

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676306	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/07/2025
NAME OF PROVIDER OR SUPPLIER Holly Hall		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to treat each resident with respect and dignity and care in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 1 (Resident #37) of 4 residents and 3 of 3 confidential group residents reviewed for resident rights. The facility failed to provide showers to Resident #37 and 3 of 3 confidential group residents. This failure could affect the residents who require assistance with their ADLs from facility staff by placing them at risk for social isolation, loss of dignity, and self-worth. The findings include: Resident #37:Record review of Resident #37's Face sheet dated 10/01/2025 indicated she was an [AGE] year-old female who admitted to the facility on [DATE] and readmitted on [DATE]. Resident's diagnoses included but were not limited to rotator cuff tear or rupture of unspecified shoulder, non-Hodgkin lymphoma (a group of cancers that originate in the lymph nodes, which are part of the immune system), muscle wasting and atrophy, muscle weakness (generalized), cellulitis of left lower limb (a common bacterial skin infection that affects the deeper layers of the skin and underlying tissues), open wound, left lower leg, displaced fracture of distal pole of navicular (a break in the wrist bone on the thumb side that has shifted out of place) [scaphoid] (the largest of the eight carpal bones in the wrist, located on the thumb side) bone of right wrist, and pain in joints of right hand. Record review of Resident #37's undated Care Plan did not reflect any ADL care needs for the resident. Record review of Resident #37's Minimum Data Set (MDS) record was asked for but not received. Observation, interview and other record reviews reflected that residents had been cognitively in tacked.Record review of Resident #37's BATHING: SELF PERFORMANCE dated 10/07/2025 at 03:49 p.m. for the month of September 2025 reflected - How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (excludes washing of back and hair): Activity itself did not occur or family or non-facility staff provided care 100% of the time for that activity on 09/12/2025, 09/14/2025, 09/16/2025, 09/18/2025, 09/20/2025, 09/28/2025.Observation/interview on 09/30/2025 at 01:46 pm. Resident #37 stated it had been 9 days since her last shower/bed bath event though she had scheduled shower days on Tuesday, Thursday, and Saturday. The resident's hair was observed looking oily. During an interview on 09/30/2025 at 1:55 p.m. Family A stated that Resident #37 had not been offered a shower or bed bath. She stated when Resident #37 asked staff when she could receive a shower, that staff responded with a nasty attitude. Family A could not provide any names of staff or descriptions because they call all the time. During an interview on 10/07/2025 at 1:26 p.m. Resident #37 stated she was happy to report that she received a shower on 10/04/2025 and felt good. Record review of Resident #37's showers sheets for the month of September reflected that the were no shower sheets recorded. During a confidential group meeting on 10/01/2025at 1:35 p.m. 3 of 6 residents stated showers were not being offered or provided on 3 days a week. One (1) of the 3 residents stated that after being admitted to the facility she had not received a shower in 10 days and had asked 3 staff on 3 different occasions when she could receive a shower each time being told they would find out and never returned. The resident was tearful when she stated that a shower was kind of important and (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 676306	If continuation sheet Page 1 of 30

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	felt that it was inhumane to deny a shower. She stated she finally received a shower 09/30/2025 and she had been grateful to have finally washed her hair. The 2nd of 3 residents who had not received a shower stated while he often refused showers to keep his dialysis port dry, often smelled foul, but because he was immune to his own scent had become unaware. He stated he would appreciate the staff telling him when he had a bad odor. The 3rd of 3 residents stated that his shower days were never consistent and changed from week to week. He stated he was always informed that he would only be offered one shower a week. During an interview on 10/02/2025 at 08:09 a.m. with ADM and DON, ADM stated that one of the residents from the confidential group meeting had refused showers due to wanting to keep the dialysis port free of moisture. The ADM stated that no other residents refused showers. DON stated that the facility had wrap coverage specifically to keep one of the residents from the confidential group meeting free of moisture during showers, yet he still refused showers. During an interview on 10/06/2025 at 04:56 p.m. ADM and DON stated that CNAs were to update a resident's POC and shower sheets for every resident on every shower day, noting if the resident accepted or refused the shower or bed bath. DON stated that nurses were responsible for signing off on shower sheets to acknowledge residents received showers. She stated if a resident refused, the nurse was supposed to circle back and encourage the resident to accept a shower document in POC and on the shower sheet the outcome. During an interview on 10/07/2025 at 12:45 p.m. Family B stated that the 3rd of 3 residents in the confidential group meeting had not received regular showers, often smelled foul and of a strong urine scent. Family B stated that the facility had been made known, yet the resident went without regular showers. Record review of logged shower sheets for 3 of 3 confidential group meeting residents revealed: 1 of 3 residents had 1 shower sheet for the month of September which the resident declined a shower, the 2nd of 3 residents had 3 shower sheets for the month of September two of which were dated for the same day by different staff, and the 3rd of 3 residents had no logged shower sheets for the month of September 2025. A record request for a policy on showers was asked for and not received.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, interview, and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received necessary services to maintain personal hygiene for 1 of 1 (Resident #37) and 3 of 5 confidential residents reviewed for ADLs. The facility did not consistently provide Resident #37 and 3 of 5 confidential residents bed baths/showers on their scheduled shower days in the month of September 2025. This failure could place residents at risk of skin breakdown and reduced feelings of self-worth. Findings included: Resident #37: Record review of Resident #37's Face sheet dated 10/01/2025 indicated he was an [AGE] year-old female who admitted to the facility on [DATE] and readmitted on [DATE]. Resident's diagnoses included but were not limited to rotator cuff tear or rupture of unspecified shoulder, essential (primary) hypertension (high blood pressure - heart working too hard to pump blood), hyperlipidemia, age-related osteoporosis without current pathological fracture (condition where bone density decreases due to aging, but the individual has not yet experienced any fractures), acute respiratory failure with hypoxia (failed respiratory system resulting in low blood oxygen), sepsis (life-threatening condition that occurs when the body's immune system overreacts to an infection), hypotension (a condition where the blood pressure falls below normal levels), elevated white blood cell count (cause for infection), non-Hodgkin lymphoma (a group of cancers that originate in the lymph nodes, which are part of the immune system), muscle wasting and atrophy, and muscle weakness. Record review of Resident #37's undated Care Plan did not reflect resident's ADL care needs. Record review of Resident #37's Minimum Data Set (MDS) record was asked for but not received. Observation, interview and other record reviews reflected that residents had been cognitively intact. Record review of Resident #37's Plan of Care (POC) Response History dated 10/07/2025 at 03:49 p.m. for the month of September 2025 reflected that BATHING: SELF PERFORMANCE - How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (excludes washing of back and hair): Activity itself did not occur or family or non-facility staff provided care 100% of the time for that activity on 09/12/2025, 09/14/2025, 09/16/2025, 09/18/2025, 09/20/2025, 09/28/2025. Observation/interview on 09/30/2025 at 01:46 pm. Resident #37 stated that she had not had a shower or bed bath in 9 days. She stated her shower days were Tuesday, Thursday, and Saturday. She stated she would like to receive her showers and/or bed baths when scheduled. and have her bedding changed. During an interview on 09/30/2025 at 1:55 p.m. Family A stated that Resident #37 had not had a shower or bed bath and the resident had to ask for clothes to wipe her face. She stated staff are not offering the residents a shower or bed bath and when they mention to staff, they have a nasty attitude with the residents. She stated she could not provide any names of staff or descriptions because they call all the time. During an interview on 10/07/2025 at 1:26 p.m. Resident #37 stated she finally received a shower on 10/04/2025. She stated she was very happy and felt good. Record review of Resident #37's showers sheets reflected the resident had no recorded showers in the Month of September 2025. During a confidential group meeting on 10/01/2025 at 1:35 p.m. with 6 confidential residents, 3 of 6 residents stated that they do not receive their scheduled showers or bed baths 3 times a week and were lucky if they received 1 once a week. One (1) of the 5 residents stated that she had surgery in the hospital and came straight from the hospital with no shower and asked 3 different staff on 3 different occasions each time was told that they would check on it had would receive no shower. She stated that her shower days were Monday, Wednesday and Friday and because her shower day kept being passed up, a staff told her that they would squeeze her in and gave her a shower on 09/30/2025. She stated on 09/30/2025 was the first shower she had since being discharged from the hospital in 10 days. The resident began to tear up and stated that it had been kind of important to have a shower and had felt inhumane to deny her a shower and she was grateful to have finally washed her hair. One of the 3 residents who had not received a shower stated that due to a dialysis portable they had been known to refuse showers in (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	fear the port would become wet in the shower. He stated as a result he would begin to smell foul, but because he was immune to his own smells he was unaware and then one day a staff member would tell him that he had an odor and should take a shower. He stated that he questioned how he smelled bad before they told him, but no one ever answered him. He stated he would like them to tell him at the first indication he has an odor and not allow him to go days with a bad odor. One of the 3 residents stated that his shower days seem to change, one day it will be on a Friday, then a Thursday and then a Wednesday and never had been consistent. He stated he was told that showers were only once a week. During an interview on 10/02/2025 at 08:09 a.m. with ADM and DON, ADM stated that one of the residents from the confidential group meeting had been the only resident that refused showers. ADM stated that one of the residents from the confidential group meeting had a dialysis port and that the resident wanted to keep the port area dry, and that resident had been afraid if he took a shower, moisture could get inside the port as such avoided showering. DON stated that the facility had to wrap/tape specifically to cover areas needing to remain dry. DON stated that Resident one of the residents from the confidential group meeting refused showers. During an interview on 10/06/2025 at 04:56 p.m. ADM and DON stated that CNAs logged into a resident's electronic clinical file to check off in the POC whether a resident received a shower, refused a shower, or received help with the shower. CNAs were to update a resident's POC on every shower day. DON stated in addition as a second means to ensure that residents receive showers, staff were to fill out shower sheets noting on the sheet if the care had been performed, refused, noted changes in the skin integrity if applicable, sign off and have a nurse sign off as well. She stated if a resident refused, it had been that shift's charge nurse's responsibility to circle back and encourage the resident to accept the shower document in POC and on the shower sheet the outcome. During an interview on 10/07/2025 at 12:45 p.m. Family B stated that 1 of 5 residents in the confidential group meeting had not been receiving their showers and was often found smelling foul from strong scent of urine. Family B stated they had addressed the issue with the facility, but still no increased showers had been provided. Record review of logged shower sheets of 3 of 3 confidential group meeting residents revealed: 1 of 3 residents had no logged shower sheets for the month of September 2025, 1 of 3 residents had 3 shower sheets for the month of September two of which were dated for the same day by different staff, and 1 of 3 residents had 1 shower sheet for the month of September which the resident declined a shower. Record review of policy on showers was asked for and not received.