STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676044	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Living and Rehabilitation	1105 N Magnolia Luling, TX 78648

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 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45937 Based on interviews and record reviews the facility failed to ensure food was prepared in a form designed to meet individual needs for 1 of 5 residents (Resident #1) reviewed for dietary services. The facility failed to follow Resident #1's altered diet when CS A gave Resident #1 a peanut butter sandwich on [DATE]. Resident #1 expired on [DATE]. An Immediate Jeopardy (IJ) situation was identified on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at no actual harm with potential for more than minimal harm that is not immediate jeopardy, due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk of not receiving their proper diet to meet their individual needs, that can cause serious injury, hospitalization , or death. Findings Include: Record review of Resident #1's face sheet, dated [DATE], reflected a [AGE] year-old-male, with a current admitted [DATE], a latest return admitted [DATE], and a discharge date of [DATE]. Resident #1's status was expired. Resident #1's had diagnoses which included lack of coordination, rheumatoid arthritis (autoimmune disorder that primarily affects joints), muscle wasting, paranoid schizophrenia (delusions of paranoia), dysphagia-oropharyngeal phase (swallowing disorder-disruption or delay in swallowing), cognitive communication deficit (challenges is communication that have underlying cause in cognitive deficit), unspecified dementia (syndrome associated with many neurodegenerative diseases, decline in cognition that affects the ability to perform everyday activities), and anxiety (panic disorder or phobias). (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's Annual MDS (Minimum Data Set), dated [DATE], reflected a BIMS summary score of 03, indicated a severely impaired cognitive skills for daily decision-making. Resident #1's speech clarity was a 1, which indicated unclear speech-slurred or mumbled words, and ability to understand others was a 2, which indicated sometimes understood-responded adequately to simple, direct communication only. Resident #1's was on a mechanically altered diet. Section GG-Functional Abilities and Goals reflected a score of 03 for Eating, which indicated Partial/Moderate assistance. Section I-Active Diagnoses reflected a code of 7, which indicated Other Neurological Conditions. Section K-Swallowing/Nutritional Status, K0520 reflected Mechanically altered diet-require change in texture of food or liquids, e.g., pureed food, thickened liquids. Record review of Resident #1's, undated, orders reflected an order description, mech (Mechanical) soft/thin liquids-fortified foods with meals, scoop/divided plate, foam cover for built up utensils all meals, and with special instructions, large portions at mealtime, no bread i.e. (that is) cakes, pancakes, sandwiches, rolls, biscuits, close supervision, with a start date: [DATE] and an end date: Open Ended, DC [DATE] reason is discharged . Record review of Resident #1's, undated, care plan, reflected: Problem start date [DATE], category is ADLs Functional Status/Rehabilitation Potential, Resident (Resident #1) is slightly limited in ability to eat and drink AEB self-feeding (self-feeding), required setup/cues at times, goal is Resident (Resident #1) will eat ,d+[DATE]% of meals and maintain hydration independently /with supervision/help, with an approach: - monitor and record intake of food/fluids and provide setup/supervision assistance during eating and drinking, disciplines responsible activities, CNA, Nursing. Problem, start date [DATE], category is Nutritional Status, Potential for weight loss R/T : dysphasia (swallowing disorder) goal is nutritional status will be maintained AEB (As Evidenced By) no weight loss within 3 lbs of current weight over next 90 days, with an approach: - Serve diet per order, disciplines responsible Nursing Problem, start date [DATE], category is Nutritional Status, high risk of aspiration (when something you swallow enters your airway or lungs), nutritional impairment and complications due to dysphasia (swallowing disorder), goal is (Resident #1) will remain free of aspiration, significant weight loss, s/sx, injury or complications related to dysphagia, with approaches: - Assess/record report to MD prn s/sx of aspiration or complications: choking/strangling on liquids, coughing during or after meals, respiratory difficulty or distress, fever, tachypnea (rapid shallow breathing), wheezes/crackles in lung field, and watery eyes, disciplines responsible Nursing. - Ensure resident is eating slowly and notify nurse ASAP if choking. Maintain upright position for 1 hour after eating, when possible, to reduce aspiration risk, disciplines responsible activities, CMA, CNA, dietary, Nursing. - Ensure that snacks and beverages offered at activities comply with diet and fluid consistency restrictions, disciplines responsible activities, CMA, CNA, dietary, Nursing. (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- serve diet as ordered, disciplines responsible activities, CMA, CNA, dietary, Nursing. Problem, start date [DATE], category is Nutritional status, Resident (Resident #1) requires a mechanically altered diet, goal is