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	05/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fox Hollow Post Acute	310 America Dr 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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered- care plan, and the resident's choices for 1 (Resident #1) of 3 residents reviewed for quality of care. The facility failed to treat a confirmed infection despite two provider orders, resulting in septic shock and death, with no evidence of clinical follow-up or intervention An Immediate Jeopardy (IJ) was identified on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with a potential for more than minimal harm that is not immediate jeopardy, due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk of delay in care, worsening of health conditions, adverse reactions, hospitalization, and death. This failure resulted in Resident #1 being admitted to the hospital with septic shock on [DATE], and expiring on [DATE].Findings included: Record review of Resident #1's face sheet dated [DATE] reflected a [AGE] year-old female with an admission date of [DATE] with pertinent diagnoses that included End Stage Renal Disease (is the final stage of chronic kidney disease (stage 5), where kidneys lose of function, causing kidney failure. It requires life-sustaining treatment, such as dialysis or a kidney transplant.) Record review of Resident #1's quarterly MDS assessment dated [DATE] reflected a Brief Interview for Mental Status (BIMS) score of 15 which meant intact cognitive status. Resident #1 received dialysis while being a resident. Record review of Resident #1's comprehensive care plan dated date initiated [DATE] revealed she was on antibiotic therapy Blujepa related to infection Urinary tract infection/E. Coli (Escherichia coli are bacteria commonly found in the intestines of humans and animals), initiated on [DATE]. Interventions: administer antibiotic medications as ordered by physician. Monitor/document side effects and effectiveness every shift. Record review of Resident #1's nurses notes on her electronic medical record dated [DATE] at 6:52 p.m., authored by LVN A reflected: Resident #1 complained of general weakness. LVN A called NP C and he ordered to draw Complete blood count (a common blood test that measures the cells circulating in your blood) and comprehensive metabolic panel (a routine 14-test blood panel used to evaluate liver/kidney function, fluid balance, and metabolism). Record review of Resident #1's nurses notes on her electronic medical record dated [DATE] at 9:41 a.m., authored by LVN B reflected Resident #1 complained of general weakness. LVN B called NP C and he ordered to ammonia level (measures the amount of ammonia in your blood to check for liver or metabolic issues) and urinalysis with culture (a two-part diagnostic test used to detect and identify urinary tract infections). Record review of Resident #1's nurses notes on her electronic medical record dated [DATE] at 1:50 p.m., authored by LVN E reflected (HE/SHE) reported lab results and urinalysis to NP C. No new orders at that time. Record review of Resident #1's urinalysis results received on [DATE] revealed leukocytes 500 in the urine (ref range- Negative).Record review of Resident #1's nurses notes on her electronic medical record dated [DATE] at 12:25 p.m., authored by LVN B reflected she notified the NP C on [DATE] of the urine culture results. NP C provided a new order for Blujepa [oral antibiotic to treat urinary tract infections] 750 mg twice per days for 5 days and a consult with infection preventionist NP D. Record review of Resident #1's on her electronic (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	medication administration record dated [DATE], reflected no documentation that her order for Blujepa was administered. Record review of Resident #1's nurses notes on her electronic medical record showed no documentation regarding the delivery/acquisition status of the medication Blujepa and no documentation of follow up communication with the pharmacy or NP/MD. Record review of Resident #1's nurses notes on her electronic medical record dated [DATE] at 6:53 p.m., authored by LVN A reflected NP D discontinued order for Blujepa and ordered Invanz 500 mg IV every night for 10 days. Record review of Resident #1's on her electronic medication administration record dated [DATE], reflected no documentation the order for Invanz [a broad spectrum antibiotic used to treat serious bacterial infection, including Urinary Tract Infections] was administered. Record review of Resident #1's nurses notes on her electronic medical record dated [DATE] at 10:46 a.m., authored by LVN A reflected, while at dialysis, Resident#1 became lethargic, had low blood pressure, and Resident #1 was sent to the hospital via EMS. Record review of Resident #1's nurses notes on her electronic medical record dated [DATE] at 4:52 p.m., authored by LVN A reflected she was admitted for septic shock (a life-threatening, advanced stage of sepsis where infection causes severe, widespread inflammation and dangerously low blood pressure), NSTEMI (a type of heart attack caused by a partial blockage of a coronary artery) and thrombocytopenia (a medical condition characterized by an abnormally low number of platelets in the