STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675241	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Place	1307 Martin Luther King Dr Jefferson, TX 75657

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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19401 Based on observation, interview, and record review the facility failed to ensure pain management was provided to residents who require such services, consistent with professional standards of practice, pain management services for 1 of 5 residents reviewed for pain. (Resident #1) Resident #1 complained of pain in her heel prior to wound care. She complained of pain during the wound care treatment and at no time was the wound care held or pain medications offered. Review of Resident #1's physician orders indicated she did not have any PRN pain medications ordered. This failure caused the resident to experience pain during wound care. Findings included: Record review of Resident #1's face sheet dated 4/23/24 indicated she was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses was diabetes, muscle wasting and difficulty walking. Record review of Resident #1's Admission MDS dated [DATE] indicated she was cognitively intact. The MDS indicated Resident #1 did not have pressure injuries when admitted to the facility. The resident required partial to moderate assistance with sitting on the side of the bed, and from sitting to standing, and transfers. Record review of Resident #1's Baseline Care Plan (with no date) indicated she was alert and cognitively intact with some confusion at times. Resident #1 required the assistance of one person for bed mobility. She was totally dependent of staff for transfers and toileting. She used a manual wheelchair for ambulation. The care plan indicated she was at risk for pressure injuries. There was no indication of pain noted. Record review of Resident #1's Pain assessment dated [DATE] indicated the resident stated she had mild pain in the last 5 days but was unable to indicate the frequency, if it affected her sleep or any activities that contributed to the pain. Record review of Resident #1's skin assessment dated [DATE] indicated she had an area on her left heel that measured 2cm x 2 cm and was not painful. (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 0697 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #1's computerized physician order dated 4/23/24 indicated an order dated 4/19/24 to cleanse unstageable of the right posterior heel with wound cleaners, and pat dry and then apply Medi Honey, and then border gauze. There was no order for pain medication noted. During an observation and interview on 4/23/24 at 10:05 a.m., of Resident #1 was in her room in bed. The treatment nurse said she had a wound on her right heal that she was going to treat. The Treatment nurse took off Resident #1's socks. The sock from the right foot had drainage from the wound or medication that had soiled the sock. Prior to the nurse starting the treatment Resident #1 said her heel hurt, the treatment nurse did not ask her if she wanted anything for pain. She removed the socks and the bandage on her heel and throughout the procedure. The resident said ouch, ouch, ouch several times with a facial grimace. The nurse took the bandage off. The Treatment Nurse used Q-tips to put medication on the wound and bandaged it and during the whole procedure the resident was saying ouch, ouch, ouch The nurse said that she covered the wound with Med-honey and gauze. Resident #1 was still saying ouch that hurts when the Treatment Nurse finished the procedure. Resident #1 said that her foot was still hurting and it had been hurting since they started doing treatments. Resident #1 said she would have liked something for pain prior to getting wound treatment. Resident #1 said she had something last night, but it was too long ago to make a difference this morning. During an interview on 4/23/24 at 10:17 a.m., the Treatment Nurse said she did hear Resident #1 say she was in pain and her continued indications that she was in pain. She said Resident #1 had complained of pain the day before when she had completed wound care. She said she did not think to ask her if she wanted anything for pain. She reviewed her orders to see if she had recently gotten something for pain and said she did not have anything ordered. She said she would check with nursing staff to see if they could get her something ordered. During an observation and interview on 4/23/24 at 3:30 p.m., Resident #1 was seen propelling her wheelchair around with her feet. She had on socks and one resident asked why she was grimacing when she moved. She told her that her heel was tender and hurt sometimes. She said earlier today when she was receiving wound care her pain was likely a 4 on a scale of 1-10. (with 10 being the worsest) During an interview on 4/23/24 at 4:40 p.m. the DON said the first time she heard Resident #1 was having pain was today. They had contacted the physician and gotten an order for PRN Tylenol for pain. Review of the facility Pain Assessment and Management Policy revised October 2022 indicated pain management is defined as the process of alleviating the resident's pain based on his or her clinical assessing and potential for pain, recognizing the presence of pain, identifying the characteristics of pain, and addressing the underlying causes of pain. Assess a resident whenever there is a suspicion of new pain or worsening of existing pain. Review the resident's clinical record for conditions or situations that may predispose the resident to pain, including wound conditions such as pressure, venous or arterial ulcers. Strategies consist of establishing a treatment regimen that is specific to the resident based on current medication regimen, nature and severity and causes of pain.