Resident (Resident #1) will maintain current body weight of Blank pounds, with approaches: - Encourage oral intake of foods and fluids, disciplines responsible Nursing. - Monitor need to advance diet consistency, disciplines responsible Nursing. Record review of Resident #1's, undated, Meal Ticket reflected Diet: Regular, Texture: mechanical soft, Other: large portions with meals, no bread cakes rolls biscuits, close supervision, Adap Equip Deep Divided Plate; Built up Spoon; Liq Consist thin. Record review of Resident #1's progress note, created and signed by LVN A, dated and timed [DATE] at 08:38 PM, reflected. at approximately 6:20 PM called to secure unit per CNA About resident possibly choking this nurse immediate to dining room and noted resident on floor laying supine (on back) lips blue no respirations or pulse noted sternum rub performed resident gasped another nurse started the Heimlich some spit up food came from residents (Resident #1) mouth did gasp a few more breaths mouth swipe done and nothing noted still without pulse or respirations 911 was called at beginning of finding resident and in facility resident asystole (heart's electrical system fail causing heart to stop pumping, otherwise known as flat-line or flat-lining) noted on monitor RN DON pronounced at 1847 [06:47 p.m.] Family notified and thankful and stated Funeral Home is where he [Resident #1] is going called Cremation Provider due to they own postmortem care was provided and body released at 2015 [08:15 p.m.]. Interview on [DATE] at 11:38 a.m., the ADON stated she worked on [DATE] and was scheduled to be off at 06:00 p.m., although she had to stay because a nurse was coming in late. The ADON was in the middle of giving a report, then she overheard LVN A initially asking to prepare for a crash cart, the ADON obtained the crash cart, went to the locked unit, and observed it was Resident #1. The ADON stated Resident #1 was a DNR, the crash cart not used. The ADON recalled observed LVN A performed a sternal rub (method used when testing an unconscious person's responsiveness). The ADON stated she performed the Heimlich Maneuver as a precaution, due to possible choking. The ADON stated during the Heimlich maneuver (used to treat choking by foreign objects) she could not confirm if food was dislodged as she was behind Resident #1. The ADON stated during the commotion, staff was instructed to call EMS. The ADON stated she could not confirm the exact diet of Resident #1 during interview, but she was aware it was altered. The ADON stated when EMS arrived, they pronounced Resident #1 expired, and recalled there were no concerns brought to her attention by EMS. (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 11:59 p.m., CS A stated she worked the night shift from 06:00 a.m. to 06:00 p.m., CS A stated she worked on [DATE] and worked in the unit where Resident #1 resided. CS A stated Resident #1 was in distress, and went to get a nurse, CS A could not recall the nurse she got. CS A arrived back to the unit, and LVN A was present, CS A was instructed to call EMS and did. CS A stated during the commotion other staff arrived, unable to recall other staff, she attempted to assure other residents were watched during the incident. The CS A stated prior to the incident, during that time it was snack time for residents, I gave a snack to Resident #1, I [CS A] gave him a sandwich that day [[DATE]], it was a peanut butter sandwich, Resident #1 liked his sandwiches. CS A knew Resident #1's dietary orders CS A stated, At the time, I didn't know what kind of diet he is on, I do now, I think it was soft or something, I [CS A] worked here for two plus years, most of the time that's what we fed Resident #1, I am part of the evening crew, I don't get in on the meals. CS A stated, yes I think its dangerous for anyone if they don't get the proper diet order. When asked where she obtained the sandwich and the details of when, CS A stated, sandwiches are pre-made by dietary staff, sandwiches are kept at front nurses' station [outside of the unit], they are together on a tray, and we take them to the residents when they want a snack. Interview on [DATE] at 12:19 p.m., the DM stated meal tickets were important for staff to follow. The DM stated for mechanical soft diets, food was placed in a food processor and pulsed to have a chopped and soft texture. The DM stated Resident #1 had a mechanical soft diet, with no breads at all. The DM stated therapy recommended this diet because Resident #1 could not swallow properly, and he could choke. The DM stated at night the facility prepared snacks that included sandwiches, pudding for altered diets, and sometimes fruits. The DM stated Resident #1 should have gotten pudding for his snacks, and it would be dangerous for Resident #1 to eat bread. The DM stated breakfast, lunch, and dinner had meal tickets on food trays that were reviewed before passing it out to residents. The DM stated staff were knowledgeable because they were trained on dietary orders. Interview on [DATE] at 12:31 p.m., the SLP stated she was also the Director of Rehabilitation, the SLP stated Resident #1 was on and off for rehabilitation services because he had difficulty self-feeding, toileting, sitting in an up-right position during meals times, his posture was poor, and he would hunch over. The SLP stated we would have therapy for Resident #1 with goals to correct his posture and sit