blood). Record review of Resident #1's hospital record dated [DATE] reflected Resident #1 expired on [DATE] from cardiac arrest (a medical emergency where the heart suddenly and unexpectedly stops beating, causing it to stop pumping blood to the brain, lungs, and other organs.) During a phone interview on [DATE] at 2:27 p.m., NP C stated that he was notified on [DATE] regarding Resident #1, and he ordered a complete blood count and a comprehensive metabolic panel. NP C stated that on [DATE], he ordered a urinalysis with culture and an ammonia level. NP C stated that on [DATE], he was called and was notified on the urinalysis results and he did not give any orders. He stated he wanted to wait for the urine culture results because Resident #1 did not have any symptoms. NP C stated that on [DATE], he received the results on the urine culture and he ordered Blujepa and a consult with NP D. NP C stated that he was not called regarding the Blujepa antibiotic not arriving to the facility from the pharmacy until after 3 to 4 days. During a phone interview on [DATE] at 3:10 p.m., NP D stated that she went to the facility on [DATE] for a consultation with Resident #1. NP D stated that she discontinued the order for Blujepa, because it was a contraindication for residents with renal failure. NP D stated she ordered Invanz 500mg IV every night for 10 days for E coli in the urine. NP D stated it was a possibility that an untreated UTI could lead to septic shock and death. During a phone interview on [DATE] at 3:30 p.m., the Pharmacy staff stated that the pharmacy received the order for the Blujepa on [DATE]. Pharmacy staff stated that the blujepa medication was a new antibiotic, and it usually took 3 to 4 days to arrive to the facility. Pharmacy staff stated that the facility was aware of the delay of the medication. Pharmacy staff stated that, on [DATE], the facility had 4 vials of Invanz 500mg available in the emergency kit machine. During an interview on [DATE] at 4:00 p.m., LVN A stated that on [DATE], Resident #1 told him that she was feeling generalized weakness and that she was not feeling her normal self. LVN A stated that he called NP C and notified him. LVN A stated that NP C ordered a comprehensive complete panel and a complete blood count. LVN A stated, on [DATE], NP D came to the facility and she changed the antibiotic order to Invanz. LVN A stated that he did not recall if he called the pharmacy to follow up regarding the antibiotic status, or when the medication was going to arrive the facility. LVN A stated, on [DATE], he received a call from dialysis that the resident was sent out to the hospital due to lethargy and weakness. During an interview on [DATE] at 6:30 p.m., LVN F stated that on [DATE], when the dose for Invanz was due, he checked the emergency kit machines that were in the facility and that he did not find the Invanz antibiotic. LVN F stated that he did follow up with the pharmacy, and that the pharmacy told him that the Invanz antibiotic would get to the facility in the morning, but he forgot to document that in the Resident #1's electronic chart. During an interview on [DATE] at 9:58 a.m., with LVN B stated that, on [DATE], she reported the (continued on next page)

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	urine culture results to NP C, NP C ordered Blujepa, and she ordered the antibiotic from pharmacy. LVN B stated that she did follow up with the pharmacy, but she did not document on the Resident's electronic chart. LVN B stated that the pharmacy said that they had received the order for Blujepa on [DATE]. LVN B stated that she forgot to ask the estimated time of arrival. During an interview on [DATE] at 3:05 p.m., with the DON stated she was not aware Resident#1 had not received her antibiotics. DON stated staff should follow up on medication to ensure it was delivered and received, and if the medication was not available, they should be in communication with the NP to see what else they could do. DON stated that she was not aware that the antibiotic was going to be delayed. During an interview on [DATE] at 4:00pm, the Administrator stated that the facility did not have a policy for quality of care. This was determined to be an Immediate Jeopardy (IJ) on [DATE] at 5:48PM. The Administrator was notified. The Administrator was provided with the IJ template on [DATE] at 5:48pm and the POR was asked at this time. The following Plan of Removal (POR) submitted by the facility was accepted on [DATE] at 05:27 p.m.: Plan of RemovalName of Facility-[Facility]Date of Compliance: [DATE] F684- Quality of CareImmediately actions1. DON and/or designee will educate nursing staff on monitoring residents with identified UTI symptoms and confirmed UTIs and documentation on [DATE]. Staff not currently working will be educated prior to their next shift. 2. DON and/or designee will educate nurses on monitoring and following up with residents who had antibiotics ordered and documenting status updates on [DATE]. Staff not currently working will be educated prior to their next shift. 3. DON an/or designee will educate the nurses and med aids on monitoring the availability and acquisition of physician ordered medication along with verifying anticipated delivery date of medication and appropriately documenting it on [DATE]. Staff not currently working will be educated prior to their next shift. 