

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 05/22/2025
NAME OF PROVIDER OR SUPPLIER Magnolia Crossing Nursing and Rehabilitation Center		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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on 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 promoted maintenance or enhancement of his or her quality of life, recognizing each residents individuality for 2 of 8 resident (Resident #36 and Resident #86) reviewed for resident rights.</p> <p>1. The facility failed to ensure CNA G treated Resident #36 with respect and dignity when CNA G left Resident #36 without a brief and exposed while in the hallway after leaving her room.</p> <p>2. The facility failed to ensure LVN R and CNA M treated Resident #86 with respect and dignity when LVN R and CNA M made the resident get out of bed and take a shower after she refused.</p> <p>These failures could place residents at risk for a diminished quality of life, loss of dignity, and self-worth.</p> <p>Findings included:</p> <p>1. Record review of Resident #36's undated face sheet, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included Congestive Heart Failure (Condition in which the heart does not pump blood as well as it should), Metabolic Encephalopathy (brain dysfunction resulting from disruption in the body's metabolism, leading to altered mental status and cognitive impairment), and Cerebral Infarction (Blood flow to the brain is blocked leading to tissue death).</p> <p>Record review of Resident #36's Quarterly MDS Assessment, dated 03/03/25, reflected she had a BIMS score of 14, which indicated the resident was cognitively intact. Resident #36 required partial/moderate assistance with toileting and substantial/ maximal assistance with lower body dressing.</p> <p>Record review of Resident #36's revised care plan, dated 03/05/25, reflected Resident # 36 had an ADL self-care performance deficit related to muscle weakness with interventions to include required assistance by (X1) staff for toileting.</p> <p>Observation of video footage, dated 04/29/25, revealed:</p> <p>8:00 PM: Resident #36 was in a wheelchair exiting he bathroom with a gown that covered the upper portion of her peri-area, but she did not have a brief on.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>8:01 PM The resident retrieves a white towel to cover her upper legs.</p> <p>8:03 PM: The resident was in a wheelchair in the hall, speaking with an unknown person .</p> <p>8:05 PM: The resident was in a wheelchair in the hall speaking with an unknown person, asking for a staff member.</p> <p>8:26 PM: Resident returned to her room via her wheelchair.</p> <p>8:28 PM: The resident could be heard speaking to an unknown individual via the camera.</p> <p>8:33 PM: CNA G left Resident #36's room across the hall and entered the room to assist Resident #36.</p> <p>During an interview on 05/21/25 at 09:06 AM, Resident #36 said the CNA who did not help her off the toilet on 04/29/25 still worked at the facility, and the only action the facility took was to reassign the CNA to a different hall.</p> <p>During an interview on 05/21/25 at 2:36 PM, CNA G said she left Resident #36 on the toilet and did not return because she was assisting another resident. She said Resident #36 could get off the toilet herself and required minimal assistance. She said she previously had spoken to the resident, and they decided to schedule her bedtime for 8:30 PM, so she proceeded to give a shower and provide incontinent care to the residents across the hall. She said after she finished incontinent care, she returned to assist Resident# 36.</p> <p>2. Record review of Resident #86's, undated, face sheet, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included Dementia (the loss of cognitive functioning to such an extent that it interferes with a person's daily life and activities), and Depression (a mental health condition characterized by persistent feelings of sadness and loss of interest or pleasure in activities).</p> <p>Record review of Resident #86's Quarterly MDS Assessment, dated 04/22/25, reflected she had a BIMS score of 05, which indicated severe cognitive impairment. The resident required substantial/maximal assistance with toileting and showering.</p> <p>Record review of Resident #86's revised care plan, dated 03/29/25 , reflected Resident #86 had an ADL self-care performance deficit related to her disease process and was resistive to care and could be combative related to dementia. Her interventions included allowing the resident to make decisions about the treatment regime, providing sense of control and educating resident/family/caregivers of the possible outcome(s) of not complying with treatment or care.</p> <p>Observation video footage, dated 05/02/25, revealed:</p> <p>8:42 AM: The resident was lying in bed and CNA M tried to get resident up and out of bed.</p> <p>8:43 AM: Resident #86 could be seen resisting and telling LVN R and CNA M to leave her alone. Staff continued to assist the resident out of bed, and she was then placed in the wheelchair.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/22/25 at 9:22 AM, CNA M said if a resident refused a shower, she would leave the resident alone and notify the nurse. She said the resident had the right to refuse. She said the resident may experience a negative outcome if they refused care, but the staff proceeded because it would be a violation of their rights.