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	09/19/2024

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50487 Based on interview and record review the facility failed to ensure prompt efforts by the facility were made to resolve grievances for the residents for 1 of 8 residents (Resident #2) reviewed for grievances. The facility failed to ensure a grievance was filled out and followed up on after Resident #2 reported her wallet was missing on 02/04/2024. This deficient practice could place residents at risk for decreased quality of life and feelings of neglect. The findings include: Record review of Resident #2's face sheet, dated 09/04/2024, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included Diabetes Mellitus Type 2 (a long term condition in which the body has trouble controlling blood sugar and using it for energy), functional quadriplegia (complete immobility due to severe disability or frailty from another medical condition without injury to the brain or spinal cord), Essential Hypertension (A condition in which the force of the blood against the artery walls is too high.) and Morbid severe obesity due to excess calories (A disorder that involves having too much body fat, which increases the risk of health problems). Record review of Resident #2's admission MDS assessment, dated 08/7/2024, reflected Resident #2 had clear speech and was understood by staff. Resident #1 was able to understand others. Resident #1 had a BIMS score of 14, which indicated no cognitive impairment. The MDS reflected Resident #2 felt like it was somewhat important to take care of personal belongings. Record review of Resident #2's comprehensive care plan, revised on 08/3/2024, reflected Resident #2 had no cognitive decline. Record review of the resident grievance form dated 02/04/2024, reflected Resident #2 had initiated a grievance on 02/04/2024 with the Administrator. The details indicated Resident #2 was missing a wallet. The form was not complete. The following sections were left blank on the form: *The person investigating; (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*The Administrator's signature; *The resolution reviewed with concerned person; *The date of notification and method of notification for the resolution During an interview on 09/5/2024 at 2:05 PM, Resident #2 stated she had her wallet inside her purse on top of the bedside table and then she went to sleep and when she woke up her purse was on top of the nightstand, opened and the wallet was not in the purse. Resident #2 stated she told the Administrator about her wallet being missing. Resident #2 stated she did not hear anything about the investigation done by the facility, no body went to speak to her, the only thing the administrator informed was a police report was made. During an interview on 9/5/2024 at 2:05 he Administrator stated the concern about the missing wallet was resolved but he failed to fill out the form. The investigation revealed the missing wallet was in possession of Resident's #2 son. The Administrator stated the interdisciplinary team was responsible for ensuring grievances were monitored and followed up on. The Administrator stated it was important to ensure grievances were documented and followed up on to validate if the grievance was an resolved. During an interview on 09/6/2024 beginning at 3:00 PM, the DON stated grievances were reported in different ways and were shared with department heads. The DON stated they had a binder on each nurses station for the nurses to document each grievance. The DON stated the person responsible for completing the grievance was dependent on what the grievance was about. The DON stated a grievance was addressed during each morning meeting. The DON stated it was important to ensure grievances were documented and initiated to come up with a resolution and address concerns made by the residents. Record review of the grievance policy, revised December 2009, reflected Grievances should be filed within the allotted time period assigned for each step. Failure to do so may indicate that the grievance has been resolved and further action may be prohibited.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50487 Based on observation, interview and record review the facility failed develop and implement a comprehensive person-centered care plan for each resident, consistent with resident the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial need that were identified in the comprehensive assessment for 1 of 8 residents (Resident #3) reviewed for comprehensive person-centered care plans. The facility failed to develop a comprehensive person-centered care plan for Resident #3 to address oxygen therapy. This deficient practice could place residents at risk of not being provided with the necessary care or services and not having personalized plans developed to address their specific needs. The Findings include: 1. Record review of Resident #3's face sheet, dated 9/4/2024, reflected a [AGE] year old male who was originally admitted to the facility on [DATE]. Resident #3 had a diagnosis which included: Pneumonia, unspecified organism (a type of interstitial lung disease that causes inflammation between the air sacs of your lungs). Record review of Resident #3's Doctor's Order Summary, dated 9/6/2024, reflected Resident # 3 was prescribed Oxygen at 2Liters Per Minute via Nasal Cannula continuous and as needed for shortness of breath. Record review of Resident #3's Medication Administration Record, dated 9/6/2024, reflected an order for Resident #3 to receive O2 at 2L/MIN via nasal cannula continuous and as needed