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	07/16/2024

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30633 Based on record review and interview, the facility failed to ensure all Pre-Admission Screening and Resident Review (PASRR) Level I residents with mental illness were provided with a PASRR Evaluation assessment for 1 of 5 residents (Resident #32) reviewed for PASRR screening, in that: The facility did not have an accurate PASRR Level 1 assessment for Resident #32 when he had a diagnosis of major depressive disorder and mood disorder unspecified which would have triggered Resident #32 for a positive assessment for mental illness. This failure could place residents with an inaccurate PASRR Level 1 evaluation at risk for not receiving care and services to meet his needs. The findings were: Review of the Face sheet for Resident #32 reflected he was admitted to the facility on [DATE] with diagnoses of: Type 2 Diabetes, Dysphasia with Cerebrovascular disease, Cerebral infarction, Mood disorder due to known physiological condition unspecified, Major Depressive disorder singe episode. Review of the MDS assessment for Resident #32 dated 5/08/24 reflected a BIMS score of 12 indicating mild cognitive impairment. His physical assessment reflected he required one person assist for all ADLs. He mobilized by wheelchair. He was assessed as always continent of bowel and bladder. Review of the Care Plan for Resident #32 dated 6/08/24 reflected interventions were in place for: Safe transfers r/t weakness, ADL deficit r/t weakness (assistance to toilet), Limited in ability to eat and drink, Limited in ability to dress/undress, Psychotropic drug use (antidepressant), Fall Risk high, Speech Impairment, disease complications r/t Cerebral Infarction. Review of Records for Resident #32 reflected one PASRR evaluation was found in his records. A level one evaluation dated 7/23/18 reflected he was negative for mental illness. Review of the physician's orders for Resident #32 dated 7/16/24 reflected he was prescribed Aricept 5 mg at bedtime daily, a medication used to treat memory loss in Alzheimer's disease. No other psychoactive medications were prescribed. (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

Printed: 05/28/2025
Form Approved OMB
No. 0938-0391

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 07/16/2024
NAME OF PROVIDER OR SUPPLIER Magnolia Living and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #32's Progress notes dated from 3/04/24 to 7/03/24 reflected he was seen by a Psychiatric clinician on 7/01/24 and 6/12/24. No signs of depression or aggressive behavior were reported. In an interview on 7/16/24 at 9:50am the MDS coordinator stated Resident #32 had only a PASRR evaluation dated 7/23/18 on record. She stated the diagnosis of Major Depressive Disorder single episode was added on 11/10/21 and the diagnosis of Mood Disorder Unspecified was added on 9/08/22. The MDS Coordinator stated only certain diagnosis automatically triggered a new PASRR assessment and the ones added for Resident #32 did not. In an interview on 7/16/24 at 10:25 am the DON stated she would defer to the MDS coordinator on the PASRR evaluations question. She stated she was unsure if Resident #32 should have received a new PASRR evaluation. In an interview on 7/16/24 at 11:30 am the ADON stated she was the charge nurse for Resident #32. She stated he was normally calm and collective, she stated she didn't believe he took any psychoactive medications. In an interview on 7/16/24 at 11:46 am the Administrator stated Resident #32 should have had a new PASRR evaluation with each new diagnosis. The Administrator stated the facility utilized the state guidelines for determining the need for PASRR assessments.

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F 0655

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 30633

Based on observation, interview, and record review, the facility failed to 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 care for 1 of 3 newly admitted residents (Resident #128) reviewed for baseline care plan.

The facility did not create a baseline care plan for Resident #128 upon admission.

This failure could place residents at-risk for decreased quality of life, improper care, and injury.

The findings were:

Review of the Face Sheet for Resident #128 reflected he was admitted on [DATE] with diagnosis of: Dysphagia following Cerebral infarction, Persistent Atrial fibrillation, Prostate cancer, Flacid Hemiplegia of right side, and Dysarthria.

No MDS assessment had been completed for Resident #128 on 7/15/24.

Review of the Baseline Care Plan dated 7/09/24 reflected it was created by MDS Coordinator and remained blank.

Review of the Care Plan dated 7/15/24 for Resident #128 reflected interventions were in place for: Swallowing problems, Incontinence of bowel and bladder, Prostate Cancer, Atrial Fibrillation, and Right sided Hemiparesis.

Review of the Physician's Orders for Resident #128 dated 7/09/24 reflected he was to receive medications, he was totally dependent for toileting, transferring and mobilizing in a wheelchair. The orders included monitoring for meal intake and liquids.

In an interview and observation on 7/16/24 at 10:10 am Resident #128 stated he had no discomfort. He stated the nurse had told him his abdominal staples should come out soon, but he was still waiting for them to do something. Resident #128 was observed lying in bed with his right arm limp and unable to move. He was alert and responsive with moderately slurred speech. His eyes were equal and reactive. His mouth was symmetrical, no drooping observed.

In an interview on 7/16/24 at 10:20 am LVN P stated it was facility policy to complete Baseline Care Plans as soon as possible on admission of new Residents. She stated a baseline care plan should have been completed before the end of shift for Resident #128. She stated she was not working that shift.

In an interview on 7/16/24 at 10:25 am the DON stated Baseline Care Plans must be completed the first day of admission for a new Resident. She stated she had observed Resident #128's Baseline Care Plan was not done and finished it yesterday (7/15/24).

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 7/16/24 at 11:46 am the Administrator stated Baseline Care Plans were to be completed on the day of admission.

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F 0677

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide care and assistance to perform activities of daily living for any resident who is unable.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 40884

Based on observation, interviews, and record review the facility failed to ensure residents unable to conduct activities of daily living (ADLs) received the necessary services to maintain good grooming and personal hygiene for six of eighteen (Resident # 21, and Resident #40) residents reviewed for ADL's.

The facility failed to ensure Resident # 21 and Resident #40's nails were cleaned, received a shower during the time period of 07/09/2024 thru 07/14/2024 and remove Resident #40's facial hair on her chin and above her upper lip.

