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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676369	A. Building B. Wing	01/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hollymead	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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 44786 Based on observation, interview, and record review, the facility failed to treat residents with respect and dignity for 1 of 4 (Resident #1) residents reviewed for dignity in that: The facility failed to ensure staff did not stand over Resident #1 while assisting the resident with her meal in her room on 11/13/2024. This failure could affect residents who require assistance with activities of daily living and place them at risk for psychosocial harm due to a diminished quality of life. The findings were: Record review of Resident #1's electronic face sheet, dated 12/31/24 reflected a [AGE] year-old female, who admitted to the facility on [DATE]. Resident #1 had a diagnosis of Metabolic Encephalopathy (brain dysfunction caused by a chemical imbalance), Vascular Dementia (condition that affects memory, thinking, and behavior), Low Back Pain, Anorexia (eating disorder that causes people to obsess about weight and what they eat), Fracture of shaft of Right Humerus (upper arm bone), Fracture of Left Forearm (bone between elbow and wrist), and Anxiety Disorder (mental health condition that causes uncontrollable feelings of fear or anxiety). Record review of Resident #1's Quarterly MDS Assessment, dated 11/05/24, reflected Resident #1 had a BIMS score of 13, meaning Resident #1's cognition was intact. Record review of Resident #1's Care Plan dated, 12/31/24, with an effective date of 05/02/24, reflected Resident #1 had a problem with weight loss. The goal noted on the care plan was for staff to supervise/provide cues and encouragement while Resident #1has food/supplement/snack. The care plan also noted to feed Resident #1 if Resident #1 was not able to feed herself. Resident #1's care plan noted Resident #1 had impaired mobility and required assistance with ADL's and mobility. The care plan noted Resident #1 needed extensive assistance at meals. Observation of a video dated 11/13/24 at 9:52 (unknown if it is AM or PM), reflected Caregiver A standing at Resident #1's bedside with one hand on her hip, as she fed the resident. On 01/02/25 at 2:19 AM, a telephone call was attempted to Caregiver A. Caregiver A did not answer and did not return the phone call. (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

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NAME OF PROVIDER OR SUPPLIER Hollymead		STREET ADDRESS, CITY, STATE, ZIP CODE 4101 Long Prairie Road Flower Mound, TX 75028	

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/02/25 at 5:15 PM, the DON stated she was not aware that Caregiver A stood as she fed Resident #1. The DON stated she would re-educate the staff on feeding. The DON stated the resident and staff should be at eye level during the feeding. The DON stated the resident nor the family informed the facility of any concerns regarding feeding, and now Resident #1 is no longer at the facility. She stated Resident #1 was discharged to a different facility. She stated the resident wanted to go to another facility prior to admitting to this facility, so Resident #1 decided to move to the original desired facility when it became available. The DON stated it was a social type of risk associated with standing while feeding residents. The DON stated the facility had an upcoming skills fair, and she would address the proper way to feed a resident. In an interview on 01/02/25 at 7:30 PM, The Administrator stated the facility had no policy on feeding residents. She stated the staff member who fed the resident should not have been standing. The Administrator stated she was unaware of any issue, and she stated Resident #1 had discharged to a different facility. The Administrator stated she had no major concerns with Caregiver A standing when she fed Resident #1. Record review of the facility's policy titled, Resident Rights, dated 2001, with a revision date of 02/2021, reflected the following: Policy Statement Employees shall treat all residents with kindness, respect, and dignity.

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F 0697

Level of Harm - Actual harm

Residents Affected - Few

Provide safe, appropriate pain management for a resident who requires such services.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 44786

Based on observation, interview, and record review the facility failed to ensure pain management was provided to residents who required such services, 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 pain management.

The facility failed to adequately assess and treat Resident #1's severe breakthrough pain.

This failure could place residents at risk for unnecessary pain, discomfort and a decreased quality of life.

Findings include:

Record review of Resident #1's electronic face sheet, dated 12/31/24 reflected a [AGE] year-old female, who admitted to the facility on [DATE]. Resident #1 had a diagnosis of Metabolic Encephalopathy (brain dysfunction caused by a chemical imbalance), Vascular Dementia (condition that affects memory, thinking, and behavior), Low Back Pain, Anorexia (eating disorder that causes people to obsess about weight and what they eat), Fracture of shaft of Right Humerus (upper arm bone), Fracture of Left Forearm (bone between elbow and wrist), and Anxiety Disorder (mental health condition that causes uncontrollable feelings of fear or anxiety).

Record review of Resident #1's Quarterly MDS Assessment, dated 11/05/24, reflected Resident #1 had a BIMS score of 13, meaning Resident #1's cognition was intact. The MDS also reflected Resident #1 received a scheduled pain regimen and noted that pain assessments should be conducted. Nothing else was noted on the MDS regarding pain management.