4. DON and/or designee will educate nurses on following up and in communication with the NP/MD when an ordered medication is not available and ensuring the communication is reflected in the clinical record on [DATE]. Staff not currently working will be educated prior to their next shift. 5. DON and/or designee will educate nurses about reviewing the ekit for availability of ordered medication on [DATE]. Staff not currently working will be educated prior to their next shift. 6. IP and/or designee audited all residents with active orders for antibiotics to confirm that medication is available and administered on [DATE]. 7. ADONS and/or designee will audit all residents with antibiotics and infections to ensure that residents are being monitored and documented daily. 8. ADONs and/or designee will audit residents with active orders for antibiotics to confirm that medication is available and administered daily.9. ADONs and/or designee will review, during workday clinical meetings, new physician ordered medication to ensure that medication was delivered, or communication and documentation is reflected in the clinical record if there is a delay or med is not available.10. DON will perform a random review of 5 residents with antibiotics weekly to ensure compliance with antibiotic administration, monitoring, and documentation. 12. [SIC]If any discrepancies are found, they will be addressed immediately.13.[SIC] Findings and trends will be reported by the administrator to QAPI Committee. Monitoring and verification of the POR included the following: In-service attendance sheet was verified on [DATE] staff were inservice on monitoring residents with identified UTI symptoms and confirmed UTIs and documentation. Interviews completed with staff members on [DATE] (LVN G, LVN H, MA I, LVN J, LVN K, LVN L, MA M, LVN N, LVN O, LVN P, ADON Q, ADON R, ADON S) reflected that all staff were educated on signs and symptoms of UTIs and the monitoring and documentation of signs and symptoms. In-service attendance sheet was verified on [DATE] staff were inservice on monitoring and following up with residents who had antibiotics ordered and documenting status updates Interviews completed with staff members on [DATE] (LVN G, LVN H, MA I, LVN J, LVN K, LVN L, MA M, LVN N, LVN O, LVN P, ADON Q, ADON R, ADON S) reflected that all staff were educated on following up and documenting, the status updates of ordered antibiotics. In-service attendance sheet was verified on [DATE] staff were inservice on monitoring the availability and acquisition of physician ordered medication along with verifying anticipated delivery (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	date of medication and appropriately documenting. Interviews completed with staff members on [DATE] (LVN G, LVN H, MA I, LVN J, LVN K, LVN L, MA M, LVN N, LVN O, LVN P, ADON Q, ADON R, ADON S) reflected that all staff were educated on calling the pharmacy to verify availability and anticipated delivery date of ordered medication and document in the resident's charts. In--service attendance sheet was verified on [DATE] staff were inservice on following up and in communication with the NP/MD when an ordered medication is not available and ensuring the communication is reflected in the clinical record Interviews completed with staff members on [DATE] (LVN G, LVN H, MA I, LVN J, LVN K, LVN L, MA M, LVN N, LVN O, LVN P, ADON Q, ADON R, ADON S) reflected that all staff were educated on notifying provider when a medication is not available and were aware of document the communication on the residents charts. In-service attendance sheet was verified on [DATE] staff were inservice on reviewing the ekit for availability of ordered medication. Interviews completed with staff members on [DATE] (LVN G, LVN H, MA I, LVN J, LVN K, LVN L, MA M, LVN N, LVN O, LVN P, ADON Q, ADON R, ADON S) reflected that all staff were aware to review the kit for any new order medication to check for availability. Record review on [DATE] of the 24 hours summary from [DATE] to [DATE] revealed all residents on antibiotics were monitored for any s/s. Record review of the Sampled residents, Resident #2, Resident #3, and Resident #4's, MAR revealed they all had orders for antibiotics, and the antibiotic was administered as prescribed. During an interviews with, the ADON clarified that whoever was assigned to work on weekends will verify medication was delivered, or communication and documentation is reflected in the clinical record if there is a delay, or med is not available. She stated, during the weekdays, the ADONs will verify. During interview with the DON, she verified random review of 5 residents with antibiotics weekly to ensure compliance with antibiotic administration, monitoring, and documentation, she also stated that any discrepancies will be addressed immediately. During an interview with the Administrator, he stated he did not identify any other residents with similar issues, however, any finding and trend will be reported to the QAPI committee. The Administrator was informed that the Immediate Jeopardy was removed on [DATE] at 5:27 p.m., however, The facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm that was not immediate