These failures placed residents at risk of a decline in their hygiene, at risk of skin breakdown, loss of dignity and decline in quality of life.

Findings included:

1. Record review of Resident # 21's Face Sheet dated, 07/16/2024, reflected a [AGE] year-old male admitted on [DATE] and readmitted on [DATE] with diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (paralysis of partial or total body function on one side of the body, whereas hemiparesis is characterized by one?sided weakness, but without complete paralysis), morbid obesity (over 80 to 100 pounds over ideal body weight), muscle weakness (a lack of muscle strength), unspecified lack of coordination (Uncoordinated movement is due to a muscle control problem that causes an inability to coordinate movements), and need for assistance with personal care (the support and supervision of daily personal living tasks and private hygiene).

Record review of Resident #21's Quarterly MDS Assessment, dated 05/10/2024, reflected the resident had a BIMS score of 11 reflected his cognition was moderately impaired. Resident #21 required assistance with personal hygiene, dressing, transfers, and showers/bathing.

Record review of Resident #21's Comprehensive Care Plan, dated 06/08/2024 reflected Resident #21 was at risk for skin breakdown related to moisture, shear friction and mobility. Intervention: keep clean and dry as possible. Resident is limited in the ability to bathe self-related to bilateral below knee amputee. Intervention: provide set up, supervision, and one staff physical assistance for showers. Resident request showers be given at night and only wants showers two times per week. Intervention: Educate on importance of hygiene in relation to skin and odor. Respect resident rights to receive shower two times per week and as needed.

Record review of Resident #21's shower record , dated 07/01/2024 - 07/31/2024, reflected he did not receive a shower or a bath during the following time period: 07/09/2024 thru 07/14/2024. According to the shower record, Resident #21 did not refuse showers/ baths during month of July.