Record review of Resident #1's Care Plan dated, 12/31/24, with an effective date of 05/02/24, reflected Resident #1 had a problem with pain management. Resident #1's care plan noted a goal for staff to actively participate in assessment of pain. An intervention noted on Resident #1's care plan was for staff to observe for behaviors that may indicate pain (rubbing, moaning, crying, guarding, withdraw, or agitation).

Record review of a hospital document dated 11/08/24 reflected Resident #1 was treated a week prior for a Left Wrist Fracture, and it noted a splint was in place.

Record review of a hospital document dated 11/12/24 reflected Resident #1 was treatment for a Right Humerus Fracture (long bone in upper arm), to be treated with immobilization.

Record review of Resident #1's physician orders reflected the following:

Tramadol 50 MG tablet, every six hours starting on 11/20/24

Tylenol Extra Strength 500 MG tablet, two times daily, starting on 11/20/24

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F 0697

Level of Harm - Actual harm

Residents Affected - Few

Acetaminophen Extra Strength 500 MG, 1 tablet rectal two times daily, starting 10/29/24, RP notified PRN fever > 100 and pain

A treatment order dated 11/01/24 for Resident #1 to be turned and repositioned every 2 hours by shift

A pain assessment order dated 11/01/24 for Resident #1 to be assessed for pain Can Verbalize by shift Monitor for pain level and pain location

Observation of a video dated 11/23/24 at 8:55 (unknown if it's AM or PM) reflected Resident #1 as she was turned and repositioned on her left side, in bed by Caregiver B. Resident #1 can be seen and heard yelling out in pain as she was returned. Resident #1 stated, You are trying to kill me.

Observation of a video dated 11/24/24 at 9:51 (unknown if it's AM or PM), reflected two staff members turning Resident #1 to her left side. Resident #1 yelled out in pain and appeared to put her hand on her hip area.

Record review of the nurse notes on Resident #1's electronic record reflected the following:

11/22/24 at 22:38 (10:38 PM)

Patient was assessed for pain when she expressed discomfort after being transferred into the bed. Patient was given PRN acetaminophen.

11/25/24 at 14:20 (2:20 PM)

During routine care, resident exhibited signs of discomfort during repositioning, nurse asked resident if she was in pain, resident verbalized pain localized to the right hip. Careful assessment done, no visible swelling, no redness or deformity observed in the right hip area at the time of assessment. Nurse administered scheduled pain medication. (Family Member) requested to transport resident to (hospital name) ER for further evaluation and treatment.

Further review revealed there were no nurse notes on 11/23/24 or 11/24/24 on Resident #1's electronic record.

Record review of the Resident #1's Pain Assessments for November 2024 reflected the following:

dated 11/02/24 noted Resident #1 had a pain face of zero and did not specify how often pain medication was needed

dated 11/11/24 noted Resident #1 had a pain face of 4, noting that meant her pain level was between mild and moderate. It noted Resident #1 needed pain mediation multiple times per day.

dated 11/12/24 noted Resident #1 had a pain face of 2, noting that meant her pain level was mild and did not specify how often pain medication was needed

dated 11/22/24 noted Resident #1 was able to verbalize a pain level of 5, noting pain medication was needed once daily

