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	07/31/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44128 Based on observation, interview, and record review, the facility failed to ensure that the resident environment remained as free of accident hazards as possible and provide supervision to prevent avoidable accidents for 1 of 6 residents reviewed for accidents. (Resident #1) The facility failed to ensure Resident #1 was properly transferred in bed by facility staff. This failure could place residents at risk of injury from accident and hazards. Findings included: Record review of the face sheet dated 07/30/24 revealed Resident #1 was [AGE] years old and admitted on [DATE] with diagnoses including Alzheimer's Disease (A progressive disease that destroys memory and other important mental functions), dementia (a term used to describe a group of symptoms affecting memory, thinking and social abilities), and age-related osteoporosis (a condition that causes bone to become weak and brittle). Record review of the quarterly MDS dated [DATE] revealed Resident #1 was sometimes understood and sometimes understood others. The MDS indicated Resident #1 had a BIMS score of 99 which indicated Resident #1 was unable to complete the interview. The MDS indicated Resident #1 required partial/moderate assistance to substantial/maximal assistance with ADLs. The MDS indicated Resident #1 required partial/moderate assistance rolling left and right and to sit from a lying position. Record review of the care plan last revised on 02/05/24 indicated Resident #1 had a behavior problem and would call out You're hurting me when no one was touching her. Record review of an undated Video #1, the time stamp was blurry, revealed Resident #1 was lying in bed on her right side. A staff member reached with her left hand and pulled Resident #1 by the right wrist into a sitting position. Resident #1 said, Owww .you are hurting me. The staff member then supported Resident #1 behind her back. The staff member was facing away from the camera. Their face was not visible. Record review of Video #2 dated 04/06 at 6:14 p.m. revealed Resident #1 sitting up in bed. The resident laid back in the bed. A staff member pulled Resident #1 up in the bed by Resident #1's upper arms. The staff member was facing away from the camera. Their face was not visible. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a Daily Staffing Schedule dated 04/05/24 indicated CNA A and CNA B were working on the memory care unit where Resident #1 was a resident. CNA A and CNA B were working the 6 a.m. to 2 p.m. shift. CNA A and CNA B had signed the schedule. Record review of a Daily Staffing Schedule dated 04/06/24 indicated CNA C was working on the memory care unit where Resident #1 was a resident, CNA C was working the 2 p.m. to 10 p.m. shift. CNA C had signed the schedule. Record review of a Skin Only Evaluation dated 04/10/2024 at 4:10 p.m. indicated Resident #1 had no skin issues. During an interview on 07/30/24 at 1:01 p.m., a family member of Resident #1 said they had an electronic device in Resident #1's room so they could see, talk to, and play music for Resident #1. The family member said in April 2024 they used their cellphone to record incidents in Resident #1's room. She said on 04/06/24 a staff member placed Resident #1 in bed. She said the staff member pulled Resident #1 up in the bed. She said she did not know the name of the staff member. The family member said Resident #1 was unable to remember the incident and could not answer questions. During an interview on 07/30/24 at 2:55 p.m., a family member of Resident #1 said Video #1 was filmed on 04/05/24 at 7:03 a.m. The family member said Video #2 was filmed on 04/06/24. During an observation and interview on 07/31/24 at 8:05 a.m., the Administrator, DON, ADON, and CNA Staffing Coordinator observed Video #1 and Video #2. The CNA Staffing Coordinator said the staff member in Video #1 was either CNA A or CNA B. The CNA Staffing Coordinator and the ADON said the staff member in Video #2 was CNA C. They each said they could tell by her voice. During an interview on 07/31/2024 at 8:26 a.m., CNA A said if she was at work on the date Video #1 was taken, she did provide care to Resident #1. She said it was her responsibility to get the resident up in the morning, take her to the dining room for breakfast, and to shower Resident #1. She said she had never pulled the resident up by herself. She said she had never pulled her up by her arm and only used a pad with another aide. She said the appropriate way to pull Resident #1 up in bed was by using the pad. She said if the pad was not there, a new pad was placed under Resident #1. She said she had never pulled the resident up by her wrist. She said the resident was combative and yelled every time care was provided. She said the family tried to help over the camera, but it did not work. During an observation and interview on 07/31/2024 at 9:10 a.m., CNA A viewed Video #1. At first she said the staff member in the video could be her. She then said she did work on 04/05/24 but she felt it was not her in Video #1 because the staff member in the video had on blue gloves and the facility did not have blue gloves. She said the facility had clear gloves. She said she always had the resident up out of the bed by 7:00 a.m. She said a resident should never be put into a sitting position by their wrist. She said the proper way was to put one arm behind their back and the other under the legs and assist them into a sitting position. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/31/2024 at 8:35 a.m., CNA C said she remembered providing care to Resident #1. She said Resident #1 kept telling her that she was going to jail. She said the only thing she said to Resident #1 was that she was not going to jail. She said the resident was combative every time she received care. She said Resident #1 was always hollering out Don't touch me, Get out. She said she did not recall ever pulling Resident #1 up in the bed by her arm. CNA C said if she did pull Resident #1 up in the bed by her arms it was because she was being combative. She said she had scratches on her arm from Resident #1. CNA C said in 04/2024 she had just had surgery and had a drainage catheter. CNA C said that may be why she pulled Resident #1 up the way she did. She said she may have pulled her up improperly. During an observation and interview on 07/31/2024 at 9:00 a.m., Resident #1 was in bed. She was clean and well groomed. There was no visible bruising. The resident did not answer questions appropriately was confused. During an interview on 07/31/2024 at 10:18 a.m., CNA B said she had helped another aide with providing care to Resident #1. She said it had been a long time ago. She said CNA A was normally the aide that provided care to Resident #1. She said there were times when Resident #1 was difficult. CNA B said she did not ever remember seeing CNA A transfer Resident #1 to a sitting position by her wrist. She said the resident was very combative the times she had assisted with care. CNA B said the proper way to sit a resident up was to support the back and under the legs and then pivot the resident up into a sitting position. During an interview on 07/31/2024 at 12:51 p.m., the CNA Staffing Coordinator said CNA A was the aide that worked Resident #1's hall. She said in Video #1 she was certain that the aide was either CNA A or CNA B. She said that she agreed that the aide in Video #1 pulled Resident #1 by the wrist while sitting her up in the bed. She said the appropriate way to sit someone up in the bed was to put the feet to the side of the bed, hold their hand and support their back sitting them up on the side of the bed. If not able to do this, they need a second person in there to help. She said a resident being pulled by the wrist could cause an injury to the wrist. She said there were boxes of blue gloves in the facility. She said in Video #2 the aide was CNA C. She said she agreed that the resident was pulled up in the bed by her arm. She said the proper way to pull a resident up in the bed would be to have a second person and use a draw sheet or pad. She said a resident being pulled up by their arm could cause a shoulder or arm injury. During an interview on 07/31/2024 at 1:14 p.m., a family member of Resident #1 said she was not aware of Resident #1 having any injuries after the incidents in 04/2024. During an interview on 07/31/2024 at 1:28 p.m., the DON said she expected aides to use proper positioning and to properly transfer residents when sitting them up on the side of the bed. She said, We don't grab by wrist, and we don't grab under the arms. She said when sitting up a resident you should elevate the head of the bed and support the resident as they sit up in a sitting position and not pull them. She said a resident being pulled by the wrist could cause skin issues, bruising, skin tears, or fractures. She said she expected when a resident was pulled up in the bed a sheet draw sheet or pad to be used by two staff members. She said if the resident was having combative behaviors there should always be two staff members. She said a resident being pulled up by their arm could cause skin injury or fractures. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/31/2024 at 1:44 p.m., the Administrator said the staff members in Video #1 was either CNA A or CNA B. He said he would expect aides to use a safe method of positioning. He said he would not expect any aide to pull a resident by their wrist. He said a resident being pulled by the wrist could create a dangerous situation such as an injury. He said CNA C was the aide in Video #2. He said he can tell by the voice. He said expected staff members to use proper procedure in repositioning a resident. A resident being pulled up in the bed by their arm could create an injury. Record review of a Repositioning facility policy revised in May 2013 indicated, .Encourage the resident to participate if able .Use two people and a draw sheet to avoid shearing while turning or moving the resident up in bed. Encourage resident to place fee flat on bed and assist with pushing up .