</p> <p>During an interview on 05/22/25 at 9:45 AM, the interim DON said residents had a right to refuse care. She also said Resident #86 should have received assistance from the staff after toileting.</p> <p>During an interview on 05/22/24 at 1:44 PM, the ADON said all residents had a right to refuse care, and her expectation was for staff to notify the RP of the refusal and document it in the electronic medical record. She said they were working with staff and conducted re-education/in-serviced on resident's rights.</p> <p>During a telephone interview on 05/22/25 at 1:52 PM, LVN R said she was taking care of Resident #86 on 05/02/25. She said the resident refused care because she did not want to take a shower. She said the resident was soiled and had stool in her brief and she thought it was best to shower the resident instead of using wet wipes. She said the resident did have a right to refuse care; however, she did not want the resident to stay in her soiled brief and clothes because that could lead to a Urinary Tract Infection (inflammation of the bladder, caused by bacteria that enter the urinary tract and multiply) or skin breakdown.</p> <p>LVN R said she did not contact the RP because she thought it would be okay to shower the resident. She said she only notified the incoming nurse and the former administrator of Resident #86's refusal during morning meeting. LVN R was unable to provide a risk to the resident.</p> <p>During an interview on 05/22/25 at 5:10 PM, the Administrator said residents had a right to refuse. She said if the resident refused care, it was their right .</p> <p>Record review of the facility's, undated, policy and procedure titled, Statement of Resident Rights read in part . 10. Participate in developing a plan of care, to refuse treatment, and refuse to participate I experiment research</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to assess the resident for risk of entrapment from bed rails prior to installation, review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation for 3 of 6 Residents (Resident #95, Resident #64, and Resident #356,) reviewed for the use of side rails.</p> <p>The facility failed to ensure nursing staff obtained physician orders and consent for the use of side rails for Residents #95, #64 and #356.</p> <p>This failure could place residents at risk of injury, hinder residents from getting out of bed, and/or cause a decline in resident's ability to engage in activities of daily living.</p> <p>Findings include:</p> <p>1. Record review of Resident #95's face sheet, dated 5/20/25, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #95 had diagnoses which included unspecified trochanteric fracture of right femur (a fracture that occurs in the region of the trochanters, which are bony prominences on the thigh bone near the hip), unspecified dementia (a group of thinking and social symptoms that interferes with daily functioning), muscle wasting and atrophy (the wasting or thinning of muscle mass), muscle weakness, unsteadiness on feet, and history of falling.</p> <p>Record review of Resident #95's quarterly MDS assessment, dated 4/9/25, reflected she had a BIMS score of 2, which indicated severe cognitive impairment. Resident #95 required supervision or touching assistance with rolling left and right, from sitting to lying and from lying to sitting on side of bed.</p> <p>Record review of Resident #95's care plan, dated 4/22/25, did not reflected she used side rails.</p> <p>Record review of Resident #95's physician orders for May 2025 reflected there was not an order for the use of side rails.</p> <p>Record review of Resident #95's EHR under the miscellaneous section reflected there was not a consent form and no assessments for the use of side rails.</p> <p>Observation on 5/20/25 at 1:55 PM revealed Resident #95 was lying in bed; the call light was within reach. There were half-sized bed rails up in the middle of the bed on each side, the bed was in lowest position and fall mats where on both sides of the bed.</p> <p>Interview with Resident #95's family member on 5/22/25 at 2:37 PM, she said she could not remember if she signed a consent for bed rails. The Family Member said Resident #95 had the bed rails the entire time she had been in the facility.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Record review of Resident #64's face sheet, dated 5/21/25, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #64 had diagnoses which included vascular dementia (caused by brain damage from impaired blood flow to the brain resulting in problems with, memory and other thought processes), morbid obesity (a condition in which a person has a body mass index higher than 35) , cerebral infarction (occurs when blood flow to the brain is blocked, causing brain tissue to die), muscle wasting and atrophy (the wasting or thinning of muscle mass), and muscle weakness.</p> <p>Record review of Resident #64's quarter MDS assessment, dated 2/16/25, reflected she had a BIMS score of 11, which indicated moderate cognitive impairment. Resident #64 required partial/moderate assistance with rolling left and right, from sitting to lying and from lying to sitting on side of bed.</p> <p>Record review of Resident #64's care plan, dated 4/2/25, did not reflect she used side rails.</p> <p>Record review of Resident #64's physician orders for May 2025, reflected an order was added on 5/21/25 for resident to use 1/4 length rails for bed mobility.</p> <p>Record review of Resident #64's EHR under the miscellaneous section reflected there was not a consent form and no assessments for the use of side rails .