up-right during meals, Resident #1 needed one on one interaction and constant redirection, he was very much non-compliant and ignored his therapy, but we kept trying to help him. The SLP stated Resident #1's cognition was poor. The SLP stated Resident #1's diet order was a mechanical soft diet with close supervision, with no breads or cakes. The SLP stated if Resident #1 had any bread, it was a dense material. The SLP described Resident #1 during therapy sessions, Resident #1 would tend to overstuff his mouth and continue to eat large portions and Resident #1 could not swallow the portions, she noticed Resident #1 would store the food on his inside cheek, and stated to staff he had swallowed the food, although when the SLP would check his mouth the SLP would see the food inside his mouth, inside his cheeks. The SLP added the training consisted of having Resident #1 learn how to eat smaller portions and learn how to swallow those portions, as the staff were hoping he could return to a full diet. The SLP stated his course was up and down, Resident #1 would have some advancements in therapy then he would decline from them. The SLP stated Resident #1 was not supposed to have dense, dry food, like cornbread. The SLP stated she communicated the needs for residents by communication forms, which informed the dietician, dietary aides, nursing, and she educated staff from different shifts. The SLP stated Resident #1's order was placed to reduce the risk of choking, if Resident #1 was left unsupervised and because his large intakes he had a high risk of choking on a peanut butter sandwich. (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 01:31 p.m., the DON stated she worked on [DATE] during the day, although she came back as she was informed Resident #1 expired. The DON stated she was informed Resident #1 was reading his bible in the dining area in the locked unit as this was his routine, and nurses were informed of Resident #1's condition and responded. The DON stated Resident #1 was on a mechanical soft diet. The DON stated the process of informing staff of diet orders was that nurses received a communication on orders, nurses would communicate with the CNAs, the orders were placed in EHR, it would transfer to the POC system, and CNAs could access care plans and orders in the tablets available. The DON stated the POC tablet in the locked unit was not working now, and in the process of getting that corrected. The DON stated she had not personally seen Resident #1 eat sandwiches, staff were educated, and all meals served during breakfast, lunch and dinner had meal tickets that were reviewed by nursing before trays were distributed. The DON stated she would agree Resident #1 would need a pudding or shake as a snack, not a peanut butter sandwich. The DON stated for the night shift, snacks were delivered by dietary staff to the front nurses' station (outside of the locked unit), staff would then be able to pick snacks on resident's needs. The DON's expectation was Resident #1 should have received a snack that met his orders, like a shake or pudding, and close supervision with meals would be always within eyesight. Interview on [DATE] at 02:38 p.m., LVN A stated she worked the 06:00 p.m. to 06:00 a.m. shift, and further stated she worked the locked unit on [DATE] and entered the building at approximately 06:00 p.m. LVN A recalled that evening on [DATE], and stated at the start of her shift she received reports and reviewed them, a minute later CS A informed her Resident #1 did not look good and was possibly choking, he was on the floor blue and was observed with no respirations. LVN A performed a sternum rub, the crash cart was brought by the ADON but was not used as Resident #1 was a DNR. LVN A stated the ADON performed the Heimlich maneuver and a little spit came out. LVN A stated she performed a swipe method to Resident #1's mouth and noticed no food or and dislodged food. LVN A stated she did not believe there was any food in the premises, dinner was usually served at 05:00 p.m., and the dining area in the locked unit had already been cleaned, LVN A stated there were no signs of wrappers, sandwich wrappers, or indications of snacks. LVN A stated when she entered the building, snacks were not served yet, she did not see any at the front nurses' station, and snacks were passed around 08:00 p.m. When asked about the progress note she created and signed, LVN A stated, I did document what I saw, but I did not see actual food, I should have been more descriptive like writing the items I saw as particles or maybe I should have described it as green small pieces, in all happened so quickly. Interview on [DATE] at 04:39 p.m., the ADM stated she was called that evening on [DATE] and was informed Resident #1 expired due to a heart attack, and EMS stated on the report Resident #1 asystole (heart's electrical system fail causing heart to stop pumping, otherwise known as flat-line or flat-lining). The ADM stated she called the local EMS and asked for a report and was informed by local EMS since Resident #1 was not transferred to a hospital or another provider, there was no report. The ADM stated that residents, which included Resident #1, had dinner around 5 p.m. and snacks typically come out at 7 p.m. The ADM stated, when I called CS A to ask if she gave [Resident #1] a sandwich that night, [CS A] said no he [Resident #1] didn't get a sandwich, then she [CS