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for 1 of 3 residents (Resident #9) reviewed for quality of care. 1. The facility failed to assess, follow-up with treatment, update the care-plan, obtain new order due to a change in resident #9's skin condition of the groin and resident's report of pain, at which time the penis slit measured 1. 8 cm length by 0.5 cm width and appeared red and raw, which was first identified on 9/22/25 and failed to ensure that Resident #9's indwelling catheter (drains urine from your bladder into a bag outside your body) had a securement device to anchor catheter.2. The facility failed to ensure that CNA B changed her gloves and perform hand hygiene while providing indwelling catheter and incontinent care to Resident #9. 3. The facility failed to ensure CNA G and CNA H did not place foley bag on Resident #9's bed during foley and incontinent care These failures could affect residents in delay of appropriate medical treatment leading to pain, discomfort, and death. Resident #9Record review of Resident #9's face sheet reflected a [AGE] year-old male originally admitted on [DATE] and last re-admitted on [DATE] with medical diagnoses including acute osteomyelitis(serious infection of the bone), cognitive communication deficit, obstructive and reflux uropathy (blockage in the urinary system that prevents urine from draining normally), and history of stroke.Record review of Resident #9's clinical admissions dated 7/3/2025, revealed nothing was marked for genitourinary (urinary system) section such as catheter. He was marked continent of bladder. He had no skin issues documented.Record review of Resident #9's baseline care plan, revealed he was on antibiotic therapy. He was totally dependent on staff for toileting and showering. He required substantial assistance with transferring, such as bed-to-chair and transferring to the toilet.Record review of Resident #9's Comprehensive MDS dated [DATE], revealed his BIMS score was a 10, indicating moderate cognitive intactness. He required total assistance with toileting. Resident #9's toileting transfer and walking 10 feet was not attempted due to current illness, exacerbation or injury.Record review of Resident #9's care plan dated 10/02/2025, revealed he had a focus area of indwelling supra-public catheter, with interventions including checking the tubing for kinks each shift, monitoring for signs or symptoms of discomfort on urination and frequency and pain/discomfort due to catheter and report to MD for s/sx of UTI such as pain. Record review of Resident #9's order summary, he had orders for urinary catheter care every shift (start date 8/11/25), secure catheter to leg with leg strap or tape to prevent pulling (start date 8/11/25) and checking skin assessment schedule and completing skin assessment on date and shift as indicated (start date 8/11/25).Record review of progress notes dated 9/17/2025 revealed Resident #9 had blood in the catheter and briefs. There was no mention of penis slit or injury.Observation of Resident #9's incontinent and Foley care on 10/2/2025, revealed the stat lock(use to secure F/C to prevent pulling) was folded up in the catheter and not secured. Resident #9's penis was red and appeared raw. There was a slit down the center of the penis. While repositioning Resident #9 in the bed, CNA B placed the F/C on the bed with 250 cc of urine in the drainage bag. The ADON later measured the penis slit which was 1.8 cm in length, 0.5 cm in width. Record review of Resident #9's physician's order included: start date of 10/2/2025 for a wound care consult, apply triple antibiotic ointment to slit penis site twice daily X 7days.Record review of Resident #9's TAR (Treatment Administration Record) for September 2025 through October 2025 revealed to monitor every shift the open penile area and notify the MD/NP of any changes. Monitor area every shift for skin integrity. Record review also revealed treatment to monitor every shift the Foley insertion site for redness, irritation every shift for skin integrity, and monitor the Foley Cath, placement for redness, irritation every shift.Record review of the weekly skin assessment from September 2025 and October 2025, revealed no documentation for slit on penis.Interview with CNA B on 10/2/25 at 10:30AM and (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA A on 10/2/25 at 10:32 revealed both saw the slit, when the other C.NA A moved the Foley catheter and Resident #9 said ouch and appeared to be grimacing. CNA A said she did see the resident grimacing. CNA B confirmed also seeing Resident #9 grimacing saying ouch. CNA B said that she was going to tell the nurse that Resident #9's Foley catheter was not secured and she was sorry for placing the F/C with the urine bag on the bed while repositioning Resident #9 in bed. Interview on 10/02/2025 6:27pm - CNA U, revealed he worked 3pm-11pm, for 6 months in the facility, and he had been working for 15 years total as CNA. If there's a resident with an indwelling catheter, they would make sure they had the catheter still inserted, clean the catheter as needed, ensure the catheter was still attached to the leg, and if there was friction the resident could bleed and he would report any bleeding to the nurse. He had noticed bleeding in Resident #9's brief two weeks ago at most. He saw the bleeding and he called the nurse KK and the nurse notified hospice who might have changed the catheter. He had not had any bleeding since. In an interview with hospice nurse RN FF on 10/3/25 at 9:42AM, RN FF said the facility nurse called them about Resident #9 bleeding from the catheter and saturated the brief, RN FF said Reading from their nurses notes said resident had a lot of amount of blood coming from urethra and there no documentation of split to the penis on 9/18/25 at 11:00PM. In an interview with LVN KK on 10/3/25 at 10:20 AM, she said she worked the night the CNA reported to her that Resident#9 was bleeding a lot the first time. She did assess Resident #9 and notifies the family and the doctor. The bleeding was coming from the rectum and he was sent to the hospital. The second bleeding Resident #9 had was from the tip of Resident #9's penis and some was in the urine bag but significant blood around the penis and it was a lot of blood. She said she did notify the hospice nurse and the hospice nurse came to the facility and the F/C was changed by the hospice nurse. LVN KK said she did not notice the slit on the penis. Interview with the ADON on 10/3/25 at 3:30 PM, she said she was the admitting nurse when Resident #9 was admitted on [DATE] and he did not have an indwelling catheter, and at the time he was swollen and had 30-40 lbs. of excessive fluids so putting in a catheter would have caused pain. Resident #9 came back on 8/17/2025 from the hospital with a Foley catheter. She said she just saw the slit on 09/22/2025 when she was changing the Foley but there was no trauma, and it did not look new or that it was hurting him, so she didn't document it. She didn't think she needed to put it in the chart as a trauma or a skin issue because it was healed up. After incontinent care on 10/02/2025, staff did not tell the ADON he was grimacing, or she would have gone in and assessed him. The staff just told the ADON 10/2/2025 that Resident #9 needed a new stat lock. Nurses were to monitor stat locks and that was reflected in the catheter care policy. ADON said, it seemed like the nurses weren't looking at stat lock because it was off. She did not know when it came off. She did not remember why he went to the hospital. She could not recall if anyone checked him for the slit. She did major treatments and nurses did cream treatments twice a day. Nurses would be taking care of the slit. She said the nurse KK who did the re-admission on [DATE] said she did not see any slit. Interview with the DON on 10/3/25 at 3:35 PM, revealed she was told about stat lock being unsecured, and they changed it. She was not aware of the slit prior to the ADON telling her. Nurses did skin assessments. Resident #9 was re-admitted with a lot of edema (swelling) and he had a Foley at that time. If the stat lock was not in place, it could cause trauma and being pulled because the stat lock remained in place. Her expectations for everyone with a stat lock was to be observed during peri-care or other types of care throughout the day and maintained daily. During an interview on 10/3/25 at 10:50 AM, CNA A said that when care was provided to a resident with a catheter, she made sure the catheter was not pulled but did not check for a securement device. She said the nurses were responsible for placing the securement device. She said a catheter that was not secure could come out or cause pain. She said she forgot to wash her hands after change gloves during F/C and incontinent care. She said she had been working with the facility for 1 year and did have the skills check off done. She said that the resident had not complained of pain before and she knew to report to the charge nurse when any resident complained of pain. During an interview on 10/4/25 at 11:00 AM, the ADON said she had been at the facility for 1 year. She said that residents (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with an indwelling catheter should be checked every shift and a securement device should be in place to prevent discomfort and dislodgment. She said she had received competency training on indwelling catheters and care. During an interview on 10/4/25 at 11:43 AM, the DON said the charge nurses were responsible for checking residents with catheters each shift and each resident with a catheter should have a securement device. She said she was responsible for all nursing oversight and training and nurses had been trained on catheter assessment and ensuring a secured device was in place. She said if a catheter was not secure it could cause abrasions and become dislodged. In an interview with the DON on 10/4/2025 at 4:30 PM, the DON stated she was made aware by the CNA involved about the infection control issue during incontinent care. The DON said every staff should wash their hands before and after every care. She said gloves should be changed and the hands should be sanitized after cleaning the resident's buttocks or the resident's front part before touching the any clean items. She said not washing the hands, not changing the gloves, and not sanitizing the hands in between changing of gloves could result in cross contamination and infection. The DON said the expectation was for the staff to remember to wash their hands and change their gloves when transitioning from a dirty area to a clean area, and to sanitize their hands when changing their gloves. The DON said he already did a one-on-one in-service with CNA A and CNA B but would do an infection control in-service for all the staff. She concluded that she would continually remind the staff to be attentive to the procedures for infection control and that he would personally monitor infection control. The DON said she would start in-services with the nursing staff. Interview with the MD (Medical Director) on 10/04/2025 at 3:22pm, revealed she did not know how long the Resident #9 had the slit to his penis. She said it was because of the prolong use of the indwelling F/C. The MD said the DON told her On 10/2/25 about the slit in the penis. She didn't know if it was evaluated on admission. The MD did not know how long the slit was and she did not see bleeding from the area the last time he saw the resident. The MD said she had seen the resident twice and that the NP has seen Resident #9 as well. The facility failed to assess, update the care-plan, and obtain new order due to a change in Resident #9's skin condition of the groin to the physician. Interview with CNA Q on 10/05/2025 at 11:25pm, revealed she worked night shift and received in-services on reporting skin issues to the nurse. If there was bleeding during catheter care, she would report to a nurse or charge nurse. CNA Q would report to the nurse if residents did not have a stat lock or if the lock was unsecured so that residents could get a new one. Interview with LVN G on 10/05/2025 at 10:58pm, she worked the night shift. LVN G had training on catheter and make sure that clamp is there on the leg. Interview, CNA A on 10/05/25 at 3:32 PM revealed the aide worked 13-years. 