Observation on 07/14/2024 at 9:58 AM Resident #21 was lying in bed watching television. He had a strong body odor. When standing near his roommate there was not a body odor. When standing within 3 feet of Resident #21 it was a strong body odor. His hair was very oily and he had blackish substance underneath all fingernails on his right hand. When he held his hand up, his hand had a scent of bowels.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/14/2024 at 10:00 AM Resident #21 stated he had not had a bath in about 8 days. He stated he requested a bath yesterday 07/13/2024 and he was told they were too busy and would tell the night shift to give him a bath. He stated he did request to get a bath at night but the night shift would tell him they would give him a bath the next night they were too busy. Resident #21 stated he was tired of asking night shift so he asked day shift yesterday (07/16/2024) to give him a bath and wash his hair. He stated his hair was so oily and he could smell odor from his body. Resident #21 apologized for having a bad odor and stated he sweats a lot and between the sweat and not getting a bath he knew he was not clean. He stated he did ask the same staff to clean his nails and they said they would clean his nails when he got a bath. Resident #21 stated he did have some bowels on his fingernails from last night. He stated he did not want to discuss his bathing and dirty fingernails any further . In an interview on 07/14/2024 at 10:32 AM Resident #40 stated she was sitting away from everyone due to being embarrassed over the hair on her face. She stated she asked someone yesterday and few days ago to cut the hair on her face and the staff stated they were busy and would get to it soon. She stated look at my nails. Resident #40 also stated she also asked her nails to be trimmed and cleaned. She stated no one ever came back and cleaned them or trimmed her nails. Resident #40 stated she asked for them to be cleaned and trimmed few days ago and she did not recall the staff name when she asked to cut the hair on her face and when she asked to cut and clean her nails. Resident #40 stated she did not recall the last time she had a shower but it had been about more than a week. In an interview on 07/16/2024 at 9:00 AM CNA C stated the nurses completed all diabetic fingernails and the CNAs was responsible for all other residents' nails. She stated the CNAs was responsible to complete nail care such as trimming, filing, and cleaning the nails. CNA C also stated if a resident's nails needed to be cleaned, trimmed, or filed and it was not their shower day the staff was expected to do nail care as needed. She stated if a resident had blackish substance underneath their nails there were a possibility it may be bowels. She stated if a resident swallowed some of their bowels the resident may develop major stomach problems such as vomiting and diarrhea. CNA C stated if a resident became severely ill from the bacteria the resident possibly needed to be assessed at the hospital. She stated she worked with Resident # 40 and Resident #21 and she was not aware of them refusing nail care or showers. She stated Resident #21 would sometimes refuse some care such as changing his clothes when it was not his shower day. She stated residents has certain days to receive showers. She stated if a resident did not receive a shower in five days or more there was a potential a resident may have body odor, may develop skin concerns such as rashes or even scabies. CNA C also stated a resident may become embarrassed to be around others and may isolate themselves in their rooms. She also stated if a female resident had hair anywhere around their chin or above their upper lip, a female resident may feel embarrassed and also may not want to come out of their room or see anyone. She stated it was the CNAs or nurses' responsibility to remove hair from females face. She also stated this could be completed on shower days or as needed. CNA C stated the residents did have a shower schedule and showers were documented in the resident's medical record and if a resident refused the CNA was to document on the shower record the resident refused. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/16/2024 at 9:35 AM the DON (Director of Nurses) stated the nurses and CNAs were responsible for nail care. She stated the nurses was responsible to trim and clean all resident's nails with a diagnosis of diabetes. DON stated it was the CNAs responsibility to clean and trim all other residents' nails. She stated anyone can report to the nurses when nail care needed to be completed on any resident. She stated if there was a blackish substance underneath the residents' nails, there was a possibility the substance may had bacteria underneath the residents' nails. She also stated if a resident swallowed the bacteria there was a possibility a resident may become extremely ill with stomach issues such as vomiting. DON also stated if a resident did not receive a shower in five days or more the resident may have body odor and develop skin concerns such as rashes. She stated it was not healthy for a resident not to receive a shower at least every other day. DON stated if a female had facial hair on her chin or above her upper lip and if a resident did not receive a shower over five days the resident may isolate themselves from other people or may become embarrassed. She stated she would need to check medical records to know if Resident # 21 or Resident #40 had refused any care. The DON stated it was the nurse's responsibility to monitor personal hygiene with all residents. She stated any refusals was documented on the shower record. In an interview on 07/16/2024 at 10:50 AM CNA F stated CNAs were responsible for nail care unless a resident was a diabetic. She stated the CNAs usually trimmed and cleaned nails during showers. She stated the nails could be cleaned or trimmed by nurses or CNAs as needed. CNA F stated the nursing staff was expected to clean and trim residents' nails immediately if there was a blackish substance underneath the residents' nails and/ or if their nails needed to be trimmed. CNA F stated the blackish substance may be fecal matter underneath the residents' nails. She stated if a resident swallowed the blackish substance there was a possibility a resident may become ill with stomach issues or any type of intestinal issues. CNA F stated if a resident went over five days without a shower or a bath there was a possibility a resident may have a strong body odor or a resident may develop skin sores, scabies, or a rash. She also stated if a female resident had facial hair on their chin and above their upper lip, the resident may isolate themselves, become depressed or be embarrassed. She stated these same emotions (becoming depressed, embarrassed or isolation) may affect residents not getting their showers over five days. She stated the CNAs did have a shower schedule and if a resident refused a shower they would document in the resident's medical record. She stated she gave care to Resident #40 and Resident #21, and with her experience they did not refuse nail care or showers. Record review of the Facility Policy on Care of Fingernails/Toenails, revised on 10/2010, reflected the purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. Review the resident's care plan to assess for any special needs of the resident. Nail care includes daily cleaning and regular trimming. Proper nail care can aid in the prevention of skin problems around the nail bed.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884 Based on observation, interview and record review, the facility failed, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community for 2 of 10 residents (Resident # 48 and Resident #50) reviewed for activities. 1. The facility failed to develop an activity program based on preferences of Resident #48 and Resident #50. 2. The facility failed to provide activities as scheduled on July 6th-July 7th, July 13th, and July 14th. These failures placed residents at risk of boredom, depression, increased behaviors, and diminished quality of life. Findings include: 1. Record review of Resident #48's Face Sheet, dated, 07/16/2024 reflected a [AGE] year-old female admitted on [DATE] and readmitted on [DATE] with diagnoses of type 2 diabetes mellitus with diabetic neuropathy (occurs when the body does not produce enough insulin to function properly and neuropathy - nerve damage caused by long-term high blood sugar), Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), polymyalgia rheumatica (an inflammatory disorder that causes muscle pain and stiffness, especially in the shoulders and hips), and pruritus (an irritating sensation on the skin that makes you want to scratch) Record review of Resident #48's Annual MDS Assessment, dated 03/26/2024, reflected the resident had a BIMS score of a 7 reflected resident cognition was severely impaired. She had limited vision; not able to see newspaper headlines but can identify objects. Resident #48 did wear eyeglasses. She was assessed of feeling down, depressed, or hopeless. Resident #48's activity preferences were the following: having books, newspapers, and magazines to read, listening to music, keep up with the news, doing things in groups of people, doing favorite activities, going outside to get fresh air when the weather was good, and participate in religious services and practices. Resident #48 was also assessed to