STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676369	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2024
NAME OF PROVIDER OR SUPPLIER: Hollymead		STREET ADDRESS, CITY, STATE, ZIP CODE: 4101 Long Prairie Road Flower Mound, TX 75028	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42971 Based on observation, interview, and record review the facility failed to provide the necessary services for residents who are unable to carry out activities of daily living to maintain good grooming and personal hygiene for 1 (Resident #3) of 8 residents reviewed for ADLs. The facility failed to ensure Resident #3 had his fingernails cleaned and trimmed. This failure could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections and a decreased quality of life. Findings include: A record review of Resident #3's Quarterly MDS assessment dated [DATE] reflected Resident #3 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses included cerebral infarction (a loss of blood flow to part of the brain, which damages brain tissue), hemiplegia (paralysis of one side of the body), and other lack of coordination. Resident #3 had a BIMS score of 15 which indicated Resident #3's cognition was intact. He required extensive assistance with personal hygiene. A record review of Resident #3's Comprehensive Care Plan, revised 04/18/24, reflected the following: problem: Personal hygiene - [Resident #3] requires extensive assistance. Goals: [Resident#3] will have oral hygiene, hair combed, and other personal hygiene needs met daily. An observation and interview on 08/06/24 at 10:40 AM revealed Resident #3 was laying in his bed. The nails on both hands were approximately 0.6 centimeter in length extending from the tip of his fingers. The nails were discolored tan and the underside had dark brown colored residue. Resident #3 did not answer the question when he was asked about the nail care. Interview on 08/06/24 at 10:50 AM, RN C stated CNAs were allowed to cut the residents' nails if they were not diabetic. RN C stated she would clean and trim Resident #3's nails right then. RN C stated the risk for not performing nailcare was increased risk of infection. In an interview with the DON on 08/07/24 9:30 AM revealed her expectation was that nail care should be provided as needed, especially during shower time. She stated that CNAs were responsible for doing nail care unless the resident had diagnosis of diabetes. She also stated that as the DON, either herself or her designee were responsible to do routine rounds for monitoring. The DON stated it was the resident's right to have clean and trimmed fingernails. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676369	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2024
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of the facility policy titled Bath-Bed dated March 2013 reflected, . Care of fingernails and toenails is part of the bath. Be certain nails are clean. Fingernails and toenails of diabetic patients are cut by the licensed nurses

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48560 Based on observation, interview, and record review the facility failed to ensure a resident who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan and the residents' goals and preferences for 1 of 2 Residents (Resident #1) reviewed for respiratory care. The facility failed to ensure Resident #1's nasal cannula tubing was labeled or dated. This failure could place residents at risk of respiratory infections. The finding were: Record review of Resident #1's Admission MDS assessment, dated 06/24/2024, reflected Resident #1 was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1's relevant diagnoses included Chronic Obstructive pulmonary disease (lung disease that block airflow and make it difficult to breathe), Diabetes mellitus (high blood sugar levels) and Hyperlipidemia (high levels of lipid in blood) and Hypertension (high blood pressure). Resident#1 had BIMS of 9 , which indicated moderate cognitive impairment. Resident #1 did not have Oxygen indicated on her Admission MDS dated [DATE]. Record review of Resident #1's comprehensive care plan, dated 06/03/2024, reflected, Problems: [Resident #1] has episodes of shortness of Breath and is at risk for respiratory distress/failure: Disease Processes of COPD. [Resident #1] has Oxygen at 2 liters. Goals: Will decrease episodes of Shortness of Breath and no signs and symptoms of respiratory distress/failure over the next 90 days. Interventions: Apply Oxygen per order, encourage to take slow deep breaths. Record review of Resident #1's Physician order, dated 06/19/2024, reflected Oxygen at 3-5 Liter per minute via nasal cannula. Titrate to keep Oxygen level at 90% or above. Record review of Resident #1's Physician order, dated 06/19/2024, reflected Oxygen tubing change weekly 10-6 shift every Sunday and date accordingly. Review of Resident#1's MAR for 8/5/24 revealed there was no notation that the oxygen tubing was changed on 8/5/24. In an Observation and Interview on 08/06/24 at 12:06 PM with Resident #1 revealed she was on continuous oxygen therapy and the nasal cannula tubing was not labeled or dated. Resident #1 stated that she required continuous oxygen therapy since admit to the facility. She stated that nursing had changed the nasal cannula tubing in the last few days but was unable to tell the writer the exact time frame. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 8/6/24 at 12:22 PM with LVN A stated she started working at the facility April 2024. She stated that she changed Resident #2 Nasal cannula tubing on the morning of 8/5/24 since it was kinked and was in a hurry to take care of other residents so did not date the tubing. She also stated that nurses were responsible for labeling and dating oxygen tubing every Sunday night shift and as needed basis. She stated that she did not enter the change on the MAR because she was not sure how to do it. She stated that the risk of not having a date on the oxygen tubing was infection control lapses since it was unknown how long the resident was on the same Oxygen tubing. In an interview on 8/7/24 at 9:15 AM with the DON stated that her expectation was that Nurses were responsible for changing and dating nasal cannula oxygen tubing weekly every Sunday on 10-6 shift or as needed basis. She stated that the risk to resident for not dating nasal cannula tubing was unable to assess when the tube was changed and that could potentially lead to infection control if date change was unknown. She stated nurses were aware that they need to notate on the MAR if tubing was changed on as needed basis. She further stated that she would educate LVN A about entering the oxygen tubing date change on the MAR. In an interview on 8/7/24 at 2:17 PM with the Nursing Manager stated she had been working in the facility for the last 3 years. She stated that it was her expectation that nurses were responsible for dating and labeling oxygen tubing every Sunday on 10-6 shift and on as needed basis. She stated there was a risk of infection if there were no date on the tubing since it would be unknown when the tubing was changed, if any. She stated that there was no facility policy for changing and dating nasal cannula tubing, however it was her expectation that they follow standard nursing protocols and physician orders for oxygen equipment.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48560 The facility failed to provide Resident #2 a divided plate to assist her with eating independently. This failure could affect residents who depended on assistive devices and infringe on the resident's dignity and feeding independence. Findings included: Record Review of Resident #2 Annual's MDS assessment dated [DATE] revealed Resident #2 was a [AGE] year-old female admitted to the facility on [DATE]. Her relevant diagnoses included: Hypertension (high blood pressure), Hyperlipidemia (high blood lipid levels), Hemiplegia (paralysis of half side of the body related to brain damage), Chronic Obstructive Pulmonary disorder (lung disease that block airflow and make it difficult to breathe), and Respiratory failure. Resident #2 had BIMS score of 12 which reflected Resident #2 had moderately impaired cognition. Resident #2 was independent with use of suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident. Record review of Resident #2's Physician orders dated 7/24/2023 reflected, Divided plate every day every shift. Record review of Resident #2's meal ticket for Wednesday Lunch 8/7/24 reflected NSOT (No Salt on Tray) , chopped meats, divided plate. In an observation on 8/7/2024 at 12:13 PM in the main dining room revealed Resident #2 was sitting in the main dining room. The food was served on a regular plate. Resident #2 ate about 1/4th of the plate and left the dining room. No assistive devices were observed to be provided to Resident #2 during lunch. In an interview on 8/7/2024 at 12:25 PM with Resident #2 revealed she was not served on a divided plate, although it was her preference to get food on a divided plate. She stated that it was better to scoop the food when served on a divided plate, and the food does not touch each other. She stated that last time she was served on a divided plate was about few days ago. She stated that she started using a divided plate a year ago related to wrist concerns. In an interview on 8/7/24 at 12:38 PM with the Regional Director of Nutrition Services stated that it was her expectation from the kitchen personnel that if there was an assistive device on the meal ticket, the resident should receive it. She stated that she was not aware of the reason Resident #2 was receiving the divided plate and stated that records indicate Resident #2 had stable weights. She stated that she would conduct an in-service with the kitchen staff regarding reading the meal ticket and providing all the items including adaptive devices listed on the ticket. She stated that the risk to the resident for not providing adaptive device could be possible loss of independent feeding and dignity concerns. (continued on next page)

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	676369	A. Building B. Wing	08/07/2024