7am to 3p.m. hall flex halls. Had in-Services on catheter care, reporting skin issues. Catheter Care: make sure that stat lock was there on the leg. Report issues with skin: anything that does not look normal, redness, irritation. Anything urine color abnormalities. Interview Staff/Agency LVN CC on 10/5/25 at 3:46 PM agency nurse. 1st day with the facility, she was working 100 and 300 halls 7am 7p. She got in-service on Foley Catheter today before she started work. Cleaning Catheter, assessing changes for signs of infection. Informs, daughter and family members. Identifying changes in Color of urine, ensure tubing placed properly, no kinks, and placing bag below the bladder. Interview Staff Staff/Lead. CNA MM on 10/5/25 at 3:59 PM, revealed they had been working with the facility for 2-years 8 am to 5pm Monday - Friday. In-services Catheters. See anything swelling, discoloration, report to charge nurse. Report resident with catheter grimacing or in pain during F/C and incontinent care to the nurse. Interview Staff, CNA. WW on 10/05/2025 at 4:02 PM revealed they worked for the facility for 9-years. 7am - 3pm. In-services Catheters: see anything slit or anything abnormal, Strap not secured she would report to the nurse immediately. So they can attend to the residents. Interview Staff with LVN JJ on 10/05/2025 at 4:15 PM. revealed they worked with the facility for 2-months. Had in-service on Catheter, Skin Assessments. Catheter in-service: properly clean, notify the doctor, change of condition, infections signs, placing the Catheter to drain below the bladder. Interview Staff FF on 10/5/25 at 4:28 PM 3pm to 11 pm worked for the past 6-years. Had Catheter in-service all the time, not in the last 2-days. She (continued on next page)		

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

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NAME OF PROVIDER OR SUPPLIER Holly Hall		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 Holly Hall St Houston, TX 77054	
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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	knew how to clean F/C and ensure urine bag was below the bladder, ensuring the urine is clear if not report to the nurse. Interview with C.NA H Agency nurse on 10/5/25 at 4:37 PM works 3pm 11 p.m. She had in-service on Catheter care: making sure it was secured on the leg, check for redness, blood, enlargement, abnormal colors in the bag, report to the nurse. Keep the bag below the bladder during care, to avoid back flow and cause UTI. Any slit on the penis, report to the nurse immediately. Stat Lock to keep F/C tubing secure. Interview LVN LL on 10/05/25 at 4:59 PM revealed that she received in-service on catheter care today. Assess Resident F/C site if in pain, immediate call charge nurse. Ensure catheter stat lock stabilized on his leg. If blood was seen in brief, assess resident, call the charge nurse, so she can evaluate. Notify the doctor right away. Inform the nurse of any changes in condition.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to ensure each resident had acceptable parameters of nutritional status such as usual body weight or desirable body weight range for discharged (DC #1) Resident and 8 of 8 residents reviewed for weight loss. 1. The facility failed to maintain acceptable parameters of nutritional status such as usual body weight or desirable body weight range for 1 of 1 discharged resident (DC) #1 and 8 of 8 (Resident #7, Resident #9, Resident #10, Resident #16, Resident #23, Resident #29, Resident #37 and Resident #42) residents, reviewed for weight loss. 2. The facility failed to ensure 3 of 3 scales used for weight were calibrated accurately. 3. The facility failed to follow up with significant weight losses discovered on 09/10/2025 for DC #1, Resident #7, Resident #9, Resident #10, Resident #23, Resident #29, and Resident #42. These failures had the potential to affect other residents requiring weight management, especially those who have weight loss and weight gain and who could be at risk of serious harm due to poor nutrition and weight loss. Findings included: Resident #10: Record review of Resident #10's Face Sheet dated 10/03/2025 indicated he was an [AGE] year-old male who admitted to the facility on [DATE]. Resident's diagnoses included but were not limited to Parkinson's disease movement disorder that affects the nervous system and causes tremor, stiffness, slowing of movement and other problems), Type 2 diabetes mellitus (insulin resistance and high blood sugar levels) without complications, chronic systolic/diastolic (congestive) heart failure (affecting the heart's ability to pump blood effectively and leading to fluid buildup in the body), and chronic obstructive pulmonary disease (COPD) (ongoing lung condition caused by damage to the lungs). Record review of Record review of Resident #10's quarterly (Minimum Data Set) MDS assessment dated [DATE] indicated he had no Brief Interview for Mental Status (BIMS) score indicating resident was unable to complete the interview. Section K - Swallowing/Nutritional Status. K0100. Swallowing Disorder Signs and symptoms of possible swallowing disorder: Complaints of difficulty or pain with swallowing. K0200. Weight: 147 lbs. Weight on most recent measurement in last 30 days. Measured weight consistently, according to standard facility practice (for example (e.g.), in a.m. after voiding, before meal, with shoes off, etc. (etcetera). K0300. Weight Loss, No, loss of 5% or more in the last month or loss of 10% or more in last 6 months. Weight Gain. No, gain of 5% or more in last month or gain of 10% or more in last 6 months. K0520. Nutritional Approaches. While a resident, mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids). Record review of Record review of Resident #10's Care Plan undated reflected:- Focus date initiated 06/22/2023, 01/15/2024 Revision on: 09/03/2025: Resident had dehydration or potential fluid deficit related to (r/t) use of diuretics.- Goal dated initiated 06/23/2023, revision on 09/11/2025, and target date of 12/18/2025: Resident will be free of symptoms of dehydration and maintain moist effectiveness. mucous membranes, good skin, turgor through review date.- Interventions/Tasks:o Administer medications as ordered dated 06/22/2023, revised on 03/18/2025o Monitor/document for side effects and effectiveness.o Laboratory (labs) test dated 06/22/2023, revised on 06/22/2023: Blood, Urine, Nitrogen (BUN) and creatinine (tests to determine kidney functionality) as ordered. dated.o Monitor vital signs as ordered/per protocol and record dated 06/22/2023, revised on 03/18/2025. Notify MD of significant abnormalities.o Monitor/document/report to MD PRN signs/symptoms (s/sx) of dehydration: decreased or no urine output, concentrated urine, strong odor, tenting skin, cracked lips, furrowed tongue, new onset confusion, dizziness on sitting/standing, increased pulse, headache, fatigue/weakness, dizziness, fever, thirst, recent/sudden weight loss, dry/sunken eyes.- Focus date 01/15/2024, revision on 09/03/2025: Resident had nutritional problems or potential nutritional problems.- He had a mechanically altered diet. He was to comply with recommended diet through review date. Date Initiated: 07/01/2025 Target Date: 12/18/2025. Honor his food preferences Date Initiated: 07/01/2025. All to monitor his hydration and encourage fluid intake at and between meals (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Date Initiated: 01/15/2024 Revision on: 07/01/2025, Dietary Staff (DS) and (Certified Nursing Assistant) CNA Monitor my weight monthly/weekly. Date Initiated: 07/01/2025 CNA Registered Dietitian (RD). Provide and serve supplements as ordered. Date Initiated: 07/01/2025. Provide diet as ordered. Monitor intake and record every (q) meal, Date Initiated: 07/01/2025 DS, CNA Pureed diet as ordered Date Initiated: 09/03/2025. Record review of Resident #10's labs dated 06/13/2025, noted Resident #10 had an Albumin (test to measure malnutrition) was low indicating the resident was malnutrition. Record review of Resident #10's admission weight dated 06/02/2025 reflected the resident weighted (147 lbs.), then on 09/04/2025 was (157.0), and then on 09/08/2025 was (147 lbs.), reflecting a -6.8% loss within 4 days. Record review of Resident #10's Nutritional Risk assessment dated [DATE] reflected Resident #10 had a body mass index (BMI) of 21.9 (considered to be in the healthy weight range), no known allergies (NKA) pureed, regular diet, pureed texture, thin liquids, with health shakes 3-times a day (TID, meal intake 50-75%, and adequate fluid intake, at risk for unintended weight loss due to under ideal body weight, pureed diet, varying po intake, assisted with meals, risk for dehydration due to assisted with meals, varying by mouth (po) intake, no nutritional diagnosis at this time focus area of nutritional problems. Had no significant weight changes, stable weight trend over last 6 months. Record review of Resident #10's weights reflected:08/04/2025 at 02:59 p.m. 155.0 Lbs. by wheelchair lift scale recorded by Lead CNA08/18/2025 at 09:00 a.m. 159.0 Lbs. by wheelchair lift scale recorded by Agency Nurse A.09/04/2025 at 10:21 a.m. 157.0 Lbs. measured on the mechanical/hoyer lift by ADON.09/04/2025 at 01:38 p.m. 147.0 Lbs. by wheelchair lift scale recorded by Lead CNA09/08/2025 at 01:07 p.m. 147.0 Lbs. by wheelchair lift scale recorded by CNA K.09/15/2025 at 11:16 a.m. 160.0 Lbs. sitting scale recorded by Agency Nurse A. (Manual) 09/29/2025 at 12:50 p.m. 160.2 Lbs. measured on the wheelchair lift scale recorded by Lead CNA 10/3/2025 at 12:26 p.m. 160.0 Lbs. measured on the mechanical/Hoyer lift by ADON. Record review of Resident #10's Dietary Consultant Report Resident Nutritional Recommendations/Review dated 10/5/2025 and completed by Medical Doctor (MD) reflected: Problem or concern: Increased nutrient needs r/t abnormal labs: As evidence by (AEB) Albumin (test to determine liver and kidney function) low (level may result from liver disease, kidney disease, malnutrition, or inflammatory). Recommendation:1. Recommended: liquid protein 30 cubic centimeters (cc) once a day (QD) times (x) 30 days.2. Record weekly weights x 4 weeks. Record review of Resident #10's 10/05/2025 at 04:38 p.m. Dietitian Progress Notes completed by RD A reflected that the resident's October, 2025 weight was 160.0 lbs., BMI: 22.3 (considered to be in the healthy weight range). The resident had a previous weight loss r/t possible error in weight documentation. Weight (Wt) stable x 6 mo. On Regular, pureed diet with regular thin liquids. House Shake TID, with meals. Resident had 50-75% average food intake, per task reports. Increased nutrient needs r/t abnormal labs AEB low Albumin of 2.6. Recommend liquid protein 30cc QD x 30 days. Recommend weekly weights x 4 weeks. Goal: Stable wt of 160 lbs. +/- 4%. Interview on 10/03/2025 at 10:31 a.m. MD stated that she had been the attending physician for Resident #10. She stated that resident's weights fluctuate, but that she had expected that as the resident was up and down with an overload of fluid. She stated that she would prefer weight loss for a resident while overload of fluids. Resident #10 was unavailable for observation and interview. Resident #37: Record review of Resident #37's Face sheet dated 10/01/2025 indicated she was an [AGE] year-old female who admitted to the facility on [DATE] and readmitted on [DATE]. Resident's diagnoses included but were not limited to rotator cuff tear or rupture of unspecified shoulder (tendons tear/damage), essential (primary) hypertension (high blood pressure - heart working too hard to pump blood), mixed hyperlipidemia (elevated levels of both cholesterol and triglycerides in the blood, increasing the risk of cardiovascular diseases), age-related osteoporosis without current pathological fracture (condition where bone density decreases due to aging, but the individual has not yet experienced any fractures), chronic atrial fibrillation (irregular and often rapid heart rhythm that can lead to stroke, heart failure and other complications), sepsis (life-threatening condition that occurs when the body's immune system overreacts to an infection), hypotension (a condition where (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the blood pressure falls below normal levels), elevated white blood cell count (cause for infection), non-Hodgkin lymphoma (a group of cancers that originate in the lymph nodes, which are part of the immune system), muscle wasting and atrophy, muscle weakness (generalized), organism, cellulitis of left lower limb, pseudomonas (aeruginosa) (mallei) (pseudomallei) (antibiotic resistant bacteria) as the cause of diseases classified elsewhere, unspecified open wound, left lower leg, subsequent encounter, displaced fracture of distal pole of navicular [scaphoid] bone of right wrist, subsequent encounter for fracture with nonunion, and pain in joints of right hand. Record review of Resident #37's undated Care Plan reflected:- Focus Date Initiated: 09/18/2025. Resident #37 had nutritional problems or potential nutritional problems r/t abnormal labs.