

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 08/19/2025
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)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (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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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record reviewed, the facility failed to implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property for 1 (Resident #1) of 4 residents reviewed for implementing abuse policy. -The facility failed to implement their abuse policy and procedures when Nurse A did not report to the Administrator that Resident #1's family member reported to Nurse A on 08/16/25 that CNA A allegedly hit Resident #1 on his right eye, on an unknown date. This failure could place residents at risk for abuse to go undetected, to continue due to lack of identification, investigation, and reporting in accordance with policy, serious psychological and physical harm, and injury. Findings included: Record review of the facility's Abuse, Neglect and Exploitation policy, date implemented 7/11/25, revealed in part .It is the policy of this facility to provide protections for the health and welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse.Abuse.it includes physical abuse.Alleged Violation is a situation or occurrence that is observed or reported by.resident, relative.but has not yet been investigated.V. A. An immediate investigation is warranted when.reports of abuse.occur.VII. A.1. Reporting of all alleged violations to the Administrator, state agency.within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause that allegation involve abuse or result in serious bodily injury, or. Record review of Resident #1's admission Record, dated 08/19/25, revealed an [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included infrarenal abdominal aortic aneurysm (a localized dilation of the abdominal aorta below the renal arteries), without rupture, unspecified mycosis (fungal infection), malignant neoplasm of prostate (prostate cancer), and major depressive disorder, recurrent, unspecified. Record review of Resident #1's MDS Assessment, dated 06/06/25, revealed a BIMS score of 12, indicating moderately impaired cognition. Further review revealed the resident required 2 or more helpers to complete toileting. Record review of Resident #1's care plan report, undated, revealed the resident had an ADL self-care performance deficit r/t Alzheimer's and limited mobility. Interventions included assistance by (x1-2) staff for toileting. During a telephone interview on 08/19/25 at 7:39 a.m., Resident #1's family member said Resident #1 told her on Saturday, 08/16/25, that on an unknown date, CNA A had turned him to his side to change him, and it caused pain. She said Resident #1 said he grabbed her hand, and she removed his hand and put it down and then hit him with her open palm on his right eye. Resident #1's family member said she reported the allegation of abuse to Nurse A later that afternoon, 08/16/25, between 3:30 p. m. and 4:00 p.m. She said Nurse A did not say what action she was going to take. She said Nurse A received a phone call during their conversation, answered the call, and then walked away. She said she did not see any marks or bruises on the Resident #1's face. She said she called the Administrator yesterday, 08/18/25, to make sure she was aware of the allegation of abuse but said she was unable to reach her as she was already gone for the day. She said she had not heard back from anyone about her reported abuse allegation as of today, 08/19/25. During an interview on 08/19/25 at 8:14 a.m., Resident #1 said the care at the facility was not good. He said about 3 or 4 days ago (was not sure of the exact date), a nurse aide (said he did not know her name) hit him on the right side of his face in the eye. He said a nurse aide was changing him. He said the nurse aide turned him on his right side, and when she turned him, it caused him pain. He said the nurse aide had her hand on his left arm, and he told her he wanted her to lay him flat, and he tried to get her hand off him. He said that was when she hit him. He said he did not say anything to the nurse aide. He said she finished changing him and she left his room. He said he told his family member what happened, on a different day (he did not know what day). He said he did not tell anyone else. He said it made him mad when the nurse aide hit him. He said no staff had come to talk to him about the nurse aide hitting him. During a telephone interview on 08/19/25 at 9:56 a.m., Nurse A said on Saturday, 08/16/25, she was in the middle of taking care of a critical resident when Resident #1's family member came up to her and told her the CNAs were in the resident's room changing him and cleaning him up when one of the aides had hit him in the face. She said the resident's family member could not name the CNA, but the two CNAs in the room were, CNA A and CNA B. She said she asked CNA B if they had encountered anything in the room, and CNA B said Resident #1 told his family