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	08/28/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 4 of 10 residents (Resident #2, Resident #25, Resident #40, and Resident #66) reviewed for rights. The facility failed to ensure CNA D and HK F knocked on Resident #2, Resident #25, and Resident #40's doors when going into the residents' rooms. The facility failed to provide Resident #66 with a privacy bag for his catheter. These failures could place residents at risk of feeling like their privacy was being invaded or could have a negative psychosocial, psychosocial harm and emotional distress. Findings included: Resident #2 Record review of Resident #2's Face Sheet dated 08/26/2025 revealed she was an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2's diagnoses included obstructive pulmonary disease (chronic progressive lung disease), hyperthyroidism (excessive production of thyroid hormones), type 2 diabetes mellitus with hyperglycemia (high blood sugar), morbid obesity, hyperlipidemia (high cholesterol), insomnia (difficulty sleeping), hypertension (high blood pressure), heart failure, respiratory failure, constipation, muscle wasting, muscle weakness, and cognitive communication deficit (problems with communication). Record review of Resident #2's Annual MDS assessment dated [DATE] revealed Resident #2 had a BIMS score of 09 indicating moderate cognitive impairment. Resident #25 Review of Resident #25's Face Sheet dated 08/26/2025 revealed he was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #25's diagnoses included hemiplegia and hemiparesis following cerebral infraction affecting left non dominant side (paralysis and weakness on left side after stroke), dementia (memory, thinking, difficulty), viral hepatitis C (a bloodborne virus that causes liver inflammation), type 2 diabetes mellitus with other specified complications (high blood sugar), hyperlipidemia (high cholesterol), glaucoma (eye disease), hypertension (high blood pressure), and cerebral infraction (stroke). Record review of Resident #25's Quarterly MDS assessment dated [DATE] revealed Resident #25 had a BIMS score of 99 indicating Resident #25 was unable to complete the BIMS. Resident #40 Record review of Resident #40's Face Sheet dated 08/26/2025 revealed he was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #40's diagnoses included hypertension (high blood pressure), trigeminal neuralgia (severe facial pain), lack of coordination, need for assistance with personal care, high risk of sexual behavior, eating disorder, metabolic encephalopathy (brain disease), muscle wasting, muscle weakness, difficulty in walking, and tobacco use. Record review of Resident #40's Quarterly MDS assessment dated [DATE] revealed Resident #40 had a BIMS score of 09 indicating moderate cognitive impairment. Resident #66 Record review of Resident # 66's face sheet dated 08/27/2025 revealed this was a [AGE] years old male who was admitted to the facility 06/15/2025 (original admission date 11/14/2024) and diagnosed with hemiplegia and hemiparesis (paralysis and weakness on one side of the body) following cerebral infarction affecting right dominant side. Hyperkalemia (high level of calcium in the blood). Pneumonia. Chronic kidney disease, stage 4 (severe). Cognitive communication deficit. Mild cognitive impairment. Depression. Anemia. Difficulty in walking. Luck of coordination. Type 2 Diabetes mellitus without complications. Vitamin deficiency. Hyponatremia (low sodium level in the blood). Essential hypertension (high blood pressure). Chronic kidney disease. Neuromuscular dysfunction (impairment of nerves and muscles) of bladder. Benign prostatic hyperplasia (increased cell production in a normal tissue) with lower urinary tract symptoms. Pain. Record review Resident # 66's MDS assessment dated [DATE] reflected BIMS score of 11=indicating moderate cognitive impairment. Record review Resident # 66's care plane (undated) revealed there were no order to provide him with urinary drainage bag covers or dignity bags. Record review Resident # 66's physician orders revealed there were no orders to keep the urinary drainage bag concealed. Observation of hall 100 on 08/26/2025 at 9:36am revealed that CNA D did not knock on Resident #2's door before entering the room. Observation of hall 100 on 08/26/2025 at 9:53am revealed CNA D did not knock on Resident #40's door before entering the room. Observation on 08/26/2025 at 10:06 AM revealed Resident # 66's urinary drainage bags were lying on both sides of the Resident #66 while he was lying in his bed. The drainage bags were not covered; both bags were filled with yellow color urine. The door to Resident #66' room was open. The urinary drainage bags could not be seeing from outside. The Resident #66 had a roommate, and the urinary drainage bags were visible to his roommate. Observation of 100 hall on 08/26/2025 at 12:35pm revealed that HK F did not knock on Resident #25's door before entering

