

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676398	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2026
NAME OF PROVIDER OR SUPPLIER Fox Hollow Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility nursing staff failed to demonstrate competencies and skill-sets to care for residents' needs, as identified through resident assessment, and described in the plan of care, for 1 of 4 (Resident #1) residents reviewed. The facility failed to ensure CNA A continuously monitored and maintained proper positioning while sitting in her wheelchair for Resident #1. This deficient practice could place residents at risk of not receiving care and services to meet their needs. Findings included:Record review of Resident #1's admission record, dated 07/24/26, reflected a [AGE] year-old female re-admitted on [DATE] and originally admitted on [DATE]. Her relevant diagnoses included acute chronic systolic heart failure (a long-term stable weak heart pumping condition), dementia (a decline in mental ability severe enough to interfere with daily life), chronic kidney disease (a long-term condition where the kidneys are damaged and cannot filter flood), and subsequent non-st elevation (NSTEMI) myocardial infarction (a heart attack that occurs within four weeks (28 days) of a previous one.Record review of Resident #1's significant change MDS assessment, dated 07/03/26, reflected a BIMS score of 03, which reflected her cognition was severely impaired.Record review of Resident #1's quarterly care plan, dated 06/27/26, reflected:Focus: 06/04/2026 [Resident #1] has impaired skin integrity as evidenced by skin abrasion (abrasion) to rt foot 1st, related to trauma. Date initiated 06/04/2026.Interventions/Tasks: See NP, x-rays 2 views R foot, administer treatments as ordered and monitor for effectiveness, notify the physician if signs or symptoms of infection occur, and use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. Date initiated 06/04/26.Record review of Resident #1's progress notes/change of condition, dated 06/04/26 at 3:13 p.m., authored by ADON C reflected: Situation: skin wound or ulcer.nursing observations: [Resident #1] sitting at nurse's station when this nurse observed bleeding from right foot. [Resident #1] does with abrasions and bleeding.Record review of Resident #1's Skin Issues assessment, dated 06/04/26 at 7:46 p.m., reflectedSkin issues: new issue, location: right dorsum (top surface of foot)1st digit, 2nd digit, 3rd digit, and 4th digit: Skin issue: abrasion, Progress: new wound, acquired: in-house acquired, .Presence of wound pain: no.During an observation and interview on 07/23/26 at 9:45 a.m., Resident #1 was observed lying in bed awake. Her right foot was observed wrapped in clean white gauze, covering her toes. Resident #1 was not interviewable.During a telephone interview on 07/24/26 at 1:43 p.m., CNA A said Resident #1 was non-verbal, was not ambulatory and relied on her specialized wheelchair for ambulation. CNA A said Resident #1 had no sensation to her left leg and feet. She said on 06/04/26, while she was exiting the employee's breakroom, Resident #1 was sitting in the dining room in her wheelchair and waved her over. CNA A said when she approached Resident #1, she asked her to take her outside to get fresh air. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 676398 If continuation sheet Page 1 of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676398	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2026
NAME OF PROVIDER OR SUPPLIER Fox Hollow Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA A said she asked her charge nurse for permission and was told it was ok to take her outside. She said Resident #1 had both feet on the footrest, wearing socks, and had a blanket covering her legs and feet. CNA A said she proceeded to wheel Resident #1 outside through the front door. CNA A said once they were outside, Resident #1 requested to be taken around the facility and she agreed. CNA A said she wheeled Resident #1 around the building one time and then proceeded to take her back inside and parked her in front of the nurse's station. CNA A said about ten minutes after leaving her in the nurse's station, CNA B confronted her and asked her what had happened to Resident #1. CNA A said she had no idea what she was talking about and asked CNA B what she meant. CNA A said CNA B told her Resident #1's right toes were bleeding. She said she was called to the DON's office where she was questioned regarding what had happened. CNA A said she advised the DON and the Administrator that she had no idea what had happened to Resident #1. She said Resident #1 had not complained or had any facial grimacing while they were outside. CNA A said the Administrator started reviewing their surveillance camera and that's when they found out what happened. CNA A said she saw on the surveillance camera Resident #1's