STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255275	A. BUILDING _____ B. WING _____	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA SENIOR CARE, LLC	3701 PETER QUINN DRIVE JACKSON, MS 39213

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an Annual Recertification Survey and Complaint Investigation (CI MS #26922) and at the facility from 12/15/24 through 12/18/24. The SA investigated CI MS #26922 related to abuse, quality of care, and environment. There were no citations related to the complaint's investigations. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F656 and F800. The facility held a license for 60 beds, with a census of 46.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656		1/15/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 01/06/2025

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F 656	Continued From page 1 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to ensure a comprehensive care plan was developed to include a resident's diagnosis of Dementia, to provide information related to treatment and appropriate interventions for one (1) of 14 care plans reviewed. Resident #9 Findings Include: A review of the facility's policy titles, "Comprehensive Care Plans," dated 10/23, revealed, "It is the policy of this facility to develop	F 656	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. Care plan of resident #9 was reviewed	

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F 656	Continued From page 2 and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychological needs that are identified in the resident's comprehensive assessment ..." A record review of Resident #9's Comprehensive Care Plan reveled it does not have a focus, with goals and interventions related to a Dementia diagnosis. On 12/18/24 at 11:22 AM, during an interview with Registered Nurse (RN) #1/ Minimum Data Set (MDS) Nurse , she stated care plans are updated with new physician orders, new diagnoses, and falls. She stated Resident #9's diagnosis of Dementia should have been in the comprehensive care plan, if the resident is taking medication for the diagnosis. RN #1 stated the care plan is used by all staff to ensure residents received appropriate care. On 12/18/24 at 11:38 AM, in an interview with the Director of Nursing (DON), she confirmed a diagnosis of Dementia should have been included in Resident' #9's care plan, to ensure that staff know how to provide care. The DON stated the care plans are used by all staff providing direct care to residents and her expectations is that all care plans should be individualized and kept up to date. A record review of Resident #9 "Admission Record" revealed Resident #9 was admitted to the facility on 10/14/21. The resident's diagnoses included Unspecified Dementia, Unspecified Severity without Behavioral Disturbance,	F 656	and updated to include the diagnosis of Dementia by Registered Nurse and Minimum Data Set (MDS) Nurse on 12/19/2024. MDS nurse was educated per Director of Nursing (DON) on the facility's comprehensive care plan policy. 2. All residents with the diagnosis of Dementia have the potential to be affected. 3. On 12/19/2024 an audit was done by the DON, Nurse Consultant Registered Nurse and MDS Nurse of all residents to identify those with an active diagnosis of Dementia. Twenty-nine residents were identified in this audit. Education by Nurse Consultant on the facility's policy and procedure for developing Comprehensive Care Plans of The Interdisciplinary Team responsible for care plan development began on 12/19/2024. Further education completed by the MDS nurse on comprehensive care plans in Smartzone on 1/2/2025. Care plans will be reviewed weekly beginning 12/19/2024 in accordance with the care plan review schedule by the MDS Nurse. All care plans will be updated as appropriate to include the diagnosis of Dementia with goals and interventions related to Dementia. 4. The DON will complete weekly audits of care plans for five (5) residents for six (6) consecutive weeks beginning 12/20/2024; then monthly for 3 consecutive months beginning 2/28/2025. Findings of the audits will be reviewed with the Quality	

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F 656	Continued From page 3 Psychotic Disturbance, Mood Disturbance or Anxiety, with an onset date of 6/1/23. A record review of Resident #9's "Order Summary Report," with active orders as of 12/18/24, revealed an order to give 1 (one) tablet of Aricept 10 mg (milligrams) by mouth to be given at bedtime related to Unspecified Dementia. Review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/8/24 revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact.	F 656	Assurance Performance Improvement Committee beginning on 1/14/2025 and will continue for three (3) consecutive months to evaluate the effectiveness of the process and changes will be made as necessary to ensure substantial compliance.	
F 800 SS=D	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, record review, and facility policy review, the facility failed to ensure dietary staff supported and respected a resident's right to make choices about his or her meal preferences for one (1) of (14) sampled residents. Resident #46. Findings Include: A review of the facility policy titled, "Residents Rights," (undated), revealed, "... Freedom to Choose... We will accommodate as much as possible individuals needs and preferences in	F 800	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. On 12/17/2024, the morning	1/15/25

