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	04/03/2026

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

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to immediately consult with the resident's physician accident involving the resident which results in injury and has the potential for requiring physician intervention, and/or a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) for 1 or 5 residents (Resident #1) reviewed for notification of physician of change of condition and falls. 1. The facility failed to ensure the physician was notified of Resident #1's fall on 04/02/2026. 2. The facility failed to ensure the physician was notified of Resident #1's pneumonia diagnosis when she was hospitalized on [DATE].3. The facility failed to ensure NP E was notified of the extent Resident #1's injuries from her fall on 04/02/2026. This failure could result in physicians not being able to provide thorough care and lead to negative or adverse outcomes to a resident's health. Findings included:Record review of Resident #1's face sheet revealed a [AGE] year-old woman admitted with a primary diagnosis of Huntington's Disease (neurodegenerative disorder characterized by chorea, which involves involuntary, dance-like movements, along with cognitive and psychiatric symptoms). Other pertinent diagnoses included bipolar disorder (mental health condition causing extreme mood swings), mild cognitive impairment (decline in memory or thinking skills, trouble with language), major depressive disorder (persistent low mood, profound sadness), abnormalities of gait and mobility (unusual patterns of walking or movement), and lack of coordination (difficulty in controlling voluntary movements). Record review of the video of Resident #1's fall on 04/02/2026 at 12:42 a.m. revealed Resident #1 was walking from her bathroom towards her bed (the long side of the bed was against the wall). Resident #1 turned her body, with her back facing the bed. Resident #1 leaned back with what appeared to be intentions of falling into bed, but Resident #1 did not make contact with the bed and fell backwards and landed on the floor. Resident #1 had a lounge chair in her room that made it unclear if she had hit her head on the floor or wall during the fall. Resident #1's body motion during the fall made it appear that she most likely hit her head. Resident #1 struggled to get up from the fall, but it was not seen when she got herself up from the fall. Record review of Resident #1's care plan, revised 04/03/2026, reflected: Initiated 05/17/2025: [Resident #1] is at risk for falls related to [sic] Hunington?s disease. [Resident #1] has documented history of falls and has been observed to independently rise after falling, subsequently reporting the incident to nursing staff. [Resident #1] refuses to use her walker related to spasticity.9/22/25: unwitnessed fall, with bruise10/2/25: unwitnessed fall, no injuries10/26/25 witnessed fall, no injuries1/15/2026: fall with major injury to right clavicle.1/19/26 unwitnessed, fall, no injury2/1/26. unwiseness fall, no injury3/30/26 unwitnessed fall, delayed bruises to bilateral [sic] eyes0 observed on 4/2/26Date Initiated: 05/17/2025Revision on: 04/03/2026Interventions included to anticipate and meet resident needs, to be sure call light was within reach and encourage resident to use it for assistance as needed, to keep door partially open to frequently check on resident, to educate resident/family/caregivers about safety reminders and what to do if fall occurred, to ensure resident wore proper footwear, to follow facility fall protocol, to (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	frequently round, to increase nursing rounds with resident, to keep environment free of clutter, to review medication, to rearrange furniture in resident's room to accommodate with needs, and therapy to educate resident on walker safety. Initiated 03/31/2026: [Resident #1] requires hospice as evidenced by terminal illness: G10-Huntington's DiseaseInterventions included hospice assist with ADLs and provide comfort measures as needed, monitor for decreased appetite and pain, report decline in condition to hospice agency, weekly skin assessments, and feed resident if she was unable to feed self. Initiated 04/03/2026: The resident has PneumoniaMedications Amoxicillin-Pot ClavulanateInterventions included to give medications as ordered, listen to lung sounds for crackles and diminished bread sounds, encourage fluid intake, monitor vitals signs and notify MD for abnormalities, monitor/document/report to MD recurrent fever, monitor/document for mental changes. Record review of Resident #1's progress notes reflected: 3/23/2026: Situation: The Change In Condition/s reported on this CIC Evaluation are/were: Abnormal vital signs (low/high BP, heart rate, respiratory rate, weight change) Altered mental status Functional decline (worsening function and/or mobility) Seems different than usual. Primary Care Provider Feedback: Primary Care Provider responded with the following feedback:A. Recommendations:B. New Testing Orders:--C. New Intervention Orders: 04/02/2026, created by LVN C: Resident was observed with bruising noted upon assessment. Resident was asked if she experienced a fall; resident responded, I don't remember. Resident assess for further signs of injury. Vitals wnl. Emergency contact, [family member], was notified and made aware of situation. [family member] reviewed camera footage and confirmed that the resident did experience a fall. Resident was [able] [NAME] [sic] to get herself up and back in bed. Resident reports headache like pain. PRN pain medication administered. DON notified. [hospice] notified. Record review of Resident #1's Fall - Unwitnessed incident