- Goals Date Initiated: 09/18/2025, Target Date 10/01/2025 Target Date: Resident will maintain weight of _admit wt_lbs +/- __5% by review date.- Interventions/Task Date Initiated: 09/18/2025.o Honor my food preferences.o Monitor resident's weight monthly/weekly.o Monitor/document/report to MD as needed (PRN) for signs/symptoms (s/sx) of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appears concerned during meals.o Monitor/record/report to MD PRN s/sx of malnutrition: Emaciation, muscle wasting, significant weight loss: 5lbs in 1 week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months.o Obtain and monitor lab/diagnostic work as ordered Date Initiated: 09/18/2025. Report results to MD and follow up as indicated.o Provide and serve supplements as ordered.o Provide diet as ordered. Monitor intake and record q meal.o RD to evaluate and make diet change recommendations PRN.o Record review of Resident #37's Baseline Care Plan dated 09/12/2025, resident had a regular diet and required supervised meal assistance. Record review of Resident #37's Minimum Data Set (MDS) record was asked for but not received. However, observation, interview, and other record reviews reflected that residents had a high level of cognitive functionality. Record review of Resident #37's hospital discharge weight dated 09/05/2025 reflected resident weighed (132.4 lbs.). Record review of Resident #37's labs dated 09/15/2025 and 09/23/2025 reflected BUN/creatinine ratios were (high) indicating resident was possibly dehydrated. Record review of Resident #37's Nutritional Risk assessment dated [DATE] reflected resident was at risk for weight loss and unintended dehydration. Resident #37's 09/05/2025 hospital discharge weight was (132.4), then on 09/22/2025 was (153.0 lbs.), on 09/28/2025 was (153.0). Staff reported on 09/18/2025 that Resident #37 good appetite, ate 75-100% that morning. Resident #37 was at risk for unintended weight loss and dehydration, no diagnosis (given related to the causes). Focus area of nutritional problems or potential nutritional problems r/t abnormal labs. Record review of Resident #37's Dietary Order dated 09/22/2025 reflected, Diet change, start/change supplement: yogurt 2x day. Breakfast/lunch. Dated/signed ADON 09/22/2025. Record review of Resident #37's weights reflected:09/22/2025 14:44 153.0 Lbs Mechanical Lift Lead CNA (Manual) 09/28/2025 12:23 153.0 Lbs Mechanical Lift Lead CNA (Manual) 10/2/2025 20:05 153.0 Lbs Lift Scale Lead CNA (Manual)10/4/2025 11:00 156.4 Lbs Mechanical Lift , by ADON (Manual) Record review of Resident #37's updated Dietary Consultant Report Resident Nutritional Recommendations/Review dated 10/03/2025 completed by RD B reflected that the resident received a consultation, and the resident should continue current diet, receive c weekly weights times (x) 4 weeks to continue to monitor for weight changes. Record review of Resident #37's updated Dietary Consultant Report Resident Nutritional Recommendations/Review dated 10/05/2025 reflected, continue current diet. Record weekly weights x4 weeks to continue to monitor for weight changes. During an observation on 10/01/2025 at 05:39 p.m. Resident #37 had been observed being weight by DON and Lead CNA resulting in a weight of 161.0. Interview on 10/01/2025 at 03:39 p.m. Resident #37 stated that she weighed 135 lbs. before she was admitted to the hospital on [DATE]. She stated she had not been weighed at the facility since admitting on 09/12/2025. Interview on 10/01/2025 at 04:36 p.m. with Lead CNA who is the CNA supervisor and responsible for taking and recording resident weights and ensuring any calibration or mechanical issues with the scales are reported to maintenance. He stated that the mechanical lift which the facility referred to as the wheelchair scale, may have some (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	calibration issues because it several attempts to get the scale to zero out or bring the weight to zero to weight residents. He stated he would reach out to the maintenance supervisor to have the scale calibration company maintenance the scale. He stated that the last scale calibration was in August of 2025. He stated Resident #37 was last weighed on 9/28/25 with the Hoyer lift scale which requires two staff members to operate. Interview on 10/01/2025 at 04:45 p.m. Resident #37 stated that she had not been weighing since she has been admitted . She stated that the facility used a Hoyer lift to move her from the bed to the chair and back a few days ago. She stated if the Hoyer lift measured her weight no one ever told her how much she weighed. She agreed that her hospital's discharge weight of 132.4 seemed correct but was surprised that her recorded weight on 09/28/2025 with the facility was 153.0. She stated however, that she had a lot of fluid on her due to her edema diagnosis, and in turn, a lot of fluid was pulling off her also. She agreed to be weighed. Interview on 10/01/2025 at 04:56 p.m. ADON stated that she had assisted Lead CNA Supervisor weight Resident #37 on 09/28/2025 with the mechanical Hoyer weight lift scale. She stated she agreed that the resident's weight recording of 153.0 on that day was accurate. Interview on 10/01/2025 at 05:19 p.m. Family A stated that on 09/28/2025 Resident #37 had been observed being transferred from a chair into resident's bed by a Hoyer lift. Family A stated that ADON and Lead CNA asked the resident what her approximate weight had lasted. Family A stated that the staff insinuated that they needed to know the resident's current weight to make sure that the resident had been the right weight for the Hoyer lift. Family A stated that staff had not shared that the Hoyer lift had been weighing the residents. Family A stated that Resident #37's last weight had been 153.0 lbs. Family A stated she had no issues with the resident's weight, but that the facility should not have stated they had been weighing the resident if they had not been. Interview on 10/03/2025 at 10:31 a.m. MD stated that she had been the attending physician for Resident #37 who had a weigh of 153.0 lbs. MD stated that Resident # had a fair appetite with some constipation that had been addressed. She stated it had been normal for the resident's weight to have fluctuate due to the resident's edema diagnosis. Resident #9: Record review of Resident #9's Face Sheet dated 10/03/2025 indicated he was a [AGE] year-old male who admitted to the facility on [DATE]. Resident's diagnoses included but were not limited to Osteomyelitis (serious bone infection caused by bacteria or fungi), atherosclerotic (heart disease) of native coronary artery (heart muscle), benign paroxysmal vertigo (inner ear disorder causing brief episodes of dizziness or spinning sensations), type 2 diabetes mellitus (chronic disease, high levels of sugar in blood) without complications, and staphylococcus (bacterial infection) as the cause of diseases classified elsewhere. Record review of Resident #9's undated Care Plan reflected:- Focus Date Initiated Date Initiated: 07/08/2025 and Revision on: 10/03/2025o I have nutritional problems or potential nutritional problems r/t diagnoses, would healing and I am on hospice. o I prefer to drink my own bottled water. I do not wish to drink from the water pitcher at bedside.- Goal revised on: 10/03/2025. Target Date 01/01/2026.o I will maintain weight of 204 lbs. +/-5% by review date.- Interventions/Tasks: Date initiated: 07/08/2025, Revision on 10/03/2025.o Administer medications as ordered. Monitor/document for side effects and effectiveness.o Carb controlled diet as ordered date initiated:08/19/2025o Honor my food preferences date initiated: 07/08/2025o Monitor my hydration and encourage fluid intake at and between meals date initiated: 07/08/2025.o Monitor my weight monthly/weeklyo Date initiated 07/08/2025o Monitor/document/report to MD PRN for x/sx of dysphagia: Pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appears concerned during meals. Dated 07/08/2025, revision on 10/03/2025o Monitor/document/report to MD PRN for x/sx of malnutrition: Emaciation, muscle wasting, significate weight loss: 5lbs in 1 week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months. Date initiated 07/08/2025.o Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Date initiated: 07/08/2025. Revision on 10/03/2025.o Provide diet as ordered. Monitor intake and required 1 meal. Date initiated 07/07/2025.o Provide me with assistance as needed at meal times. Date initiated:07/08/2025.o RD to evaluate and make diet change (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	recommendations PRN. Date initiated: 07/08/2025. Revised on: 08/11/2025. Record review of Resident #9's MDS dated [DATE] reflected the resident had a BIMS score of 10 indicating that the resident had moderate cognitive impairment. Section K - Swallowing/Nutritional Status. K0100. Swallowing Disorder, none. K0200 Weight: 261 lbs. Weight on most recent measurement in last 30 days. Measured weight consistently, according to standard facility practice (for example (e.g.), in a.m. after voiding, before meal, with shoes off, etc. (etcetera). K0300. Weight Loss, No, loss of 5% or more in the last month or loss of 10% or more in last 6 months. Weight Gain. No, gain of 5% or more in last month or gain of 10% or more in last 6 months. K0520. Nutritional Approaches. While a resident, therapeutic diet (e.g., low salt, diabetic, low cholesterol) Record review of Resident #9's labs dated 07/28/2025 reflected BUN/creatinine ratios were (high) indicating possibly dehydrated. No additional labs noted. Record review of Resident #9's Nutritional Risk Assessment Resident Effective Date 07/08/2025 11:45 a.m. reflected hospital discharge weight of 197 lbs. BMI 28.3. Usual food percentage 75-100% at risk for unintended weight loss and dehydration due to wound healing. Record Review Resident of Resident #9's 08/08/2025 Diet Order reflects, Regular diet. Labs dated 07/28/2025 BUN 55/Creatinine 1.51 (both high), ratio is 36 (high). Record review of Resident #9's Nutritional Risk Assessment Resident Effective Date: 08/11/2025 at 01:24 p.m. created by RD B. admission Weight of 261.0 lbs. BMI 37.4. Resident readmitted with Wt gain of 33 lbs. (14.5%) x 1 mo. Reweight requested. Fluid gain. Weight trend over last 6 months: Weight gain. Fluid status: Edema. DIET ORDER 1. Diet Order: Consistent Carbohydrate Diet (CCHO), regular texture, thin liquids. Feeding self, needs assistance. BUN/creatinine level 55H/1.51H (high, indicating potential kidney issues). PERTINENT MEDICATIONS 1. Including diuretics, antipsychotics, antidepressants: spironolactone 25mg twice a day (BID), lasix 20mg TID, senna, morphine, levothyroxine. On hospice care. Wt loss and general decline may be unavoidable. Record review of Resident #9's weights reflected:08/07/2025 04:42 p.m. 261.0 Lbs Mechanical Lift [NAME] (Manual)08/12/2025 09:44 a.m. 258.0 Lbs Mechanical Lift ADON (Manual) 09/04/2025 01:38 p.m. 205.0 Lbs Lift Scale Lead CNA09/08/2025 12:52 p.m. 204.0 Lbs Lift Scale CNA K (Manual)09/29/2025 02:02 p.m. 204.0 Lbs Lift Scale CNA B (Manual)10/01/2025 08:55 p.m. 204.0 Lbs Mechanical Lift CNA K (Manual) Record review of Resident #9's Dietary Order dated 10/05/2025 at 12:04 p.m. reflected residents' weights:10/03/2025 180.6 lbs. -5.0% change. Comparison from09/04/2025, 205.0 Lbs, -11.9% , -24.4 Lbs] -7.5% change, comparison from08/07/2025, 261.0 Lbs, -30.8% , -80.4 Lbs] -10.0% change, comparison from07/03/2025, 228.0 Lbs, -20.8% , -47.4 Lbs] BMI: 25.9. Resident # 9 was readmitted with fluid gain. Diet downgraded to pureed. Continuing with poor intake, resident now on hospice care. Wt loss and general decline may be unavoidable. Surgical incision to R heel. No recommendations at this time for comfort care. Goal: comfort care. Record Review Resident of Resident #9's 10/03/2025 Diet Order reflects, Regular Pureed diet. Record review of Resident #9's updated Dietary Consultant Report Resident Nutritional Recommendations/Review dated 10/03/2025 completed by RD B reflected weight loss, hospice, wound - continue comfort care. Record Review Resident of Resident #9's Progress Notes dated 10/04/2025 at 06:38 p.m. reflected. MD and RD A notified of 23 lbs. weight loss. Hospice aware. Awaiting further instruction. Interview on 10/02/2025 at 01:30 p.m. ADON stated that the scale calibration company came out 10/02/2025 and found that the sitting chair scale showed it was off +9 lbs. She stated she was unsure how long the sitting scale had not been weighting correctly. She stated that it appeared that the Hoyer lift/mechanical scale had been rounding resident's weights to the nearest whole number. She stated that the facility was waiting on the calibration company to provide the final report for the standing/wheelchair scale and Hoyer Lift/mechanical scale results. She stated that the facility staff had planned to reweigh every resident. She stated most of the residents were skilled patients and outside of the initial weights, weights were not monitored because those residents usually had not stay longer than a month for any dietary/weight concerns to be reported. She stated that the facility had not been monitoring any residents for excessive weight loss or gain. She stated that a weight summary report was generated at the beginning of every month (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Holly Hall		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 Holly Hall St Houston, TX 77054	
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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	outlining resident's weight progress. She stated by the end of every week; Lead CNA had been responsible for ensuring residents were weighed and new weights entered the resident's electronic clinical file. She stated that all clinical staff including the CNAs were able to enter weights into a resident's electronic clinical file. She stated that CNAs had not had the viewing privileges to view what a resident's previous weight had been so it was impossible for them to enter a duplicate without weighing a resident. She stated that since the weight discrepancies have been identified, the facility's weight policy has been updated to include: CNAs no longer having had access to document weights into a resident's electronic clinical file, all weights will have been taken using the standing/wheelchair scale along with a designated wheelchair when applicable, and a weight book had been created where all residents' weights will be recorded, and signed off by a nurse verifying the weights taken were accurate. She stated that the facility provided training in-service to the staff that weights were no longer rounded to the nearest whole number. She stated once resident's weights were verified as accurate, either ADON and/or DON, will enter the weight into the electronic clinical file. She stated no residents had been effective by the weight discrepancies. Interview on 10/02/2025 at 5:39 p.m. DON stated that she had been in her role for a little over a 1 year. She stated that the facility performed a weight audit on 10/01/2025 and found some inconsistent weights: Resident #9 had a weight recorded on 10/01/2025 at 08:55 p.m. by CNA K. She stated the time of day the weight was recorded had been suspicious to her because the facility staff should not be weighing residents at night. DON stated CNA K had been interviewed and had entered Resident #9's weight of 204.0 lbs. based on the resident's previous weight from 09/29/2025 rather than weighing the resident. She stated that CNA K had not given her an explanation as to why he had entered the weight without weighing the resident. She stated that CNA K received training on how to weight resident's from the Lead CNA. DON stated that the facility completed a monthly weight summary report at the beginning of each month outlining resident's weight progress. DON stated that ADON ran the weight report for October 2025 and DON had not been made aware of any residents with significant weight loss/gains. She stated the resident's weight report had been shared with RD A. She stated she was not aware if RD A had any dietary recommendations for any of the residents based on the October 2025 weight report. She stated that the facility had their September 2025 QAPI meeting at the end of September 2-weeks prior and no weight discrepancies were brought up or addressed. She stated that the weight summary report compares weights for 30/60/90 days making it clear to identify significant weight loss/gains. DON stated that the importance of recording accurate resident weights had been to be advised of any negative effects from a loss/gain of weight and avoid implanting a delayed intervention. She stated a resident's accurate weight had been required for prescribing medication. She stated the ADON had been responsibility to ensure weights were obtained and documented correctly. She stated that she was responsible for ensuring ADON accurately performed her tasks. She stated that ADON had been over weights and Lead CNA had been assisting with those weights. She stated that the facility had disabled the capacity for CNAs to enter resident's weights due to the inconsistencies. Interview on 10/02/2025 at 06:09 p.m. CNA K. stated he had worked for the facility for 6 months, normally worked on the 3 p.m. - 11 p.m. shift, and had been a CNA for 15 years. He stated he had been responsible for entering resident weights. He stated on this day the DON asked him about a weight entered on 10/01/2025 for Resident #9. He stated he told DON he had not weighed Resident #9 on 10/01/2025 because he had not had enough time and was in a hurry to come off shift. He stated that he entered in the resident's last recorded weight as the resident's new weight. He stated he had not done that before and should have taken the resident's weight before recording it. He stated the importance of capturing a resident's accurate weight had been to know if a resident had accurate weight loss/gain for the proper administration of medication, care, and treatment. He stated inaccurate weights could result in a resident being misdiagnosed. He stated 3 weeks ago he learned from Lead CNA and DON to no longer use the sitting chair scale as it had not been capturing accurate weights and advised to only use the wheelchair scale or the Hoyer lift scale. Interview on 10/03/2025 (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	at 10:31 a.m. MD stated that she had been the attending physician for Resident #9. MD stated that the resident admitted with puffiness and received a diuretic, to reduce the swelling. MD stated that the resident's condition had declined and as a result the resident had begun receiving hospice services, and the resident's weights could decline rapidly at any point. Resident #7: Record review Resident #7's Facesheet dated 10/01/2025 reflected the resident was a [AGE] year-old male who admitted to the facility on [DATE] with diagnosis that included but were not limited to malignant neoplasm of esophagus, neoplastic (malignant) related fatigue, weakness, muscle wasting and atrophy. Record review Resident #7's undated Care Plan reflected:- Focus: Date Initiated 09/04/2025.o I have nutritional problems or potential nutritional problems and weight loss r/t and diagnosis of malnutrition.- Goal: Date Initiated 09/04/2025.o I will maintain weight of 150 lbs. +- by review date.- Interventions: Date Initiated 09/04/2025.o Provide me with fortified foodso Honor my food preferenceso Monitor my hydration and encourage fluid intake at and between meals.o Monitor my weight monthly/weeklyo Monitor/document to MD PRN for s/sx of dysphagia: Pocketing, Choking, coughing, drooling. Holding food in mouth. Several attempts at swallowing, refusing to eat, appears concerned during meals.o Monitor/record/report to MD PRN s/sx of malnutrition: Emaciation, muscle wasting, significant weight loss 5 lbs in 1 week, >5% in 1 month, >7.5% in 3 months, >1-%in 6 months.o Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated.o RD to evaluate and make diet change recommendations PRN.o Regular diet, regular texture, thin consistence Record review of Resident #7's MDS/BIMS asked and not received. Record review Resident #7's Dietary Order dated 08/29/2025 reflected resident required a NKA allergy, regular diet and texture diet. Resident #7 required assistance with eating. Record review Resident #7's RD Order dated 09/01/2025 for monthly weights. Weight on 09/02/2025 was (160 lbs.) and then on 09/04/2025 was (150 lbs.) reflecting a weight loss of 6.3% within 2 days.Record review Resident #7's 09/04/2025 Nutritional Risk Assessment reflected resident had a regular diet, regular thin liquids, possible error weight measurement. Resident's 09/02/2025 weight 160 lbs. and then on 09/04/2025 had been 150 lbs. Resident eating more than >50% q meal, 50-75%, at risk for unintended weight loss, at risk for dehydration. Record review of Resident #7's Dietary Order dated 09/05/2025 no allergies, fast-mimicking diet. Record review Resident #7's weights reflected: 9/2/2025 12:30 a.m. 160.0 Lbs Wheelchair CNA P (Manual)9/4/2025 01:38 p.m. 150.0 Lbs Wheelchair Scale Lead C.N.A (Manual) - 5.0% change [Comparison Weight 9/2/2025, 160.0 Lbs, -6.3% , -10.0 Lbs]9/13/2025 01:00 p.m. 148.4 Lbs Wheelchair Agency Nurse A. (Manual) - 5.0% change [Comparison Weight 9/2/2025, 160.0 Lbs, -7.2% , -11.6 Lbs]9/28/2025 01:01 p.m. 148.4 Lbs Wheelchair Lead CNA (Manual) - 5.0% change [Comparison Weight 9/2/2025, 160.0 Lbs, -7.2% , -11.6 Lbs] Record review Resident #7's Labs dated 09/18/2025 reflected BUN 11 creatinine .65 (low), ratio within range. Record review Resident #7's Labs dated 10/03/2025 reflected normal ranges. During an observation on 10/01/25 at 3:29 p.m. Resident #7 was weighed on the standing/wheelchair scale by Lead CNA Resident #7 weighed 156.8 lbs. During an i[TRUNCATED]		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that its medication error rate was not 5 percent or greater. The medication error rate was 22 percent with 8 errors out of 36 opportunities involving 3 of 3 staff members (MA A, MA B and LVN R) and 2 of 7 residents (Resident #14, Resident #39, Resident #37 and Resident #18) reviewed for medication administration. MA A did not administer Vitamin D (medicine used to maintain strong, healthy bones) and Carvedilol (a medication used to help your heart by lowering blood pressure) to Resident #14 as ordered by the physician on 9/30/25. MA A did not administer Ferrous Sulfate (a drug used to treat iron -deficiency anemia) as ordered by the Physician on 9/30/2025 to Resident #39. MA B did not administer cetirizine Hydrochloride (helps to relieve common allergy symptoms), Chewable tab Gas Relief (Simethicone 80 mg) and Eliquis (blood thinner) as order by the physician on 9/30/25 to Resident #37. LVN R did not administer Lisinopril (used to treat high blood pressure by relaxing your blood vessels) and Geri-Kot (used to relieve occasional constipation) via Gastrostomy Tube as ordered by the physician to Resident #18 on 10/1/2025. These failures could place residents at risk of not receiving the intended therapeutic benefits of prescribed medications. Findings included: Record review of Resident #14's face sheet revealed a [AGE] year-old female admitted on [DATE] . Her diagnoses included weakness, adult failure to thrive, frequency of micturition (frequent urination), other specified abnormal findings of blood chemistry, cervicgia (pain in the neck region), occlusion and stenosis (narrowing) of bilateral carotid arteries, essential primary hypertension(high blood pressure), spondylosis without myelopathy or radiculopathy, lumbar region, (age-related wear and tear of the spine that causes symptoms like pain and stiffness, but does not involve nerve damage) chronic kidney disease, stage 3 unspecified, muscle wasting and atrophy, not elsewhere classified, right lower leg, muscle wasting and atrophy, not elsewhere classified, left lower leg, other lack of coordination, muscle weakness (generalized), unsteadiness on feet, shortness of breath, pain, unspecified, cognitive communication deficit, unspecified protein-calorie malnutrition, hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease, chronic kidney disease, stage 3a, other chronic pain, unspecified urinary incontinence, anxiety disorder, osteoarthritis (degenerative joint condition causing pain and stiffness), unspecified site, insomnia (lack of sleep), age-related osteoporosis (disease that weakens the bone) without current pathological fracture Record review of Resident #14's admission MDS assessment dated [DATE] revealed a BIMS score of 5 out of 15 which indicated severe cognitive impairment. She needed extensive assistance with 1-2 staff for ADLs. Record review of Resident #14's Physician Order Report dated 09/11/2025 revealed an order for Cholecalciferol Oral Tablet (Cholecalciferol) Vitamin D Give 1000 unit by mouth one time a day for supplement and Carvedilol Oral Tablet 25 MG (Carvedilol) Give 1 tablet by mouth two times a day for blood pressure with meals HOLD FOR SBP<110, HR<60 (0.5 mg). 