diagnoses depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), asthma, COPD, or chronic lung disease (swelling in your airways that make it hard to breathe), Parkinson's disease and diabetes mellitus. Record review of Resident #48's Quarterly MDS Assessment, dated 04/26/2024, reflected the resident had a BIMS score of a 7 reflected resident cognition was severely impaired. Resident #48 had limited vision; not able to see newspaper headlines but can identify objects. She did wear eyeglasses. Resident #48 was assessed to have depression. She was assessed to have the following diagnoses: diabetes mellitus, depression (a mood disorder that causes a persistent feeling of sadness), and asthma, COPD, or chronic lung disease (swelling in your airways that make it hard to breathe) (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #48's Comprehensive Care Plan revised on 06/05/2024 reflected Resident #48 had impaired vision related to macular degeneration (a condition affected by the central part of the retina and results in distortion or loss of central vision) Intervention: Provide with talking books or large print books as desired. She had potential for complications related to Parkinson's disease, including poor balance, constipation, drooling, poor coordination, tremors, and gait disturbances. Intervention: Encourage daily exercise. Resident had potential for complications, discomfort, related to diagnosis of GERD (gastric acid flowing from your stomach back up into your food pipe) Intervention: encourage activities that involve bending and lifting. Avoid foods or beverages that aggravate the condition such as alcohol, chocolate, caffeine, acidic or spicy foods, fried or fatty foods. Resident #48 had a potential nutritional problem. Intervention: invite to activities that promote additional intake of food and fluids. Encourage resident to attend activities of choice. Activity Director to monitor resident's activity preferences. Resident #48 enjoys activities. Intervention: make calendar of scheduled activities and events available to resident. Resident was at risk for alteration in comfort and or pain. Intervention: Invite to activities involving gentle exercise. Record review of Resident #48's participation records, dated 07/01/2024 - 07/31/2024 reflected Resident #48 did not refuse to attend any activity. She attended the following group activities from 07/01/2024 - 07/14/2024: 1. Exercise - 1st- 4th and 8th -12th 2. Religious Group- 1st and 8th 3. Socials- 4th, 10th, 11th, and 12th. 4. Bingo- 1st and 8th. Independent activities: 8 times (TV 1 day and Reading 8 days) Observation on 07/16/2024 at 11:16 AM Resident #48 was sitting in wheelchair in her room. Resident #48 did not have television on and was staring at the wall. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/16/2024 at 11:18 AM Resident #48 stated she did attend some activities. She stated she went to exercise when someone helped her to exercise. She stated she was not able to do the exercises very much due to having breathing problems. Resident #48 stated she did not have anything to read and she could not read very much maybe two lines due to her vision. She also stated she wore her glasses and her glasses were new but she could not read very well due to her eye disease. She stated she did not have an activity calendar in her room. She said she did not know where it was located and would not be able to see if she did know where it was located. Resident #48 stated it was the same activities all the time. She stated some days they have the same activity twice a day. She said all they do is popcorn and movies. She said she enjoyed going to the activities when they served food but they did not have food for diabetics. She said they had popcorn all the time and when she ate popcorn it hurt her stomach and it would come up from her stomach when she laid down sometimes. She stated that they did not have food at parties for her most of the time. She stated she does become so bored and there was nothing to do. Resident #48 also stated she did have depression and it became worse when she sat in her room and did not have anything to do in her room or when she left her room. She began picking at her skin. She stated she had something wrong with her skin and it itched a lot but she focused on it more when she was sitting in her room. Resident #48 stated if I had something else to do I would not pick at my skin. Observation on 07/15/2024 at 9:10 AM Resident #48 was sitting in her room and the television was off and she was staring toward the door exiting into the hallways. Did not observe any reading material, puzzles, cards, craft items, games, or any activity item for Resident #48 to do independently in her room except Television. In an interview on 07/15/2024 at 9:13 AM Resident #48 stated she was not able to put puzzles together due to her health and her vision. She stated she had Parkinson's and she was not able to see puzzle pieces. She stated her vision has not declined it has remained the same in a year. Record review of Resident #50's Face Sheet, dated 07/16/2024, reflected a [AGE] year-old male admitted on [DATE] and readmitted on [DATE] with diagnoses of muscle wasting and atrophy, not elsewhere classified, multiple sites (the decrease in size and wasting of muscle tissue), hemiplegia, unspecified affecting left nondominant side (paralysis of partial or total body function of the body), depression (a mood disorder that causes a persistent feeling of sadness), diabetes mellitus with hyperglycemia (a condition in which the level of glucose in the blood higher than normal), and dysphagia following unspecified cerebrovascular disease (difficulty with swallowing and a group of conditions that affect blood flow and the blood vessels in the brain) Record review of Resident #48's Annual MDS Assessment, dated 04/24/2024 reflected Resident #50 had a BIMS score of 9 reflected resident's cognition was moderately impaired. Resident #48 had depression. Resident #50 was assessed to have activity interests in the following: music doing things in groups of people and going outside to get fresh air when the weather is good. Resident had a diagnosis of depression, hemiplegia unspecified affecting left dominant side, and dysphagia following unspecified cerebrovascular disease. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #50's Comprehensive Care Plan revised on 06/05/2024 reflected Resident #50 needed encouragement to attend activities. Intervention: Involve Resident #50 with other residents with shared interests. Resident had communication problem. Intervention: provide a program of activities that accommodates resident's problem. Seat Resident #50 close to front to enhance understanding. Use written instructions, pictures, demonstrations to facilitate participation with activities as desired. Resident had visual impairment. Intervention: provide with talking books, large print books as desired. Resident #50 was at risk for alteration in comfort and or pain. Intervention: Invite to activities involved with gentle exercise groups. Resident required one to one activities related to resident was not at ease joining other residents in activities. Resident was at risk for social isolation. Intervention: report signs of isolation. Record review of Resident #50's participation records, dated 07/01/2024 - 07/31/2024 reflected Resident #50 did not refuse to attend any activity. He attended the following group activities from 07/01/2024 - 07/14/2024: 1. Music (this was not a group activity it is played in the dining room when residents are gathering for meals) 2. Cooking- 4th 3. Bingo - 1st- 4th and the 8th 4. Outside- 1st- 4th, 8th, and 10th -12th 5. In room activities - did not receive from 07/01/2024 - 07/14/2024 Observation on 07/14/2024 at 11:24 AM Resident #50 was sitting in his wheelchair at the end of 400 hall near his room. He stated the only concern he had was there was not anything to do and he was bored. In an interview on 07/14/2024 at 11:26 AM Resident #50 stated he was bored every day. Resident #50 stated it was the same activities every day and some activities were offered twice in the same day. He stated he did not relate to any of the activities being provided. Resident #50 stated he did attend bingo because sometimes they would offer food. He stated he did attend very few socials. Resident #50 stated he goes outside and sits alone most of the time. He stated if he watched movie it was in his room and not in the lobby with other people lives here because it was impossible to watch a movie in the lobby with people coming in and out of the front door. He stated if they offered movies in the dining room and closed the doors where it was quiet that would be different but movies were always in the lobby. Resident #50 also stated he becomes depressed and if he had something to do he believed it would help with his depression. He stated he is accused of making things up about staff and he laughed when he stated maybe sometimes he did but it was sometimes entertaining to him because he did not have anything else to do. He stated he had a lot of time to think about things and he would think of things to do that may not be in the best interest of him and everyone in the facility. He also stated if this were reported he talked about what he did he would deny it. Resident #50 also stated reason he reported it due to not having anything else to do. (continued on next page)