member that they had hit him in the face, but CNA B said she was by the bed with the other aide the whole time and it did not happen. She said CNA B told her they washed the resident's face with a washcloth. She said CNA B told her Resident #1 alleged she was the one who hit him in the face. She</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record reviewed, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 1 (Resident #1) of 4 residents reviewed for reporting of alleged allegations. - The facility failed to ensure Nurse A reported to the facility Administrator when Resident #1's family member's reported an alleged abuse allegation. Resident #1's family member reported to Nurse A on 08/16/25 that CNA A allegedly hit Resident #1 on his right eye, on an unknown date, when changing him. This failure could place residents at risk for not having incidents reported as required and continued abuse which could result in diminished quality of life. The findings included: Record review of Resident #1's admission Record, dated 08/19/25, revealed an [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included infrarenal abdominal aortic aneurysm (a localized dilation of the abdominal aorta below the renal arteries), without rupture, unspecified mycosis (fungal infection), malignant neoplasm of prostate (prostate cancer), and major depressive disorder, recurrent, unspecified. Record review of Resident #1's MDS Assessment, dated 06/06/25, revealed a BIMS score of 12, indicating moderately impaired cognition. Further review revealed resident required 2 or more helpers to complete toileting. Record review of Resident #1's care plan report, undated, revealed the resident had an ADL self-care performance deficit r/t Alzheimer's and limited mobility. Interventions included assistance by (x1-2) staff for toileting. During a telephone interview on 08/19/25 at 7:39 a.m., Resident #1's family member said Resident #1 told her on Saturday, 08/16/25, that on an unknown date, CNA A had turned him to his side to change him and it caused pain. She said Resident #1 said he grabbed her hand, and she removed his hand and put it down and then hit him with her open palm on his right eye. Resident #1's family member said she reported the allegation of abuse to Nurse A later that afternoon, 08/16/25, between 3:30 p. m. and 4:00 p.m. She said Nurse A did not say what action she was going to take. She said Nurse A received a phone call during their conversation, answered the call, and then walked away. She said she did not see any marks or bruises on the Resident #1's face. She said she called the Administrator yesterday, 08/18/25, to make sure she was aware of the allegation of abuse, but said she was unable to reach her as she was already gone for the day. She said she had not heard back from anyone about her reported abuse allegation as of today, 08/19/25. During an interview on 08/19/25 at 8:14 a.m., Resident #1 said the care at the facility was not good. He said about 3 or 4 days ago (was not sure of the exact date), a nurse aide (said he did not know her name) hit him on the right side of his face in the eye. He said a nurse aide was changing him. He said the nurse aide turned him on his right side, and when she turned him, it caused him pain. He said the nurse aide had her hand on his left arm, and he told her he wanted her to lay him flat, and he tried to get her hand off him. He said that was when she hit him. He said he did not say anything to the nurse aide. He said she finished changing him and she left his room. He said he told his family member what happened, on a different day (he did not know what day). He said he did not tell anyone else. He said it made him mad when the nurse aide hit him. He said no staff had come to talk to him about the nurse aide hitting him. During a telephone interview on 08/19/25 at 9:56 a.m., Nurse A said on Saturday, 08/16/25, she was in the middle of taking care of a critical resident when Resident #1's family member came up to her and told her the CNAs were in the resident's room changing him and cleaning him up when one of the aides had hit him in the face. She said the resident's family member could not name the CNA, but the two CNAs in the room were, CNA A and CNA B. She said she asked CNA B if they had encountered anything in the room, and CNA B said Resident #1 told his family member that they had hit him in the face, but CNA B said she was by the bed with the other aide the whole time and it did not happen. She said CNA B told her they washed the resident's face with a washcloth. She said CNA B told her Resident #1 alleged she was the one who hit him in the face. She said after their conversation, she went into her critical resident's room to provide care. She said she sent out the critical resident to the hospital, stayed very late, forgot about the reported allegation of abuse from the resident's family member until this Investigator called her for an interview. She said she did not report the alleged abuse to anyone because she was ignoring the allegation of abuse and the critical resident at the</p>		