

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676333	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/24/2025
NAME OF PROVIDER OR SUPPLIER  Magnolia Crossing Nursing and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE  10800 Flora Mae Meadows Rd Houston, TX 77089	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 26454</p> <p>Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision to prevent accidents for 1 of 9 residents (Resident #1) reviewed for accidents and supervision.</p> <p>CNA A fell asleep while feeding Resident #1 lunch on 04/18/2025 and did not wake up to evaluate Resident #1 after she began to cough.</p> <p>This failure placed residents who required feeding assistance at risk of aspirating food particles, pneumonia (an infection that inflames air sacs in one or both lungs), and possible death.</p> <p>Findings include:</p> <p>Record review of Resident #1's face sheet dated 04/23/2024 revealed she was a [AGE] year-old female who was initially admitted to the facility on [DATE] and recently readmitted on [DATE]. She was diagnosed with dementia (a group of symptoms affecting memory, thinking, and social abilities that interfere with daily living), severe protein-calorie malnutrition (a serious condition where the body lacks sufficient energy and protein), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), age-related osteoporosis (a condition where bones become weak and brittle due to a decrease in bone density), diabetes (a group of diseases that result in too much sugar in the blood), and essential hypertension (a chronic condition of persistently high blood pressure with no identifiable cause).</p> <p>Record review of Resident #1's admission MDS dated [DATE] revealed she had a BIMS score of 5 (severe cognitive impairment); Resident #1 did not exhibit behaviors related to rejection of care; Resident #1 required supervision or touching assistance for eating; and Resident #1 did not exhibit signs and symptoms of possible swallowing disorders.</p> <p>Record review of Resident #1's care plan revised on 04/18/2025 revealed the following care areas:</p> <p>* [Resident #1] has an ADL self-care performance deficit related to disease process. Goal included: [Resident #1] will maintain current level of function. Interventions included: Eating: Provide milkshakes or liquid food supplements when the resident refuses or has difficulty with solid food or provide nutritious foods that can be taken from a cup or a mug where appropriate. Eating: The resident requires set up and assistance as needed x 1 staff.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>* [Resident #1] is at risk for potential nutritional problems related to dementia and malnutrition. Goal included: The resident will comply with recommendation. Interventions included: Monitor/document/report PRN any s/sx of dysphagia (difficulty swallowing): pocketing (when food accumulates in the cheeks, gums, or tongue due to difficulty chewing or swallowing), choking (a situation where a person's airway is partially or completely blocked, preventing them from breathing effectively), coughing, drooling, holding food in the mouth, several attempts at swallowing, refusing to eat, or appears concerned during meals.</p> <p>Record review of Resident #1's hospital records revealed she was admitted to an acute care hospital from the facility on 04/15/2025 and was transferred back to the facility on [DATE]. Further review of Resident #1's hospital record revealed no documentation of speech, swallowing, or feeding concerns.</p> <p>Record review of Resident #1's nursing progress notes for April 2025 revealed:</p> <p>* On 04/17/2025 at 5:47 p.m., LVN B wrote, Received resident by private vehicle escorted by family member from [acute care hospital]. Resident was transferred extensive assist to wheelchair x 1 person. Resident confused, answering questions in Spanish . Resident was given dinner .</p> <p>* On 04/18/2025 at 12:48 p.m., Staff D (only Staff D's name was documented, not her credentials, such as RN or LVN. Staff D's name was not listed on the staff roster) wrote, Resident was assisted with repositioning in bed and assisted with breakfast. Resident enjoyed eating the oatmeal, half the biscuit, orange juice, and a couple of bites of scrambled eggs. Resident ate about 50%, then stated she was full. Resident was cheerful, cooperative, and readily interacted during breakfast. No s/sx of any distress.</p> <p>* On 04/18/2025 at 6:15 p.m., LVN C wrote, Patient has a new consult order for speech evaluation and treatment.</p> <p>* On 04/24/2024 at 12:31 p.m., LVN E wrote, New order per [NP] chest x-ray, 2 views - cough, one time .</p> <p>Record review of Resident #1's physician's orders for April 2025 revealed:</p> <p>* ST Clarification: ST to treat 5x's a week x's 30 days to address dysphagia treatment methods including caregiver training. One time a day 5 days on and 2 days off for 30 days. Order date: 04/18/2025. Start Date: 04/18/2025.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's Speech Therapy Evaluation and Plan of Treatment dated 04/18/2025 revealed, . Recommendations: Intake: Solids - Mechanical Soft Textures, Mechanical Soft/Ground Textures. Liquids - Thin Liquids. Supervision: Supervision for Oral Intake - Close supervision . Assessment Summary: . Risk factors: Due to the documented physical impairments and associated functional deficits, the patient is at risk for: aspiration, compromised general health, decreased ability to return to prior level of assistance, decreased participation with functional tasks . increased dependency upon caregivers, malnutrition, pneumonia, weight loss, and muscle atrophy (progressive loss of muscle mass). Impressions: Patient presents with moderate oral (difficulty with the oral phase of swallowing, which is the first stage of the swallowing process and occurs in the mouth) and mild pharyngeal phase (difficulty swallowing that specifically affects the pharynx, the area of the throat where food and liquids are transported from the mouth to the esophagus) dysphagia consisting of reduced lingual (tongue) strength and coordination along with reduced bolus propulsion and movement that results in post swallow oral residue in the left lateral sulci (the space or groove formed between the gums and cheek) .</p> <p>Record review of Resident #1's Radiology Interpretation dated 04/24/2025 revealed she had a 2-view chest x-ray completed on 04/24/2025. The x-ray determined that Resident #1's lungs were clear and well inflated bilaterally.