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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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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/15/2024 at 10:15 AM Resident #50 stated he knew how to play bingo and he did not require someone to demonstrate it to him, show him pictures or give him written instructions. He also stated he had not received in room activities and never heard of in room activities. Resident #50 stated noon had offered in room activities to him. He also stated no one had introduced him to other residents with similar interests. Resident #50 stated he did not have the same interest with anyone else lived in this nursing home. He stated it would be nice if they had a band sometimes come in and play any music except gospel. He stated music they consider an activity is played in the dining room at meals and could not hear the music with everyone talking and he did not believe this would be a group activity. He stated he watched television in his room. Resident #50 stated he went to few food activities this month but he went to get the food and left immediately. He stated he was in the dining room maybe 5 or 10 minutes he did not stay for the group activity. He also stated they counted popcorn being popped in the lobby almost every day as a social and it was residents sitting in the lobby and staff popping popcorn and passing it out to the residents. He stated there was not any interaction with the residents during popcorn and they would have the television on for a movie but could not hear the movie due to everyone talking and people coming in and out of the facility. He stated his preference would have a band to come in and play country or some other type of music except for gospel, blue grass, or something like that. He stated the same activities was on the calendar every day. Resident #50 also stated he hated to read and did not want any books or talking books. He stated he did not know who got that idea he wanted to read. 2. Record review of the Activity Calendar for the month of July there were activities scheduled for on July 6-July 7th, July 13th, and July 14th such as the following. a. 6th: 8:00 AM: Current Events, 10:00: Movie and Popcorn, 10:30 AM: Coffee and Snacks, 2:30 AM: Table Games, 6:00 PM: Movie. b. 7th: 8:00 AM: Current Events, 10:00: Movie and Popcorn, 10:00 AM: Spiritual Services (TV or radio), 3:00: Table Games, 4:00: PM Movie. c. 13th: 8:00 AM: Current Events, 10:00: Movie and Popcorn, 10:30: AM Coffee and Snacks, (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2:30 AM: Table Games, 6:00 PM: Movie. d. 14th: 8:00 AM: Current Events, 10:00: Movie and Popcorn, 10:30: AM Coffee and Snacks, 2:30 AM: Table Games, 6:00 PM: Movie. Record Review of the resident participation records. Activities did not occur on 07/06/2024- 07/07/2024 and 07/13/2024. Observation on 07/14/2024 at 10:10 AM a movie was not on in the lobby or dining room. There were approximately 15 residents sitting in the lobby waiting on popcorn. In the lobby the shooting of the former President of the United States was on television instead of a movie. The activity calendar in the common area did not have the modification of the shooting of former President of the United States would be substituted for the movie. There was not an announcement made over the intercom of the substitution for the movie. In an interview on 07/15/2024 at 2:30 PM the Activity Director stated she had been an activity director [AGE] years at this facility. music on the participation records was in reference to music played in dining room when staff was assisting residents into the dining room and when residents eating in the dining room. She stated sometimes the residents and staff was talking in the dining room and it was possible it may be difficult for residents to hear the music. She also stated movies was on in the lobby area and she did not think about the noise of visitors/ staff entering and exiting the facility and coming in the lobby to speak to other residents may affect the ability for residents to watch a movie in the lobby. The Activity Director also stated TV/ Movie on the participation record did not always reflect the resident watched in a group. The residents possibly watched movies on television in their room. She stated popcorn/movie on the calendar was a group activity of serving popcorn and watching a movie in the lobby. She stated on 07/14/2024 there were two residents wanted to watch the shooting of the previous President of the United States. The Activity Director stated she did not ask the other residents if they wanted to watch a movie or the shooting of the President of the United States. She stated there was a possibility watching the shooting of the former President possibly may bring back memories from their past or from previous shootings of Presidents. She stated she did not think about watching shootings may affect other residents. The Activity Director stated she did not ask the other residents sitting in the lobby what did they want to watch on television and she was expected to consider everyone's preferences and not the two residents' preferences. She also stated if a resident was not attending activities of their preference and did not have activities of their preferences to do in their room there was a possibility a resident may isolate themselves, become depressed and become anxious. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/16/2024 at 8:30 AM the Activity Director stated music did not always reflect the resident attend music group activity. The resident listened to music in their room and she would document it as a group activity on their participation record. She stated what is documented on the care plan and the MDS Assessment was the activity program she was to follow for each resident. The Activity Director stated if a resident had music or movie documented on their activity participation record it did not always reflect the resident attended a group activity. She also stated during sit and fit exercise group this was the same exercise every time it was offered. She stated if a resident had asthma and respiratory issues the resident may need a different type of exercise program. Activity Director also stated current events at 8:00 AM every day was not a group activity and it was listed on the group calendar every day. She stated this was the resident watching news in their room or in the dining room. She stated she could not verify if all residents watched news every day. She also stated there were residents did not prefer to watch or listen to the news. She stated she was not aware of Resident #48 or Resident #50 was bored and may have depression due to not having anything to do in their rooms and was not happy with the group activities. She stated there was not another Resident she was aware of that Resident #50 may have something in common with to do an activity or visit with in the facility. She stated after viewing the calendar she realized there were some changes needed to be made where there were a variety of activities and not the same activities according to what day of week it was on the calendar. She stated if a resident refused to attend an activity it was required to be documented on the resident's participation record. In an interview on 07/16/2024 at 11:15 AM the Administrator stated the activity director was expected to follow the resident's activity preference assessed on the MDS and comprehensive care plan. She stated if a resident was not attending activities she expected the activity director to reassess the resident's activity preference as well as the activity programs. The Administrator stated the residents was watching movies at one time in the dining room and it was quiet. She stated watching movies in the lobby was not the best place for residents to be able to hear the movie. She also stated music being played in the dining room for meals was not a group activity. The Administrator stated she expected there be a variety of activities on the calendar. She reviewed the calendar and stated there were the same activity offered two times in one day and this was not acceptable. The Administrator stated she monitored the Activity Director. She also stated if a resident was bored and the resident's activity preferences was not being offered to the resident there was a potential the resident may become depressed or isolate themselves in their room. Record review of the Activity Director Personnel Record she had been an Activity Director for [AGE] years at this facility and she did have her current Activity Certification. Record review of the Facilities Policy on Group Programs and Activities Calendar, revised in January 2011, reflected Group activities are available in this facility and an activities calendar is completed to inform residents, families, and staff of the activity opportunities available. 1. Both large and small group activities are part of our activity programs. 2. The activities calendar states all activities available for the entire month, which may also include scheduled room visitation. 3. Residents are encouraged to participate in all group activities, especially those that are best suited for their interests and physical, mental, and emotional needs. (continued on next page)