right foot had slipped off the footrest and dragged along the gravel as wheelchair moved. CNA A said she had failed to ensure Resident #1's feet were on her wheelchair's footrest periodically while she wheeled her around the building. CNA A said the fact that Resident #1 had a blanket covering her legs and feet might have caused her to overlook where her feet were. CNA A said she never saw blood, and Resident #1 never verbally complained or had facial grimacing. CNA A said that was the first time she had ever taken a resident outside the facility. CNA A said she had been in-serviced many times on transfer procedures, feet positioning while in the wheelchair, and safety. CNA A said a negative outcome to Resident #1 not having her feet on the wheelchair's footrest would be that she can get hurt. She said she had successfully completed her annual skill checks. During an interview on 07/24/26 at 2:09 p.m., CNA B said on 06/04/26 at around 2:30 p.m., she noticed Resident #1 sitting in her wheelchair in front of the nurse's station. She said when she proceeded to wheel her back to her room to lay her down, she noticed Resident #1's right foot was bleeding. She said Resident #1 did not have any facial grimacing or complained of pain. CNA B said she immediately called ADON C to go assess Resident #1. CNA B said ADON C helped her take Resident #1 back to her room. CNA B said when they got to Resident #1's room, the wound care nurse was also assisted in transferring Resident #1 back to bed. CNA B said once Resident #1 was in bed, she continued rounding other residents. During an interview on 07/24/26, at 2:18 p.m., ADON C said Resident #1 was non-verbal, non-ambulatory, and relied on her specialized wheelchair to get around. She said Resident #1 had no feeling to her right leg/foot. She said on 06/04/26, she had been called by CNA C to the nurse's station to assess Resident #1. She said she observed Resident #1's had abrasions to her 1st, 2nd, 3rd, and 4th toes and were bleeding. She said she Resident #1 was wearing socks so the blood had already absorbed. She said between her and CNA B took Resident #1 back to her room to lay her down. She said while in Resident #1's room, the wound care nurse arrived, and both assessed Resident #1. She said they notice Resident #1's 1st, 2nd, 3rd, and 4th, toes had abrasions and no deformities were observed. She said Resident #1's NP was notified and ordered x-rays of her foot, pain medication was administered, and family member was notified. ADON C said Resident #1 was seen by her podiatrist on 06/05/26 and no new orders were given. ADON C said Resident #1's x-rays were negative for fractures. She said wound care was initiated immediately after laying Resident #1 in bed and continued to this date. ADON C said Resident #1's wounds were healing and looked good. ADON C said she and the facility's DON regularly in-service staff on proper foot placement in wheelchairs and assuring footrest are in place. During an interview and observation on 07/24/26 at 2:25 p.m., the WCN said on 06/04/26, she had been called to Resident #1's room. She (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676398	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2026
NAME OF PROVIDER OR SUPPLIER Fox Hollow Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said when she arrived, ADON C and CNA B were with Resident #1. She said between all three, they transferred Resident #1 back to her bed. The WCN said Resident #1 had not voiced any pain, nor she had any facial grimacing during the transfer. The WCN said she immediately assessed Resident #1 and observed she had an abrasion to her right foot 1st, 2nd, 3rd, and 4th digits. She said she had immediately initiated wound care and as of today, her 2nd, 3rd, 4th abrasions were resolved. The WCN said Resident #1's 1st digit nail was still being treated. The WCN said she was later told Resident #1's right foot slipped off the wheelchair's footrest more than likely had contact with street. The WCN said Resident #1 had no sensation to her legs and feet. During an interview on 07/24/26 at 2:45 p.m., the DON said Resident #1 is non-verbal, was non-ambulatory, had a specialized wheelchair for transport, and relied on staff for all her ADLs. The DON said on 06/04/26, she was told Resident #1 was observed sitting in her wheelchair by the nurse's station. She said CNA B observed Resident #1's right foot bleeding and immediately notified ADON C. She said upon being assessed by the facility's WCN and ADON C, Resident #1 was observed with an abrasion on 1st, 2nd, 3rd, and 4th right toes. The DON said she was told that earlier that day CNA A had taken Resident #1 taken Resident #1 outside because she felt a bit anxious. She said she and the Administrator immediately interviewed CNA A but denied any incident occurred to Resident #1 while she wheeled her around the facility. The DON