1. In an observation on 9/30/25 at 8:AM MA A prepared and administered Carvedilol F/C 25 mg tablet 1 tablet from the blister packet had Take with meal and picked up OTC bottle of Vitamin D 25mcg (25 mcg equivalent 1000 iU) 4 tablets by mouth along with other additional medications to Resident #14. Resident #14 was not eating a meal and was not given any snacks before administering medications. Resident #14 had breakfast tray at bedside not open. In interview on 9/30/25 at 8:31 AM with MA A, she was asked if Resident #14 has had breakfast, MA A said not yet, she had to be fed and then said a staff would be coming very soon to feed Resident #14. At 8:33AM, C.NA K was seen entering Resident #14's room to feed MA A was shown the blister packets of Carvedilol F/C 25 mg tablet (that indicated to be given with meals, and MA A said, I did not read that, am very sorry. 2. Record review of Resident #39's face sheet revealed a [AGE] year-old female admitted on [DATE], readmitted on [DATE] to the facility. Her diagnoses included gout, unspecified (abnormal deposit of uric acid in joint, causing pain), elevated blood-pressure reading, without (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	diagnosis of hypertension, unspecified fall, initial encounter, hypothyroidism (low thyroid hormone which affects metabolism), unspecified, presence of cardiac pacemaker, localized swelling, mass and lump, head, polyneuropathy (disease that affects the nerves especially in the hands and feet), unspecified intestinal obstruction, unspecified as to partial versus complete obstruction, muscle weakness (generalized), other abnormalities of gait and mobility, unsteadiness on feet, myopathy (disease affecting the skeletal muscle), unspecified, acute embolism and thrombosis of unspecified deep veins of right lower extremity (blood clots), difficulty in walking, not elsewhere classified, and cognitive communication deficit. Record review of Resident #39's quarterly MDS assessment dated [DATE] revealed a BIMS score was blank which indicated cognitive impairment. She needed extensive assistance with 1-2 staff for ADLs. Record review of Resident #39's Physician Order Report dated 11/25/24 revealed an order of Ferrous Sulfate give 1 tablet by mouth daily. Record review of Resident #39's MAR dated 9/30/25 reflected Ferrous Sulfate 1 tablet was initiated as given at 9:00AM. In an observation on 9/30/25 at 8:34 AM, MA A, did not administer Ferrous Sulfate 1 tablet by mouth. In an interview with MA A on 10/1/25 at 5:20 PM regarding not administering Ferrous Sulfate and initialed as given at 9:00 AM. She said it was an oversight. MA B said she had training on medication monthly by the ADON and she monitors her pass medication. 2. Record review of Resident #37's face sheet revealed an [AGE] year-old female admitted on [DATE], to the facility. Her diagnoses included asthma (difficulty breathing), overactive bladder, essential (primary) hypertension (high blood pressure), mixed hyperlipidemia (high cholesterol), age related osteoporosis without current pathological fracture (inflammation of the bone), chronic atrial fibrillation (irregular heart beat), pain in right shoulder, pain in left shoulder, unspecified rotator cuff tear or rupture of unspecified shoulder, not specified as traumatic, acute respiratory failure with hypoxia (low oxygen in the blood), sepsis (bacterial infection of the blood), unspecified organism, hypotension (low blood pressure), unspecified, elevated white blood cell count, unspecified, pneumonia (infection in the lungs), unspecified organism, non-Hodgkin lymphoma (blood cancer), unspecified, unspecified site, unspecified fall, initial encounter, insomnia, unspecified, muscle wasting and atrophy, not elsewhere classified, right lower leg, muscle wasting and atrophy, not elsewhere classified, left lower leg, other lack of coordination, muscle weakness (generalized), bronchopneumonia (bacterial infection of the lungs), unspecified organism, cellulitis of left lower limb (infection of the skin), pseudomonas (aeruginosa) (mallei) (pseudomallei) as the cause of diseases classified elsewhere (a type of bacteria found in the environment that can cause illness), unspecified open wound, left lower leg, subsequent encounter, displaced fracture of distal pole of navicular [scaphoid] bone of right wrist, subsequent encounter for fracture with nonunion, (fracture of the bone near the hand and fingers) and pain in joints of right hand. Record review of Resident #37's quarterly MDS assessment dated [DATE] revealed her BIMS score was 14 of 15 which indicated no cognitive impairment. She needed extensive assistance with 1-2 staff for ADLs. Record review of Resident #37's Physician Order Report dated 11/25/24 revealed an order of: 1. cetirizine Hydrochloride 10 mg, give 0.5 tablet by mouth one time a day (order date 9/22/2025). 2. Simethicone oral tablet 80 mg. Give 1 tablet by mouth three times a day for bloating for 3 days, (start date 9/27/25) and 3. Apixaban (Eliquis) oral 5 mg, give 1 tablet by mouth two times a day for anti-coagulation therapy related to chronic atrial fibrillation (start date was 9/12/25) Record review of Resident #37's MAR dated 9/30/25 reflected cetirizine Hydrochloride 10 mg, give 0.5 tablet by mouth one time a day, Simethicone oral tablet 80 mg. Give 1 tablet by mouth three times and Apixaban (Eliquis) oral 5 mg, give 1 tablet by mouth two times a day. In an observation on 9/30/25 at 8:59AM, MA B, punched Apixaban (Eliquis) oral 5 mg, 2 tablets from the blister pack, (MA B was stopped before giving the medication to Resident #37 at 9:08 AM). Cetirizine Hydrochloride 5 mg, give 2 tablets, OTC bottle had Chewable tab Gas Relief (Simethicone 80 mg) poured 1 tablet, MA B poured it with in the medication cups with other medications and administered. In an interview with MA B on 10/1/25 at 5:20 PM regarding Cetirizine Hydrochloride 5 mg, giving 2 tablets instead 1 tablet Cetirizine Hydrochloride and punching Apixaban (Eliquis) oral 5 mg, 2 tablets (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	from the blister pack instead of 1 tablet (5mg) of Apixaban, MA B said, because you are standing there and she said she knew it can cause bleeding if Apixaban administer wrongly. MA B was asked about the chewable tab Gas Relief (Simethicone 80 mg) administered by mouth with other medications. MA B said Simethicone 80 mg was just ordered for TID (three times a day), the order of Simethicone did not have it to be chewed. MA B was asked if she had any training on medication administration. MA B said she was working through an agency about 4 to 5 times, she said she did not have any training she only signed some papers. Record review of Resident #18's face sheet revealed a [AGE] year-old male admitted on [DATE], to the facility. His diagnoses included Alzheimer's disease with late onset (neurodegenerative disease affecting memory and thinking), unspecified severe protein-calorie malnutrition, essential (primary) hypertension (high blood pressure), hyperlipidemia (high cholesterol), unspecified, chronic obstructive pulmonary disease (disease affecting the lungs making it hard to breathe), Gastrostomy tube ((a surgically placed tube through the abdominal wall into the stomach, providing a route for delivering nutrition, medications, and fluids directly into the digestive system when a person cannot eat or drink adequately by mouth) diabetes mellitus due to underlying condition with hypoglycemia without coma (high blood sugar), gastro-esophageal reflux disease without esophagitis (when acid from the stomach flows back to your throat). Record review of Resident #18's quarterly MDS assessment dated [DATE] revealed a BIMS score was blank which indicated severe cognitive impairment. He needed extensive assistance with 1-2 staff for ADLs. Record review of Resident #18's Physician Order Report dated 1/1/25 revealed an order of:Lisinopril Oral Tablet 20 MG (Lisinopril) Give 1 tablet via PEG-Tube (gastrointestinal tube) one time a day for HTN] (HOLD IF SBP < 110) (order date 1/1/2025)Sennosides Oral Tablet 8.6 MG (Sennosides) Give 1 tablet via PEG-Tube two times a day for constipation (order date 1/1/2025) Record review of MAR dated 1/1/25 reflected Lisinopril Oral Tablet 20 MG (Lisinopril) Give 1 tablet via PEG-Tube one time a day and Sennosides Oral Tablet 8.6 MG (Sennosides) Give 1 tablet via PEG-Tube two times a day. In an observation on 10/1/25 at 8:26AM , LVN R punched Lisinopril Oral Tablet 20 MG, crushed and poured in the medicine cup and diluted it with 10cc of water and crushed Sennosides Oral Tablet 8.6 MG (Sennosides) She crushed the medications into a powder form in each medication cup, dissolved it in water, LVN R did not ensure she got all the medication out of the medication cup during administration. LVN R used 60 cc syringe tip to stir, then aspirated medication and plunged it via G Tube. LVN R then aspirated 30cc of water and plunged it via G Tube and was about to throw all medicine in the trash when the surveyor stopped LVN R and showed her medicine left in the medicine cup. In an interview with LVN R on 10/1/25 at 9:20AM regarding powered medications in the cup and if she was supposed to plunge water and medication via G Tube. LVN R said she was supposed to rinse the medication cups and she was going to rinse the medication cups and for plunging water and medications, LVN R asked the Surveyor how was she supposed to give the medication. LVN R said not giving all the medications could cause slow therapeutic effects. She said she was working through a nursing agency, and she did not have any training at the facility. In an interview on 10/2/25 at 4:13 PM the DON said the staff should read the MAR and blister packets before medication administration to Residents. She said she expected nursing staff to ensure the medication order and inventory matched because the correct dosage needed to be provided to the resident, and pharmacy recommendation for chewing the medications were not followed, it could cause stomach cramps and other drug interactions .The DON said regarding G Tube medications, it should be given as ordered by gravity unless ordered by the doctor to push/plunge it via G Tube. The DON said not giving medication by gravity could cause air in the stomach and could dislodge the tube. DON was asked if agency nurses were given orientation in the facility, DON said the facility does not give any in- services because each nurse was answerable to her license. In an interview on 10/2/25 at 4:22 PM the Administrator said he expected nursing staff to follow the physician's orders. She said charge nurses, or the nurse managers oversaw medication administration. Record Review of facility's policy Medication Administration Procedures with revised (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	date of April 2019 revealed .4. Medications are administered in accordance with prescriber orders, including any required time frame.5.Medication administration times are determined by resident need and benefit, not staff convenience. Factor that are considered include:a. enhancing optimal therapeutic effect of the medication,b. preventing potential medication or food interactions.		