for shortness of breath. Record review of Resident #3's Care Plan, dated 8/2/24, reflected oxygen was not care planned. Record review of Resident #3's quarterly MDS assessment, dated 07/25/24, reflected a BIMS score of 0, which indicated Resident #3's cognition was severely impaired. Oxygen was not marked on the MDS. Observation on 9/5/24 at 9:00 AM, revealed Resident #3 in his room with Oxygen at 2 liters per minute via nasal cannula . Interview on 9/5/24 at 9:25 AM, the ADON stated the MDS nurses completed the care plan for oxygenation use. She stated the charge nurses got the orders from the physician and then the nurses put them in the point click system. She stated the ADON or DON checked any new orders on the morning meetings. Interview on 9/6/28 at 10:20 AM with LVN D, MDS nurse, stated that the negative effect for not having the oxygen care planned was that the residents can go into hypoxia, respiratory distress, and altered mental status. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 9/6/24 at 1230 PM, LVN C stated the oxygen needed to be care plan and checked updates in a quarterly basis. LVN C stated the purpose of a comprehensive plan was to give the best care for the residents. Interview on 9/6/24 at 3:40 PM, the DON said Resident #3 did not have oxygen care planed. She stated the MDS nurses were responsible for updating the care plans. Record review of the Comprehensive Person-Centered Policy, dated September 2010, read in part An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. The facility's Care Planning/Interdisciplinary Team, in coordination with resident, his/her family or representative, develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. The resident comprehensive care plan is developed within seven days of the completion of the resident's comprehensive assessment MDS.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32107 Based on observation, interview and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 1 resident (Resident#1) reviewed for indwelling catheters. The facility failed to prevent Resident#1's urinary catheter tubing (bag) from touching the floor. This failure could place residents at risk for cross contamination and urinary tract infections. Findings include: Record review of Resident#1's face sheet reflected a [AGE] year-old male originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1 had primary/admitting diagnoses which included cerebral infarction (lack of oxygen to the brain due to clot), acute kidney failure (sudden loss of kidney function), obstructive and reflux uropathy (when flow of urine is blocked in the bladder, ureter urethra), cystitis (inflammation of the bladder), hematuria (blood in the urine), and legal blindness. Record review of Resident #1's Quarterly MDS, dated [DATE], Section C-Cognitive patterns reflected Resident #1 had a BIMS score of 7, which indicated Resident #1 had severely impaired cognition. Section B-Hearing, Speech and Vision reflected Resident #1 had severely impairment-no vision or sees only light, colors or shapes, eyes do not appear to follow objects. Section H-Bladder and bowel reflected Resident #1 has an indwelling catheter. Record review of Resident #1's care plan reflected Resident #1 has a foley catheter Obstructive and reflux uropathy, date initiated 06/05/23 and revised on 02/14/24, Resident #1 had (indwelling/foley) Catheter Obstructive and Reflux uropathy, date initiated 02/14/24 and revised on 02/20/24, Intervention/tasks listed Provide catheter care every shift and Position catheter bag and tubing below the level of the bladder and away from entrance room door, initiated and revised on 09/04/24. Record review of Order Summary had an order printed 09/18/24 reflected order to Change Foley Catheter 20 # FR with 10mL/cc balloon q 30 days and if plugged out or dislodged PRN. Order Foley catheter care q shift and PRN start dated 05/26/23. During interview and observation conducted with Resident #1 on 09/18/24 at 2:30 PM, Resident #1's foley catheter bag was noted laying on the floor on the left side of Resident #1's bed. Resident #1 stated he had been at the facility for about 6 months. Resident #1 said the nurses recently changed his catheter because it was blocked, and he had discomfort. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with LVN A on 09/18/24 at 2:33 PM, LVN A stated it should be hung, it has two hooks to hang referring to the catheter bag on the floor. LVN A put on gloves after sanitizing hands with hand sanitizer and hung the foley bag on Resident#1's bedframe. She replied to a negative outcome of the foley catheter bag being on the floor the catheter wouldn't drain well and pick up bacteria from floor. During interview with the DON on 09/18/24 at 4:31 PM, she stated for catheters they should be on the side of bed. The DON stated, foley bag should not be on the floor, if on the floor it is not necessarily a problem because it is a closed system, but if open then something can go in. During interview with LVN B on 09/19/24 at 1:12 PM, LVN B stated after changing the catheter she usually clipped the bag on the bed frame below on the flat part, not part that went up and down, ensured it was not touching the floor and ensured it had a privacy cover . LVN B stated if the catheter bag did touch the floor there would be s risk of infection but sometimes it could fall but as soon as seen, she would correct it. Record review of the Policy Titled Catheter Care, Urinary with revision date August 2022, under heading of Infection Control #2 reflected Be sure the catheter tubing and drainage bag are kept off the floor.