Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/16/2026**

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

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M0000	Initial Comments The State Agency (SA) conducted an annual recertification survey at the facility from 04/13/2026 to 04/16/2026. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and cited M500 and M1570.	M0000		
M0500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse	M0500		

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

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M0500	Continued from page 1 medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract;	M0500		

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M0500	Continued from page 2 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, record review	M0500		

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M0500	Continued from page 3 and facility policy review the facility failed to honor residents' rights as evidenced by posting of personal signage in the resident's room for one (1) of (14) residents reviewed. Resident #6. Findings include: Record review of the facility's "Resident Rights Policy" dated 2025 revealed the facility will ensure that all direct care and indirect care staff members, including contractors and volunteers, are educated on the rights of residents and the facility's responsibility to provide proper care to residents. On 04/13/2026 at 11:20 AM, during an observation and interview revealed Resident #6 was in bed. Observed signage on the wall "Please put on compression hose daily even when resident is in bed. They are to be removed every night at bedtime" Resident #6 stated, "my legs are swollen, I do not have my compression hoses on yet. My Certified Nursing Assistant (CNA) will come to put them on after lunch." Resident #6 pulled her bed covers back and her legs were swollen. She had red slip free socks on. She stated the facility put that sign on the wall and stated, "I guess it is to remind them to do it, but they still don't". On 04/13/2026 at 2:13 PM, during an interview and observation with Licensed Practical Nurse #1 (LPN) of the h on the signage on the wall. She stated the signage on the wall is to notify the CNAs to put on the compression hose. She confirmed the CNAs have a Kardex and the task pops up daily to remind them. She confirmed that Resident #6 did not have them on. She stated they should be on daily. On 04/14/26 at 2:54 PM, in an interview with Director of Nursing (DON) stated the signage posted in the room is a dignity issue. She stated it should not be on the wall. She stated CNAs should have placed compression hose on in the morning. She stated the reminder for the CNA shows up in "task." She stated that it is their reminder. She stated the purpose of compression hose is to decrease swelling and increase circulation through the body. She stated her expectations for CNAs to put hose on in the morning after breakfast. On 04/16/2026 at 2:40 PM, in a phone interview with CNA #1 stated Resident #6 went to bingo at 2:00 PM and did not want them on. The State Agency (SA) informed CNA #1 that Resident #6 did not go to bingo, that LPN #1 and the SA was in an interview and observation with her at 2:13 PM. CNA #1 did not respond.	M0500		

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M0500	Continued from page 4 Record review of the "Admission Record" revealed Resident #6 was admitted to the facility on 10 /14/21 with diagnoses that included personal history of other venous thrombosis and embolism and localized edema. Record review of Resident #6 Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/26/26 revealed a Brief Interview for Mental Status (BIMS) of 13 which indicated the resident was cognitively intact. Record review of the "Order Summary Report" revealed apply bilateral knee-high compression hose every AM and remove at sleep every day and night shift for edema.	M0500		
M1570	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, record reviews and facility policy review the facility failed to prevent the possibility of spreading infection as evidenced by not wearing proper personal protective equipment	M1570		

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M1570	Continued from page 5 (PPE) and not adhering to Enhanced Barrier Precautions (EBP) during high contact care, not performing hand hygiene prior to care and not protecting suction equipment from bacteria, changing tubing, and cleaning a suction device for three (3) of five (5) care observations. Resident# 8, Resident #22 and Resident #49. Findings include: Record review of the facility policy “Hand Hygiene Policy” dated 2025 revealed, “Staff involved in direct resident contact will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents and visitors... Before performing residents care procedures…” Record review of the facility policy “Enhanced Barrier Precautions” dated 2025 revealed it is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. EBP refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and gloves use during high contact resident care activities. Resident #8 On 04/15/2026 at 2:32 PM, during an observation Resident #8 received peri care from Certified Nursing Assistant (CNA) #2. Resident #8 had a percutaneous endoscopic tube (peg) tube and was on EBP. Resident #8 had a bowel movement. CNA did not have a gown on as she was performing perineal (peri) care. On 04/15/2026 at 2:46 PM, in an interview with CNA #2 she confirmed she did not have a gown on while providing peri care. She stated the purpose of the gown to prevent transferring infections to the resident. She stated she placed resident at risk for infection by not wearing a gown. On 04/16/2026 10:48 AM, in an interview with the Director of Nursing (DON) stated CNA#2 should have donned (put on) a gown before doing peri care. She stated Resident #8 is on EBP due to the peg tube. She stated staff should wear gowns anytime they are doing high contact care. She stated her expectation of staff while doing care on residents who are on EBP, is that they give proper care and adequate care. Peri care is high contact care. She stated CNA #2 placed the resident at higher risk for infection by not wearing a gown.	M1570		