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility admitted a resident with a mental disorder before the Stated mental health authority had determined she was appropriately placed for 1 of 1 resident (Resident #9) reviewed for PASARR screening. The MDS Coordinator failed to complete the PASARR screening process for Resident #9. This failure could place residents at risk of not receiving specialized services. Findings included: During an interview with Resident #9 on 08/28/2025 at 11:48am, was present in her room with her son who is also a resident. Resident #9 was lying in bed with her son's dog, she did not speak much, and her son did most of the talking. He stated they have been in facility for a while and have no complaint are issues, he stated they are very happy at facility and are happy to have someone to help them. Son stated that he is from California and has been here with Grandfather who is from Texas. Record review of Resident #9 admission record revealed the resident was admitted to the facility on [DATE], with diagnoses including schizoaffective disorder (bipolar type), insomnia, depression, and generalized anxiety disorder. Record review of the quarterly MDS assessment for Resident #9 completed on 06/19/2025, Section C, revealed a BIMS score of 12/15, indicating mild cognitive impairment. Section I (Active Diagnoses) Indicated no active diagnoses for Resident #9. Record review of the Care Plan, dated 06/22/2025, revealed Resident #9 has depression related to schizoaffective disorder, with goals to exhibit indicators of depression, anxiety, or sad mood less than daily by the review date. Record review of the PASRR documentation in Resident #9's electronic health dated 10/11/2023, from Texas Medicaid & HealthCare Partnership with the Subject: You are not eligible for PASRR specialized services. Record review of Resident #9's psychiatric evaluation and medication review dated 08/20/2025, revealed Resident #9's psychiatric history includes significant diagnoses. During the evaluation, the resident reported increased depression and anxiety due to the passing of her [family member], along with sleep difficulties, though appetite remained good. Observations noted agitation, anxiety, forgetfulness, and confusion. Record review on 08/28/2025, did not reveal a PASRR Level I Am screening report for Resident #9. During an interview and observation on 08/28/2025 at 1:35 PM, the MDSN, was able to give a breakdown of MDS process and explain that the PASRR must be submitted after the IDT meeting no later than 14 days. During an interview on 08/28/2025 at 2:18 PM, the DON stated that the PASRR evaluation was covered by the MDSN, he was not sure how long the facility had to submit the PASRR application. The DON stated that not submitting the PASRR application timely could cause the residents to miss benefits that would help them in therapy and on useful equipment. During an interview on 08/28/2025 at 2:53 PM, with ADM, the ADM stated she had been at facility for around 6 months. The ADM takes care of all training and thought the facility had 24 hours to submit the PASRR applications but stated she would research this information. The ADM stated if this information were not submitted within 24 hours the negative effective on residents would be the facility would not know what was wrong with resident and what service to provide to each resident. Review of facility PASRR policy dated 07/29/2025, reflects, The PASRR program aims to ensure that individuals with mental illness or intellectual disabilities receive appropriate care and services. It assesses whether the nursing home is the most suitable setting for the individual's needs. Procedure 2. Screening Process: a). Level I Am screening: This initial screening determines if the individual may have a mental illness or intellectual disability. It is generally completed by the nursing facility before admission.b). Level II Evaluation: If the Level I screening indicates potential mental illness or intellectual disability, a Level II evaluation is conducted. This comprehensive assessment is performed by a qualified mental health professional and evaluates the individual's needs and whether nursing home placement is appropriate. 3. Documentation: Facilities must maintain thorough documentation of the PASRR assessments, including the Level I and Level II evaluations, as well as the recommendations made.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives and time frames to meet a residents' mental, nursing and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 8 Residents (Resident #3) reviewed for care plans. The facility failed to care plan Resident #3's dialysis that he received 3 times a week from an external dialysis center. This failure could lead to residents on dialysis receiving improper care/treatment. Findings included: Review of Resident #3's face sheet dated 08/27/25 reflected a [AGE] year-old male who was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including end stage renal disease, depression, dementia, muscle wasting, vitamin d deficiency, type 2 diabetes, and hypertension. Review of Resident #3's annual MDS assessment, dated 08/14/25 reflected a BIMS score of 9 indicating the cognition was moderately impaired. It indicated Resident #3 had dialysis as special treatment for the end stage renal disease. Review of Resident #3's care plan dated 08/20/25 revealed there was no care plan for dialysis that he was receiving for end stage renal disease. During an observation and interview on 08/27/25 at 3:10pm Resident #3 was in his wheelchair socializing with other residents in the hall at the entrance. He stated he was doing good at the facility and was taken care of by the staff. Resident #3 stated he was on dialysis on