said the Administrator reviewed the surveillance camera and that's when they discovered what happened to Resident #1. She said what they saw was while Resident #1 was being wheeled, she had a blanket covering her legs and feet and only wearing socks. The DON said while CNA A wheeled Resident #1 around the facility, in one of the turns, her right foot slipped from the wheelchair's footrest and dragged along the street while she was being wheeled. The DON said she observed Resident #1 with no facial grimacing. The DON said CNA A was observed failing to ensure Resident #1's feet were properly positioned on the wheelchair footrests, which resulted in Resident #1's right foot dragging on the street while she was being wheeled. She said Resident #1's NP was immediately notified; x-rays were ordered with no acute findings. She said Resident #1 continues with wound care treatment and abrasions were almost healed. The DON said she and the facility's ADONs regularly in-serviced staff on wheelchair safety, which included proper placement of feet. The DON said CNA A was immediately terminated because of the fact that it happened. The DON said a negative outcome for CNA failure to ensure Resident #1 had her feet resting on the wheelchair's footrest at all times was the possibility of an injury. During an interview on 07/24/26 at 2:59 p.m., the Administrator said after reviewing the facility's CCTV that Resident #1's right foot abrasions occurred while she was being wheeled outside by CNA A. He said he initiated an investigation, in-services were conducted to all staff, nursing interventions were added as well, MD and family were made aware, police report made, skill checks were initiated on all direct contact staff. He said CNA A was terminated. The Administrator said all staff were in-serviced on the topic of ANE weekly and as needed. Record review of the facility's Staffing, Sufficient and Competent Nursing policy revised April 2025, reflected: The facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment. Policy Interpretation and Implementation: Competent Staff: 1. Competency is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles occupational functions successfully. 3. Licensed staff must demonstrate the skills and techniques necessary to care for residents needs including. b. resident rights. g. person-centered care		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676398	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2026
NAME OF PROVIDER OR SUPPLIER Fox Hollow Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0755 Level of Harm - Minimal harm or potential for actual harm 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 #2) reviewed for medications. Facility failed to administer physician ordered medications Lisinopril and Clopidogrel Bisulfate to Resident #2 on 07/12/26. This failure could place residents at risk of delay in care, worsening of health conditions, adverse reactions, hospitalization, and death. Finding included: Record review of Resident #2' admission record, dated 07/23/26, reflected a [AGE] year-old male admitted on [DATE] and discharged on 07/13/26. His relevant diagnoses included cerebral infarction due to unspecified occlusion or stenosis of right middle cerebral artery (an ischemic attack where blood flow to the right side of the brain is reduced or blocked by a narrowed or closed vessel), toxic encephalopathy (a brain dysfunction caused by exposure to harmful substances (prescription drugs or heavy metal), diastolic heart failure (when the main pumping chamber of the heart becomes thick and stiff), and hypertension (when blood pushes too strongly against your artery walls at readings consistently at or above 130/80). Record review of Resident #2's MDS assessment was still in progress. Record review of Resident #2's initial care plan, dated 07/13/26, reflected: Focus: Hypertension: [Resident #2 has a diagnosis of hypertension and is at risk for elevated blood pressure. Date initiated: 07/13/26. His interventions included administer medication as ordered. Date initiated: 07/13/26. Record review of Resident #2's physician order summary, dated 07/23/26, reflected: Lisinopril Oral tablet 5 mg (Lisinopril) give 2 tablet by mouth two times a day for HTN. Order date 07/11/26 and start date 07/12/26. Clopidogrel Bisulfate tablet 75 mg. Give 1 tablet by mouth one time a day for blood clot prevention. Date ordered 07/11/26 and start date 07/12/26. Record review of Resident #2's July 2026 MAR reflected: Lisinopril Oral tablet 5 mg (Lisinopril) give 2 tablet by mouth two times a day for HTN, start date 07/12/26 had a code 9 (pending medication) on 07/12/26 at 8:00 a.m. Clopidogrel Bisulfate tablet 75 mg. Give 1 tablet by mouth one time a day for blood clot prevention, start date 07/12/26 had a code 9 (pending medication) on 07/12/26 at 8:00 a.m. Record review of the facility's emergency automated