</p> <p>Observation on 5/21/25 at 5:00 PM revealed Resident #64 was lying in bed with the head of the bed raised. There were half-sized bed rails up in the middle of the bed on each side, and a fall mat in place.</p> <p>3. Record review of Resident #356's face sheet, dated 5/22/25, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #356 had diagnoses which included vascular dementia (caused by brain damage from impaired blood flow to the brain resulting in problems with, memory and other thought processes), Chronic Obstructive Pulmonary Disorder (lung disease that block airflow and make it difficult to breathe), and muscle wasting and atrophy (the wasting or thinning of muscle mass).</p> <p>Record review of Resident #356's Quarterly MDS Assessment, dated 2/03/25, did not document a BIMS for the resident. Resident #64 required substantial/maximal assistance with rolling left and right, from sitting to lying and from lying to sitting on side of bed.</p> <p>Record review of Resident #356's care plan, dated May 2025, did not reflect she used side rails.</p> <p>Record review of Resident #356's physician orders for May 2025 reflected an order was added on 5/22/25 to use bilateral 1/4 siderails to maintain the bed perimeter related to restless movement.</p> <p>Record review of Resident #356's electronic medical record reflected no signed consent and no assessments for bed rails .</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with the Interim DON on 5/21/25 at 1:51 PM, she said rail assessments were completed upon admission. The Interim DON said she was unsure why the assessments and consents were not completed. She said the nurses were responsible for the assessments and consents and the ADON and the DON looked behind the nurses to make sure assessments and consents were completed. The Interim DON said the facility switched to a different EHR system back in December and the assessments and consents were probably in the old EHR system . She said the risk to the resident when there are no orders in place for bed rails, could cause bruises or even a choking hazard.</p> <p>During an interview with LVN A on 5/21/25 at 5:14 PM, she said if she saw a resident who was able to use their arms but had trouble turning, she would discuss with the DON, family, and doctor for the recommendation of bed rails. LVN A said the assessment should come first, then the consent . She said the bed rails that were in the middle of the of the bed were used for residents who were considered a fall risk. She said the risk to the resident when they were not assessed for bed rails could be they could put their arms through the bed rail and get stuck.</p> <p>During an interview with LVN B on 5/21/25 at 5:39 PM, she said bed rails were used for mobility. LVN B said, for example, if they provided incontinent care, the resident could hold onto the bed rail and roll over . LVN B said she did not know what the side rails located in the middle of the bed were used for. LVN B said there should be orders and assessments for bed rails, and they should be included in the care plan. LVN B said the purpose of the bed rails was for the resident to hold onto them while repositioning. She said bed rails were not to be used as a fall risk because it could be considered a restraint for the resident.</p> <p>During an interview with ADON A on 5/22/25 at 3:18 PM, she said bed rails should be used as assist bars, which were not normally located in the middle of the bed . There should be an order and consent for bed rails and the bed rails should be care planned. ADON A said bed rails should not be used as a restraint. She said the risk to the resident could lead to injury, trauma, or death.</p> <p>During an interview with the Administrator on 5/22/25 at 5:00 PM, she said if a resident needed a bed rail, the resident should have orders, and the bed rails could be included in the care plan. She said if PT recommended bed rails, they would include them in the care plan. The Administrator said the DON was responsible for obtaining consents and care planning the bed rails. She said bed rails for a resident were also reviewed in the clinical meetings. The administrator said the risk to the resident was a risk of falls. They could attempt to get out of bed and harm themselves getting across the bed rail.</p> <p>A policy for bed rails was requested from Interim DON on 5/22/25 at 3:45 pm and the Administrator on 5/22/25 at 5:00 PM, the facility did not have a policy for bed rails.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to establish and 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 infection for 2 of 10 residents (Resident #36 and Resident #86) reviewed for infection control.</p> <p>1. The facility failed to ensure CNA G followed appropriate infection control and hand hygiene procedure when providing care to Resident #36 and Resident #86</p> <p>2. LVN U failed to follow appropriate Enhanced Barrier Precautions; and, failed to wash or sanitize her hands prior to, and after providing incontinent care to Resident #86.</p> <p>These failures could place the residents at risk for infection and cross-contamination.</p> <p>Findings included:</p> <p>1. Record review of Resident #36's, undated, face sheet, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included Congestive Heart Failure (Condition in which the heart does not pump blood as well as it should), Metabolic Encephalopathy (brain dysfunction resulting from disruption in the body's metabolism, leading to altered mental status and cognitive impairment), and Cerebral Infarction (Blood flow to the brain is blocked leading to tissue death).