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	02/20/2025

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 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** 48560 Based on observation, interview, and record review, the facility failed to ensure residents fed by enteral means received the appropriate treatment and services to prevent complications for 1 (Resident #1) of 2 residents reviewed for enteral nutrition. The facility failed to ensure Resident #1's correct G-tube feeding was administered as ordered by the physician on 2/19/25. This deficient practice could affect residents who receive tube feedings by not receiving the appropriate nutrition and hydration. Findings included: Review of Resident #1's Quarterly MDS assessment dated [DATE] revealed that Resident #1 was an [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included Stroke (interrupted blood flow to the brain) , Hypertension (high blood pressure), Diabetes Mellitus (high blood glucose), Hyperlipidemia (high blood lipids), Anxiety Disorder, Depression, Malnutrition. Resident #1 had a G-tube. Resident #1 had BIMS score of 11 suggesting moderate cognitive impairment. Review of Resident #1's comprehensive care plan revised undated revealed, Focus: [Resident #1] requires Enhanced Barrier Isolation as evidenced by G-tube status. Goal: Will not have any psycho-social concerns and will no longer require isolation within the next 90 days. Intervention: Inform staff and visitors of isolation requirements. Provide protective equipment at entrance to room. Post isolation precautions on the door to the room. Review of Resident #1's Physician order dated 1/21/2025 reflected, Isosource 1.5 Cal Oral Liquid (Nutritional Supplements) Give 250 ml via G-Tube five times a day for supplement. Observation on 2/19/25 at 11:07 AM, revealed LVN A proceeded to feed Resident #1 via G-tube. LVN A performed hand hygiene, wore gloves, opened 1 can of enteral (Enteral nutrition is nutrition delivered into the intestine by a tube is used where nutrition cannot be taken normally by mouth) formula with name Fibersource HN 1.2 She then administered the enteral formula via bolus method (administering formula through a feeding tube in large, rapid doses over a short period) into Resident#1's G-tube. She threw away the empty enteral formula carton in the trash can next to the resident bedside. (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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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 2/19/25 at 11:18 AM, LVN A revealed Resident#1 gets a formula starting by name Iso. She stated she will need to look through Resident #1's Physician orders to find out the exact name. She reviewed the physician orders in the EHR and stated that the G-tube formula's name was Isosource 1.5. She then added that Resident #1 had complained of heart burn with the Isosource 1.5 G-tube formula, and she was going to talk to the physician about changing it. She stated that all medications and supplements including enteral formula should be administered per physician order. She stated that G-tube formula Fibersource HN 1.2 that was administered to Resident #1 was not ordered by the physician. She stated that Isosource 1.5 was more calorically dense than Fibersource HN 1.2 and the risk of administering incorrect formula was resident receiving inadequate nutrition. In an interview and observation on 2/19/25 at 11:44 AM, ADON B revealed her expectation was that nurses should follow physician orders while administering medications and G-tube feeds. She picked up the empty feed carton from Resident #1's room and read the name as Fibersource HN 1.2 She stated that Resident #1 was NPO and dependent on G-tube feeding for all his nutrition needs. She stated Resident #1 was on Isosource 1.5 G-tube formula for nutrition. She stated that they had Isosource 1.5 in the med storage room. Observation of the med storage room revealed facility had 2 boxes (48 cartons) of Isosource 1.5 formula on stock. She stated that the risk of administering incorrect formula could be weight loss and decreased nutrition. She stated that she will educate the nurse regarding following physician orders all times. In an interview on 2/19/25 at 1:17 PM, the DON revealed her expectation was to follow physician orders each time. She also stated that Nurses should be cross checking the physician order for G-tube feeds against the formula and quantity to be administered to the resident. She stated that the two formulas were calorically different, with Isosource 1.5 being more calorically dense and the risk of not providing correct enteral formula was decreased nutrition and decreased quality of care. In an interview on 2/20/25 at 1:06 PM with Dietitian revealed that her expectation was tube feeding should be admisnitered per physician orders. She stated that failure to proivde the correct tube feeding formula can lead to tube feeding complications such as nausea, vomiting, and potential weight concerns. She stated that LVN A informed her yesterday about Resident #1 not tolerating Isosource 1.5 and she will be assessing Resident #1 after the interview. Record review of facility policy titled, Administration of formula via feeding tube Gravity, Bolus, Pump updated March 2019 reflected, To administer nutrients to Patients who are unable to eat normally, without complications; to assure proper absorption of nutrients by proper administration, without side effects . Bolus Method: Open formula and pour prescribed amount into a graduated container .

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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** 48560 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 1 (Resident #1) of 2 residents observed for infection control. The facility failed to ensure LVN A donned the appropriate PPE (personal protective equipment) required for EBP (enhanced barrier precautions) during administering G-tube (external tube inserted in the stomach to provide nutrition and hydration) for Resident #1 who was on enhanced barriers precautions on 2/19/25. These failures could place residents at risk for infection and cross contamination of pathogens and illness. Findings included: Review of Resident #1's Quarterly MDS assessment dated [DATE] revealed that Resident #1 was an [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included Stroke (interrupted blood flow to the brain), Hypertension (high blood pressure), Diabetes Mellitus (high blood glucose), Hyperlipidemia (high blood lipids), Anxiety Disorder, Depression, Malnutrition. Resident #1 had a G-tube while admitted as a resident in the facility. Resident #1 had BIMS score of 11 suggesting moderate cognitive impairment. Review of Resident #1's comprehensive care plan revised undated revealed, Focus: [Resident #1] requires Enhanced Barrier Isolation as evidenced by G-tube status. Goal: Will not have any psycho-social concerns and will no longer require isolation within the next 90 days. Intervention: Inform staff and visitors of isolation requirements. Provide protective equipment at entrance to room. Post isolation precautions on the door to the room. Record review of physician orders dated 2/20/25 revealed Resident #1 did not have orders for Enhanced Barrier precautions. Observation on 2/19/25 at 11:07 AM, revealed Resident #1 had EBP signage on the door. LVN A entered Resident #1's room, performed hand hygiene, donned gloves, she did not wear a gown or any other PPE that was indicated for EBP. LVN A checked G-tube residuals and administered the water flushes and feeding via G-tube. In an interview on 2/19/25 at 11:18 AM, LVN A revealed she had worked in the facility for about 6 months. She stated that EBP was required for all residents that had wounds or external devices such as catheters. She added PPE for EBP was gowns and gloves and any additional PPE per resident condition. She stated that she forgot to don a gown while administering G-tube feeding to Resident #1. She also stated that PPE for EBP was necessary to prevent infections and failure to do so can cause increase 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	In an Interview on 2/19/25 at 1:17 PM, the DON revealed her expectation was all direct care staff follow Enhance Barrier precautions (EBP) while providing high contact resident care to resident with who had central line, urinary catheter, or G-tube. She added that gowns and gloves were the minimum level of PPE required for EBP resident care activities. However, as part of Standard Precautions, additional PPE may be required depending on the resident. She stated that failure to follow EBP while providing care can put residents at greater risk for infection. The DON stated that all staff were trained on EBP precautions and PPE to be used. She added she will ensure that all direct care staff was retrained on EBP. Competency skill checks for LVN A for EBP was requested from the facility. The competency skillcheck list for LVN A for EBP was not provided by the date and time of exit. Record review of facility policy titled, Enhanced Barrier Precautions dated August 2020 reflected, Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents .2.a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.); and wound care (any skin opening requiring a dressing)