STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676333	A. Building B. Wing	12/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Crossing Nursing and Rehabilitation Cente	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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 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 interview and record review, the facility failed to ensure a resident received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 (CR #1) of 5 residents reviewed for quality of care. The facility failed to perform an assessment on CR #1 when she reported to have trouble breathing.This failure could place residents at risk for a delay in treatment or diagnosis, a decline in the resident's condition and/or the need for hospitalization and prolonged treatment.Findings included: Record review of CR #1's face sheet dated 10/28/25, revealed an [AGE] year-old female admitted to the facility with an initial admission date of 2/4/25 and readmitted on [DATE]. Diagnoses included: nontraumatic intracerebral hemorrhage in brain stem (a stroke that occurs when blood vessels in the brain rupture without any external trauma), dysphagia (difficulty swallowing), shortness of breath, other specified symptoms and signs involving the circulatory and respiratory systems, Stage 4 pressure ulcer, anemia (low levels of healthy red blood cells to carry oxygen throughout your body), Type 2 diabetes, hypertension, atherosclerotic heart disease (the buildup of fats, cholesterol and other substances in and on the artery walls), chronic combined systolic and diastolic heart failure, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, and peripheral vascular disease. Record review of the comprehensive MDS dated [DATE] indicated CR #1 had a BIMS score of 6 reflecting severe cognitive impairment. Record review of CR #1's care plan dated 8/22/25 indicated CR #1 had shortness of breath r/t perception or cognitive impairment. Interventions included: monitor/document changes in orientation, increased restlessness, anxiety, and air hunger; monitor/document breathing patterns, report abnormalities to MD: nasal flaring, respiratory depth changes, altered chest excursion, use of accessory muscles, pursed-lip breathing or prolonged expiratory phase, increased anteroposterior chest diameter; monitor/document/report breathing abnormalities to MD: bradypnea (abnormally slow breathing), tachypnea (abnormally rapid breathing), hyperventilation, Kussmaul's respirations (deep and labored breathing pattern), Cheyne-Stokes (alternating periods of rapid deep breathing followed by pauses in breathing), apneusis (prolonged, gasping inhalations followed by short, inadequate exhalations), Biot's respirations (alternating periods of rapid, shallow breaths and pauses in breathing); position resident with proper body alignment for optimal breathing pattern. Review of video dated 8/21/25 at 8:56 pm, CR #1 was lying in bed, bed was at 45-degree angle, the Restorative Aide entered the room and asked CR #1 what's going on? CR #1 stated I can't hardly breathe. LVN A walked in the room and the Restorative Aide told LVN A, CR #1 can't hardly breathe. MA D walked in the room followed by RN C. LVN A told CR #1 You have to take your medicine. What's going on with you? Your family member just left. LVN A asked CR #1 Can you take your medicine? CR #1 responded I will take my medicine. LVN A said, So what is the problem now, so we can figure out what we need to do for you? CR #1 responded I do not know. LVN A then stated, Ok we can talk later, you can bring the medicine. LVN A told everyone in the room When she calms down, we can come back, let's go. Everyone exited the room. CR #1 was moaning. MA D came back in the room and brought CR #1 some water. MA D said to CR #1 I'm going to sit you up a little bit. MA D then raised the head of the bed. CR #1 started moaning again. MA D then lowered the bed. Record review of progress note dated 8/21/25 at 11:25 pm written by LVN B read in part .CR #1's family member called facility with concerns about CR #1's breathing. LVN B went to CR #1's room and checked the resident. O2 saturation was checked- O2 saturation 96% and 97% on room air. LVN B repositioned resident and raised her head. This nurse asked CR #1 is that better and CR #1 stated yes while shaking her head. CR #1 is not showing any s/s of distress at this time . Interview with the family member on 10/30/25 at 10:10 am, she said CR #1 started having trouble breathing on the evening of 8/21/25. She said CR #1 told the Restorative Aide I can't breathe, so the Restorative Aide got the nurse. The family member said MA D was trying to give CR #1 her medicine. The family member said LVN A went into CR #1's room and started yelling at CR #1 to take her medication. LVN A said to CR #1 What is wrong with you?. The family member said LVN A ordered everyone out of the room and did not take CR #1's vitals. The family member said CR #1 was cognitive and was able to tell staff her needs. Interview with the Hospice Nurse on 10/28/25 at 11:40 am, she said the family member called her on 8/21/25 at approximately 10:41 pm. The Hospice Nurse said she did a PRN visit on 8/21/25 and was at the facility around 11:20 pm. She said CR #1 was stable at the time of her visit. She said CR #1 was resting and her O2 saturation was 98% on RA. The Hospice Nurse said she did not see any signs of distress from the resident