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Pain assessment dated [DATE] noted Resident #1 was able to verbalize a pain level of 4, noting pain medication was needed once daily dated 11/24/24 noted Resident #1 was able to verbalize a pain level of 4, and did not specify how often pain medication was needed dated 11/25/24 noted Resident #1 had a pain face of 4, noting that meant her pain level was between mild and moderate and did not specify how often pain medication was needed Record review of the Hospital document dated, 11/25/24, reflected the following: Chief Complaint Hip Pain (non-traumatic) Per EMS patient reports sudden onset of right hip pain. History of Present Illness The patient, (Resident #1's name) presents with a chief complaint of right leg pain, specifically noting tenderness in the right hip area upon palpation. Additionally, the patient exhibits some confusion and difficulty answering basic questions, which is thought to be associated with her history of dementia. Past Medical History Diagnosis Osteoarthritis Vitamin D deficiency Physical Exam Musculoskeletal: Cervical back: Normal range of motion and neck supple. Comments: Left wrist in a Velcro splint. Right arm in a sling. Right hip tender to palpation and pain with range of motion. Neurovasc intact distally. Final Result Impression: Right subcapital hip fracture. Findings: Subcapital fracture of the right hip. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Spoke with patient's (family member) regarding test results and she right the bedside. Reviewed images with her. Discussed with Dr. and he consulted in the ER with plan for surgery tomorrow. In an interview on 12/31/24 at 4:22 PM, Resident #1's Family Member stated Resident #1 did not have any hip pain on Friday, 11/22/24. The Family Member stated she was not aware Resident #1 had additional pain from other areas other than her arm injuries. The Family Member stated Resident #1 was already taking pain medications for those injuries. Family Member stated she was notified by facility staff on 11/25/24 that Resident #1 had hip pain. In an interview on 01/02/25 at 11:19 AM, Resident #1's Physician stated she was informed of Resident #1's hip or leg pain on 11/25/24 by facility staff. The Physician stated the resident had recent arm injuries and had pain from that, but the hip pain was new. In an interview on 01/02/25 at 6:03 PM, the DON stated she batched printed all the pain assessments in the electronic record for Resident #1. She stated those are all the pain assessments that were available for Resident #1. The DON stated there was a physician's order for Resident #1 to be assessed three times a day for pain, but when she looked at the electronic record, she could not locate all of the pain assessments. The DON stated staff would look at a resident's face for pain indicators if a resident was not able to verbalize pain. The DON stated if a caregiver tended to a resident, and the resident was yelling out in pain, then the caregiver would have verbally told a nurse, then nurse should have documented she was informed of pain, ensure the resident had taken their scheduled pain medication as ordered. The DON stated then the nurse could give PRN pain medication, and there was an area on the MAR to document that. The DON did not see any PRN medication given for pain for Resident #1. The DON stated that both of Resident #1's arms were fractured at the time, so the staff may have assumed those injuries caused the pain. The DON stated the nurse documentation helped with follow-ups, but she did not feel that not documenting put the resident at a greater risk. The DON stated on 11/23/24, Resident #1 received her scheduled pain medications, Tylenol and Tramadol. She stated she did not receive any PRN medication on 11/23/24. The DON stated no PRN medication was given on 11/24/24 for pain. In an interview on 01/02/25 at 6:29 PM, Caregiver B stated Resident #1 usually screamed anytime staff touched her. Caregiver B stated Resident #1 had been like that a while. Caregiver B stated she tried to be as gentle as possible, but Resident #1 would scream the moment anyone touched her. She stated Resident #1 had injured arms, so she thought that was why she was in pain. Caregiver B stated she did not see or hear Resident #1 complain of hip pain. She stated she did not see her grab her hip. Caregiver B stated she always reported concerns of pain of a resident to the nurse. Caregiver B stated she did not remember which nurse she informed about Resident #1's pain. Caregiver B stated it was her job to tell a nurse, and then it was the responsibility of the nurse to document that concern and to assess the resident. Caregiver B stated sometimes the nurse would say Resident #1 already had pain medication. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	In an interview on 01/02/25 at 7:00 PM, RN C stated she worked with Resident #1. She stated she would have assessed a resident if a caregiver told her the resident was in pain. She stated she would check a resident's face for grimaces if a resident was non-verbal or didn't communicate a lot. RN C stated she would document the pain level. She stated if the pain was abnormal for the resident, then she would have documented in the nurse notes. RN C stated if the pain was not abnormal, then she probably would not document in the nurse notes. RN C stated in the past, when she assessed Resident #1, she hardly ever said she was in pain, and always would say she was okay. She stated generally, Resident #1 did not like to be moved and would try to do things herself. RN C stated Resident #1 would be stubborn at times. RN C stated maybe the resident would yell in pain when being moved, but if she was not in motion when she was assessed by a nurse, she might not have a higher pain level at the time of the assessment. In an interview on 01/02/25 at 7:30 PM, the Administrator stated if a resident was in pain, a caregiver should have reported it to a nurse. She stated the nurse should have assessed a resident after a caregiver told the nurse. The Administrator stated the pain assessments should be noted in the notes or on a pain assessment form. The Administrator stated she had not reviewed Resident #1's chart and had not seen all of the videos. She stated Resident #1 discharged from the facility after her last hospital visit. The Administrator stated she did not know if yelling out was the norm for Resident #1, so she could not say if there were any risks or concerns of pain management. Record review of the facility's policy titled, Pain Management, dated 03/2016, reflected the following: Pain Management 1. A pain assessment must be completed for a patient upon admission, including re-admission, the onset or an increase in pain, quarterly and with any significant change in the patient's condition. 2. Every patient must be assessed for pain utilizing the pain intensity scale (faces/ 0-10) for the nonverbal, cognitively impaired patient. a. Every shift b. Prior to and one hour following the administration of as needed pain medication. c. Prior to and immediately following any invasive procedure, including dressing changes 3. If a Patient's Pain intensity score is ? 1 or has been assessed with non- verbal/non-cognitive signs of Pain; the Pain must be addressed through pharmacological and/or non-pharmacological Pain interventions and documented. 4. If a Patient is assessed with Pain that limits function, the Patient must be screened by appropriate therapy disciplines. 5. If a Patient is assessed for unrelieved Pain, the nurse must notify the attending physician to obtain an order for appropriate Pain management.