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Form Approved OMB
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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 03/05/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one resident (Resident #1) of five residents reviewed for nursing services received adequate supervision and assistive devices to prevent accidents. Findings include:-Resident #1 was transferred without the use of a gait belt.-The CNA conducting the transfer grabbed the resident's left hand to lift her to the sitting position without placing an arm behind the resident's back for support. -Resident #1 was not gently lowered into the wheelchair but was set down abruptly.This failure could place residents at risk for injury and falling. Findings included:Record review of the admission Record (no date) for Resident #1 revealed she was [AGE] years old and admitted [DATE], diagnoses included dementia, a history of falls, abnormalities of gait (walking) and mobility, muscle weakness, and lack of coordination.Record review of the annual MDS assessment, dated 01/25/2026, revealed Resident #1 scored 4 of 15 on the BIMS, indicative of severe cognitive impairment. The MDS revealed Resident #1 required substantial/maximum assistance for repositioning from lying to sitting on the side of the bed. The MDS reflected Resident #1 required substantial/maximum assistance for transitioning from sitting to standing. The MDS reflected Resident #1 required substantial/maximum assistance for transfer to the wheelchair.Record review of the Care Plan for Resident #1, dated 03/29/2025, revealed she required a one person assist for transfers. Record review of a series of time dated and stamped photos from a video produced by a private surveillance video camera in Resident #1's room revealed the following:Date/Time Photo 02/14/2026@5:01 p.m. CNA A transferred Resident #1 with no gait belt. Resident #1 appears to be grimacing.02/14/2026@5:01 p.m. Resident #1 was sitting in the wheelchair. 02/14/2026@5:13 p.m. CNA A transferred Resident #1 with no gait belt.During an interview on 03/04/2026 at 12:23 p.m., the DON said she had a care plan meeting with a family member of Resident #1 and addressed the issue of the transfer. She identified the staff as CNA A. She said she thought CNA A no longer worked at the facility. During an interview via telephone on 03/04/2026 at 12:45 p.m., a family member of Resident #1 said there was an incident on 02/14/2026. She said she spoke with the Administrator about it. Record review on 03/05/2026 of videos date stamped 02/14/2026 from the camera in Resident #1's room revealed a sequence of events initiated at 5:01 p.m.: Resident #1 was visible in bed, lying on her right side. CNA A placed the wheelchair at the right side of the bed, facing the resident. CNA A pulled back the cover. With her right hand, CNA A grabbed Resident #1's left hand and pulled her up to a sitting position. She did not provide support to the resident's back while lifting her to nearly a sitting position. Resident #1 screamed. CNA A grasped Resident #1's upper right arm. She held the resident by the resident's right bicep area. She adjusted the resident's blouse. The bed was not locked and rolled slightly. CNA A then transferred the resident from the bed to the wheelchair without a gait belt. Both appeared to struggle, and Resident #1 was assisted to the wheelchair abruptly. Resident #1 appeared to be crying. The resident was taken to the shower/restroom. Continued observation of the video revealed at 5:12 p.m., CNA A propelled Resident #1 in her wheelchair from the restroom in Resident #1's room to the resident's bedside. The resident's upper body was covered but did not have a brief on. Her private area was exposed. CNA A transferred Resident #1 from the wheelchair to the (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bed with no gait belt. During an interview on 03/05/2026 at 12:54 p.m. the Director of Therapy said the staff should use a gait belt for transfers. He said if a gait belt was not used, the resident could fall.In an interview on 03/05/2026 at 1:00 p.m., the DON said she was aware of the video but had not seen it. She said staff should use a gait belt for transfers. The DON said if a gait belt was not used, it could result in a fall or injury.In an interview on 03/05/2026 at 1:33 p.m., the Administrator said she saw the video. She said CNA A performed an improper transfer but did not think it was malicious. She said Resident #1 could be combative. During an interview via telephone on 03/15/2026 at 2:05 p.m., CNA A said she sat the resident up. She said she placed her hand behind the resident's back and pulled her up. She said she normally used a gait belt, but did not have one at that time. She said she was supposed to use a gait belt. She said if a gait belt was not used, the resident could get hurt or have a fall. Record review of the facility policy entitled, Safe Resident Handling /Transfers, dated 02/19/2025, revealed, .All residents require safe handling when transferred to prevent or minimize the risk of injury to themselves and the employees that assist them.5. Handling aids may include gait belts.13. Staff members are expected to maintain compliance with safe handling/transfer practices.