report, dated 4/2/2026 and timed 00:08 (12:08 a.m.), and completed by LVN C reflected: . Incident Description Nursing Description: Resident was observed with bruising noted upon assessment. Resident was asked if she experienced a fall; resident responded, I don't remember. Resident assessed for further signs of injury. Vitals wnl. Emergency contact, [family member], was notified and made aware of situation. [family member] reviewed camera footage and confirmed that the resident did experience a fall. Resident was able to get herself up and back in bed. Resident reports headache like pain. PRN pain medication administered.Immediate Action TakenDescription: First aid rendered, vital signs obtained, xray ordered, pain medication administered, Neuro intact, neuro checks initiated, ROM WNL.Injuries Observed at Time of Incident Injury Type Injury LocationAbrasion 5) Back of headBruise 4) FaceBruise 62) Right Upper ArmSkin Tear 4) Face . Agencies/People NotifiedAgency / Person Name DateDirector of Nursing/ Designee [DON] 4/2/2026 08:14 [a.m.]Physician/NP/PA [MD] 4/2/2026 09:08 [a.m.]Physician/NP/PA Hospice 4/2/2026 10:08 [a.m.]Family Member/Guardian [family member] 4/2/2026 08:07 [a.m.] . Record review of Resident #1's orders revealed an order was placed on 04/02/2026 at 9:13 a.m. for an x-ray of Resident #1's facial bones (the front part of the skull), which includes around the eyes, nose, and mouth. Record review of Resident #1's Radiology Results Report dated 04/02/2026 11:13 (a.m.) reflected: PROCEDURE: FACIAL BONES COMP MIN 3V (complete minimum 3 views; complete x-ray of face bones from 3 different angles). FINDINGS: Suboptimal views [images obtained not high quality] of the facial bone demonstrate no fracture [crack or break] or dislocation [bones out of normal position]. Intact nasal [nose] bones. The orbits [eyes] appear normal. The visualized paranasal sinuses [sinus cavity] are grossly [obviously] clear without opacification [cloudiness] or air-fluid [mucus] levels [in sinuses]. No bony sclerotic or lytic lesion [hardening or thickening of bone] identified. The soft tissues [i.e. body muscles or body fat] are unremarkable [normal] without focal [specific spot or location] soft tissue swelling.CONCLUSION: Suboptimal views of the facial bones suggest no acute [present] fracture or dislocation. CT may be considered for more optimal [effective, higher quality] evaluation based on degree of clinical suspicion [healthcare provider's assessment of how likely a specific disease is causing a patient's symptoms before tests confirm it].Record review of Resident #1's neurological (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	checks dated 04/02/2026, revealed Resident #1 neurological checks did not show variation in results and remained intact. During an interview on 04/03/2026 at 10:10 a.m. the Hospice Nurse said Resident #1 was just admitted to hospice on 03/31/2026 and had fallen on 04/02/2026. The Hospice Nurse said Resident #1's Huntington's Disease process caused a lot of involuntary movements and at that time, Resident #1 was very agitated, and she could not even touch the resident. She said there was no bruising on Resident #1's face when she was admitted to hospice on 03/31/2026. During an observation and attempted interview on 04/03/2026 at 10:15 a.m. with Resident #1 revealed she had bruising around her eyes and a scab on her nose. She had what appeared to be involuntary movements. The state surveyor attempted to talk to her, but she was not able to communicate strongly but was able to indicate she wanted a nurse. The state surveyor went to request nursing staff and CNA A went to assist Resident #1.During an interview on 04/03/2026 at 10:19 a.m. with CNA A, she said she saw the bruises on Resident #1's face yesterday morning, 04/02/2026, around 5:30 a.m. and had reported it to LVN C. CNA A said she did not see any blood. She stated Resident #1 had involuntary movements and it was a part of the disease process. During an interview on 04/03/2026 at 10:32 a.m. with LVN C, she said Resident #1 had a lot of falls since she had come back from the hospital and she guessed a fall caused the bruises on her face because they were not there the day before (04/01/2026). She said Resident #1 could communicate when asked yes or no questions. LVN C said she saw the bruises when she came to pass medication. She said she took her vitals right before 8:00 a.m. and contacted Family Member #1. She then assessed the rest of the resident and gave her medication for pain and then reviewed Resident #1's chart to see if something happened the day before. LVN C said the injuries were on her eyes, her nose, and one side of her face was more swollen. LVN C said she did not notice the abrasion on the back of her head right away; she said she noticed an hour later when she did a thorough skin check. LVN C said the private caregiver did not notify her, but she notified the caregiver when she got to the facility. LVN C said the skin check was documented in the incident report. LVN C said if a resident fell, nurses were to initially not move the resident. She said nurses checked vitals, checked neuros, checked skin to make sure there were no injuries, assessed pain, and then helped the resident up and reeducated them to use the call light. She said she would notify the family, MD, and supervisor (DON).During an interview on 04/03/2026 at 11:13 a.m. Family Member #1 said the LVN C contacted her the morning of 04/02/2026 around 8:30 a.m. to notify her of the bruises to Resident #1's face. Family Member #1 said she reviewed the video and told them she saw Resident #1 fall backwards based on the video footage recording from 04/02/2026 at around 12:30 a.m. Family Member #1 said the facility