and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free of significant medication errors for 1 of 3 Residents (Resident #1) reviewed for antibiotic medication. Facility failed to acquire and administer physician ordered antibiotics to treat Resident #1's identified UTI. On [DATE] R#1was sent to hospital, admitted with septic shock and expired on [DATE]. An Immediate Jeopardy (IJ) was identified on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated with a potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk of delay in care, worsening of health conditions, adverse reactions, hospitalization, and death.Findings included: Record review of Resident #1's face sheet dated [DATE] reflected a [AGE] year-old female with an admission date of [DATE] with pertinent diagnoses that included End Stage Renal Disease (is the final stage of chronic kidney disease (stage 5), where kidneys lose of function, causing kidney failure. It requires life-sustaining treatment, such as dialysis or a kidney transplant.) Record review of Resident #1's quarterly MDS assessment dated [DATE] reflected a Brief Interview for Mental Status (BIMS) score of 15 which meant intact cognitive status. Resident #1 received dialysis while being a resident. Record review of Resident #1's comprehensive care plan dated date initiated [DATE] revealed she was on antibiotic therapy Blujepa related to infection Urinary tract infection/E. Coli (Escherichia coli are bacteria commonly found in the intestines of humans and animals), initiated on [DATE]. Interventions: administer antibiotic medications as ordered by physician. Monitor/document side effects and effectiveness every shift. Record review of Resident #1's nurses notes on her electronic medical record dated [DATE] at 6:52 p.m., authored by LVN A reflected: Resident #1 complained of general weakness. LVN A called NP C and he ordered to draw Complete blood count (a common blood test that measures the cells circulating in your blood) and comprehensive metabolic panel (a routine 14-test blood panel used to evaluate liver/kidney function, fluid balance, and metabolism). Record review of Resident #1's nurses notes on her electronic medical record dated [DATE] at 9:41 a.m., authored by LVN B reflected Resident #1 complained of general weakness. LVN B called NP C and he ordered to ammonia level (measures the amount of ammonia in your blood to check for liver or metabolic issues) and urinalysis with culture (a two-part diagnostic test used to detect and identify urinary tract infections). Record review of Resident #1's nurses notes on her electronic medical record dated [DATE] at 1:50 p.m., authored by LVN E reflected (HE/SHE) reported lab results and urinalysis to NP C. No new orders at that time. Record review of Resident #1's urinalysis results received on [DATE] revealed leukocytes 500 in the urine (ref range-Negative).Record review of Resident #1's nurses notes on her electronic medical record dated [DATE] at 12:25 p.m., authored by LVN B reflected she notified the NP C on [DATE] of the urine culture results. NP C provided a new order for Blujepa [oral antibiotic to treat urinary tract infections] 750 mg twice per days for 5 days and a consult with infection preventionist NP D. Record review of Resident #1's on her electronic medication administration record dated [DATE], reflected no documentation that her order for Blujepa was administered. Record review of Resident #1's nurses notes on her electronic medical record showed no documentation regarding the delivery/acquisition status of the medication Blujepa and no documentation of follow up communication with the pharmacy or NP/MD. Record review of Resident #1's nurses notes on her electronic medical record dated [DATE] at 6:53 p.m., authored by LVN A reflected NP D discontinued order for Blujepa and ordered Invanz 500 mg IV every night for 10 days. Record review of Resident #1's on her electronic medication administration record dated [DATE], reflected no documentation the order for Invanz [a broad spectrum antibiotic used to treat serious bacterial infection, including Urinary Tract Infections] was administered. Record review of Resident #1's nurses notes on her electronic medical record dated (continued on next page)

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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 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE] at 10:46 a.m., authored by LVN A reflected, while at dialysis, Resident#1 became lethargic, had low blood pressure, and Resident #1 was sent to the hospital via EMS. Record review of Resident #1's nurses notes on her electronic medical record dated [DATE] at 4:52 p.m., authored by LVN A reflected she was admitted for septic shock (a life-threatening, advanced stage of sepsis where infection causes severe, widespread inflammation and dangerously low blood pressure), NSTEMI (a type of heart attack caused by a partial blockage of a coronary artery) and thrombocytopenia (a medical condition characterized by an abnormally low number of platelets in the blood). Record review of Resident #1's hospital record dated [DATE] reflected Resident #1 expired on [DATE] from cardiac arrest (a medical emergency where the heart suddenly and unexpectedly stops beating, causing it to stop pumping blood to the