Monday, Wednesday, and Friday. He stated he received transportation to the dialysis center organized by the facility and had no immediate issues currently. During an interview on 08/28/25 at 2:30pm LVN F stated whenever she was on duty, she was the nurse who prepared the resident, before going out for dialysis. She stated Resident #3 goes to the dialysis center 3 days a week. LVN F said before sending out Resident #3 she ensured the ports (a surgically created connection that allows blood to be accessed during dialysis) were in good condition without any infection or any other complications. She stated every time before he left the facility, she would check his vitals to make sure there were no abnormal readings, also filled out all the forms and communication logs. LVN F said she did all the preparation work before sending the resident for dialysis from her years of experience in nursing and had not checked his care plan for dialysis yet. She stated she would refer the care plan or contact the physician if there were any issues or concern related to dialysis care. LVN F stated care plan was an important part of nursing care as it provides information about goals and interventions however, she had not checked Resident #3's dialysis care plan as there were no such complicated situation occurred so far. LVN F stated creating care plan was the duty of the MDS nurse. In an interview on 08/28/25 at 10:48 AM, the MDS nurse said she was responsible for completing MDS assessments and care plans. She said if a resident had an active problem that was addressed by the facility it should be in the MDS and then care planned appropriately. The MDS nurse stated the dialysis treatment of Resident #3 should have been incorporated into the care plan. She said it was an unintentional negligence from her however she added Resident #3's dialysis treatment to the care plan on 08/27/25, as soon the surveyor informed her about the absence of it. She stated care plan was an integral part of resident's care as it provides guidelines to the nursing staff about the presenting problems, goals, and interventions. Record review of facility's policy Comprehensive Care Plans, revised in October 2023, reflected: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with residents' rights, which includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 2 (Resident #66 and Resident #8) of 4 residents reviewed for catheter care. The facility failed to ensure Resident #66 and Resident #8's catheters' drainage bag positioned lower than Resident's urinary bladder to prevent urine from flowing back into the kidneys and urinary bladder. This failure could place residents at risk of UTI and other serious infections.Findings included: Record review of Resident # 66's face sheet dated 8/27/25 revealed a [AGE] year-old male who was admitted to the facility originally on 11/14/24 and re admitted on [DATE]. His diagnoses were hemiplegia and hemiparesis (paralysis on one side of the body), acute respiratory failure, chronic kidney disease, difficulty in walking, muscle weakness, lack of coordination, need for assistance with personal care, type 2 diabetes mellitus , neuromuscular dysfunction of bladder (impaired nerves and muscles that control bladder function) , and benign prostatic hyperplasia(enlargement of prostate gland) with lower urinary tract symptoms. Record review Resident#66's initial MDS assessment dated [DATE] reflected a BIMS score of 11 indicating moderate cognitive impairment. Record review Resident#66's care plan dated 07/21/25 revealed he had indwelling Suprapubic.Catheter (catheter tube inserted through small incision in the lower abdomen into the kidney/urinary bladder). The positioning of the urinary drainage bags was not included in the in the interventions in the care plan. During an observation on 08/26/2025 at 10:06 AM, on 08/27/25 at 9:22AM and on 08/28/25 at 08:40AM it was revealed Resident # 66's urinary drainage bags were lying on both sides of Resident # 66 while he was lying in his bed. The drainage bags were filled with yellow color urinary. During an observation on 08/27/2025 at 10:12 AM Resident # 66's urinary drainage bags were placed into two pockets of an apron he was wearing. The urinary drainage bags were in the pockets and were positioned at the chest level (above the level of the kidneys of Resident # 66). During an interview on 08/27/2025 at 12:07 PM Resident # 66 stated his kidneys were all that he had left and if they went, he also would go. He was unable to explain further about his conditions. During an interview on 08/28/2025 at 09:13 AM LVN F stated the urinary drainage bags must be placed below the bladder level for the gravity drain, however Resident #66 requested to be placed at his side on the bed as that made him feel safer and more comfortable. Record review of Resident# 8's face sheet dated 08/27/25 revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses were Urinary tract infection, Chronic obstructive pyelonephritis (inflammation of kidneys due to urinary tract obstruction), hydronephrosis (swelling of kidneys due to urine backup), Chronic kidney disease, Neuromuscular disfunction of bladder, retention of urine, Pressure ulcer of left buttock, stage 4, Unsteadiness on feet. Mild cognitive impairment, Type 2 Diabetes mellitus, Chronic heart failure, Constipation, acute kidney failure and need for