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 8/7/24 at 12:46 PM with [NAME] B stated she had worked in the facility for last 4 years. She stated that as a cook, she was responsible for ensuring all the meal tickets were read and residents were served food according to the ticket. She stated that she was aware that Resident #2 was served on a divided dish, however the dish was broken on 8/3/24. She stated that a new divided dish was ordered and delivered on 8/5/24, however she was not aware of it until the time of the interview. She stated that divided dish was an adaptive device, which was on Resident #2 meal ticket and should have been provided. She stated that failure to provide adaptive device could lead to resident's loss of dignity. In an interview on 8/7/24 at 1:19 PM with the Regional Director of Rehabilitation stated that she was not familiar with the Resident #2. She stated that she would have to refer to the electronic health record system for answering questions. She stated that the order for the divided plate was entered by the DON of the facility on 7/24/2023 and resident was on occupational therapy in the past, but not receiving therapy at the time of interview. She stated divided plate was used for residents with difficulty feeding themselves, keeping food on the plate or scooping the food. She added failure to provide adaptive devices such as a divided plate could lead to eating difficulties, decreased independent feeding, and dignity concerns In an interview on 8/7/24 at 2:00 PM with the DON stated that they do not have an in-house occupational therapist at the time of interview. She stated that Resident #2 needed occupational therapy at one point during her stay at the facility but was not receiving therapy currently. She stated that Resident #2 had wrist concerns and the divided plate order was initiated by nursing team. She stated that the order should had been completed. She stated that any resident with need for adaptive device should be provided with one and failure to do so could lead to dignity concerns. Record Review of facility's policy titled, Adaptive equipment dated 11/3/2024 reflected , The facility shall provide adaptive equipment as ordered/recommended by the therapist and/or physician. Purpose: To ensure that all Residents receive the proper utensils/equipment for meals

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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** 42971 Based on observation, interview and record review, the facility failed to maintain an infection control program designed to prevent the development and transmission of infection for one of one resident (Resident #4) observed for infection control. The facility failed to ensure CNA D and CNA E performed hand hygiene while providing incontinence care to Resident # 4. This failure could place the residents at risk for infection. Findings include: A record review of Resident #4's Quarterly MDS assessment, dated 06/28/2024, reflected Resident #4 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses included hemiplegia (paralysis of one side of the body) following cerebral infarction (a loss of blood flow to part of the brain, which damages brain tissue) affecting left side. Resident #4 had a BIMS score of 06 which indicated Resident #4's cognition was severely impaired. Resident#4 required extensive assistance of 2-person physical assistance with toileting hygiene and bathing. In an observation on 08/06/24 at 11:10 AM revealed CNA D and CNA E were providing bed bath to Resident #4. Both CNAs had gloves on, CNA E held resident on her right side, CNA D applied skin barrier cream to the resident's buttocks. Without changing gloves CNA D put a clean brief under Resident #4. Both CNAs assisted Resident #4 onto her left side. CNA E removed and discarded the soiled linen, without changing gloves CNA E helped CNA D to fasten the clean brief. Both CNAs assisted Resident #4 with dressing. CNA D applied lotion to the Resident #4's lower extremities. CNA D removed her gloves and re-gloved without performing hand hygiene. Both CNAs repositioned the resident in the bed. CNA E gathered the dirty clothes and trash, removed her gloves, and left the room. CNA D removed and discarded gloves and washed her hands. In an interview on 08/06/24 at 11:40 AM, CNA D stated she was to wash hands before and after care. CNA D also stated she was supposed to complete hand hygiene after removing the dirty gloves and she supposed to change gloves after she applied the skin barrier cream to the resident's buttocks. CNA D stated she did not change her gloves and she did not complete hand hygiene between change of gloves because she was nervous, and she forgot to do it. CNA D stated she was supposed to complete hand hygiene and change gloves to prevent the spread of infection. In an interview on 08/06/24 at 11:45 AM, CNA E stated she was to change gloves when moving from dirty to clean. She stated she was supposed to change gloves after she discarded the soiled linen. CNA E stated she forgot to change gloves. She stated not changing gloves would put resident at risk for infection. In an interview on 08/07/24 at 9:30 AM, the DON stated her expectation was that staff should complete hand hygiene before and after care. The DON also stated in between care CNA was to complete hand hygiene and change gloves. The DON stated the staff were to change gloves and complete hand hygiene between change of gloves to prevent the spread of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy reviewed August 2015, titled Handwashing/Hand Hygiene reflected, . This facility considers hand hygiene the primary means to prevent the spread of infections . Use an alcohol-based hand rub . for the following situations: . Before moving from a contaminated body site to a clean body site during resident care. After removing gloves .