brain, lungs, and other organs.) During a phone interview on [DATE] at 2:27 p.m., NP C stated that he was notified on [DATE] regarding Resident #1, and he ordered a complete blood count and a comprehensive metabolic panel. NP C stated that on [DATE], he ordered a urinalysis with culture and an ammonia level. NP C stated that on [DATE], he was called and was notified on the urinalysis results and he did not give any orders. He stated he wanted to wait for the urine culture results because Resident #1 did not have any symptoms. NP C stated that on [DATE], he received the results on the urine culture and he ordered Blujepa and a consult with NP D. NP C stated that he was not called regarding the Blujepa antibiotic not arriving to the facility from the pharmacy until after 3 to 4 days. During a phone interview on [DATE] at 3:10 p.m., NP D stated that she went to the facility on [DATE] for a consultation with Resident #1. NP D stated that she discontinued the order for Blujepa, because it was a contraindication for residents with renal failure. NP D stated she ordered Invanz 500mg IV every night for 10 days for E coli in the urine. NP D stated it was a possibility that an untreated UTI could lead to septic shock and death. During a phone interview on [DATE] at 3:30 p.m., the Pharmacy staff stated that the pharmacy received the order for the Blujepa on [DATE]. Pharmacy staff stated that the blujepa medication was a new antibiotic, and it usually took 3 to 4 days to arrive to the facility. Pharmacy staff stated that the facility was aware of the delay of the medication. Pharmacy staff stated that, on [DATE], the facility had 4 vials of Invanz 500mg available in the emergency kit machine. During an interview on [DATE] at 4:00 p.m., LVN A stated that on [DATE], Resident #1 told him that she was feeling generalized weakness and that she was not feeling her normal self. LVN A stated that he called NP C and notified him. LVN A stated that NP C ordered a comprehensive complete panel and a complete blood count. LVN A stated, on [DATE], NP D came to the facility and she changed the antibiotic order to Invanz. LVN A stated that he did not recall if he called the pharmacy to follow up regarding the antibiotic status, or when the medication was going to arrive the facility. LVN A stated, on [DATE], he received a call from dialysis that the resident was sent out to the hospital due to lethargy and weakness. During an interview on [DATE] at 6:30 p.m., LVN F stated that on [DATE], when the dose for Invanz was due, he checked the emergency kit machines that were in the facility and that he did not find the Invanz antibiotic. LVN F stated that he did follow up with the pharmacy, and that the pharmacy told him that the Invanz antibiotic would get to the facility in the morning, but he forgot to document that in the Resident #1's electronic chart. During an interview on [DATE] at 9:58 a.m., with LVN B stated that, on [DATE], she reported the urine culture results to NP C, NP C ordered Blujepa, and she ordered the antibiotic from pharmacy. LVN B stated that she did follow up with the pharmacy, but she did not document on the Resident's electronic chart. LVN B stated that the pharmacy said that they had received the order for Blujepa on [DATE]. LVN B stated that she forgot to ask the estimated time of arrival. During an interview on [DATE] at 3:05 p.m., with the DON stated she was not aware Resident#1 had not received her antibiotics. DON stated staff should follow up on medication to ensure it was delivered and received, and if the medication was not available, they should be in communication with the NP to see what else they could do. DON stated that she was not aware that the antibiotic was going to be delayed. During an interview on [DATE] at 4:00pm, the Administrator stated that the facility did not have a policy for quality of care. This was determined to be an Immediate Jeopardy (IJ) on [DATE] at (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5:48PM. The Administrator was notified. The Administrator was provided with the IJ template on [DATE] at 5:48pm and the POR was asked at this time. The following Plan of Removal (POR) submitted by the facility was accepted on [DATE] at 05:27 p.m.: Plan of RemovalName of Facility-[Facility]Date of Compliance: [DATE] F684- Quality of CareImmediately actions1. DON and/or designee will educate nursing staff on monitoring residents with identified UTI symptoms and confirmed UTIs and documentation on [DATE]. Staff not currently working will be educated prior to their next shift. 2. DON and/or designee will educate nurses on monitoring and following up with residents who had antibiotics ordered and documenting status updates on [DATE]. Staff not currently working will be educated prior to their next shift. 3. DON an/or designee will educate the nurses and med aids on monitoring the availability and acquisition of physician ordered medication along with verifying anticipated delivery date of medication and appropriately documenting it on [DATE]. Staff not currently working will be educated prior to their next shift. 4. DON and/or designee will educate nurses on following up and in communication with the NP/MD when an ordered medication is not available and ensuring the communication is reflected in the clinical record on [DATE]. Staff not currently working will be educated prior to their next shift. 