assistance with personal care. Review of Resident # 8's of quarterly MDS assessment, dated 07/15/25 revealed a BIMS score of 07 indicating severe cognitive impairment. Review of Resident # 8's care plan, dated 06/25/2025 revealed resident had foley catheter. The relevant intervention was to position catheter bag and tubing below the level of the bladder and away from her room's entrance door. During a wound care observation on 08/27/2025 at 2:28 PM, Resident #8 was lying in bed. LVN H entered Resident #8's room for wound care and the urinary drainage bag of Resident #8 was removed from the lower part of her bed by LVN H and placed on Resident's # 8's bed. During an interview on 08/27/2025 at 2:45 PM LVN H stated she started working at the facility about two weeks ago and had not received any specific training on catheter management. She stated she placed Resident # 8's urinary drainage bag on resident's bed during the wound care and that could cause the urine to flow back into Resident # 8's body. She stated back flow of external urine into the body could lead to varieties of infection to the resident. During an interview on 08/28/2025 at 10:36 AM the MD stated it was OK if the urinary drainage bags were positioned next to the resident on the bed as the pressure inside of the kidneys are higher and urine could not get back to the kidneys easily. When the surveyor asked what if the urinary drainage bags were full, and they were in bed, MD stated in that case, the urine from the bags could flow back to the kidneys risking residents with infections. During an interview on 08/28/2025 at 8:35 AM with DON stated the placement of Resident 66's urinary drainage bags were not important as Resident # 66 had nephrostomy catheter, and the urine drains directly from his kidneys. He stated it was impossible for Resident #66 to get infection as kidneys have no reservoirs for urine to back up there. He stated since

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interviews, and record review, the facility failed to use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week for 2 of 58 days (08/09/2025 and 08/10/2025) reviewed for RN coverage. The facility failed to ensure they had an RN scheduled on duty for 08/09/2026 and 08/10/2025 and failed to ensure the DON was not acting as the charge nurse when the facility had an average daily occupancy of more than 60 residents. This failure placed residents at risk of missed nursing assessments, interventions, care, and treatment.Findings included: Review of the daily staffing for June 1, 2025, through August 28, 2025, reflected zero hours worked by an RN on the following days: 08/09/2025 and 08/10/2025. The census both days was over 60 residents. Record review of staff schedules dated 08/01/2025 through 08/31/2025 revealed that there was no RN who worked on 08/09/2025 and 08/10/2025. The DON was the only RN scheduled for 08/09/2025 and 08/10/2025. Record review of time punches for Nursing staff for August 2025 revealed no RN punched in for 08/09/2025 and 08/10/2025. During an interview with the ADON on 08/28/2025 at 1:13p.m., she said she had been trained on staffing. She said that she was responsible for doing the nursing schedule. She said that the facility was to have an RN scheduled 8 consecutive hours every day. She said it was important to have an RN for 8 hours a day because the RN's skill set was a bit more than an LVN's. She said an RN can pronounce a resident if they were to pass. She said that she never had a concern where there were not enough staff because if there was not enough staff, she would come in to work. She also said that the DON could cover the RN shift. She said usually if someone called in or there was a staff shortage, she would try to call someone in to work or if she could not find coverage, she would go in to cover. She said the facility did not have a lot of issues with not being able to cover staff shortages. She said that the facility did not use agency or temporary staff. She said that the facility always had RN coverage. She said the residents' needs have never gone unmet because the facility always had an RN. She said she did not know what could happen if there was not an RN because she said the LVN can do the same things except pronounce a resident who passed. She said that she was not sure why an RN did not work on 08/09/2025 and 08/10/2025. During an interview with the DON on 08/28/2025 at 2:28p.m., he said he had been trained on staffing. He said the ADON was responsible for the nursing scheduling. He said the facility should have an RN scheduled 8 hours a day, 7 days a week. He said that it was important for the facility to have an RN because they were smarter than an LVN. He also said it was important to have an RN to supervise the care in the facility. He said the ADM and DON monitored to ensure there was an RN scheduled for 8 hours a day. He said he had never had concerns there were not enough staff to meet the resident's needs. He said the facility managed call outs or unanticipated staff shortage by calling someone else in or him and the ADON came in to assist if needed. He said that it was very infrequent that the facility could not find coverage. He said the facility did not use agency or temporary staff. He said there was never a time an RN was not available to provide care at the facility. He said if there was no RN