did not know about the injury to the back of Resident #1's head. She said Resident #1's private caregiver noticed the injury to the back of her head when they were walking to lunch. She said the facility never notified her of the injury to the back of the head and did not think the nurse checked the back of her head. Family Member #1 said she sent the facility the video of Resident #1's fall after they called her. Family Member #1 had also said Resident #1 was recently hospitalized on [DATE] due to pneumonia and was there until 3/30/2026. During an interview on 04/03/2026 at 11:27 a.m. with Resident #1's Private Caregiver, she said the facility did not know about Resident #1's injury to the back of her head until she was walking with Resident #1 to lunch on 04/02/2026. She told LVN C and LVN C said Oh let me see. She said it was the first time LVN C saw that. The Private Caregiver was not sure if LVN C did a full body assessment. She said when she changed Resident #1's clothes, LVN C asked if the Private Caregiver saw any other injuries and the Private Caregiver told her she saw bruising on Resident #1's right arm and LVN C noted that. The Private Caregiver said it was later when LVN C saw the injury to the back of her head. During an interview on 04/03/2026 at 1:20 p.m. with NP D, she said she provided care for Resident #1. She said she or the primary care provider were notified by staff about Resident #1's falls. It was unclear if she had been notified about Resident #1's fall on 04/02/206, but she had been notified about previous falls. NP D said she had to provide care to another patient; she could not be interviewed further. During an interview on 04/03/2026 at 1:55 p.m. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with the MD, he said he provided care for Resident #1 and knew she had multiple falls. He said he had not seen her in a few months. The MD said his NP (NP E) may know more about Resident #1. He said he was aware of her having falls, but indicated nobody notified him of the fall on 04/02/2026. The MD said the facility was typically supposed to notify him of falls, but sometimes they notified NP E, and they may have notified NP E. The MD said he did not know Resident #1 recently had pneumonia. The MD deferred to NP E again and said she may be a more appropriate contact. During a phone call interview on 04/03/2026 at 2:00 p.m. with NP E, she said she had known about the recent falls Resident #1 had. NP E said she knew about the fall on 04/02/2026 because someone sent her an x-ray of Resident #1's face but did not tell her directly that Resident #1 fell. She said she pieced it together, but no one had called her about it. NP E said there was no fracture on the x-ray and that was all that was communicated. NP E said she believed the falls were a part of the neurological disease process, and there had been interventions in place to reduce falls including increased rounding, scheduled toileting, and review of medications. She said the family did coordinate appointments with a specialist to see Resident #1 for Huntington's Disease management. NP E said she did not know that Resident #1 was recently hospitalized with pneumonia as well. She said [NP D, NP for specialized health care plan] was notified for things, but the facility was supposed to notify the primary care providers. NP E said she was not aware of the injury to the back of Resident #1's head and she would have sent Resident #1 to the hospital to get a CT scan to rule out bleeding. She said when it was a head injury, it was standard for her to request a CT scan and send a resident to a hospital to rule out a bleed. NP E said she was not aware Resident #1 had recently been placed on hospice. She said it would not make a difference in her providing care to Resident #1. NP E said she would still see residents even if they were on hospice; in a skilled setting, she would still see them while on hospice. NP E said it was important the facility contacted her about Resident #1 because she knew Resident #1 and it made sense to contact her about those situations. She said if the facility talked to a provider that did not know Resident #1, they would not really know how to direct care and know her baseline. She said it was better that they contact the providers that know Resident #1. Interview on 04/03/2026 at 2:23 p.m., NP E called the state surveyor. NP E said not that she was aware of the injury to the back of Resident #1's head, and she would need to call the nurse at the facility to see what was going on with Resident #1 and know her neuro status to determine next steps. She said the facility initiated neuro checks and if neuro condition changes, Resident #1 would need to go to the ER. NP E then said Resident #1 being on hospice care changed the situation on whether she would go to the hospital or not. NP E said if the family wanted her to go to the hospital, Resident #1 would have had to come off of hospice. During an observation and interview on 04/03/2026 at 3:00 p.m. Family Member #2 said she did not know who knew about Resident #1's fall first, but she did not think the facility had mentioned anything about the injury to the back of the head. She indicated the Private Caregiver noticed the injury and said something about it. Family Member #2 said Resident #1 had two brain bleeds in the past from falls; one was from when she had fallen in December 2025. She said she did not know if Resident #1 was susceptible to brain bleeds, but it may be part of the condition of the brain (due to Huntington's Disease). During the interview, Family Member #2 attempted to have Resident #1 show the state surveyor the back of her head. Resident #1 did not want to show the back of her head; there were no signs of blood on her sheets or in her hair. During an interview on 04/03/2026 at 3:44 p.m. with the ADM, he said when a resident fell, staff were to notify the attending physician, family, and DON. He said it was expected that staff included all details when notifying of falls. The ADM said he was notified of the bruises on Resident #1's face the morning of the fall on 04/02/2026, but he was not aware of the injury to the back of her head. The ADM said he expected staff to communicate. During an interview on 04/03/2026 at 4:15 p.m. with the DON, she said Resident #1 was not sent to the hospital after her fall because her neuros were intact and they had an order for a face x-ray. The DON said she talked to LVN C and LVN C told her she talked NP E when they got the x-rays. The DON said when she came in to work on 04/02/2026, she (continued on next page)