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M1570	Continued from page 6 Record review of Resident #8 "Admission Record" revealed an admit date of Hemiplegia and Hemiparesis' following unspecified Cerebrovascular Disease affecting left non-dominant side, Personal History of Transient Ischemic attack (TIA) and Cerebral Infarction without residual deficits and Dysphagia unspecified. Record review of Resident #8 Minimum Data Set (MDS) Assessment Reference Date 4/2/26 with a Brief Interview of Mental (BIMS) score of 13, which indicates cognitively intact. Section GG reveals he is dependent on hygiene. Resident #22 On 04/13/2026 at approximately 11:28 AM in an interview and observation of Resident #22 sitting up in bed watching TV. Resident #22 has suction set up on the bedside table. Resident #22 picks up canker and uses tip of canker to turn it on and then placed canker in her mouth to suction. The canker was on the bed exposed to bacteria. There was no covering or shield to protect it from bacteria. After suction she uses the tip to turn it off and places it on her bed not enclosed in a zip lock bag. During the interview and observation Resident #22 uses canker to suction three times each time using the tip to turn suction on and off. The canker is dated 9/15/25, the canker and tubing are dingy yellow, cloudy. On 04/13/26 at 2:30 PM, during an observation of Resident #22 suctioning herself revealed she used same technique that she had used the previous time. On 04/13/26 at 2:52 PM, during an observation of Resident #22 suctioning herself and placing the yankeaer on bed. She continued to use the of exposed canker to turn it on and off as she used it. On 04/14/2026 10:19 AM in an interview and observation of Resident #22 with LPN #1 confirmed the tubing is dated 9/15/25. She stated Resident #22 son-in- law comes and changes the yankauer and tubing every evening. She stated the coloring of the tube normally looks like that. She stated it comes that way. She confirmed it is the nurse’s responsibility to change tubing and yankauer, not the family. On 04/14/26 at 10:26 AM, an interview the Director of Nurses (DON) stated she was not aware of the son-in-law coming and changing the tubing and cleaning the machine. She stated it is the nurse's responsibility to change yankauer weekly and clean the machine on night shift. She stated the family is	M1570		

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M1570	Continued from page 7 not supposed to change tubing, yanker or clean it. She stated it should be in a bag to prevent infection and cross contamination. She confirmed it is on the Electronic Medication Administration Record (EMAR,) and nurses are signing off on it. She stated it is not the family's responsibility to change the tubing or clean it. She stated Resident #22 "is our resident and our responsibility." She stated, "we don't know if the family uses gloves or how they clean the machine or if they are doing it correctly." She stated family doing it could cause the resident to get a respiratory infection. On 04/14/26 at 10:30 AM, in an interview and observation in the room of Resident #22 with the DON, she confirmed the date and discoloration of the tubing. Resident#22 stated my son in law comes every evening and changes the tubing and cleans it. On 04/16/26 at 9:28 AM, during a phone interview with Resident #22's son- in- law, he confirmed that he does the care for resident suction machine. He stated he washes the machine and the tubing out daily. He stated he does not change out tubing he only washes it out daily. He stated the facility knows he does it. Record review of Resident #22's "Admission Record" revealed an admission date of 1/27/25 with diagnoses including Myasthenia Gravis and Dysphagia following Cerebrovascular Disease. Record review of the MDS with an ARD of 2/4/26 revealed a BIMS score of 15 indicating the resident is cognitively intact. Record review of Resident #22's "Order Summary Report" revealed an order dated 11/17/25 "Change canker to suction weekly on the PM (night) shift. May change tubing if visibly unable to flush particles. An order dated 9/10/25 revealed "Empty suction nightly and rinse with tap water. An additional order dated 1/28/25 revealed "Resident may suction self as needed (PRN) due to increased salivation. Resident may use suction independently." Record review of the EMAR for April 2026 revealed nurses' signatures indicating they changed the tubing and cleaned the suction machine. Resident #49 On 04/15/2026 at 2:10 PM, during an observation of CNA #2 revealed she entered Resident #49's room and pulled gloves from the box and donned (put on) them. CNA#2 assisted the resident to the bed,	M1570		

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M1570	Continued from page 8 removed his pants and shoes. She then removed her gloves and exited the room. On 04/15/2026 at 2:23 PM, CNA #2 returned to Resident #49's room and put on gloves. She retrieved peri wipes out of the drawer with gloves on. She provided peri care for Resident #49. She did not perform hand hygiene prior to either of the care observations. On 04/15/2026 at 2:43 PM, in an interview with CNA #2 she confirmed that she did not wash or sanitize her hands either time she entered the room to provide care to Resident #49. She stated "I sanitized my hands in the hallway before entering the room." She stated Resident #49 could get infection from her not performing hand hygiene. On 04/16/2026 at 10:43 AM, in interview with the Director of Nursing (DON) confirmed CNA #2 should have washed her hands before and after care and that she should have changed gloves after opening the drawer to get peri wipes. She stated CNA #2 placed the resident at increase for infection. Record review of Resident #49 "Admission Record" revealed an admission date of 3/17/2017 with diagnoses that included Parkinson disease with dyskinesia, with fluctuations and urinary tract infection. Record review of Resident #49's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 2/10/26 revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicates the resident is cognitively intact. Section GG revealed Resident #49 is dependent on hygiene. On 04/16/2026 12:16 PM, in an interview with RN #2/ Infection Preventionist (IP) nurse stated that CNA #2 should have performed hand hygiene upon entry before starting peri care on Resident #8. She stated Resident #8 could get an infection by CNA #2 giving care without a gown in place. She stated the resident is on EBP due to a peg tube. She stated Resident #22 yankeaer should have been in a bag to prevent contamination tubing should have been changed and device should have been cleaned by nurse. She stated Resident #22's yankeaer should have been placed in a bag to prevent cross contamination. She stated that Resident #22 was put at risk for a mouth or bacterial infection or bacterial infection. She stated Residents #8, #22 and #49 were all placed on higher risk for infection.	M1570		