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	10/03/2024

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47277 Based on observation, interviews, and record reviews, the facility failed to ensure residents who were unable to carry out activities of daily living were provided with the necessary services to maintain good personal hygiene for 1 of 5 (Resident #1) residents reviewed for ADL care. The facility failed to provide Resident #1 showers as scheduled. The facility failed to provide, the necessary care and services to attain or maintain the highest practicable, physical, mental, and psychosocial well-being consistent with the resident's comprehensive assessment and care plan This failure could place residents who are dependent on staff for ADL care at risk for loss of dignity, and a decreased quality of life. Findings included: Record review of Resident # 1's Face Sheet revealed a [AGE] year-old male admitted to the facility on [DATE], readmitted [DATE] and discharged [DATE] who was diagnosed with Amyotrophic Lateral Sclerosis (nervous system disease that weakens muscles and impacts physical function). Record review of Resident #1's Order dated 1/21/2024 at 10:28pm revealed change BIPAP (helps push air into the lungs) mask daily in afternoon one time a day related to respiratory failure, unspecified whether with hypoxia or hypercapnia dated 3/21/2024; ensure mask is secured and ventilation is on AVAP-AE (average volume assured pressure support-automated expiratory positive airway pressure) Passive mode in upper right corner every 12 hours for ventilation (movement of fresh air around a closed space, or the system) dated 11/15/2023; Monitor site to nose and face under mask for pressure related injury q shift every 12 hours for skin integrity dated 11/15/2023; release top straps of BIPAP one by one, clean with warm wash cloth, dry off area and apply lubricant cream (located at resident's bedside) to area once dry. Re-Secure straps two times a day for skin integrity dated 8/29/2024. Record review of Resident #1's Comprehensive MDS assessment dated [DATE] reflected diagnoses included amyotrophic lateral sclerosis, hypertension, hyperlipidemia, dysphagia, pulmonary respiratory failure. Resident #1's BIMS score was 00, which indicated Resident #1 was unable to complete the interview. The functional limitation (Movement of limbs) in range in motion revealed Resident #1 was impaired on both sides. The MDS assessment indicated Resident #1 required maximal assistance with toileting and personal hygiene. (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Care Plan dated 11/2/23, reflected Resident is totally dependent on staff for all his ADLs, which includes bed mobility, transfers, eating, dressing, toilet use and personal hygiene. The Care Plan did not have specific shower or Bed bath days for Resident #1. Record review of the facility's shower schedule revealed Resident #1's scheduled shower days are Monday, Wednesday and Friday between 3:00pm - 11:00pm. Record review of Resident #1's skin assessment dated [DATE] to 9/24/2024 showed no wounds. Record review of the facility's ADL (staff assistance) for Resident #1's bed bath, revealed Resident #1 had not received a bath since prior to 8/31/2024. Resident #1's ADL also revealed that the last time Resident #1 received personal hygiene assistance was 9/23/2024; therefore, between the dates of 8/31/2024 - 9/22/2024 Resident #1 had not received a bed bath or shower. Record review of Resident #1's shower sheet revealed Resident #1 refused a bath 9/11/2024; however, skin report indicated no issues on the same date by CNA A. CNA A initialed and dated the sheet. There are no other shower sheets. Record review of Resident #1's ER Diagnosis revealed, Resident #1 arrived at hospital on 9/27/2024 with a chief complaint of G-tube (tube inserted through the belly that brings nutrition directly to the stomach) Dislodgment. On exam it was reported by ER Doctor that Resident #1 had wounds on his nose, ears and hands. It further stated Resident #1 had Cerumen Impaction (Ear wax build up and prevents the ear canal from functioning properly) that is visible outside. He has poor hygiene. In an interview on 10/1/2024 at 10:42am, ERSW stated Resident#1 came into the Hospital on 9/27/2024 at 9:02pm because his G-Tube was dislodged, and he was diagnosed with Aspiration Pneumonia. There were pressure wounds on his ears, hands and nose. ERSW stated Resident #1 had earwax coming out of his ears. ERSW stated the medical term given to her was Cerumen Impaction. ERSW stated contact was made with FM A who indicated her concern with Resident #1's lack of care at the facility. FM#1 continued that a conversation was conducted with the Administrator in January 2024 about Resident #1's care. In an interview on 10/1/2024 at 11:21am with FMA, said she received notification from FM B that Resident#1 had been taken to the hospital. FM#A said Resident #1 has been at the facility since 2023 and she has spoken with facility on previous occasions regarding Resident #1's care, especially his ears, which at times makes it difficult for him to hear. FM A stated Resident #1 was worried about the vent on the BIPAP coming out during bed bath, which scares him. FM A further stated Resident #1 told her that staff is too rough when they provide care. FM A Stated Resident #1 can text this information to a telephone by using his eye gaze machine and sometimes his speech. These issues are usually at night. FM A acknowledged Resident #1 is stubborn and will not allow every nurse to take the mask off; which is an issue for Resident #1. FM A stated Resident #1 is fully cognizant he is unable to speak very well with the mask on He uses eye gaze technology, which allows him to write. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/1/2024 at 1:07pm with FMB said it was a shocking to find out what condition (Hygiene) Resident#1 was in when he went to the hospital. FM B stated Resident #1's condition is unacceptable. FMB stated Resident #1 had complained about the staff on weekend, they are not careful with his feeding tube, and he is scared for his mask. FMB stated resident has an eye gaze device (allows the user to control a computer or tablet using eye movements instead of a mouse or hands), and he sends text messages to the family. Observation and interview on 10/3/2024 at 9:45am of Resident#1 at the hospital revealed Resident #1 lying in bed. Surveyor asked resident permission to turn the room light on and he nodded yes. Resident #1's face, hands and hospital gown were clean. Resident #1 was clean shaven. An introduction was made to Resident #1. Resident was unable to speak however communication was established by nodding head up and down for yes and sideways for no. He nodded he understood. Observation revealed resident with a Full-Face Mask with straps positioned around his neck and head area. The straps around the neck area appeared to have thin pantie liners under, that was used as a barrier between the strap and skin. There were no wounds on his hands, ears, or nose. There was a small cut on the top of his nose from wearing his mask, which he nodded yes. Resident #1 nodded yes that staff turns him often. He nodded no to having any wounds on his bottom, feet, or legs. Resident#1 stated he knew how the G-Tube was dislodged and it was not dislodged by staff. He stated staff were not rough with him. He nodded he did it because his stomach was itching, and he rubbed it with his hand. He stated he has not been getting bed baths as required and he has refused some on occasion He stated his refusal was because of his bipap. He stated he was afraid that staff would pull the cord of the mask and he would lose the oxygen. He stated staff does not ask if he wants bed baths daily. He stated it can be difficult to hear. Resident appeared agitated (trying to talk and appeared to be breathing heavily) because he couldn't get his words out. Resident #1 was asked if the mask could be lifted from his chin so that he could talk Resident #1 shook his head NO. As a result, the interview ended. In an interview on 10/3/2024 at 1:22pm with CNA C revealed she has provided aide duties to Resident #1, but not often. She stated she has not provided care for Resident #1 in a couple of months but assisted CNA B with changing him recently. CNA C stated the two of them rolled (Peri care) Resident #1 from side to side. She stated they wash him by getting water in two buckets, one to wash and the other to rinse him off. CNA C stated when Resident #1 was more active in getting up he was going to the shower, but that has been a long time. She stated she did not complete any ADL's because she was assisting and could not remember the dates, she gave assistance. In an interview on 10/3/2024 at 3:23pm it was revealed CNA A was assigned to provide Resident #1 with Peri care, changed his brief, and provided as bed bath as needed, which includes, shampoo Resident #1's hair. CNA A stated because resident wears a ventilator mask and resident gets scared when he thinks the mask may be taken off during this time he will not allow his hair to be washed or shampooed. CNA A stated Resident #1 gets bathed daily; however, unable to produce documentation or bath/shower sheet(s) to support daily baths. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/3/2024 at 4:09pm it was revealed CNA B worked with Resident#1 frequently. She stated she bathed Resident#1 frequently and stated Resident #1 refused a lot of showers and bed baths due to the mask. She was unable to produce documentation or bath/shower sheets to support the denial. She stated she documented the refusals in PCC (electronic record) and ensured the charge nurse was also notified. CNA B stated Resident#1 would refuse to take a bed bath once or twice weekly. CNA B stated Resident #1 put on his call light. CNA B observed Resident#1's G-Tube out and blood on his gown. CNA B stated she immediately called RN A. CNA B did not observe that Resident #1 was dirty or unclean. In an interview on 10/3/2024 at RN A it was revealed she was getting a report from outgoing nurse when CNA B came to her and told her Resident #1's G-Tube came out. RN A stated she immediately went to the room, completed an assessment, then inserted a foley to prevent blockage and notified MD, DON and Administrator. RN A stated Resident #1 was sent out to hospital ER. She stated she did not notice that Resident #1 was unkept (dirty). In an interview on 10/3/2024 at 6:00pm the Admin revealed he was unaware of the resident being in an unkept way when he was transported to the hospital. Admin stated there are policies in place. He stated he and the DON were new to their positions and are in the process of re-vamping policies so that they are more resident centered. He stated staff not giving Resident #1 a bed bath or not documenting it is unacceptable. In an interview on 10/3/2024 at 7:30pm with the DON revealed her expectation of nursing staff is to promote core values of excellence and give compassionate care. DON stated she has only worked in the facility since August 2024 and is in the process on initiating In Service (training with current nursing staff) training and ensuring regulations on residents' care are followed. DON stated she has an open-door policy. The DON stated there was an ADL system that staff are to complete if they give a shower/bed bath and if there are any concerns that need addressing. Upon her search for the shower documentation on Resident #1 for the week the resident went to the hospital the DON was unable to find any shower sheets completed. DON stated Resident#1 does not have wounds on his bottom, legs or feet because they are ensuring he is turned often, like every two hours. DON stated resident will not allow staff to remove the bipap mask, which is why pantie liners were placed around his neck to prevent wound around the area. DON states she will complete in-service of quality of care for residents with all staff. She stated resident going to the hospital smelling and ear wax is totally unacceptable, uncalled for, embarrassing for the resident and makes the resident feel a lack of dignity. Record review of the facility's policy, Giving a Bed bath dated October 2010 indicated the purpose of the procedure is to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. According to Steps in the Procedure section: #14 Face, Ears and Neck: Subsection: C. Wash the resident's eyes from the nose to the outside of the face using water only G. Wash the resident's ears and neck. Rinse well and dry. According to Documentation section - should be recorded on the resident's ADL record and/or in the resident's medical record: 1. Date and time the bed bath was performed. (continued on next page)

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