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19401 Based on observation, interview, and record review the facility failed to maintain an infection prevention program designed to provide a safe sanitary and comfortable environment and to prevent the development of infections for 4 of 5 residents reviewed for infections. (Residents #1, #3, #4, and #5) The Treatment Nurse did not wash her hands while providing wound treatments for Residents #1, #3, #4, and #5. The treatment nurse did not change her gloves between dirty and clean wounds for Resident #1. The Treatment Nurse did not change gloves from one wound to the next wound during Resident #5's wound treatments. This negative finding had the potential to cause infections. Finding included: Record review of Resident #1's face sheet dated 4/23/24 indicated she was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included diabetes, muscle wasting and difficulty walking. Record review of Resident #1's computerized physician order dated 4/23/24 indicated an order dated 4/19/24 to cleanse unstageable of the right posterior heel with wound cleaners, and pat dry and then apply Medi Honey, and then border gauze. During an observation and interview on 4/23/24 at 10:05 a.m. of Resident #1 was in her room in bed. The Treatment Nurse said Resident #1 had a wound on her right heal she was going to treat. The Treatment Nurse did not wash her hands prior to beginning the treatment. She sanitized her hands with sanitizer from her cart outside the room and put her gloves on. The Treatment nurse took off Resident #1's socks. The sock from the right foot had drainage from the wound or medication that had soiled the sock. She removed the socks and the bandage on her heel. The nurse took the bandage off and did not wash her hands or change gloves. She cleansed the wound with normal saline and wiped it with gauze. The Treatment Nurse used Q-tips to put medication on the wound and bandaged it. The nurse said that she covered the wound with Med-honey and gauze. The Treatment Nurse took the gloves off and sanitized her hand at the end of the treatment. Observation of the trash bag only had one pair of gloves in the bag. The Treatment nurse said she missed a step. She said she forgot to change her dirty gloves prior to putting medication and a bandage on the cleaned wound area. The Treatment nurse left the room and did not wash her hands. Record review of Resident #3's face sheet dated 04/23/24 indicated she was [AGE] years old and admitted to the facility on [DATE]. Her diagnoses included Parkinson's disease and anxiety. Record review of Resident #3's wound care orders dated 04/20/24 included to apply skin prep to right and left heel daily. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 4/23/24 at 10:25 a.m., Resident #3 was laying in the bed. The Treatment Nurse did not wash her hands before contact with Resident #3. The treatment nurse said she was just to apply skin prep to Resident #3's heels for preventive measures. Resident #3 did not respond when spoken to and appeared to be asleep for the whole treatment. The Treatment Nurse removed the covers from Resident #3's feet, and her heels were observed. The Treatment Nurse sanitized her hands and put gloves outside the room but did not wash your hands. She put the wound prep on the residents heels and again she sanitized her hands she did not wash her hands prior to leaving the room. Record review of Resident #4's face sheet dated 04/23/24 indicated she was [AGE] years old and admitted to the facility on [DATE]. Her diagnoses included heart failure and pressure injury to the left buttock. Record review of Resident #4's orders dated 04/20/24 included to apply barrier creat to area on left buttock daily and clean areas to right lower leg with wound cleaner, apply Xeroform, cover with dressing and Kerlix daily. During an observation and interview on 04/23/24 at 11:12 a.m., the Treatment Nurse cleanses an area to left buttock with wound cleanser and then applied barrier cream to Resident #4. The resident said at one time she had a blister in that spot and the blister had burst. The Treatment Nurse used hand sanitizer prior to the procedure. During the procedure, the Treatment Nurse changed her gloves appropriately and sanitized her hands between glove changes. At no time did the Treatment Nurse wash her hands. Record review of Resident #5's face sheet dated 04/23/24 indicated she was [AGE] years old and admitted to the facility on [DATE]. Her diagnoses included dementia and difficulty in walking. Record review of Resident #5's wound care orders dated 04/22/24 included to apply Duoderm to area on upper right thigh every Monday, Wednesday, and Friday and clean area to left buttock with wound cleaner, apply Duoderm every Monday, Wednesday, and Friday. During an observation on 04/23/24 at 11:23 a.m., the Treatment Nurse provide wound care to Resident # 5. There were two open areas to the posterior right thigh. The Treatment Nurse did use hand sanitizer prior to the procedure and during each glove change. The Treatment Nurse did not wash her hands at any time during the procedure. The Treatment Nurse cleaned each wound with wound cleanser and applied a duoderm to each area. The Treatment Nurse did not change her gloves between care to the wound on the resident's sacrum and providing care to the area on her right thigh. During an interview on 4/23/24 at 12:50 p.m., the DON and the ADON said the Treatment nurse was new and she had only been doing wound care since last week. She had not received a full week of training as planned. They said the Treatment Nurse was in school to receive her RN license now, and once she completed that they would be sending her to the Wound Care Classes. They said she had informed them on the failure to change gloves during wound care with Resident #1. The ADON said the CDC said that hand sanitizer was just as good as using soap and water. She was reminded that was not what their policy said. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility Wound Care Policy dated October 2010 indicated: the steps in the procedure after arranging supplies for wound care supplies wash and dry hands and put on gloves. After removing the dressing discard gloves and wash and dry hand thoroughly. Then put on gloves. Complete the cleaning and dressing the wound. Remove gloves, wash hands thoroughly. Make the resident comfortable remove soil supplies, dispose them, and then wash and dry hands thoroughly.