it could cause lack of supervision and professional judgement. He said he can change his days and come in on the weekend and be an RN if he had another RN cover him for the two days he missed during the week. He said he was working as the RN on 08/09/2025 and 08/10/2025 so the facility did have an RN. During an interview with the ADM on 08/28/2025 at 2:57p.m., she said that she had been trained on staffing. She said that the ADON was responsible for doing the nursing schedules. She said that the policy was that an RN should be scheduled for 8 hours a day. She said it was important to have an RN because the RN was needed to be able to make the proper decisions and some fell outside the LVN's scope of practice. She said the ADON, and the DON were responsible for ensuring that there was an RN scheduled or working every day. She said she had never been concerned that there were not enough staff to meet the resident's needs because the facility had additional people who would come in to work. She also said she would come in and work as a CNA if needed. She said if they had a staff shortage or call out the facility would call other staff to come in to work. She also said she had some nurses would come in and help when she needed them. She said the facility did not use temporary or agency staff. She said it was rare that the facility did not have an RN. She said she did not know how to answer when asked about the types of services or care not provided when an RN was not onsite. She said if there was not an RN the facility would not have a supervisor. She said that she thought there was no RN on 08/09/2025 and 08/10/2025 due to a scheduling error. She also said she was going to check into it. Record review of Staffing, Sufficient and Competent Nursing revised 08/2022 revealed our facility provides sufficient numbers of nursing staff with the appropriate skills and competency

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, interviews, and record review, the facility failed to ensure drugs and biologicals were stored in locked compartments for 1 of 3 medication carts (100 hall) reviewed for medication storage. The facility failed to ensure the medication cart for 100 hall was locked when unattended by LVN A on 08/26/2025 at 12:37p.m. These failures could place residents at risk of harm due to unauthorized access and potential ingestion of medication, needles, and other biologicals. Findings included: Observation on 08/26/2025 at 12:37p.m., revealed the 100-hall medication cart was unlocked and unattended by a resident's room. LVN A was in a resident's room with the door closed and was out of sight of the medication cart. During an interview on 08/28/2025 at 12:09p.m., with LVN A, she stated she was responsible for the 100-hall medication cart on 08/26/2025. She said that she had been trained on medication storage for medication carts. She said the policy was that the medication cart was to be always locked when the nurse was away from the cart. She said if the medication cart were left unattended and unlocked the risk could be a resident or staff could get into the medication cart and take medications, needles or the wrong medications and can harm themselves. She said the DON monitored to ensure the medication carts were locked but ultimately it was the nurse's responsibility. She said the DON monitored through observations. She said she forgot to lock the cart because she was worried about a resident and was rushing. During an interview on 08/28/2025 at 2:25p.m. with the DON, he said he and nursing staff had been trained on medication storage in the medication carts. He said the policy for medication storage was that the medication cart was to be always locked when unattended. He said the nurse who was using the medication cart was responsible for locking the cart when leaving the cart unattended. He said that the risk of the medication cart being left unlocked and unattended could possibly be a resident getting in the drawers and taking something. He said the DON and ADM monitored to ensure the medication carts were locked. He said the DON and ADM monitored through compliance rounds. He said he did not know why LVN A left the 100-hall medication cart unlocked, except she was dealing with a resident. During an interview on 08/28/2025 at 02:54p.m. with the ADM, she stated she and nursing staff had been trained on medication storage in the medication carts. She said the policy for medication storage was that all medication carts were to be locked. She said the nurse or medication aide who was working on the medication cart was responsible for ensuring it was always locked when unattended. She said if the medication cart were not locked and was unattended a resident or employee could take some medications. She said the charge nurse and the DON were responsible for monitoring to ensure that the medication carts were locked. She said they monitored by making walking rounds. She said LVN A left the medication cart because she was in a hurry to tend to a resident and was not aware she left it unlocked. Review of Medication Labeling and Storage Policy revised 2/2001 revealed the facility stores all medications and biologicals in locked compartments under proper temperature, humidity, and light controls. Only authorized personnel have access to keys. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others.

