

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 06/25/2026
Form Approved OMB
No. 0938-0391

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 04/24/2026
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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Purpose for Visit: Complaint and Incident Investigations. Entrance date: 4/22/2026 Census: 102 Intakes: 2988707297733729832282975728298799829764842989108 Abbreviations: ADM: Administrator CMA: Certified Medication Aide DON: Director of Nursing G-tube: Gastrostomy HCl: Hydrochloride MCG: microgram Mg: milligrams NP: Nurse Practitioner Based on observation, interview, and record review the facility failed to store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys to meet the needs for 1 out of 2 medication (Medication Cart #1) carts reviewed for pharmacy service in that: The facility failed to ensure CMA B did not leave medications on top of the medication cart. This failure could place residents at risk of not receiving their medications, choking and respiratory distress. Observation of Medication Cart #1, Hall A on 04/23/26 at 9:38 a.m., revealed 4 bottles and 5 blister packs of medication left on top of the medication cart unsupervised. The medications on top of Medication Cart #1 consisted of 1 bottle of Aspirin 81mg Oral Tablet Chewable (Aspirin) (anti-inflammatory drug), Zyrtec Allergy Oral Tablet 10mg (antihistamine used to relieve allergy), Iron Oral Tablet 325mg (prevent iron deficiency anemia), Vitamin B-12 1,000mg (support brain health), Cyanocobalamin Oral Tablet 500 MCG (used to prevent pernicious anemia), Eliquis Oral Tablet 2.5mg (blood thinner), Metformin HCl Oral Tablet 1000mg (manage type 2 diabetes by lowering sugar levels), hydroxyzine Oral Tablet 25mg (antihistamine used to treat anxiety), Lisinopril Oral Tablet 10mg (used to treat high blood pressure), Protonix Oral Tablet delayed release 20mg (used to treat gastroesophageal reflux disease). During an interview on 04/23/26 at 1:24 p.m., CMA B said she was trying to figure out what happened because she was informed that a picture of her medication cart was taken. The picture of Medication Cart #1 was revealed to CMA B. She said, moving too fast. CMA B stated that the medications should be placed inside the medication cart locked before leaving Medication Cart #1 unattended. CMA B stated she was in a resident's room when Medication Cart #1 was left unattended. CMA B said that the potential negative outcome for leaving medications on top of the medication cart would be residents could have taken the medications, resulting in an overdose. During an interview on 04/23/26 at 1:43 p.m., CMA C said to ensure medications remain safe, after preparing medications you should place the medications back into the medication cart and lock it. CMA C said medications should not be on top of the cart unsupervised due to safety and confidentiality concerns. CMA C said that a negative outcome of leaving the medications on top of Medication Cart #1 is that a resident could take the medication and overdose. CMA C said if the resident took Eliquis inappropriately, the resident could experience excessive bleeding. During an interview on 04/24/26 at 1:36 p.m., ADM said the negative effect of the residents taking the medications include drowsiness. The ADM said Metformin can be harmful to the resident if not administered appropriately, and if the resident took Eliquis, it would increase the risk of excessive bleeding. During an interview on 04/24/26 at 2:00 p.m., the DON said to ensure medications are secured, all medications must remain locked inside the medication cart when not in immediate use. The DON said leaving medications unattended on top of the cart creates a significant safety risks. (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON said any resident could access and ingest the medications which could cause serious physical, mental and psychological harm, including nausea, vomiting, neurological complications, allergic reactions, and other adverse effects. The DON said a resident who ingests medication such as Eliquis, it could result in severe bleeding and significant blood loss. During an interview on 04/24/26 at 2:26 p.m., the NP said that if a resident ingested Eliquis, it could result in serious adverse effects, including hypotension, excessive bleeding with the potential to bleed out. The NP said that hypoglycemia or low sugar could occur depending on the resident's overall condition and medications interactions. Record review of the facility policy on medication carts and supplies for administering meds dated 10/01/19., read in part, Policy .The mobile medication cart will be used to facilitate administrations of medication to residents.The purpose of the mobile medication system is to insure appropriate control and surveillance of resident assigned medications. Policy statement procedure 3.Do not leave the medication cart unlocked or unattended in the resident care areas.		