A] later said yes I did give him [Resident #1] a sandwich, then later changed her [CS A] answer to no I didn't give him [Resident #1] a sandwich. On [DATE] at 04:56 p.m., attempt made to contact the local EMS, no findings at this time as local EMS had not made any return calls. (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 05:46 p.m., the RD stated there was a nutritional assessment completed around , d+[DATE], with orders in detail, and further stated, [Resident #1] has no bread, although I do not know if his orders were updated because I know that this particular resident (Resident #1) was not eating and all he wanted was a peanut butter and jelly sandwich, this is okay just as long as there is a one to one person sitting with him (Resident #1) while he eats, although that was just a conversation, to my understanding the last RD that is familiar with him (Resident #1) is on leave, from what I understand SLP allowed him to have sandwiches but with one on one supervision with small bites. The RD stated, if he (Resident #1) is on a mechanical soft diet there would more than likely be a choking. Record review of the facility's Food and Nutrition Services Policy, revised [DATE], reflected a Policy statement that Each resident is provided with nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preference of each resident. 7. Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident, the food appear palatable and attractive, and it is served at a safe and appetizing temperature. a. If an incorrect meal is provided to a resident, or a meal does not appear palatable, nursing staff will report it to the food service manager so that a new food tray can be issued. b. Foods that are left without a source of heat (for hot foods) or refrigeration (for cold foods) longer than 2 hours will be discarded. This was determined to be an Immediate Jeopardy (IJ) on [DATE] at 05:09 p.m. The Administrator was notified. The Administrator was provided with the IJ template on [DATE] at 6:26 p.m. The following Plan of Removal submitted by the facility was accepted on [DATE] at 4:09 p.m.: Plan of Removal Immediate Jeopardy On [DATE], an abbreviated survey was initiated the Facility. On [DATE], at 6:30 PM, the surveyor provided an Immediate Jeopardy (IJ) Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate jeopardy to resident health and safety. The notification of Immediate Jeopardy states as follows: The facility failed to provide Food prepared in a form designed to meet individual needs for Resident #1, who was provided a peanut butter and jelly sandwich and choked/passed away. ACTIONS Start Date: [DATE]. Completion Date: [DATE] (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Responsible: Administrator/Director of Nursing Action: On [DATE], the regional nurse consultant, regional reimbursement consultant, the director of nursing, and the MDS audited all Matrix EHR orders to validate that they matched the RD Dining Meal ticket system and that they were on the Resident Profile so that the CNAs and other facility workers can identify the diet that the resident is on and any precautions that are in place. Any concerns or discrepancies were corrected immediately upon discovery. Snacks ordered for weight loss interventions were audited and all were correct. The director of nursing/designee in-serviced facility staff on where to find the diet information for a resident. Facility staff will receive the information before starting their next assigned shift. Agency staff will receive the information before starting their assigned shift. The CNA who fed the resident bread was individually re-educated by the administrator and the director of nursing on [DATE] regarding following the resident diet and where to find diet information. Start Date: [DATE] Completion Date: [DATE] Responsible: Administrator/Director of Nursing Action: On [DATE], the regional nurse consultant in-serviced the administrator and the director of nursing on new admissions to the facility and the process of entering the diet into the Matrix EHR and completion on the Resident Profile. New admission orders will be reviewed the next morning in the Interdisciplinary Team Meeting (IDT) and corrections made when needed. The RD Dining Meal Ticket system will also be checked at that time to validate that everything matches. The MDS will then develop a care plan for any dietary needs identified by day fourteen (14) or sooner, per the regulation. The RD recommendations will be reviewed upon receiving by the director of nursing/designee for any diet changes and new orders entered per the above processes. The Resident Profile and care plan will be updated at that time. Any concerns will be discussed in the weekly Quality of Care meeting. Speech therapy recommendations will be reviewed upon receiving by the director of nursing/designee for any diet changes and new orders will be entered per the above processes. The Resident Profile and care plan will be updated at that time. Any concerns will be discussed in the weekly Quality of Care meeting. Start Date: [DATE] Completion Date: [DATE] Responsible: Administrator Action: An Ad Hoc QAPI meeting was held with the facility medical director to discuss the deficiency and actions put in place by the facility. (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The administrator will monitor the new orders for diets from the RD or the Speech Therapist, weekly for