STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676398	A. Building B. Wing	07/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fox Hollow Post Acute	310 America Drive Brownsville, TX 78526

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45737 Based on interview and record review, the facility failed to provide notice of transfer or discharge at least 30 days before a resident was transferred or discharged for 1 of 5 Residents (Resident #1) reviewed for discharges, in that: Resident #1 and their representative were not provided a 30 day discharge notice before being discharged home from facility on 07/01/24. This deficient practice could affect residents at the facility by placing them at risk of being transferred/discharged and not having access to available advocacy services, discharge/transfer options, and appeal processes. The findings included: Record review of Resident #1's face sheet, dated 07/09/24, revealed the resident was a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses that included: non-st elevation (NSTEMI) myocardial infarction (heart attack that happens when the hearts need for oxygen can't be met), type 2 diabetes mellitus with hyperglycemia (high blood sugar), hypertensive heart disease (heart problems that occur due to high blood pressure) with heart failure (when the heart doesn't pump enough blood for the body's need), chronic obstructive pulmonary disease, unspecified (chronic inflammatory lung disease that causes obstructed airflow from the lungs), chronic atrial fibrillation (irregular and often very rapid heart rhythm). Record review of Resident #1's optional Minimum Data Set assessment, dated 03/31/24, revealed Resident #1 had a BIMS score of 15, indicating no impaired cognition. Record review of Resident #1's physician order dated 07/01/24 at 11:59am ordered by MD A stated D/C HOME F/U WITH PCP. GIVEN MEDICATION AND TWO BOXES OF COLOSTOMY BAGS SENT HOME WITH RESIDENT. Record review of Resident #1's care plan with a print date of 07/09/24 did not reflect verbiage regarding discharge goals. Record review of Resident #1's uploaded miscellaneous documents from 03/08/24 - 07/02/24 did not include a 30-day notice for discharge. (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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's notice of Medicare non-coverage dated 04/12/24, revealed his last coverage date was 04/14/24. Record review of Resident #1's Kepro (the beneficiary and family centered care quality improvement organization that evaluates if skilled services need to continue) document dated 04/16/24 stated the letter provided was in follow up to their telephone call regarding their appeal closure. Record review of Resident #1's activity report revealed a note under the collection's activity section dated 04/16/24 completed by the ABOM stated she called Resident #1's family member to initiate the Medicaid application process however Resident #1's family member stated she did not see the need to file a Medicaid application since Resident #1 would be discharging home and not staying long term. Record review of Resident #1's activity report revealed a note under the collection's activity section dated 05/03/24 completed by the ABOM stating the Medicaid application for Resident #1 was completed over the phone with Resident #1's family member and they were provided a list of items needed to submit the Medicaid application, bank statements from February were requested by facility. Record review of Resident #1's activity report revealed multiple notes under the collections activity section regarding staff requesting Resident #1's family member to submit bank statements for Resident #1's Medicaid application. The dates of these notes were dated 05/09/24, 05/15/25 and were documented by the ABOM. On 05/17/24 the BOM documented speaking with Resident #1 about his family member refusing to submit bank statements and that they were needed for the Medicaid application. On 06/27/24 a note that did not have an assigned staff name but did include the initials of the ABOM at the end stated Resident #1 signed the Medicaid application and was made aware that his family member had not cooperated by bringing in bank statements. On 06/28/24 there was a note documented but there was no staff name assigned to identify who wrote it. The note stated Resident #1's family member was informed of need to do the Medicaid application due to last coverage date on 04/14/24 and was informed of balance of $21,175 with Resident #1's family member stating she was not going to leave Resident #1 long term. Record review of Resident #1's progress notes from 04/22/24 - 07/02/24 revealed no documentation related to a 30-day notice for discharge. Record review of Resident #1's progress note dated 06/28/24 at 3:56pm written by the Social Worker stated, SW informed that [family member] is not assisting in providing bank statement for Medicaid to B.O.M. Administrator is wanting discharge planning with family. [Family member] stated that she is ill and will not be coming to give bank statements to B.O.M. SW informed [family member] that discharge plans need to be made for 7-01-2024, she stated fine that she would pick him up at 5pm. [MD A] is out of country however his NP [NP] will be called for orders. Record review of Resident #1's progress note dated 07/01/24 at 10:39AM written by the Social Worker stated, SW informed Administrator in the morning meeting during review of discharge that [Resident #1] that his [family member] will be picking him up today at 5pm. Record review of Resident #1's progress note dated 07/01/24 at 12:00pm written by LVN B stated, RESIDENT D/C HOME WITH MEDICATION AND TWO BOXES OF COLOSTOMY BAGS. RESIDENT TO FOLLOW UP WITH PCP. RP WAS NOT PRESENT TO SIGN INVENTORY LIST. RESIDENT WAS TAKEN VIA FACILITY VAN. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Resident #1's family member on 07/08/24 at 10:41am Resident #1's family member stated she had previously done an appeal, but it had been closed and stated she had requested the appeal to be reopened and stated it was pending for July 12, 2024. Resident #1's family member did not clarify when the appeal was reopened, nor did she provide any documentation of appeal. Resident #1's family member stated Resident #1 was discharged on [DATE] due to owing the facility money and lack of payment. Resident #1's family member stated the facility had been asking her to bring in bank papers but stated she did not want to because she did not want Resident #1 there long term and because Resident #1 was low income and she had to pay for his rent and figured if she took the bank statements how would she pay Resident #1's rent. Resident #1's family member stated the 2 weeks before Resident #1 was discharged on [DATE] the facility told her the amount owed had reached $23,000 and she voiced to the facility that she would go pick Resident #1 up and take him home instead of letting the bill get higher and stated the facility wanted her to give a percentage of the debt she owed but she did not have it. Resident #1's family member stated she was notified by the facility on 06/28/24 that she had until Monday 07/01/24 to pick up Resident #1 and was asked what time she wanted to pick up Resident #1. Resident #1's family member stated she had made arrangements to pick up Resident #1 on 07/01/14 at 5:00pm. Resident #1's family member stated the Administrator called her on 07/01/24 and told her that because of the situation of the large debt and her not taking the bank papers they were going to discharge Resident #1. Resident #1's family member stated she told the Administrator that she could pick up Resident #1 at 5:00pm that day but the Administrator stated they were not going to wait until 5:00pm and would be dropping him off at that time. Resident #1's family member stated Resident #1 wanted to go home. During an interview with the Social Worker on 07/08/24 at 4:53pm she stated the facility initiated the discharge. The Social Worker stated she was informed by the BOM during a morning meeting that the Administrator wanted to discharge Resident #1 as soon as possible and for her to initiate the discharge . The Social Worker stated she called Resident #1's family member and asked if Monday (07/01/24) was okay for Resident #1's discharge and she stated that was fine. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the BOM on 07/09/24 at 4:14pm she stated Resident #1 had been at the facility for more than 30 days. The BOM stated Resident #1's family member had not submitted the bank statements needed for Resident #1's Medicaid application. The BOM stated they had been attempting to get bank statements since Resident #1 first admitted in March of 2024. The BOM stated Resident #1 and his family member had appealed their letter of Medicare non coverage but had lost the appeal. The BOM stated Resident #1's family member would mention discharge whenever they would check the status of the appeal and stated Resident #1's family member had made it clear Resident #1 was not going to stay at the facility and that she would be taking him. The BOM stated Resident #1's family member went into the office once and had refused the Medicaid application and had said she was not going to leave Resident #1 at the facility. The BOM stated during the last call she had with Resident #1's family member she stated she was going to take Resident #1 but could not take him at that time, the BOM did not specify when this conversation happened. The BOM stated both the facility and Resident #1's family member initiated the discharge and stated once Resident #1's family member was told how much was owed she would say she wanted to take Resident #1 home and stated that was when transportation was offered. The BOM stated Resident #1 was discharged due to financials and being non complaint with the Medicaid application and accumulating a huge balance. The BOM stated in this case a 30 day notice did not have to be given to Resident #1 or his family member and stated Resident #1's family member wanted to take him home and had everything for him and stated Resident #1's family member did not want to buy room and board at the facility. The BOM stated they would give a 30 day notice if they refused to pay or take the resident. The BOM stated its important to provide a 30 day notice for discharge because it gave time to plan. The BOM stated she did not know off the top of her head what the facility discharge policy stated regarding issuing 30 day notices. The BOM stated she monitored and ensured residents were notified within an appropriate amount of time prior to discharge through their care plan meetings, speaking with residents, and stated she tracked residents' days as they approached end of coverage or co-days (days when they have a copayment) with her manual census. The BOM stated she did not know how not providing a 30 day discharge notice could negatively impact residents and stated they rarely did 30 day discharge notices and only did them when residents were flat out refusing to pay or take the resident home. The BOM stated she could not give a 30 day notice because Resident #1's family member was on her 2nd or 3rd appeal. The BOM stated they only received notice the 1st appeal decision in writing and the rest had to be via call. No documentation of appeal results other than the 1st one was provided. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow up interview with the Social Worker on 07/09/24 at 5:25pm she stated Resident #1 was at the facility for more than 30 days. The Social Worker stated she did not know any of the business office information and only knew as of 06/28/24 that Resident #1's family member was not assisting in providing bank statements to the BOM. The Social Worker stated Resident #1's reason for discharge was financial. The Social Worker stated when a 30-day discharge was given the business office would send her and the ombudsman a copy and the Social Worker stated she did not receive one. The Social Worker stated they gave out 30-day notices for resident who were non-compliant, refused care, financial or behavior reasons. The Social Worker stated she didn't know if they gave Resident #1 a 30-day discharge notice and stated, probably, maybe they should have but stated business office did that. The Social Worker stated it was important to provide a 30-day discharge notice to residents and their family so that they knew what was going on and the reason for discharge. The Social Worker did not know why Resident #1 was not given a 30-day notice and did not know what the facility discharge policy stated about issuing 30 day discharge notices. The Social Worker stated she monitored and ensured residents were notified within an appropriate amount of time prior to being discharged by reviewing Medicare and managed care residents 2 to 3 times a week and had meetings where they would check what day a resident was on and stated she would ask if they were staying or going home. The Social Worker stated the negative impact of not providing a 30 day discharge notice depended on the doctors orders and stated some said to discharge with medication or follow up with PCP. During an interview with the Administrator on 07/09/24 at 5:04pm he stated Resident #1 was at the facility for more than 30 days. The Administrator stated Resident #1's family member was pending to submit bank statements for the Medicaid application. The Administrator stated Resident #1 was in an appeal process at one point but after that Resident #1's family member told the facility she would bring in the bank statement and there was no appeal because he would be Medicaid pending, pending the application. The Administrator stated they had been attempting to get bank statements submitted from Resident #1's family member for the last 2 months. The Administrator stated Resident #1's family member had stated she did not want to leave Resident #1 in the facility, the Administrator stated long term was never the option. The Administrator stated Resident #1 had not spoken to him directly about discharge planning but stated he spoke to him on his last day and stated Resident #1 expressed he was okay and wanted to leave. The Administrator stated Resident #1's discharge initiation was twofold between the facility and resident, and they were assisting with transporting Resident #1. The Administrator stated Resident #1 was discharged because he was ready to go. The Administrator stated the problem was deception and stated if Resident #1's family member had told him upfront that she wasn't going to submit anything for the Medicaid application then he would have given a 30 day notice. The Administrator stated with how things unfolded he should not have given Resident #1 a 30 day discharge notice and stated he did not give a 30 day notice because they were never under the impression that they were going to have an issues and stated Resident #1's family member always said she would bring the bank statement the following day or week but had not. The Administrator stated the facility discharge policy stated they could issue a 30-day discharge notice to residents for harassment, aggression, or payment reasons . The Administrator stated they monitored and ensured residents were notified within an appropriate amount of time prior to discharge by having Medicare meetings Monday, Wednesday and Friday and reviewing how many days out skilled patients were and making sure they had a process for residents nearing their days and stated they discussed those things in the morning meeting and in their Medicare meeting. The Administrator stated not issuing a 30-day notice could negatively impact residents because they might not be ready to go and might not feel mentally ready to go, or they may still need nursing services or their DME (durable medical equipment) may not be ready. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1's family member was attempted to be reached for follow up interview on 07/09/24 at 9:55am and 12:34pm with no success. Resident #1 was attempted to be reached for interview via telephone number for family member on Resident #1's chart on 07/09/24 at 9:50am and 5:32pm with no success. Resident #1 was attempted to be reached for interview via telephone number provided by facility on 07/08/24 at 5:33pm, 07/09/24 at 10:14am with no success. Resident #1 was attempted to be reached for interview by calling local hospitals on 07/09/24 at 9:52am and 9:53am with no success. On 07/09/24 at 5:19pm the Administrator stated they did not have training that covered discharges and stated they just read the policy. On 07/09/24 at 5:55pm the Administrator stated he did not have a policy that specifically included verbiage of a 30-day discharge notice. Record review of facility policy titled, Transfer or Discharge with a revised date of August 2018 did not include any verbiage on issuing of a 30 day discharge notice.