</p> <p>Record review of Resident #36's Quarterly MDS Assessment, dated 03/03/25, reflected she had a BIMS score of 14, which indicated the resident was cognitively intact. Resident #36 required partial/moderate assistance with toileting and substantial/ maximal assistance with lower body dressing.</p> <p>Record review of Resident #36's revised care plan, dated 03/05/25, reflected Resident #36 had an ADL self-care performance deficit related to muscle weakness with interventions to include required assistance by (X1) staff for toileting.</p> <p>Record review of video footage, dated 04/29/25 at 8:33 PM, revealed: CNA G entered the room with gloves, and she dropped the dirty linen bag and trash bag from another resident's room at the entrance of the door. She removed her gloves and did not wash her hands.</p> <p>During an interview on 05/20/25 at 2:23 PM, LVN U said staff should wash their hands before donning gloves and wash their hands after doffing gloves. She said the risk of bringing soiled linen from one resident's room to another room could cause cross contamination. The risk of not washing hands could lead to infection to self and other residents. She said all staff should wash/sanitize hands before and after contact with residents.</p> <p>During an interview on 05/21/25 at 2:00 PM, the Interim DON said her expectation was for staff to remove gloves and wash their hands after dealing with soiled linen. She said the staff should not use the same gloves from one room to another. She said the gloves should be removed in the resident's room and the staff should wash/sanitize their hands before leaving that room. The Interim DON said the risk was cross contamination and infection.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/21/25 at 2:36 PM, CNA G said she was supposed to discard the soiled linen, gloves, and trash prior to entering another resident's room. She said she should wash /sanitize her hands before leaving and entering a resident room. She said her last in-service on infection control was last week. CNA G said the risk of using the same gloves to go to another room could start the spread of infection.</p> <p>2. Record review of Resident #86's, undated, face sheet indicated reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #86 had diagnoses which included dementia (loss of cognitive functioning - thinking, remembering, and reasoning), with other behavioral disturbance, nausea with vomiting, dysphagia (difficulty of swallowing), other abnormalities of gait and mobility, type 2 diabetes mellitus without complications (diabetes where no long-term complications have yet developed), unspecified glaucoma (buildup of fluid in the eye, leading to increased pressure that can damage the optic nerve, potentially causing vision loss or blindness), essential hypertension (high blood pressure where the cause is not known or identifiable).</p> <p>Record review of Resident #86's MD orders, dated 2/22/25, revealed reflected an order for Accu-Check's BID in AM and HS two times a day for DM II AM and HS.</p> <p>Record review of general notes from intake #1005735 reflected .on 04/25/25, at 12:35 AM, LVN U entered the resident's room and grabbed gloves by the door. One of the gloves fell on the floor, but the nurse picked it up and put it on anyway. The nurse checked the resident's blood sugar.</p> <p>Record review of video footage, recorded on 4/24/25 at 9:40 PM, showed LVN U walked into Resident #86's room, knocked on the open door, took gloves from the box located by the door, then the gloves fell on the floor. LVN U picked the pair of gloves up from the floor, and donned (put on) the gloves on her hands. LVN U then administered water from the cup on the bedside table to Resident #86. Next, LVN U opened and assessed the resident's briefs. LVN U was not seen discarding the gloves, before and/or after leaving the resident's room. LVN U also did not wash or sanitize her hands before leaving the resident's room.</p> <p>In an interview with Resident #86 on 5/20/2025 at 9:48 AM, she said the nurse checked her blood sugar in the morning and before she went to bed at night. Said she could not remember if she saw the nurse drop the gloves or knew/ever saw nurses wash or sanitize their hands before or after they provided care to her.</p> <p>In an interview with LVN U on 05/20/25 at 2:23 PM, she said Resident #86 got her bedside blood sugar checks every morning and at bedtime. LVN U said Enhanced Barrier Precaution (EBP) signs were placed by the resident's door entrance was necessary due to the wounds on the resident's roommate's legs. She said PPE necessary for EBP was just a gown and gloves. The process she was trained to follow was to wash her hands, don gloves, provide care to the resident, and wash her hands after she doffed the gloves. She said if staff were donning gloves and the glove accidentally dropped on the floor, the glove should be discarded and another pair of gloves should be taken. She denied ever picking a pair of gloves up from the floor and put them on her hands before administering water to the resident. She said the risk of not washing her hands or using contaminated gloves could be infection to herself and other residents. She said all staff should wash/sanitize their hands before and after contact with residents. She said she received in-services on infection control last week.</p> <p>(continued on next page)</p>		

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