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	676044	A. Building B. Wing	07/16/2024

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Smaller monthly activity calendars are placed in each resident room at a height and location that is accessible to the resident. 5. Activities are also advertised through announcements over the public address system and verbal invitations to join an activity on an individual basis. If public address announcements are appropriate for the facility the following format is recommended: Orientation (i.e., Today is Monday, April 27, 2009); brief description of the activity; location of the activity; time activity will begin. 6. Modifications, time changes, cancellations or substitutions are reflected on all large, posted calendars. It is recommended that final versions of the monthly calendar be kept on file for three years. Record Review of the Facilities Policy on Activity Programs- Staffing, revised in January 2011, reflected the following: 1. The Activity Director/Coordinator shall at least: a. Complete or delegate the completion of the activity's component of the comprehensive assessment. b. Contribute or ensure the contribution of activity goals and approaches that are individualized to match the skills, abilities, and interest of each resident. c. Monitor and evaluate the resident's responses to activities and revise the approaches as appropriate; and d. Develop, implement, supervise, and evaluate the activity programs. 2. When a qualified professional is not on premises, the day-to-day functions of the activity programs will be under the supervision of an Assistant Activity Director/Coordinator or another facility staff member as designated by administration. 3. Sufficient activity personnel will be on duty to meet the needs of the residents and the functions of the activity programs.

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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** 30633 Based on observation, interview and record review, the facility failed to ensure each resident's environment remains as free of accident hazards as is possible for 1 of 24 residents (Resident #53) whose care was reviewed for accidents and hazards in that: Resident #53 was observed with a 12-ounce aerosol air freshener bottle at the bedside. Resident #53 had a diagnosis of Asthma and Oxygen therapy, both of which contraindicated use of aerosols. This failure could affect residents and place them at risk of contributing to avoidable accidents and injury. The findings were: Review of the Face Sheet for Resident #53 reflected she was admitted on [DATE] with a diagnoses of: Joint Replacement Surgery, Acute vaginitis, herpes Zoster, Headache, Pneumonitis, Deep vein thrombosis to right leg, Major Depressive disorder, and Diabetes Type 2. Review of the quarterly MDS assessment for Resident #53 dated 4/23/24 reflected a BIMS score of 13 indicating mild cognitive impairment. Her Physical assessment reflected she was independent in eating but required substantial assistance for transfers, dressing and bathing. She was assessed as frequently incontinent of bowel and bladder. Review of the Care Plan for Resident #53 reflected interventions were in place for: Diabetes, Oxygen therapy, a history of making up allegations, Unsteady gait, Limited Mobility (electric wheelchair), risk of bleeding, chronic pain r/t back issues, Psychotropic Drug use. Observation and interview on 7/14/24 at 9:20 am revealed Resident #53 had a bottle of aerosol air freshener, a 12-ounce bottle on her nightstand. She stated she was not sure where the aerosol had come from. In an interview on 7/16/24 LVN B stated she was unaware Resident #53 had spray air freshener in her room and stated it was not allowed in resident rooms. In an interview on 7/16/24 at 11:46 am the DON stated Resident #53 should have not have aerosol air freshener in a spray bottle in her room. She stated residents order things in all the time and the staff doesn't always catch them right away. She stated she would go and remove the bottle right away. In an interview on 7/16/24 at 11:46 am the Administrator stated the facility had a policy of not allowing aerosol sprays or air fresheners in resident rooms. The Administrator stated Resident #53 had a history of ordering and having goods delivered, adding she should not have had aerosol air freshener in her room. She stated staff can't always catch things in time. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility admission packet contained no information on allowed materials in rooms and the facility was asked for a policy on air fresheners and did not supply one from 7/14/24 to 7/16/24.

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F 0695

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide safe and appropriate respiratory care for a resident when needed.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 30633

Based on observation, interview, and record review, the facility failed to ensure that residents who needed respiratory care were provided such care, consistent with professional standards of practice, for 2 of 3 residents (Residents #24 and #30) reviewed for oxygen in that:

The facility failed to ensure Resident #53's oxygen humidifier, tubing, and cannula were changed, dated, and initialed according to facility policy.

The facility failed to ensure Residents #53's tubing was clean , changed weekly and initialed or signed.

This failure could affect residents who received oxygen by placing them at risk for respiratory infections.

The findings included:

Review of the Face Sheet for Resident #53 reflected she was admitted on [DATE] with a diagnoses of: Joint Replacement Surgery, Acute vaginitis, herpes Zoster, Headache, Pneumonitis, Deep vein thrombosis to right leg, Major Depressive disorder, Diabetes Type 2.

Review of the quarterly MDS assessment for Resident #53 dated 4/23/24 reflected a BIMS score of 13 indicating mild cognitive impairment. Her Physical assessment reflected she was independent in eating but required substantial assistance for transfers, dressing and bathing. She was assessed as frequently incontinent of bowel and bladder.

Review of the Care Plan for Resident #53 reflected interventions were in place for: Diabetes, Oxygen therapy, a history of making up allegations, Unsteady gait, Limited Mobility (electric wheelchair), risk of bleeding, chronic pain r/t back issues, and Psychotropic Drug use.

Observation on 7/14/24 at 9:20 am revealed Resident #53 had oxygen tubing dated 7/01/24. Her humidifier reservoir was empty. A photograph by surveyor showed the date on the tubing as 7/01/24.

Observation on 7/15/24 at 10:14 am revealed Resident #53's oxygen tubing attached to her concentrator had a date of 7/01/24.

In an interview and observation on 7/16/24 at 8:20 am, Resident #53 stated yes they finally changed the oxygen tubing., Resident #53's tubing was observed to have a date of 7/14/24.