one (1) month and randomly thereafter by reviewing the facility activity report, actual food on meal trays, and documenting findings on a log created by the facility. Any concerns or trends will be brought to the monthly QAPI meeting for tracking and trending and new IDT recommendations. Monitoring of the POR included the following: Observation on [DATE] from 03:22 p.m. to 05:19 p.m. revealed staff received in-service training from regional staff, ADM, DON, on topics of where to find the diet information, how to pull up Resident Profile to review-Diets-Diagnosis-Care Plans, the importance of following diet orders, and to check with charge nurse prior to giving resident(s) an altered diet texture. Interview on [DATE] at 03:31 p.m., the ADM stated she was in-serviced on [DATE], last night, by the Regional Nurse Consultant on new admissions to the facility and the process of entering the diet into the Matrix EHR and completion on the resident profile, also including topics of facility activity report review, new admission orders reviewed every morning to assure diet was completed and entered in EHR, the MDS coordinator would create dietary care plans or before day 14, the RD recommendations would be reviewed upon receiving by the director of nursing/designee for any diet changes and new orders, new orders and concerns would be review in the weekly quality care meeting by the DON, and the new processed would be reviewed in the monthly QAPI meetings for three months. The ADM stated staff were in-serviced on topics of where to find the diet information, and CS A was individually re-educated and the DON on [DATE] regarding following the resident diet and where to find diet information. Interview on [DATE] at 03:39 p.m., the DON stated the Regional Nurse Consultant in-serviced her the evening of [DATE] on new admissions to the facility and the process of entering the diet into the Matrix EHR and completion on the Resident Profile. The DON stated all staff were in-serviced on topics of where to find the diet information, and CS A was individually re-educated by her and the ADM last night ([DATE]) on topics of following the resident diet and where to find diet information in the POC tablets. The DON stated other topics the regional consultant trained her on was the facility activity report review, new admission orders reviewed every morning to assure diet was completed and entered in the EHR, the MDS coordinator would create dietary care plans or before day 14, the RD recommendations would be reviewed upon receiving by the director of nursing/designee for any diet changes and new orders, new orders and concerns would be reviewed in the weekly quality care meeting by the DON, and the new process would be reviewed in the monthly QAPI meetings for three months. Observation and interview on [DATE] at 04:49 p.m., RN A stated she was also the MDS Coordinator and works the day shift, RN A stated she was in-serviced on topics of where to find the diet information, how to pull up Resident Profile to review-Diets-Diagnosis-Care Plans, the importance of following diet orders, and to check with charge nurse prior to giving resident(s) an altered diet texture. RN A stated she will create dietary care plans or before day 14. Observation of RN A revealed the use of the POC tablet to obtain information on resident diet orders, also including care plans and orders. (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation and interview on [DATE] at 04:53 p.m., the ADON stated in-service training on topics of where to find the diet information, how to pull up Resident Profile to review-Diets-Diagnosis-Care Plans, the importance of following diet orders, and to check with charge nurse prior to giving resident(s) an altered diet texture. ADON stated all staff were in-serviced on topics of where to find the diet information, and CS A was individually re-educated by the DON and the ADM on ([DATE]) on topics of following the resident diet and where to find diet information in the POC tablets. Observation of ADON revealed the use of POC tablet to obtain information on resident diet orders, also including care plans and orders. The ADON stated new admissions to the facility and the process of entering the diet into the Matrix EHR and completion on the Resident Profile. The ADON stated QAPI was conducted on the evening of [DATE] to discuss the IJ and plan of removal. Interview on [DATE] at 05:01 p.m., LVN B stated she works the day shift. LVN B stated she was in-serviced on topics of where to find the diet information, how to pull up Resident Profile to review-Diets-Diagnosis-Care Plans, the importance of following diet orders, and to check with charge nurse prior to giving resident(s) an altered diet texture. LVN B further stated CNAs were instructed to come to nursing if they had questions on dietary orders or any orders. Observation on [DATE] at 05:09 p.m., revealed dinner service, trays had meal tickets, nursing reviewed meal tickets before distribution, and staff reviewed meal tickets before serving meals to residents. Interview on [DATE] at 05:11 p.m., CNA A stated she was in-serviced on topics of where to find the diet information, how to pull up Resident Profile to review-Diets-Diagnosis-Care Plans, the importance of following diet orders, and to check with charge nurse prior to giving resident(s) an altered diet texture. CNA A stated staff were further trained and