

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

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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 01/22/2026
NAME OF PROVIDER OR SUPPLIER Fox Hollow Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for kitchen sanitation. The facility failed to ensure food was properly labeled and dated. The facility failed to clean the equipment properly. This failure placed all residents who ate food served by the kitchen at risk of cross contamination and food-borne illness. Findings Include: Observation of the juice machine on 01/20/26 at 8:27 AM revealed one of the spouts had a green substance around the entire rim. Observation of the walk-in refrigerator on 01/20/26 at 8:31 AM revealed a plastic container of tomatoes and a plastic container of oranges, not labeled or dated indicating when it was received. Observation of the walk-in pantry on 01/20/26 at 8:40 AM revealed a case of five coffee creamer bottles not labeled or dated indicating when it was received. In an interview on 01/20/26 at 8:47 AM, the DM stated that all staff were responsible for cleaning the juice machine. The DM stated that every morning after breakfast, staff cleaned all equipment used. The DM stated that she was responsible for checking that the kitchen and equipment was clean but forgot to look at the juice machine spout. The DM stated that she would be inspecting the spouts from now on. The DM stated it was important for equipment to be clean because equipment could have germs and make the residents sick. The DM stated she had a system for labeling food items; the morning shift labeled the refrigerated foods, and the afternoon shift labeled the dry foods. The DM stated that she or the cook was in charge of overseeing that all food items were labeled properly. The DM stated it was important for food to be labeled and dated because food needed to be disposed of when it expired. The DM stated it was also important that food was labeled and dated because expired food would be dangerous for residents; the residents could get sick. In an interview on 01/22/26 at 9:32 AM, the Administrator stated he did not know why the juice machine was not cleaned. The Administrator stated he had spoken to the DM to ensure all areas of the kitchen were cleaned properly. The Administrator stated that labels fell off from the plastic containers in the refrigerator because the refrigerator was cold. The Administrator stated he did not know why the coffee creamers were not labeled but after speaking with the DM, the DM ensured him that all food was going to be labeled and dated. Record review of the Sanitation policy dated April 2026 revealed: 2. All utensils, counters, shelves and equipment shall be kept clean. 10. The Food Services Manager will be responsible for scheduling staff for regular cleaning of kitchen and dining areas. Record review of the Refrigerators and Freezers policy dated 2001 revealed: 7. All food is appropriately dated to ensure proper rotation by expiration dates. Received dates (dates of delivery) are marked on cases and on individual items removed from cases for storage.		