In an interview on 7/16/24 LVN B stated she had changed the tubing for Resident #53 on Sunday per regular practice of the facility. Surveyor informed her tubing was dated 7/01/24 and humidifier was empty. She stated she had replaced the humidifier and the tubing on Sunday, she added her handwriting was on the current tubing marked 7/14/24.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 7/16/24 at 11:46 am the DON stated Resident #53 should have her tubing changed weekly. She stated she had no explanation for the tubing dated 7/01/24 unless the resident had retrieved the old tubing from the trash and saved it. She stated the LVN who stated she had replaced it was a reliable employee and she had no reason to believe she had not replaced the tubing. In an interview on 7/16/24 at 11:46 am the Administrator stated the facility had a policy of replacing oxygen tubing weekly. She stated when surveyors entered the tubing for Resident #53 labelled 7/01/24 should not have been in place. Review of the Oxygen Administration Policy supplied by the facility dated October 2010 reflected oxygen tubing/masks were to be changed by the nursing department weekly and documented on the treatment administration record.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884 Based on observation, interview and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs to each resident for one (Resident #58) of four residents reviewed for medications. The facility failed to ensure Resident #58 was administered anti-acid medications without a physician order and to ensure the resident swallowed the medication prior to leaving the resident's room. This deficient practice could place residents at risk of consuming unprescribed medications, harm, and hospitalization . Findings included: Record review of Resident #58's Face Sheet dated, 07/14/2024 reflected a [AGE] year-old male admitted on [DATE] and readmitted on [DATE] with diagnoses dyspepsia (pain or burning of the stomach), essential hypertension (when the force of blood is stronger than it should be normally), and long-term use of antithrombotic/antiplatelets (prevent blood from clotting), and anemia (iron deficiency). Record review of Resident #58's Annual MDS Assessment, dated 07/03/2024, reflected Resident #58 had a BIMS score of 13 his cognition was intact. Resident required assistance with tub/shower transfer and with showers. Record review of Resident #58's Comprehensive Care Plan, dated 06/06/2024 and revised on 07/08/2024, reflected Resident was not assessed to have any physical problems with indigestion. Record review of Resident #58's Physician Order, dated 07/01/2024-07/16/2024, Resident #58 did not have a physician order for any anti-acid except for Pepcid (famotidine)tablet; 20 mg, amount: 1 TAB; oral (diagnosis of dyspepsia- pain or burning of the stomach) once a day; 9:00 AM. Record review of Resident #58's MAR, dated 07/01/2024-07/14/2024 reflected Resident #58 anti-acid medications given to Resident # 58 was not listed on the MAR. Pepcid (famotidine) tablet; 20 mg; Amount to Administer: 1 TAB; oral was listed on the MAR. Observation on 07/14/2024 at 10:43 AM Resident # 58 had four tablets of anti-acid medicine in a medication cup at bed side. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/14/2024 at 10:45 AM Resident #58 stated he had indigestion a lot and the med aide will bring him two anti-acid medications to him when they bring him his other medications or other times when he has indigestion before his medications are given to him. Resident #58 stated he had four anti-acid medications and he received two last night (07/13/2024) and two more of the anti-acid medications before 6:00 AM today (07/14/2024. He also stated the nurse brought the anti-acid medication in his room and leaves them for me to take when I have indigestion. Resident #58 stated he did not take them last night or this morning due to his indigestion got better. He stated there were times he did take four anti-acid pills at the same time if he had them in his room. Resident #58 stated he did take another anti-acid medicine when he gets his other medicines, however, he will request these other anti-acid medications during the day and when he gets his medicines. He stated he hurt at night when he laid down and if he had these in his room he could take two of four of them at the same time and it helped his indigestion. In an interview on 07/15/2024 at 10:30 AM Med-Aide D stated Resident #58 did receive anti-acid medications. She stated he will request the anti-acid medications when his prescribed pills are given or he will come to her and request anti-acid medications. She looked at the picture taken on 07/14/2024 and identified the medications in the cup as the anti-medications given to Resident #58. She stated Resident #58 did require a physician order to administer any medications to him including over the counter medications such as anti-acids. Med-Aide D also stated she was required to follow the MAR. She stated any medications on the Physician orders was pulled over by the computer system to the MAR. She stated if she gave a medication without a physician order this would be a mistake. Med-Aide D stated the med pass protocol was to match the resident with the picture on the computer system. She stated each medication was compared to the MAR to verify it was the correct medication. She also stated the Med-[NAME] or a nurse was not to leave the resident until all medications had been taken by the resident. Med-Aide D would not respond if she would leave anti-acid medications in Resident #58's room without observing him taking the medication. She stated he would sometimes come to the medication cart and ask her for the anti-acid (Rolaids) and she would give him two of the Rolaids at the medication cart and did not notice if he took the medication at that time or if he took them to his room. She stated if a resident ingested too many anti-acids there was a potential a resident may become sick with gastritis or interact with some other medications. She stated it was not good practice to take four anti-acids at the same time. She stated it may cause all types of issues with the resident's stomach. In an interview on 07/16/2024 at 9:35 AM the Director of Nurses stated any over the counter medication required to have a physician order. She stated all medications from the physician orders was on the MARS. The DON also stated the med-aide and nurse was expected to look at the MAR before administering any type of medications including over the counter anti-acid medications. She stated this was not best practice to administer medications by not reviewing the MAR prior to administering the medications. The DON also stated all med-aides and nurses was expected to observe the resident take the medications in their mouth and ensure the resident did swallow all of the medications. She stated under no circumstance was any type of medications including over the counter anti-acid leave on the bed side table. The DON stated if a resident came to the medication cart and requested anti-acid medication the med-aide or nurse was required to observe the resident had swallowed the medication. She also stated if Resident #58 did take four or more anti-acids at the same time there was a potential he may develop gastro issues. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Magnolia Living and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/16/2024 at 10:30 AM Med- Aide E stated if a resident did not have an order for any type of medication including over the counter anti-acids it was not to be administered to the resident. She stated the med-aide and the nurse was expected to review the MARs prior to giving any type of medication to a resident. She stated if there was a physician order for over-the-counter medication it would transfer over to the MAR from the computer system. She stated she was not aware of any medication not being on the MAR that was not on the physician order. Med-Aide E stated if a resident received over the counter medication the med-aide or nurse was expected to observe the resident swallow the medication and not allow the resident take the medication to their room or leave medication in their room. She stated if a resident had four anti-acid medications in their room and swallowed all four pills there was a possibility the resident may become sick with gastritis. She also stated a resident may develop gastro or stomach problems. Attempted to call and interview the Physician on 07/16/2024. Unable to leave message. Record review of the Facilities Administering Medication Policy, revised December 2012 reflected medications shall be administered in a safe and timely manner, and as prescribed. Medications must be administered in accordance with the orders, including any required time frame. The individual administering the medication must initial the resident's MAR on the appropriate line after giving each medication and before administering the next ones. As required or indicated for a medication, the individual administering the medication will record in the resident's medical record: 1. The date and time the medication was administered. 2. The dosage. 3. The route of the administration. 4. The injection site (if applicable). 5. Any complaints or symptoms for which the drug was administered. 6. Any results achieved and when those results were observed; and 7. The signature and title of the person administering the drug.