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NAME OF PROVIDER OR SUPPLIER Holly Hall		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that residents were free of significant medication errors for 2 (Resident #14 and Resident #18) of 5 residents reviewed for pharmacy services. MA A did not administer Carvedilol (medication used to help your heart by lowering blood pressure) to Resident #14 as ordered by the physician on 9/30/25. LVN did not administer Lisinopril (used to treat high blood pressure by relaxing your blood vessels) via Gastrostomy Tube. She crushed the medications into a powder form in each medication cup, dissolved it in water. LVN R did not ensure she got all the medication out of the medication cup during administration, as ordered by the physician to Resident#18 on 10/1/2025. Findings included: 2. Record review of Resident #14's face sheet revealed a 93 years female admitted on [DATE]. Her diagnoses included weakness, adult failure to thrive, frequency of micturition (frequent urination), other specified abnormal findings of blood chemistry, cervicgia, occlusion and stenosis (narrowing)of bilateral carotid arteries, essential primary hypertension(high blood pressure), spondylosis without myelopathy or radiculopathy, lumbar region,(age-related wear and tear of the spine that causes symptoms like pain and stiffness, but does not involve nerve damage) chronic kidney disease, stage 3 unspecified, muscle wasting and atrophy, not elsewhere classified, right lower leg, muscle wasting and atrophy, not elsewhere classified, left lower leg, other lack of coordination, muscle weakness (generalized), unsteadiness on feet, shortness of breath, pain, unspecified, cognitive communication deficit, unspecified protein-calorie malnutrition, hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease, chronic kidney disease, stage 3a, other chronic pain, unspecified urinary incontinence, anxiety disorder, osteoarthritis, unspecified site, insomnia (lack of sleep), age-related osteoporosis without current pathological fracture Record review of Resident #14's admission MDS assessment dated [DATE] revealed a BIMS score of 5 out of 15 which indicated severe cognitive impairment. She needed extensive assistance of 1-2 staff for ADLs. Record review of Resident #14's Physician Order Report for 09/11/2025 revealed an order for Carvedilol Oral Tablet 25 MG (Carvedilol) Give 1 tablet by mouth two times a day for blood pressure with meals HOLD FOR SBP<110, HR<60 (0.5 mg). In an observation on 9/30/25 at 8:AM MA A prepared and administered Carvedilol F/C 25 mg tablet 1 tablet from the blister packet had Take with meal. In interview on 9/30/25 at 8:31 AM MA A was asked if Resident #14 has had breakfast, MA A said not yet, she had to be feed and a staff would be coming very soon to feed resident#14 At 8:33AM, C.NA K was seen entering Resident #14's room to feed MA A was shown the blister packets of Carvedilol F/C 25 mg tablet (that indicated to be given with meals, MA A said I did not read that, am very sorry. Record review of Resident #18's face sheet revealed a 73 years- male admitted on [DATE], to the facility. His diagnoses included Alzheimer's disease with late onset, unspecified severe protein-calorie malnutrition, essential (primary) hypertension, hyperlipidemia, unspecified, chronic obstructive pulmonary disease, Gastrostomy tube ((a surgically placed tube through the abdominal wall into the stomach, providing a route for delivering nutrition, medications, and fluids directly into the digestive system when a person cannot eat or drink adequately by mouth) diabetes mellitus due to underlying condition with hypoglycemia without coma, gastro-esophageal reflux disease without esophagitis.Record review of Resident #18's quarterly MDS assessment dated [DATE] revealed a BIMS score was blank which indicated severe cognitive impairment. He needed extensive assistance of 1-2 staff for ADLs. Record review of Resident #18's Physician Order Report for 1/1/25 revealed an order of:Lisinopril Oral Tablet 20 MG (Lisinopril) Give 1 tablet via PEG-Tube one time a day for HTN (HOLD IF SBP < 110) (order date 1/1/2025) Record review of MAR dated 1/1/25 reflected Lisinopril Oral Tablet 20 MG (Lisinopril) Give 1 tablet via PEG-Tube one time a day. In an observation on 10/1/25 at 8:26AM, LVN R punched Lisinopril Oral Tablet 20 MG, crushed and poured in the medicine cup and diluted it with 10cc of water, LVN R did not (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ensure she got all the medication out of the medication cup during administration. LVN R used 60 cc syringe tip to stirred, then aspirated medication and plunged it via G Tube. LVN R then aspirated 30cc of water and plunged it via G Tube and was about to throw all medicine in the trash when the surveyor stopped LVN R and showed her medicine left in the medicine cup. In an interview with LVN R on 10/1/25 at 9:20AM regarding powered medications in the cup and if she was supposed to plunged water and medication via G Tube. LVN R said she was supposed to rinse the medication cups and she was going to rinse the medication cups and for plunging water and medications, In an interview on 10/2/25 at 4:13 PM the DON said the staff should read the MAR and blister packet before medication administration to Residents. She said she expected nursing staff to ensure the medication order and regarding G Tube medications, it should be given as ordered by gravity unless ordered by the doctor to push/plunge it via G Tube. Record Review of facility's policy Medication Administration Procedures with revised date of April 2019 revealed .4. Medications are administered in accordance with prescriber orders, including any required time frame.5.Medication administration times are determined by resident need and benefit, not staff convenience. Factor that are considered include:a. enhancing optimal therapeutic effect of the medication,b. preventing potential medication or food interactions.		

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F 0779 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep signed and dated reports of x-rays and other diagnostic services in the residents record. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to file in the resident's clinical record of radiologic and other diagnostic services for 2 of 8 (Residents #3, #4) residents reviewed for clinical records. -Resident #3's blood test result ordered on 9/14/2025 was not in his medical records reviewed on 10/08/2025.-Resident #4's blood test results ordered on 2/8/2025, 3/16/2025, 3/18/2025 and 4/11/2025 were not in his medical records reviewed on 10/08/2025.This failure puts residents at risk of not having a complete picture of their current health status in their records.Findings included:Resident #3Record review of Resident #3's face sheet dated 10/06/2025 reflected an [AGE] year-old male originally admitted on [DATE] and last re-admitted on [DATE] with medical diagnoses including cerebral infarction (stroke), dysphagia (difficulty swallowing), acute myeloblastic leukemia not having achieved remission (type of cancer affecting bone marrow, active), multiple myeloma (type of cancer affecting the white blood cells that produce antibodies that are a part of the body's immune system) and immunodeficiency (low immune system function which increases risk of infection).Record review of Resident #3's Quarterly MDS dated [DATE] reflected a BIMS score of 13, indicating high cognitive intactness. Record review of Resident #3's care plan dated 10/06/2025, revealed he had a focus area of chemotherapy treatment dated 06/16/2025 with interventions including educating resident / representative on the importance of routine laboratory monitoring. Record review of Resident #3's active order summary report dated 10/06/2025 reflected an active order for cbc (cbc is a blood test that measures different types of blood cells to monitor for health conditions, infections and cancer) cmp (cmp blood test measures overall health especially function of liver and kidneys) dx MM (diagnosis of multiple myeloma) with an order date of 09/14/2025.Record review of Resident #3's labs on 10/06/2025, revealed his lab ordered on 09/14/2025 was not uploaded to his electronic medical records.Resident #4Record review of Resident #4's face sheet dated 10/07/2025 reflected a [AGE] year-old male originally admitted on [DATE] and last re-admitted [DATE] with medical diagnoses including muscle weakness, diabetes mellitus (high blood sugar), hyperlipidemia (high cholesterol), hypertension (high blood pressure), atherosclerotic heart disease (plaque buildup leading to hardening of the arteries), atrial fibrillation (irregular heart beat) and heart failure.Record review of Resident #4's Quarterly MDS dated [DATE] reflected a BIMS score of 06 indicating severe cognitive impairment related to thinking and memory. Record review of Resident #4's care plan dated 10/07/2025, revealed he was last care-planned for pressure ulcers due to decreased mobility and incontinence with interventions including obtain and monitor lab/diagnostic work as ordered. Resident #4 was also care-planned for coronary artery disease with a diagnosis of hyperlipidemia with interventions including giving meds as ordered and monitoring cholesterol levels and report findings, and care-planned for diabetes mellitus with an intervention of fasting serum blood sugar as ordered by doctor. Record review of Resident #4's active order summary report dated 10/07/2025 reflected the following active orders for labs:-order date of 02/09/2025 for HGB A1C dx DM (glucose test for a diagnosis of diabetes)-order date of 03/16/2025 for cbc cmp tsh (tsh test hormones that control metabolism, energy levels, and overall bodily functions) dx sacral ulcer (an ulcer located in the sacrum which is the tailbone)-order date of 05/10/2025 for cbc cmp tsh dx chf -order date of 06/30/2025 for CBC CMP TSH HGB1AC DX DM-order date of 08/01/2025 for CBC CMP TSH HGB A1c dx dmRecord review of Resident #4's labs on 10/07/2025, revealed his labs ordered on 02/08/2025, 03/16/2025, 03/18/2025 and 04/11/2025 were not uploaded to his electronic medical records. Interview with the Administrator and the DON on 10/07/2025 at 2:52pm, the DON said that Resident #3 went to an off-site cancer treatment center and the medical records staff was responsible for uploading all labs received and should have uploaded Resident #3's labs. The DON did not know why his lab was not uploaded. The DON said that Resident #4's labs should have been automatically transferred from the lab portal to the resident's electronic medical records and upon (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Holly Hall		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 Holly Hall St Houston, TX 77054	
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F 0779 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	review she found that some residents had labs transferred and some did not but that all labs were in the portal but not transferred to the medical records. The DON said she thought labs were fully integrated with the facility's medical records system and she would be following up on ensuring labs are transferred to the facility's system going forward.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents who are fed by enteral means receive the appropriate treatment and services to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers for 1 (Resident #18) of 3 residents for the administration of medication via gastrostomy in that: -LVN R did not administer medication by gravity via gastrostomy tube, per the facility policy, for Resident #18's medication on 10/1/25. This failure placed residents at risk for aspiration (choking), unwanted hospitalization, and decrease in quality of life. Findings included: Record review of Resident #18's face sheet revealed a [AGE] year-old male admitted on [DATE], to the facility. His diagnoses included Alzheimer's disease with late onset, unspecified severe protein-calorie malnutrition, essential (primary) hypertension, hyperlipidemia, unspecified, chronic obstructive pulmonary disease, Gastrostomy tube (a surgically placed tube through the abdominal wall into the stomach, providing a route for delivering nutrition, medications, and fluids directly into the digestive system when a person cannot eat or drink adequately by mouth), diabetes mellitus due to underlying condition with hypoglycemia (low blood sugar) without coma, gastro-esophageal reflux disease without esophagitis (inflammation of the esophagus). Record review of Resident #18's quarterly MDS assessment dated [DATE] revealed the BIMS score was blank which indicated severe cognitive impairment. He needed extensive assistance of 1-2 staff for ADLs. Record review of Resident #18's Physician's Order Report for 1/1/25 revealed an order of: Had NPO (nothing per oral) only GT: Flush feeding tube with 30 ml water before and after administration of meds, flush with 10 cc between each medication every shift. Lisinopril Oral Tablet 20 MG (Lisinopril) Give 1 tablet via PEG] -Tube one time a day for HTN (HOLD IF SBP < 110) (order date 1/1/2025) Sennosides Oral Tablet 8.6 MG (Sennosides) Give 1 tablet via PEG-Tube two times a day for constipation (order date 1/1/225) Record review of Resident #18's MAR dated 1/1/25 reflected Lisinopril Oral Tablet 20 MG (Lisinopril) Give 1 tablet via PEG-Tube one time a day and Sennosides Oral Tablet 8.6 MG (Sennosides) Give 1 tablet via PEG-Tube two times a day. In an observation on 10/1/25 at 8:26AM, revealed LVN R punched out Lisinopril Oral Tablet 20 MG, crushed and poured it in the medicine cup and diluted it with 10cc of water and crushed the Sennosides Oral Tablet 8.6 MG (Sennosides). She crushed the medications into a powder form in each medication cup, dissolved them in water and LVN R did not ensure she got all the medications out of the medication cups during administration. LVN R used a 60 cc syringe tip to stir the Lisinopril and Sennosides mixture, then aspirated the medication (meaning she used the syringe to put the medication into the stomach through the tube)] and plunged it via G Tube. LVN R then aspirated 30cc of water and plunged it via G Tube and was about to throw all medicine in the trash when the surveyor stopped LVN R and showed her the medicine left in the medicine cup. In an interview with LVN R on 10/1/25 at 9:20AM regarding the powered medications in the cup and plunging water and medication via G Tube, LVN R said she was supposed to rinse the medication cups and she was going to rinse the medication cups. For plunging water and medications, LVN R asked the Surveyor how was she supposed to give the medication. LVN R said not giving all the medications could cause slow therapeutic effects. She said she was working through the nursing agency, and she did not have any training at the facility. In an interview on 10/2/25 at 4:13 PM the DON said she expected nursing staff to ensure the medication order regarding G Tube medications should be given as ordered by gravity unless ordered by the doctor to push/plunge it via G Tube. Review of the facility's Administering Medications through an Enteral Tube policy, dated November 2001, reflected: Procedure Purpose: The purpose of this procedure is to provide guidelines for the safe administration of medications through an enteral tube. 12. Administering medication by gravity flow. Pour diluted medication into the barrel of the (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Holly Hall		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 Holly Hall St Houston, TX 77054	
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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	syringe while holding the tubing slightly above level of insertion.b. Open the clamp and deliver medication slowly.Review of the Texas Administrative Code Title 22, Part 11, Chapter 217, Standards of Nursing Practice (TACS217.11(1)(T)) , retrieved from http://www.bon.texas.gov/rr_current/217-11. asp on 03/18/19, reflected the following: (1) Standards Applicable to All Nurses. All vocational nurses, registered nurses and registered nurses with advanced practice authorization shall:. (G) Obtain instruction and supervision as necessary when implementing nursing procedures or practices. (H) Make a reasonable effort to obtain orientation/training for competency when encountering new equipment and technology or unfamiliar care situations; .		

