 freezer with the DM indicated there was:<br><br>* an open, undated, original cardboard box containing a clear plastic bag of frozen garlic bread, not properly sealed and exposed to the elements.<br><br>The DM said it was garlic bread. When asked about the frozen garlic bread, the DM tied the plastic bag and said it should be sealed and not exposed to the air in the freezer because it could lose its taste.<br><br>During an interview on 06/30/25 at 11:30 a.m. with the DM who confirmed the #10 cans contained dents and should have been stored separate from non-dented cans. The DM said he was not sure who, on Friday, put up the can goods. The DM said he was to check Monday for dented cans but had not had a chance to check for dented cans because surveyors walked in before he could check. The DM said he keeps the dented cans in his office so he could return them. The DM said risk of using dented cans could contaminate food. The DM said he expected all products in the kitchen to be stored correctly. He said packages of food items should be sealed so as not to expose food to the elements. The DM said it was the responsibility of all the dietary staff to ensure products were labeled and stored correctly. The DM said he could not explain why the expired or spoiled foods had not been removed from the refrigerator. The DM said all kitchen staff completed the required food preparation and food storage trainings. The DM said the potential harm to residents would be food poisoning, diarrhea, sickness, and bacteria on food. The DM said the failure occurred due to staff not paying attention.<br><br>During an interview on 06/30/25 at 12:39 p.m., the Administrator said her expectation was for kitchen staff to follow policies on food storage, preparation, and that everything was dated. She said the DM monitored that kitchen staff were following the facility's policy. The Administrator said not storing and preparing food appropriately could cause residents to be given food beyond the expiration date and not the correct time frame. The Administrator said it could also affect the freshness and quality of resident’s food. The Administrator said the facility did not have a policy on storing dented cans of food.<br><br>Record review of facility policy revised dated 3/2019 titled, “Food Storage: Policy: Sufficient storage facilities are provided to keep food safe wholesome and appetizing food is stored prepared and transported in an appropriate temperature and by methods designed to prevent contamination… Procedure: …5. Plastic containers with tight fitting covers must be used for storing cereals cereal products flour sugar dried vegetables and broken lots of bulked food all containers must legit fully and accurately labeled including the date the package was open… 16. Frozen Foods…c. Foods should be covered labeled and dated…”<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Review of the Food and Drug Administration Food Code, dated 2022, reflected, . 3-201.11 Safe, Unadulterated, and Honestly Presented. Compliance with Food Law. FDA considers food in hermetically sealed containers that are swelled or leaking to be adulterated and actionable under the Federal Food, Drug, and Cosmetic Act. Depending on the circumstances, rusted and pitted or dented cans may also present a serious potential hazard .3-302.12 Food Storage Containers, Identified with Common Name of Food. Except for containers holding food that can be readily and unmistakably recognized such as dry pasta, working containers holding food, or food ingredients that are removed from their original packages for use in the food establishment, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the food 3-305.11 Food Storage.(B) .refrigerated, ready-to eat time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the assessments accurately reflected the resident's status for 1 of 20 residents reviewed for accuracy of assessments. (Resident #244)The facility failed to ensure Resident #244's Nursing admission Assessment was complete and accurately reflected the resident's status at the time of the assessment.This failure could place the resident at risk of not receiving the appropriate care and services. Record review of Resident #244's face sheet, dated 07/02/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included chronic gout (characterized by repeated episodes of joint pain and inflammation due to uric acid in the blood), emphysema (chronic lung disease that progressively damages the tiny air sacs in the lung, making it difficult to breathe), and adjustment disorder with anxiety. Record review of the 5-day MDS showed in progress in Resident #244's clinical record due to the admission date of 06/28/2025. Record review of Resident #244's Nursing admission Assessment gave no indication of behaviors, fall history, elimination status, gait/balance, bowel and bladder status, nor medication listed. Record review of the Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual last updated May 2025 indicated .1. Review the medical record for references to functional range-of-motion limitations during the 7-day observation period. 2. Talk with staff members who work with the resident as well as family/significant others about any impairment in functional ROM. 4. Assess the resident's ROM bilaterally . 6. Although this item codes for the presence or absence of functional limitation related to ROM, thorough assessment ought to be comprehensive and follow standards of practice for evaluating ROM impairment. During an interview on 07/02/2025 at 3:00 p.m., the Administrator, she said her expectations were for all assessments to be complete and accurate. The administrator said the DON was responsible for ensuring that. The administrator said all staff had been trained and retrained. The administrator said it was not done; it was incomplete. Risk was for not providing person-centered care. The Administrator said the Admissions Nurse had previously been responsible for completing admission Assessments, however due to performance issues, she was no longer employed at facility and a new employee had started within the past week. The administrator added if an assessment was not done properly, it was considered incomplete. The administrator said the risk of an incomplete assessment was facility staff could fail to provide person-centered care. The administrator said the facility did not have an admission Assessment policy for completing accurately, as the questions were self-explanatory. |