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	08/28/2025

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 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. Based on observations, interviews, and record reviews the facility failed to store, prepare, and distribute food in accordance with professional standards for food service safety for 1 of 1 kitchen.The facility failed to ensure food was properly labeled and dated. The facility failed to maintain proper kitchen sanitation when [NAME] B, did not follow proper hand hygiene protocols.These deficient practices could place residents who were served from the kitchen at risk for health complications and foodborne illnesses. Finding included:Observations of the kitchen on 8/26/25, at 8:51am revealed four Chocolate flavored Creme Pies located in a second spare refrigerator located in the kitchen area that were not labeled or dated. Observations of [NAME] B, on 8/27/2025, at 10:25pm performing puree meal preparation revealed the [NAME] did not wash her hands to start the puree process. The [NAME] then began the food preparation process without wearing gloves. She added eight scoops of tamale pie bread to the food processor but forgot the tomato juice in the refrigerator to the left of her. Immediately after retrieving the tomato juice from the refrigerator the [NAME] did not wash her hands or don new gloves. [NAME] B handled multiple utensils which included a scoop, spatula, and a large spoon throughout the preparation without washing her hands in between. After preparing pureed beans, [NAME] B licked her finger to remove the excess beans. It was also observed that she failed to adequately wash and sanitize the pan after each pureed dish, and only rinsed out the blender cup instead in a nearby sink behind her. She stated she could not go in the area where the dishwasher was located, but did not say why she was not able to go to other area. An Interview with the Kitchen Manager, on 8/27/2025, at 2:06pm, revealed that the Manager was last in serviced on hand hygiene on 08/14/2025. The Kitchen Manager stated if staff did not properly sanitize their hands and wear gloves while preparing food residents could become sick. The Manager also said all items in the kitchen should be labeled and dated after opened. An Interview with Head [NAME] B, on 8/28/2025, at 10:00am, revealed that she has been trained on hand hygiene and labeling and dating foods. She stated if they did not use proper hand hygiene or label and date food correctly this could have a negative effect on residents by causing them to become sick.Record Review of the Food Receiving and Storage Policy Revised November 2022, revealed refrigerated foods are labeled, dated, and monitored so they are used by their use-by date, frozen, or discarded.Record Review of the Handwashing/Hand Hygiene Policy Revised October 2023 revealed the facility considers hand hygiene the primary means to prevent the spread of healthcare associated infections. Policy Interpretation and Implementation. Administrative Practices to Promote Hand Hygiene 1. All personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing thetransmission of healthcare-associated infections.2. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread ofinfections to other personnel, residents, and visitors.3. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub) are readilyaccessible and convenient for staff use to encourage compliance with hand hygiene policies. Alcohol-basedhand-rub (ABHR) dispensers are placed in areas of high visibility and consistent with workflow throughoutthe facility.4. Personnel are educated regarding ways to prevent contact dermatitis and other skin irritation, and providedwith supplies that support healthy hand skin.