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received services in the facility with reasonable accommodation of each resident's needs, for two residents (Resident #1 and Resident #2), of twenty-eight residents reviewed for call light access. Residents #1 and #2's call light was placed out of reach of Resident #1 and Resident #2 while in bed. This failure could place residents at risk for not being able to call for assistance from staff. The findings included: 1. Record review of Resident #1's admission Record, dated 01/20/26, revealed Resident #1 was a [AGE] year-old resident and was admitted to the facility on [DATE]. Resident #1's diagnoses included hypertension (high blood pressure), nontraumatic intracerebral hemorrhage (a serious stroke type, bleeding directly into the brain tissue), stroke, and speech and language deficits following stroke. Record review of Resident #1's Quarterly MDS assessment, dated 10/20/25, revealed Resident #1: -was usually understood by others, -was usually able to understand others, -BIMS was 03 which indicated he had severe cognitive impairment, -Resident was dependent on 2 or more staff for bed mobility, Eating, Shower/bath, and toileting. -was frequently incontinent of bowels and bladder. Record review of Resident #1's care plan, dated 11/10/25, revealed: FOCUS: Cognitive Impairment: Resident #1 exhibits cognitive loss related to altered cognitive performance with BIMS (Brief Interview for Mental Status) Score of:(SEVERE IMPAIRMENT 3.0) Date Initiated: 05/02/2025 Revision on: 05/02/2025 GOALS: Will avoid complications (i.e., falls, injury, impaired nutrition/hydration, decline in ADLs) related to cognitive deficits to extent possible. Date Initiated: 05/02/2025 Revision on: 11/05/2025 Target Date: 01/31/2026 INTERVENTIONS/TASKS: Anticipate needs and meet promptly. Date Initiated: 05/02/2025 CNA LPN LVN RN Discuss concerns regarding overall status/health with resident/family as needed. Date Initiated: 05/02/2025 LPN LVN SSD CM RN Encourage routine daily decision making as indicated. Date Initiated: 05/02/2025 CNA LPN LVN RN Explain all care before providing to reduce resident tension and promote a comfortable experience. Date Initiated: 05/02/2025 CNA LPN RN LVN Invite, encourage, remind, and escort to activity programs as desired. Date Initiated: 05/02/2025 ACTA ACTD CNA LPN LVN Medication as ordered. Date Initiated: 05/02/2025 LPN LVN RN Monitor for changes in cognitive status. Notify physician if observed. Date Initiated: 05/02/2025 LPN LVN RN. 2. Record review of Resident #2's admission Record, dated 01/20/26, revealed Resident #2 was an [AGE] year-old resident and was admitted to the facility on [DATE]. Resident #2's diagnoses included Alzheimer's Disease (a progressive, irreversible neurodegenerative brain disorder), dementia (an umbrella term for a decline in mental function - including memory, language, problem-solving, and reasoning - severe enough to interfere with daily life and independent functioning), white matter disease (conditions that damage the brain's white matter which causes symptoms like cognitive decline, memory loss, balance issues, and gait disturbances), and heart disease. Record review of Resident #2's Medicare 5-Day MDS assessment, dated 11/22/25, revealed Resident #2: -was usually understood by others, -was usually able to understand others, -BIMS was 05 which indicated he had severe cognitive impairment, -Resident required supervision or touching assistance for eating; -Resident was dependent on 2 or more staff for Shower/bath, and -Resident required partial to moderate assistance with toileting. -was occasionally incontinent of bowel and continence of bladder was not rated due to catheter. Record review of Resident #2's care plan, dated 01/14/26, revealed: FOCUS: Resident #2 has impaired cognitive function/dementia or impaired thought processes r/t Alzheimer's, Dementia, WHITE MATTER DISEASE, UNSPECIFIED Date Initiated: 06/19/2024 Revision on: 06/19/2024 GOAL: [Resident #2] will be able to communicate basic needs on a daily basis through the review date. Date Initiated: 06/19/2024 Revision on: 11/07/2025 Target Date: 04/14/2026 INTERVENTIONS/TASKS: Administer medications as ordered. Monitor/document for side effects and effectiveness. Date Initiated: 06/19/2024 LPN RN Ask yes/no questions in order to determine the resident's needs. Date (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Initiated: 06/19/2024 ACTA CNA LPN RN SW Cue, reorient and supervise as needed. Date Initiated: 06/19/2024 CNA LPN RN Discuss concerns about confusion, disease process, NH placement with resident/family/caregivers). Date Initiated: 06/19/2024 LPN RN SW Monitor/document/report PRN any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. Date Initiated: 06/19/2024 LPN RN In an observation on 01/20/26 at 10:39 AM Resident #1 was lying in bed with the head of his bed inclined. There were fall mats on the floor at the sides of his bed. Resident #1's call light was not within reach. The call light was at the head of the bed to the side dangling toward the floor. Resident #1 closed his eyes and would not speak with surveyor. In an observation and interview on 01/20/26 at 10:40 AM Resident #2 was lying in bed with the head of his bed inclined. Resident #2's call light was not in reach. His call light was tucked between the mattress and the bedrail. Resident #2 stated he did not know where the button for the light was. He said he had not seen it. He said he did not know how he would call for the nurse if he needed anything. In an interview on 01/20/26 at 10:55 AM CNA A for Resident #1 and Resident #2 stated Resident #1 could not reach his call light because it was too far out of reach. CNA A stated the call lights were to always be in reach of residents. CNA A stated if the call light was not within reach of the resident, the residents would not be able to notify them if they needed help. CNA A stated they were in-serviced on call lights twice a week. She said the last in-service on call lights was on Friday (01/16/26). CNA A stated Resident #2's call light was right next to the bed and it was also supposed to be within his reach. CNA A stated it was mostly the CNAs responsibility to ensure the call light was within reach of the resident, but it was also everyone's responsibility. CNA A stated if the resident's call light was not within reach, they may fall trying to get up without assistance. In an interview on 01/20/26 at 10:59 AM CNA B for Resident #1 and Resident #2 stated Resident #1 could not reach his call light. She said he was supposed to be able to reach his call light. CNA B stated if Resident #1 had an emergency, he could scream to call them. CNA B stated they were in-serviced all the time on call lights. She said the last time she was in-serviced was two weeks ago. CNA B stated Resident #2's call light was also supposed to be within his reach. CNA B stated everyone was responsible for making sure the call lights were within reach of the residents. She said the residents may fall if their call light was not within reach because they would try to get up by themselves. In an interview on 01/22/26 at 01:50 PM LVN C stated everyone was responsible for call lights. She said the call light should be within reach of the residents whenever they are in their bed. She said if the resident did not have the call light within their reach, the resident may fall because they may attempt to get out of bed without assistance or they would not get help if it was wanted. In an interview on 01/22/26 at 02:00 PM LVN D stated everyone was responsible for call lights. She said the call light needed to be within the patient's reach. She said if the call light was not within the patient's reach and the patient needed assistance, they could fall or if they needed assistance immediately the assistance would be delayed. In an interview on 01/22/26 at 03:23 PM ADON E stated everybody was responsible for call lights and rounding. She said the call lights were to be within the resident's reach. She stated if the residents could not use their call light to call for assistance, they may try to get up from bed unassisted and fall. She said they are in-serviced on call lights 1 - 2 times a week. She said the last in-service they received on call lights was on Tuesday, 01/20/26. In an interview on 01/22/2026 at 04:05 PM the Administrator stated all staff were responsible for call lights and making sure the call light was readily available for the residents. He said if the residents could not reach or use their call light, that may cause a lapse in care. He said the staff were just in-serviced on call lights on Tuesday (01/20/26). In an interview on 01/22/2026 at 04:12 PM the DON stated everybody was responsible for making sure the call lights were within reach of the residents. She said the call lights are to be next to the resident so they could call for assistance when they need it. She said if the call light was not within reach, it could delay the need of the residents and ADL care they require. Record review of the facility's policy Answering the Call Light, 2001 Med-Pass, Inc. (Revised March (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2021) revealed: Purpose The purpose of this procedure is to ensure timely responses to the resident's requests and needs. General Guidelines 4.Be sure that the call light is plugged in and functioning at all times. 5.When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident. 6.Some residents may not be able to use their call light. Be sure you check these residents frequently.		