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 07/16/2024
NAME OF PROVIDER OR SUPPLIER Magnolia Living and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 40884 Based on interview and record review, the facility failed to provide sufficient support personnel with the appropriate competencies and skills sets to carry out the functions of the food an d nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and a diagnoses of the facility's resident population in accordance wit the facility assessment for one of one kitchen staff (Dietary Aide H) reviewed for qualified dietary staff. The facility failed to ensure the Dietary Aide H received orientation and training prior to beginning work in the kitchen. This failure could place the residents at risk for the spread of food borne illness and residents not having their nutritional needs met. Findings included: Record review of the personnel file for dietary aide H reflected he did not have a certificate of food handlers' course; he did not have any orientation or training records. In an interview on 07/14/2024 at 12:27 PM Dietary Manager interpreted for Dietary Aide H. He stated he began working at the facility today (07/14/2024). He stated he had not been trained or had any orientation. He stated he did not take food handler class and did not have his certificate. In an interview on 07/14/2024 at 12:35 PM the Dietary Manger stated she needed someone to work today (07/14/2024) and she called Dietary Aide H in to help in the kitchen. She stated she realized she made a mistake by asking him to come into work without orientation or any training. She stated he had not taken his food handler class and he was qualified to work as a dietary aide. She stated she was going to let him go home and they would work with one less person in the kitchen. She stated he was not qualified to do anything in the kitchen as of today 07/14/2024. In an interview on 07/14/2024 at 1:05 PM the Human Resource Manger stated Dietary Aide H did not have his orientation, training, or food handler certificate in the personnel record. She stated she was not aware he was working today (07/14/2024). She stated all staff was required to be trained and go through orientation prior to them working anywhere in the facility. She stated this was not the facilities protocol. (continued on next page)

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 07/16/2024
NAME OF PROVIDER OR SUPPLIER Magnolia Living and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/16/2024 at 11:50 PM the Dietary Manager stated dietary aide H was required to go through 3 days of training and orientation before he began working alone in the kitchen. She stated he was working alone in the kitchen without any guidance from her on 07/14/2024. Dietary Manager stated he was asked to go home on 07/14/2024 prior to his shift was completed. She stated he was expected to observe staff do tasks in the kitchen for three days prior to working alone. She also stated he was also required to have his food handlers' certificate prior to do any tasks in the kitchen and he did not have his food handler certificate the AM of 07/14/2024 when he worked in the kitchen. She stated he was not cooking but assisted with food service and helped with some of the food preparation. She did not specify when asked what type of preparation he did in the kitchen on 07/14/2024. Requested dietary protocol/policy for orientation/training for new hires. This was not provided at the time of exit. The orientation/training for nursing was provided at time of exit but not for dietary.

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 07/16/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49556 Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety for 1 of 1 kitchen reviewed for food safety and sanitation. The facility failed to ensure food that was prepped was labeled and dated. The failure placed residents at risk of foodborne illness. Findings included: Observation of the kitchen on [DATE] at 9:00am revealed milk, orange juice, and cranberry juice were not dated or labeled with the date that they were prepped. There was a pitcher of juice in the refrigerator covered, but not labeled. There was a personal drink in a large Styrofoam cup with name of Sonic on it. There was a package of cheddar cheese in a plastic resealable baggie that was not sealed or dated. There was a large container of Mustard dated [DATE] and large container of Ranch dated [DATE]. In the freezer there was a large container of Blue Bunny Sherbet that was not dated, and lid was on part of the container. In the pantry there was an opened box of taco shells with no dated label or any container or plastic resealable bag to keep food fresh. There was an opened bag of Ruffles in a clear resealable bag but not labeled or dated. An interview with Dietary [NAME] I on [DATE] at 11:20 am revealed that any food that has been opened should be labeled and dated. She told me the reason it is important to the food is to know when it was opened and how long it has been opened. [NAME] A told me the reason food is to be kept cover is to keep bacteria from growing in it and to keep it from becoming contaminated. An interview with Dietary Manager G [DATE] at 11:30 am revealed that all food in refrigerator, freezer and pantry should be dated and labeled. The reason is to know how long it has been there, when it was opened and when it should be thrown out. She revealed the importance of keeping clear resealable bags closed or have food in a sealed bag or container is to keep the food fresh and to keep bacteria and bugs out. An interview with the Administrator on [DATE] at 10:00am revealed that all food items should be labeled and dated. She stated food should be dated to know when it was opened and when it has expired. The importance of keeping food covered, in a container or resealable plastic bag is to keep food from becoming contaminated. Her expectation is the dietary staff know the policy. Record Review of the Food Receiving and Storage Policy reveals All food stored in the refrigerator or freezer will be covered, labeled, and dated.