instructed to monitor snacks they gave to all residents to assure the proper diet order. CNA A stated and explained the process to confirm orders and care plans, ADL needs with the use of POC tablet. Observation and Interview on [DATE] at 05:21 p.m., CMA A stated she was in-serviced on topics of where to find the diet information, how to pull up Resident Profile to review-Diets-Diagnosis-Care Plans, the importance of following diet orders, and to check with charge nurse prior to giving resident(s) an altered diet texture. CMA A stated staff must always confirm all orders which included dietary orders. CMA A stated she had access to POC on her medication cart as she used this for her duties in medication administration. Observation of CMA A revealed the use of POC to obtain information on resident diet orders, also including care plans and orders. Observation on [DATE] at 05:26 p.m., revealed dinner service in the locked unit, trays had meal tickets, nursing reviewed meal tickets before distribution, and staff reviewed meal tickets before serving meals to residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676044	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Living and Rehabilitation	1105 N Magnolia Luling, TX 78648

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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 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Phone interview on [DATE] at 05:40 p.m., CS A stated in-service training on topics of where to find the diet information, how to pull up Resident Profile to review-Diets-Diagnosis-Care Plans, the importance of following diet orders, and to check with charge nurse prior to giving resident(s) an altered diet texture. CS A stated she was re-trained on the use the facility's POC tablet, accessing diet orders, reviewing residents' profile for diet order and other orders. CS A stated, I took the in-service last night ([DATE]) before I started, if I have any concerns, I am going to check with the nurse to confirm orders, and that I want to avoid and prevent any choking or risks of resident eating fast because that is serious. CS A stated, I have been schooled on the tablet and I am aware of the risks, I come in at the tail end of the shift after everything is said and done, and we want to make sure residents get snacks and I know the risk of giving something they aren't supposed to eat, a resident can choke and that is a very serious matter. Phone interview on [DATE] at 05:51 p.m., LVN A stated she works the night shift. LVN A was in-serviced on topics of where to find the diet information, how to pull up Resident Profile to review-Diets-Diagnosis-Care Plans, the importance of following diet orders, to check with charge nurse prior to giving resident(s) an altered diet texture. Phone Interview on [DATE] at 05:56 p.m., CNA B stated in-service completed on topics of where to find the diet information, how to pull up Resident Profile to review-Diets-Diagnosis-Care Plans, the importance of following diet orders, and to check with charge nurse prior to giving resident(s) an altered diet texture. CNA B observed the use of POC to obtain information on resident diet orders, also including care plans and orders. CNA B stated she was aware of the risks of resident noncompliance of dietary orders, further stating, if we don't follow orders, it is dangerous for residents this could be from choking to food allergies, also I'm fully aware that I can always go to a nurse to confirm any orders or care for my residents. Interview on [DATE] at 05:58 p.m., NA A stated she was in-serviced on topics of where to find the diet information, how to pull up Resident Profile to review-Diets-Diagnosis-Care Plans, the importance of following diet orders, and to check with charge nurse prior to giving resident(s) an altered diet texture. NA A stated. We must follow all orders, this is how we provide care for our residents, all orders, dietary, everything, if we don't, we could cause harm to residents. Interview on [DATE] at 06:11 p.m., the DM stated she completed in-service training on topics of where to find the diet information, how to pull up Resident Profile to review-Diets-Diagnosis-Care Plans, the importance of following diet orders, and to check with charge nurse prior to giving resident(s) an altered diet texture, and there was a process of orders to confirm they matched the RD Dining Meal ticket system, and they were on the Resident Profile. Record review of in-services for ADM and DON on [DATE] on topics of new admissions to the facility and the process of entering the diet into the Matrix EHR and completion on the Resident Profile. Record review of in-service from [DATE] to [DATE] on topics of where to find the diet information for a resident completed, Subject: Resident Profile-how to pull up Resident Profile to review-Diets-Diagnosis-Care Plans, all care a resident requires, importance of following diet orders-check with charge nurse prior to giving resident(s) an altered diet texture. (continued on next page)

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	676044	A. Building B. Wing	08/29/2024

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Ad Hoc QAPI meeting occurred [DATE] at 08:30 p.m. with the facility medical director, regional staff, ADM, DON, ADON, RN A to discuss the deficiency and actions put in place by the facility. Record review of in-service for th [TRUNCATED]