dispensing cabinet list of medications reflected that on 07/12/26 there were 6 Lisinopril Oral tablet 5 mg and 6 Clopidogrel Bisulfate tablet 75 mg. Record review of the Resident #2's Delivery Manifest Report, dated 07/12/26 at 4:57 p.m., reflected lisinopril and clopidogrel were delivered to the facility on [DATE] at 4:57 p.m. Record review of Resident #2's progress notes on 07/12/26 did not reflect LVN D's attempts to contact the pharmacy or NP regarding his orders for lisinopril and clopidogrel. During an interview on 07/23/26 at 3:28 p.m., LVN D said she was Resident #2's charge nurse on 07/12/26 from 6 a.m. to 6 p.m. She said Resident #2 was admitted the evening of 07/11/26 and since his admission he displayed aggressive behaviors towards staff and family members. She said Resident #2 refused all his over the counter medications (vitamins) during her shift. LVN D said Resident #2 had an order for lisinopril 2 tablets twice a day at 8:00 am and 8:00 pm and clopidogrel one time a day at 8:00 a.m. LVN D said she entered code 9 for both lisinopril and clopidogrel because they were pending for the pharmacy to deliver the medications. LVN D said she did not check the facility's emergency automated dispensing cabinet to see if lisinopril and clopidogrel were available. She said since Resident #2 refused the over the counter medications she figured he was going to refuse lisinopril and clopidogrel also. LVN D said sometime during her shift she notified Resident #2's NP that he was noncompliant with his over the counter medications but did not mention the facility had not yet received lisinopril and clopidogrel. She said she must have forgotten to mention it because (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676398	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2026
NAME OF PROVIDER OR SUPPLIER Fox Hollow Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she was too busy monitoring Resident #2 and continued thinking he would have also refused those two medications also. LVN D said there were no negative outcomes to Resident #2 not administered lisinopril and clopidogrel because she continued thinking he would refuse them also. LVN D said she had been in-serviced on medication administration and knew to check of the facility's emergency automated dispensing cabinet when a resident's order is pending to be delivered by the pharmacy to ensure residents don't skip medications. During a telephone interview on 07/24/26 at 11:25 a.m., the Dr. said he was called on 07/11/26 when Resident #1 was admitted to reconcile his medications. He said Resident #2 was admitted with altered mental status. The Dr. said Resident #2 started displaying noncompliance with medications and behavioral problems upon admission. He said on 07/12/26, a facility nurse called him to let him know Resident #2 was being non-compliant with his medications but was not told the pharmacy had not yet delivered lisinopril and clopidogrel. The Dr. said in my professional opinion, there were no negative outcomes to Resident #2 not being administered lisinopril and clopidogrel for one day (07/12/26). He said Resident #2 was sent out to the hospital the morning of 07/13/26 due to his altered mental status and remained hospitalized where he continued to refuse medication. During an interview on 07/24/26 at 10:18 a.m., the DON said Resident #2 was admitted the evening of 07/11/26 and discharged to the hospital on [DATE]. She said Resident #2 displayed verbal and physical aggression towards staff and family members since his he was admitted . The DON said LVN D should have checked the facility's emergency automated dispensing cabinet to see if lisinopril and clopidogrel were available. The DON said staff are continuously reminded to the facility's emergency automated dispensing cabinet to ensure medications were administered as ordered. The DON said if the medication(s) have not been delivered by the pharmacy, nursing staff should be calling the pharmacy to check on their status, notify the resident's NP, and ensure they document all their efforts. The DON said all nursing staff were regularly in-serviced on the topic of medication administration. The DON said there were no negative outcomes to Resident #2 because he had been non-compliant with his medications since he was admitted and the following day he was sent out to the hospital for altered mental status. Record review of the facility's Administration Medication policy, not dated reflected: Medications are administered in a safe, timely, and clinically appropriate manner in accordance with all prescriber orders and regulatory requirements. Any medication refusals, omissions, or errors must be documented and reported in accordance with facility policy and reviewed through the QAPI process. Staff are expected to follow all established procedures to ensure accountability and continuous quality improvement.		