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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** Based on observation, interview, and record review, the facility failed to ensure food items were not cross contaminated for 1 of 5 (Resident #1) residents reviewed for infection control. The facility failed to ensure CNA A did not contaminate Resident #1's cookie when she picked up wrapped chocolate candies off the floor and put them on the plate with the unpackaged cookie.This failure could place residents at risk of consuming contaminated food items that could result in foodborne illness or foodborne intoxication. Findings included:Record review of Resident #1's face sheet revealed a [AGE] year-old woman admitted with a primary diagnosis of Huntington's Disease (neurodegenerative disorder characterized by chorea, which involves involuntary, dance-like movements, along with cognitive and psychiatric symptoms). Other pertinent diagnoses included bipolar disorder (mental health condition causing extreme mood swings), mild cognitive impairment (decline in memory or thinking skills, trouble with language), major depressive disorder (persistent low mood, profound sadness), abnormalities of gait and mobility (unusual patterns of walking or movement), and lack of coordination (difficulty in controlling voluntary movements). During an observation and attempted interview on 04/03/2026 at 10:15 a.m. with Resident #1, revealed she was not able to communicate strongly but was able to indicate she wanted a nurse. The state surveyor went to request nursing staff and CNA A went to assist Resident #1.During an observation on 04/03/2026 at 10:19 a.m., revealed CNA A was seen setting up a snack for Resident #1. CNA A had put an unpackaged cookie on a plate on Resident #1's bedside table. CNA A then picked up wrapped chocolate candies off Resident #1's floor and put them onto the plate with the unpackaged cookie. During an interview on 04/03/2026 at 10:21 a.m. with CNA A, she said it was a risk to place the wrapped chocolate candies from the floor onto the plate because it was contaminated. She then realized she had contaminated the cookie that was on the plate with the chocolate candies and said, I never do that; I am so sorry. CNA A said the risk was Resident #1 could get sick (from the contamination). During an interview on 04/03/2026 at 6:16 p.m. with CNA B, she said she would not pick up food off the floor to give to residents. She said the risk was a resident could choke if not sure what the item was, a chance of chemical residue on the floor, it could make residents sick resulting in diarrhea or convulsions but did not want to take a chance. CNA B indicated she had been in-serviced on infection control and proper protocols. During an interview on 04/03/2026 at 6:48 p.m. with the DON, she said she heard about the wrapped chocolate candies being transferred from the floor to the plate with the unpackage cookie. She said they had done an in-service on infection control. The DON said it was a problem because of infection control, and germs from the floor could transfer over. She said, The likelihood of anything happening is nothing. I get where you are going but in real world actuality, just like if [CNA A] wasn't in the room and [Resident #1] picked up chocolate off the floor and eats it, it transfers. Worst case scenario something could happen. Record review of the facility's Infection Prevention and Control Program, dated 12/1/2025, reflected: Policy:This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines.Policy Explanation and Compliance Guidelines:1. The designated Infection Preventionist is responsible for oversight of the program and serves as a consultant to our staff on infectious diseases, resident room placement, implementing isolation precautions, staff and resident exposures, surveillance, and epidemiological investigations of exposures of infectious diseases.2. All staff are responsible for following all policies and procedures related to the program.3. Surveillance:a. A system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon a facility assessment and accepted national standards.b. The Infection Preventionist serves as the leader in (continued on next page)

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	04/03/2026

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

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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	surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility and reports surveillance findings to the facility's Quality Assessment and Assurance Committee.c. The RNs and LPNs participate in surveillance through assessment of residents and reporting changes in condition to the residents' physicians and management staff, per protocol for notification of changes and in-house reporting of communicable diseases and infections.