STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676306	A. Building B. Wing	06/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holly Hall	2000 Holly Hall St Houston, TX 77054

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 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26244 Based on observation, interview and record review the facility failed to ensure personnel provided basic life support including CPR to a resident in an emergency situation and subject to related physician orders and the resident's advance directive. (CR #1). --CR #1 received CPR when he had a physician signed out of hospital DNR, which was not on the resident's electronic medical record. This failure placed residents with DNR status at risk of not having their preferences honored in the event of an emergency. Findings include: Record review of CR#1's admission information revealed admitted [DATE] and discharge date (death in facility) [DATE]. His diagnoses included metastatic cholangiocarcinoma (cancer cells spread from bile ducts to other parts of the body). Record review of CR #1's Admission MDS dated [DATE] revealed Hospice services were provided in the facility, he required total assistance for ADLs, and was NPO. Record review revealed the care plan was not completed, and baseline care plan was not completed. Record review of CR#1's electronic record dated [DATE] revealed DNR was not listed on profile. Record review of handwritten physician orders dated [DATE] revealed pt is a DNR. Record review of nurses note in CR #1's electronic record dated [DATE] revealed RN B found the CR #1 with pale skin and was unable to obtain blood pressure or pulse. The resident was moved from bed to floor, CPR was started, 911 was called, paramedics arrived and continued CPR. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with DON on [DATE] at 10:45 am, she said RN C put the signed DNR form in the Hospice binder per admission procedure. She said RN B who was with CR #1 did not see the DNR code listed on the electronic record, so she started CPR. The DON said the nurse called 911, and on arrival paramedics continued CPR. The nurse called the family, and the family said CR#1 was a DNR. RN B found the DNR form in the Hospice book, and CPR was stopped at that point. She said RN B involved was spoken to after the incident. RN C was not available for interview, and phone messages were unreturned. Interview with RN C on [DATE] at 1:00 pm revealed CR#1 did not have the DNR form when he was admitted , and family brought it to the facility. She said the procedure was to put the DNR form in the resident's Hospice binder, which are kept separately on a shelf at the nurses' station. She said Medical Records would then upload the DNR in the resident's electronic record. In an interview with DON on [DATE] at 2:00pm, she said she did not know why the DNR was not documented on CR #1's electronic record. She said the procedure would be to ask for the DNR prior to the resident coming, and if they did not have it, the admitting nurse would call the Hospice company for it and upload it to the record. In further interview, she said the risk of not having correct code status on the resident's electronic record would be their wishes would not be granted: the resident would get CPR when they did not choose to have it, or they would not get CPR when they did choose to have it. Record review of facility policy Advance Directives, revised [DATE], revealed, in part: .information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record .