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	08/28/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (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	08/28/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program, designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections for 4 (Resident #7, Resident #75, Resident #49 and Resident #2) of 8 residents reviewed for infection control practices, in that: The facility failed to:1. Ensure CNA E changed dirty gloves when handling clean items while providing peri care to Resident #7 and Resident #75.2. Ensure MA D sanitized blood pressure monitor in between Resident #49 and Resident #2 while obtaining blood pressure. 3. Ensure MA D had not stored her orange juice in use, in the med cart at the facility. This failure could place residents at risk for healthcare associated cross-contamination and infections. Findings included:Review of Resident #7's face sheet dated 08/27/25 reflected an [AGE] year-old male who was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including unsteadiness on feet, cognitive communication deficit, weakness, need for assistance with personal care, dementia, muscle weakness, lack of coordination and hypertension. Review of Resident #7's quarterly MDS assessment, dated 08/07/25 reflected he rarely /never understood a BIMS interview questions, indicating a severely impaired cognition. Review of Resident #7's care plan dated 08/07/25 reflected he had functional & mixed bladder incontinence r/t immobility, cognitive deficit. The relevant intervention was cleaning peri-area with each incontinence episode. Review of Resident #75's face sheet dated 08/27/25 reflected an [AGE] year-old female who was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including urinary tract infection, acute respiratory failure, chronic pain, muscle weakness, lack of coordination, severe sepsis (life threatening reaction to an infection), end stage renal disease and need for assistance with personal care. Review of Resident #75's initial MDS assessment dated [DATE] reflected a BIMS score of 10, indicating moderately impaired cognition. Review of Resident #75's care plan dated 08/07/25 reflected she had functional bladder incontinence r/t Confusion, Impaired Mobility, Physical limitations. The relevant intervention was checking every two hours and wash, rinse, and dry perineum. During an observation on 08/27/25 at 1:10pm CNA E was providing peri care for Resident #7. CNA E put on gloves after washing her hands. After that she opened the brief and cleaned Resident #7's front and back with wet wipes dispensed directly from the packet. In that process she handled the whole wipe packet with the soiled gloves. During an observation on 08/27/25 at 2:20pm CNA E was providing peri care for Resident #75. She performed peri care by cleaning Resident #75's front and back with wet wipes dispensed directly from the whole packet. In that process she handled the wipe packet containing clean wipes, with the soiled gloves. CNA E had not changed her gloves before handling the clean wet wipe packet while providing peri care to Resident #7 and Resident#75. After the completion of peri care she saved the contaminated wipe packets containing wet wipes in Resident #7 and Resident #75's rooms for future use (as stated by CNA E). During an interview on 08/27/25 at 2:45pm CNA E stated she was a CNA for many years and was diligent in following infection control protocol. When the surveyor walked through the entire process CNA E pointed out that she had not changed the soiled gloves before handling the clean packet containing wet wipes. She stated her negligence contaminated the whole packet of wipes. CNA E stated she was risking spreading diseases by handling a clean packet with contaminated gloves. CNA E stated she could not remember any in services on peri care in the recent past. Review of Resident #49's face sheet dated 08/26/25 reflected an [AGE] year-old female who was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including hypertension, pain, abnormal weight loss, unsteadiness on feet, lack of coordination, muscle wasting, vitamin D deficiency, heart disease, muscle weakness, and lack of coordination. Review of Resident #49's quarterly MDS assessment, dated 08/08/25 reflected a BIMS score of 9 indicating her cognition was moderately impaired. Review of Resident #49's care plan dated 04/22/25 reflected she had hypertension, and a relevant intervention was evaluating blood pressure. Review of Resident # 49's medication order revealed: Lisinopril 5 mg tablet: Give 1 tablet orally in the morning related to essential (primary) hypertension. Hold if BP <115/55 or HR <55. -Start Date- 07/09/2025. Review of Resident #2's face sheet dated 08/26/25 reflected an [AGE] year-old female who was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease, type 2 diabetes, vitamin d deficiency, hypertension, congestive heart failure, orthostatic hypotension (sudden drop in blood pressure when standing up), and muscle weakness. Review of Resident #2's annual