5. DON and/or designee will educate nurses about reviewing the ekit for availability of ordered medication on [DATE]. Staff not currently working will be educated prior to their next shift. 6. IP and/or designee audited all residents with active orders for antibiotics to confirm that medication is available and administered on [DATE]. 7. ADONS and/or designee will audit all residents with antibiotics and infections to ensure that residents are being monitored and documented daily. 8. ADONs and/or designee will audit residents with active orders for antibiotics to confirm that medication is available and administered daily.9. ADONs and/or designee will review, during workday clinical meetings, new physician ordered medication to ensure that medication was delivered, or communication and documentation is reflected in the clinical record if there is a delay or med is not available.10. DON will perform a random review of 5 residents with antibiotics weekly to ensure compliance with antibiotic administration, monitoring, and documentation. 12. [SIC]If any discrepancies are found, they will be addressed immediately.13.[SIC] Findings and trends will be reported by the administrator to QAPI Committee. Monitoring and verification of the POR included the following: In-service attendance sheet was verified on [DATE] staff were inservice on monitoring residents with identified UTI symptoms and confirmed UTIs and documentation. Interviews completed with staff members on [DATE] (LVN G, LVN H, MA I, LVN J, LVN K, LVN L, MA M, LVN N, LVN O, LVN P, ADON Q, ADON R, ADON S) reflected that all staff were educated on signs and symptoms of UTIs and the monitoring and documentation of signs and symptoms. In-service attendance sheet was verified on [DATE] staff were inservice on monitoring and following up with residents who had antibiotics ordered and documenting status updates Interviews completed with staff members on [DATE] (LVN G, LVN H, MA I, LVN J, LVN K, LVN L, MA M, LVN N, LVN O, LVN P, ADON Q, ADON R, ADON S) reflected that all staff were educated on following up and documenting, the status updates of ordered antibiotics. In-service attendance sheet was verified on [DATE] staff were inservice on monitoring the availability and acquisition of physician ordered medication along with verifying anticipated delivery date of medication and appropriately documenting. Interviews completed with staff members on [DATE] (LVN G, LVN H, MA I, LVN J, LVN K, LVN L, MA M, LVN N, LVN O, LVN P, ADON Q, ADON R, ADON S) reflected that all staff were educated on calling the pharmacy to verify availability and anticipated delivery date of ordered medication and document in the resident's charts. In--service attendance sheet was verified on [DATE] staff were inservice on following up and in communication with the NP/MD when an ordered medication is not available and ensuring the communication is reflected in the clinical record Interviews completed with staff members on [DATE] (LVN G, LVN H, MA I, LVN J, LVN K, LVN L, MA M, LVN N, LVN O, LVN P, ADON Q, ADON R, ADON S) reflected that all staff were educated on notifying provider when a medication is not available and were aware of document the communication on the residents charts. In-service attendance sheet was verified on (continued on next page)

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	05/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fox Hollow Post Acute	310 America Dr 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 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE] staff were inservice on reviewing the ekit for availability of ordered medication. Interviews completed with staff members on [DATE] (LVN G, LVN H, MA I, LVN J, LVN K, LVN L, MA M, LVN N, LVN O, LVN P, ADON Q, ADON R, ADON S) reflected that all staff were aware to review the kit for any new order medication to check for availability. Record review on [DATE] of the 24 hours summary from [DATE] to [DATE] revealed all residents on antibiotics were monitored for any s/s. Record review of the Sampled residents, Resident #2, Resident #3, and Resident #4's, MAR revealed they all had orders for antibiotics, and the antibiotic was administered as prescribed. During an interviews with, the ADON clarified that whoever was assigned to work on weekends will verify medication was delivered, or communication and documentation is reflected in the clinical record if there is a delay, or med is not available. She stated, during the weekdays, the ADONs will verify. During interview with the DON, she verified random review of 5 residents with antibiotics weekly to ensure compliance with antibiotic administration, monitoring, and documentation, she also stated that any discrepancies will be addressed immediately. During an interview with the Administrator, he stated he did not identify any other residents with similar issues, however, any finding and trend will be reported to the QAPI committee. The Administrator was informed that the Immediate Jeopardy was removed on [DATE] at 5:27 p.m., however, The facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm that was not immediate and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.