</p> <p>Record review of the facility's staff sign-in sheet for 04/18/2025 revealed CNA A's first name was listed as the CNA assigned to Resident #1's room for the day shift (6:00 a.m. - 2:00 p.m.).</p> <p>Record review of the facility's staff roster revealed no staff with CNA A's first name. Further review of the record revealed Staff D was not listed.</p> <p>Observation of camera footage from a camera behind and above Resident #1's bed (Video #1) revealed the video was dated 04/18/2025 and time-stamped 12:38:17. In the camera's view, you could see the top of Resident #1's head, both arms/hands, and her personal belongings on the other side of the room. CNA A was sitting in a chair to the right of Resident #1 (by the window), facing the camera. There was a plate of food on the table directly in front of CNA A. The plate cover was placed at the foot of Resident #1's bed. At the beginning of the video, CNA A's eyes are closed. The video did not show if Resident #1 was chewing or that CNA A placed any food into her mouth. Resident #1 could be seen moving her head and arms/hands while CNA A was asleep. At 12:38:27, Resident #1 started to cough. CNA A moved her head from one side to the other, but she did not open her eyes. At 12:38:31, resident put her left hand over her mouth, while still coughing. CNA A's eyes fluttered, like they opened and closed at 12:38:36, while Resident #1 was still coughing. CNA A looked over at Resident #1 at 12:38:44, then quickly turned her head back towards the wall and closed her eyes again. Resident #1 stopped coughing and waived her left hand from side-to-side and said no (as if to say no more food). At 12:38:05, CNA A's head started dropped and raised as she slept. Her head rose and fell several times, and her eyes fluttered a few times. At 12:41:37, CNA A woke up and attempted to give Resident #1 more food. Resident #1 shook her head and said no. CNA A put the food down and closed her eyes again. CNA A adjusted herself slightly in the chair, chewed on whatever was in her mouth a few times, and then she closed her eyes again. Her head began to rise and fall again. The video ended at 12:42:40 with the staff still asleep. A television could be heard in the background and an inaudible voice was heard twice throughout the video. It was unknown if the voice came from inside the room or from the hallway.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with the Interim Administrator on 04/24/2025 at 11:07 a.m., she stated Resident #1's family member had not showed her any video or informed her that a CNA fell asleep while feeding Resident #1. After watching the video, the Interim Administrator said she did not recognize the CNA who fell asleep. She stated the facility used staff from other buildings to fill shifts when they were short. She stated she would look at the facility's schedule to try and identify the staff member. She stated it was not appropriate for staff to sleep while providing care to a resident. She said if the CNA had something going on or needed a break, she should have advised the nurse. She said recently, Resident #1 had not been eating as much as she previously did and after looking at her clinical records (regarding the decrease in appetite), they wanted to get her evaluated for speech therapy. The Interim Administrator stated the negative effect of the situation was that the CNA did not assist the resident with eating while she was asleep. She also said the CNA never got up to check on the resident when she started coughing. She stated she would initiate an investigation, call in a self-report to HHSC, and decide what disciplinary action, including termination, should be issued to the CNA. She stated the facility educated all staff on how to properly assist resident with feeding if the resident was known to not eat a lot.</p> <p>In an interview with the Regional Clinical Specialist on 04/24/2024 at 12:04 p.m., she reviewed the video and stated it was not appropriate for the CNA to fall asleep while feeding Resident #1. She stated a negative effect would be that Resident #1 possibly did not complete her meal. She said a possible negative effect would be that the CNA would not have known if Resident #1 was in distress because she did not wake up while the resident was coughing. She stated she was going to assess Resident #1 for a COC and have her evaluated for swallowing issues.</p> <p>In an interview with Resident #2 on 04/24/2025 at 12:30 p.m., she stated on Friday (04/18/2025), a nurse (it was a CNA) fell asleep three times while she was feeding Resident #1. She said she did not know who the nurse was, but she had seen her working at the facility a few times. She said she could see Resident #1 when she started coughing because she usually tried to keep the privacy curtain open. She said Resident #1 looked like she was choking, and she (Resident #2) yelled for the nurse to wake up, but the nurse just looked up at her and grinned. She said she could not recall if she yelled at the nurse while Resident #1 was coughing.</p> <p>In an interview with Resident #1, her family member, and Resident #2 on 04/24/2025 at 12:50 p.m., Resident #1 said she once choked at the facility when someone said something funny. Resident #1 said the staff sometimes fell asleep while helping her eat. Resident #2 said the nurse asked the lady about falling asleep inside of their room and the lady said she was not asleep. Resident #2 said she told the lady she was a [expletive word] lie. Resident #2 said the lady and the nurse left the room after that. Resident #1's family member said the cameras in Resident #1's and Resident #2's room were motion activated.</p> <p>In an interview with Resident #1's NP on 04/24/2025 at 1:15 p.m., she stated Resident #1 did not previously have any issues with dysphagia and choking would be a new concern. She said Resident #1 recently declined and her muscles were weakening. After reviewing the video, the NP said the staff should know to not fall asleep. The NP said it looked to her like Resident #1 was coughing and not choking because if she was choking, she would have been in a lot more distress. She said if Resident #1 choked, there would be something in her lungs. She said she just ordered a chest x-ray a few minutes prior, after learning from staff that there was concern about Resident #1 choking. She said the negative result was that the CNA could have responded more quickly had she not been sleeping.</p> <p>(continued on next page)</p>		

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