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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 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. Based on observation, interviews and record review the facility failed to ensure all drugs and biologicals were stored securely for one (Nurse Cart A) of three medication carts reviewed for storage of medications. Nurse Cart A had multiple medications open, some had no names and the open date was not written on the medications. [BR1] This failure could place all residents at risk of not receiving the therapeutic benefit of medications, adverse reactions to medications and drug diversion. Findings included: Nurse Cart Observation of the Nurse Cart on 10/02/2025 at 12:40 PM revealed the following medications open, with no names and not dated: 1. Dozolamide Hydrochloride 2% -0.5% opened and not dated 2. Artificial tears lubricant eye drops opened and not dated 3. Latanoprost ophthalmic solution, opened and not dated. In an interview on 10/01/25 at 1:27PM LVN R said the medications were supposed to have an open date when medications were opened because she didn't want to keep it forever. In an interview on 10/1/25 at 1:48 PM, LVN R stated she always checked the medication cart whenever she worked. She would always place an open date on medications to ensure therapeutic effectiveness. LVN R stated she would notify the ADON of the medications not dated. In an interview on 10/4/25 at 2:30 PM for medication storage and medications not dated when opened administration with the DON and Administrator, the DON said the nurses were not supposed to date the ointments. The DON was told most of the ointments and gels on nurse's medication carts had open date on it. Record review of the facility policy on Medication labeling and Storage revised 2001 reflected in part . medication labeling 1. Labeling of medication and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical 2. The medication label includes at a minimum. d. expiration date, when applicable.		

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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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to obtain laboratory services to meet the needs of its residents for 1 of 8 residents (Resident #5) reviewed for clinical records. -Resident #5's labs ordered on 07/31/2025 and 08/09/2025 had collection dates of 08/04/2025 and 08/12/2025 respectively. This failure puts residents at risk of not getting timely care for their conditions. Record review of Resident #5's face sheet dated 10/07/2025 reflected a [AGE] year-old male originally admitted on [DATE] and last re-admitted on [DATE] with medical diagnoses including chronic kidney disease, Parkinson's Disease (a chronic and progressive neurological disorder affecting movement other bodily functions), atherosclerotic heart disease (plaque buildup leading to hardening of the arteries), and hypertension (high blood pressure). Record review of Resident #5's PPS (Prospective Payment System) MDS dated [DATE] reflected a score of 5, indicating severe cognitive impairment related to thinking and memory. Record review of Resident #5's active order summary report dated 10/07/2025 reflected the following lab orders:-order date of 07/31/2025 for cbc, cmp, and tsh dx stroke (cbc is a blood test that measures different types of blood cells to monitor for health conditions, infections and cancer, cmp blood test measures overall health especially function of liver and kidney and the tsh tests hormones that control metabolism, energy levels, and overall bodily functions)-order date of 08/09/2025 bmp (a blood test that monitors several key substances in the body like blood sugar levels and can provide information about kidney function, cbc dx anorexia (eating disorder characterized by restriction of food intake leading to low body weight) Record review of Resident #5's labs on 10/07/2025, revealed his lab ordered on 07/31/2025 was collected on 8/4/2025 and his lab ordered on 08/09/2025 was collected on 08/12/2025 Record review of Resident #5's BMP and CBC labs ordered on 08/09/2025 with a collection date of 08/12/2025 reflected critically high levels of sodium of 160, with a reference range of 146-145 mmol/L and a BUN level of 93 with a reference range of 8-26mg/dL. Interview with the Administrator and DON on 10/07/2025 at 2:52pm, the DON said that Resident #5's lab orders for 08/09/2025 were on a weekend so since it was routine and not a critical lab, it would have taken time for his labs to be completed. She said the labs should have been automatically transferred from the lab portal to the resident's medical chart. The DON said she reached out to the medical record portal company and was investigating why the results did not transfer over.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in the facility's only kitchen reviewed for food safety requirements and kitchen sanitation.-There were 5 boxes of angel hair spaghetti with a best if used by date of 01/29/2025 in the dry storage room.The failure could place residents at risk of foodborne illness and food contamination. During an observation on 09/30/2025 at 8:35am, the surveyor and the DM observed 5 rectangular boxes of angel hair spaghetti on a shelf of the dry storage room with best if used by date of 01/29/2025. The DM took the boxes, reviewed the dates and threw them in the trash in the main kitchen area.During an interview with the DM on 09/30/2025 at 8:35pm, the DM said the boxes should have been thrown out and that he posted reminders for staff around the facility to throw out expired food as everyone was responsible for checking for expired food. He said best if used by meant the quality or peak of the food. He said that he didn't see any risk with the expired boxes being there but that it should have been thrown out and it should not be served. The DM was requested for a policy on expired food.'During an interview with the Administrator and DON on 10/07/2025 at 2:52am, the Administrator said that food should be discarded to ensure safety to residents not getting expired food that could get them sick and that the dietary manager was responsible for discarding expired food items.Record review of the facility's policy on Environmental Services with an effective date of 09/30/2025, there was no specific mention of expired food.		

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain an infection control program designed to provide a safe, comfortable, and sanitary environment to help prevent the development and transmission of diseases for 1 of 3 Residents (Residents #9) and 1 of 2 staff (CNA A) reviewed for infection control. 1. CNA A failed to perform hand hygiene between glove changes when providing incontinent care for Resident #9 on 10/2/25. These failures could place residents at risk for spread of infection and cross contamination. Record review of Resident #9's face sheet reflected a [AGE] year-old male originally admitted on [DATE] and last re-admitted on [DATE] with medical diagnoses including acute osteomyelitis (inflammation of the bone caused by bacteria or fungus), cognitive communication deficit, obstructive and reflux uropathy (urine flow blockage), and history of stroke. Record review of Resident #9's clinical admissions dated 7/3/2025, nothing was marked for genitourinary (genital and urinary) section such as catheter. He was marked continent of bladder. He had no skin issues documented. Record review of Resident #9's baseline care plan revealed he was on antibiotic therapy. He was totally dependent on staff for toileting. He required substantial assistance with transferring such as bed-to-chair and transferring to the toilet. Record review of Resident #9's Comprehensive MDS dated [DATE], revealed his BIMS score was a 10, indicating moderate cognitive intactness. He required total assistance with toileting. Resident #9's toileting transfer and walking 10 feet was not attempted due to current illness, exacerbation or injury. Record review of Resident #9's care plan dated 10/02/2025, revealed he had a focus area of indwelling catheter, with interventions including checking tubing for kinks each shift, monitoring for signs or symptoms of discomfort on urination and frequency and pain/discomfort due to catheter and report to MD for s/sx of UTI such as pain. Record review of Resident #9's order summary dated 10/02/2025, revealed he had orders for urinary catheter care every shift (start date 8/11/25), secure catheter to leg with leg strap or tape to prevent pulling (start date 8/11/25) and checking skin assessment schedule and completing skin assessment on date and shift as indicated (start date 8/11/25). Observation of Resident #9's Foley catheter/incontinent care on 10/02/25 at 10:20 AM with CNA A and CNA B assisting, revealed CNA A washed her hands and donned (put on) clean gloves during incontinent/Foley catheter care. Using the wet wipes, CNA A cleaned the Foley catheter tubing, and she changed gloves 3 times and did not wash her hands or used hand sanitizer. Interview with CNA A (Lead CNA) on 10/02/25 at 10:25 AM regarding her technique of incontinent/F/C care, revealed she said she did a good job. CNA A said she forget to wash her hands or use hand sanitizer, and she knew not washing hands or using hand sanitizer after gloving dirty could result to reinfesting resident. CNA A said she had training for incontinent care and hand washing monthly. During an interview with the DON on 10/03/2025 at 2:25 PM., the DON stated that during the incontinent care, staff should wash their hands or use hand sanitizer with each glove change. The DON said the facility staff had monthly in-services with skills checks. The DON said she was going to start incontinence care and hand washing skill checks. In an interview on 10/5/2025 at 2:05 PM, the DON stated the expectation was that hand sanitizer or hand washing would be performed prior to donning clean gloves. The DON stated that cross contamination could occur if hands were not cleaned prior to donning clean gloves. The DON stated that infections could be prevented through hand sanitizer or hand washing. The DON stated this information was trained during new hire orientation, during In-Service trainings and on annual competency trainings. Record review of the facility's policy entitled, Handwashing/Hand Hygiene, revised December 2021, reflected under the heading Applying and Removing Gloves, perform hand hygiene before applying non-sterile gloves.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676306	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/07/2025
NAME OF PROVIDER OR SUPPLIER Holly Hall		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0814 Level of Harm - Potential for minimal harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, interview and review, the facility failed to dispose of garbage and refuse properly for their only dumpster reviewed for garbage disposal. -The facility failed to ensure the dumpster door was closed.This failure could place residents at risk of infection from improperly disposed garbage. Observation of the dumpster area and interview with the DM on 09/30/2025 at 8:35am, revealed the metal dumpster door was left a quarter of the way open, and some cardboard containers were observed in the dumpster. The DM said it wasn't supposed to be open and he fully closed the door which then began to compress the trash. He reminded staff to ensure the dumpster door was closed while walking back into the building. He said the door should be closed to maintain a clean area, and he had no concerns with pests.Interview with the Administrator and DON on 10/07/2025 at 2:52pm, the Administrator said the dumpster should be closed to prevent residents from going in there and ensure the environment stays clean. The Administrator said pests could go into the dumpster and that could bring pests into the facility. Record review of the facility's policy on Environmental Services-including Dumpster management with an effective date of 09/30/2025 revealed in part, The facility will maintain a clean, safe, and odor-free environment through effective environmental services operations and proper waste management practices .3. Dumpster Use and Maintenance .2. Lids must remain closed at all times to prevent pests and odors .		