

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676044	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/05/2025
NAME OF PROVIDER OR SUPPLIER  Magnolia Living and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949</b></p> <p>Based on interview and record review, the facility failed to immediately inform the resident, consult with the resident's physician when there was a significant change in the resident's physical, mental, or psychosocial status for one (Resident #1) of four residents reviewed for resident rights.</p> <p>The facility failed to notify the facility MD when Resident #1 was experiencing shortness of breath and chest pain on 02/28/25.</p> <p>This failure could place residents at risk of illness, injury, uncontrolled pain, and a decreased quality of life.</p> <p>Findings included:</p> <p>Review of Resident #1's undated face sheet reflected an [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including heart failure, hypertension (high blood pressure), chronic kidney disease, age-related physical debility, and muscle wasting and atrophy (wasting away).</p> <p>Review of Resident #1's quarterly MDS, dated [DATE], reflected a BIMS score of 10, indicating he was moderately cognitive impaired.</p> <p>Review of Resident #1's quarterly care plan, dated 02/12/25, reflected he desired a DNR code status with an intervention of ensuring staff was aware of his advanced care planning decisions.</p> <p>Review of Resident #1's progress note, dated 02/28/25 at 9:06 PM and documented by the ADON, reflected the following:</p> <p>[Resident #1]'s call light was on and [CNA A] went to assist the resident when he stated to [CNA A] that he was having a hard time breathing and his chest was hurting . This writer raised his head and took his vitals - 106/63 (blood pressure) - 60 (pulse) - 18 (respirations) - 97.2 (temperature) - 97% (oxygen saturations) on RA . [Resident #1] was made comfortable at this time and [Resident #1] stable at this time . [CNA A] called to writer and upon entering room tried to call [Resident #1]'s name with no response . found to have no pulse or respirations at this time .</p> <p>Attempt to interview CNA A was made on 03/05/25 at 12:32 PM. A returned call was not received prior to exit.</p> <p>(continued on next page)</p>

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/05/25 at 12:47 PM, the ADON stated she worked the night of 02/28/25. She stated Resident #1 was on the light frequently to be changed because he had several bowel movements. She stated his nurse, LVN B, was on break when CNA A came to inform her that Resident #1 was short of breath and his chest was hurting (around 8:30 PM). She stated she went to his room, elevated his bed, and took his vitals which looked normal. She stated to her, he did not complain of pain but just that his chest was uncomfortable because he was short of breath. She stated she did not notify the MD because his vitals were normal, and he appeared comfortable. She stated approximately 15 minutes later he pressed his call light and CNA B went to assist him but could not arouse him. She stated he did not answer and would not respond.</p> <p>During a telephone interview on 03/05/25 at 12:47 PM, LVN B stated she worked with Resident #1 on 02/28/25 but was on break when he passed away. She stated she never heard about him having pain in his chest or being short of breath. She stated if she had known that [NAME] would have assessed his vitals, assessed him, and notified the MD.</p> <p>During a telephone interview on 03/05/25 at 1:20 PM, Resident #1's MD stated if a resident had shortness of breath, pain/tightness in their chest he would expect to be notified. He stated he expected to be notified for any problem whatsoever. He stated being short of breath was something important for him to know as something could be wrong. He stated he was not notified of Resident #1 experiencing pain or shortness of breath before he passed away on 02/28/25. He stated Resident #1 had a long heart history of issues. He stated if he would have been notified, he would have ordered a STAT chest x-ray. He stated in that specific instance, because it was so quick, it would not have made a difference.</p> <p>During an interview on 03/05/25 at 2:12 PM, the DON stated she expected the nurses to notify the MD immediately for any changes in the residents, whether it be complaints of chest pain, or any kind of pain or discomfort. She stated the MD needed to be part of the medical decision-making process. She stated a negative outcome of the MD not being involved could be harm or death.</p> <p>Review of the facility's Change in a Resident's Condition or Status Policy, revised February 2021, reflected the following:</p> <p>Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status.</p>		