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F 800	Continued From page 4 daily routines and activities. Self-determination and reasonable accommodations of individual choices are an important part of residents' rights ..." On 12/15/24 at 12:25 PM, during an interview with Resident #46, he mentioned that sometimes he likes the food, but he does not have alternative options available and would sometimes prefer to choose different foods instead of eating what is provided to him. He also noted that he is unaware of what is on the menu because there is not one in his room, and the staff do not inform him of the daily menu choices. On 12/16/24 at 10:19 AM, in a follow-up interview with Resident #46, he revealed that no one has come into his room to ask about his menu options today. He added that no one ever comes for that purpose and feels that he must eat what is brought to him. He stated that he would like to have different options available but has not been made aware that he has a choice. On 12/16/24 at 10:30 AM, in an interview with the Dietary Manager, she revealed that the menus are posted in the halls and the dining area. She stated that, at this point, no one from her team retrieves meal choices from residents who are unable to leave their rooms. From her understanding, it is the Certified Nurse Aides (CNA's) responsibility to do so. On 12/16/24 at 10:55 AM, in an interview with the Activities Director, she said she thinks it is the dietary aide who goes out to ask residents their food preferences if they are not able to leave the room to view menus.	F 800	announcements were updated to include the main menu offer and the available alternate. The Activities Director was educated on 12/17/2024 by Administrator In Training (AIT) to change the morning announcement done by the resident volunteer to include this change. 2. All residents who are unable to leave their bedroom independently to inquire about the meal menu or alternative options have the potential to be affected. 3. On 12/19/2024 an audit was done by Director of Nursing (DON), Dietary Manager and Charge Registered Nurse of all residents to identify those who cannot independently leave their bedroom to be informed of meal options. Sixteen residents were identified in this audit. Education of Nursing and Dietary Departments began 12/19/2024 by the Registered Charge Nurse. Certified Nursing Assistant (CNA) and/or the Dietary Department will inform each resident of the menu prior to meal service along with alternative options and inform the dietary department. This action was further enhanced to include a "Meal Choice Form" tool for the CNA to communicate the resident's menu preferences to the Dietary Department on 12/30/2024. The menu will continue to be announced by overhead paging system daily to include the meal and alternate menu items by the resident volunteer or the RN supervisor.	

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F 800	Continued From page 5 On 12/16/24 at 11:06 AM, in an interview with CNA #1, she revealed that she has worked in the facility for the last twenty years and has occasionally cared for Resident #46 during her shifts. She acknowledged that he is unable to leave his room to view the menu. While she indicated that it is not her assigned task to ask bed-bound residents about their lunch preferences, she said that if they ask her while she is in their room, she will check the menu for them and report back on their options. On 12/17/24 at 8:15 AM, in an interview with the Director of Nursing (DON), she revealed the facility does not currently have a way of ensuring that residents residents who are unable to walk out of their rooms are able to see the menu. She acknowledged that residents should have access to the menus to ensure they can make choices about their food preferences, as this aligns with resident rights and acknowledges that this is their home. A record review of the "Admission Record" revealed the facility admitted the Resident #46 on 3/18/24, with diagnoses that included Weakness, Unsteadiness on feet, and Muscle Wasting and Atrophy, not Elsewhere Classified, Multiple Sites. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/25/24, revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact.	F 800	4. The Dietary Manager will complete weekly interviews of three (3) residents for four (4) consecutive weeks beginning 12/31/2024; then monthly for three (3) consecutive months beginning 02/21/2025. Resident meal service satisfaction will continue to be discussed during monthly Resident Council meetings. Findings of interviews and observations will be reviewed with the quality assurance performance improvement committee beginning 1/14/25 and monthly for three (3) consecutive months to evaluate the effectiveness of the process and changes will be made as necessary to ensure substantial compliance.	