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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** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and time frames to meet a resident's medical, nursing, mental and psychosocial needs, for 1 Resident (Resident#72) of 3 residents reviewed for care plans. The facility did not develop and implement a comprehensive person-centered care plan to address Resident#72's behaviors. These failures could place all 121 residents in the facility at risk for their mental and psychosocial needs not being met. The findings included: Record review of Resident#72's face sheet, dated 1/21/26, revealed Resident #72 was 66 years-old male and was initially admitted to the facility on [DATE]. Resident#72's diagnoses included: Muscle Weakness, unspecified lack of coordination, unsteadiness on feet. Record review of Resident#72's Quarterly MDS assessment, dated 11/30/25, revealed Resident#72:-had moderate cognitive impairment;-was able to make self understood;-was usually able to understand others;-was able to walk 10 feet with supervision of touching assistance;-was able to walk 50 feet with supervision of touching assistance;-was able to walk 150 feet with supervision of touching assistance;Record review of Resident #72's Comprehensive care plans dated 12/1/25 revealed no focus, goals or interventions/tasks related to Resident#72's behavioral issues, refusing using shoes or non-skid socks. During an observation on 1/20/26 at 12:30 p.m., Resident #72 was in the dining room without shoes or non-skid socks. During an interview on 1/20/26 at 12:41 p.m., CNA J stated that Resident #72 refused to wear shoes or non-skid socks. She stated nurses were aware of Resident #72 refusing to wear shoes or non-skid socks. During an interview on 1/20/26 at 12:45 p.m., LVN K stated Resident #72 refused to wear shoes or non-skid socks. LVN K said when Resident #72 refused to wear shoes or non-skid socks, nurses should have informed DON about the refusal. LVN K said that she was sure the refusal of the shoes was already care planned. LVN K said that the negative outcome for refusal to wear shoes or non-skid socks not being on the care plan was that staff would not know Resident#72 could fall. She said that by being care planned, staff could minimize the falls or prevent falls for Resident #72. During an interview on 1/20/26 at 1:00 p.m., Resident #72 said that he was offered to wear the shoes, but he left to the dining room without the shoes. During an interview on 1/22/26 at 3:00 p.m., the DON said Resident #72 had refused wearing shoes or non-skid socks. DON said that MDS nurse and all nurses were responsible for updating the care plan. DON said that when a resident refused wearing shoes it should have been care planned. DON said that the negative outcome would be not following the plan of care. Record review of the facility's policy on, Care Plans, Comprehensive Person-Centered, with revision date March, 2022, revealed: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The facility's Matrix for Providers revealed 121 residents in the facility.		

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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** 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 restore continence to the extent possible for 1 of 3 residents (Resident#116) reviewed for indwelling catheters. The facility failed to prevent Resident#116's urinary catheter tubing (bag) from touching the floor. This failure could place residents at risk for cross contamination and urinary tract infections. Findings included: Record review of Resident#116's face sheet revealed an [AGE] year-old male originally admitted on [DATE]. Resident#116 admitted with diagnosis of other obstructive and reflux uropathy (when flow of urine is blocked in the bladder, ureter urethra). Record review of Resident #116's MDS dated [DATE], Section C-Cognitive patterns revealed Resident #116 had a BIMS score of 4 which indicated Resident #116 had severely impaired cognition. Section H-Bladder and bowel revealed Resident #116 had an indwelling catheter. Record review of Resident #116's care plan dated 12/1/2025 revealed Resident #116 has a foley catheter Obstructive and reflux uropathy Date initiated 11/4/25 and revised on 11/9/25, Intervention/tasks listed: the resident #116 has a 18 french 10 milliliters balloon, Intervention: indwelling position catheter bag and tubing below the level of the bladder and away from entrance room door. Record review of Resident #116's Order Summary printed 1/21/26 revealed an order to Change Foley Catheter 18 # French with 10milliliters balloon every 30 days and if plugged out or dislodged as needed. Order Foley catheter care every shift and as needed start dated 09/30/25. During an observation conducted on 01/20/26 at 10:15 AM, Resident #116's indwelling catheter bag was noted laying on the floor on the right side of Resident #116's bed. During interview with CNA I on 01/20/26 at 10:15 AM, CNA I was informed and shown the catheter bag laying on the floor. She stated the foley bag should not be touching the floor. CNA I put on gloves after sanitizing hands with hand sanitizer and hung the foley bag on Resident#116's bedframe. CNA I stated by the foley bag touching the floor, Resident #116 could be at risk for infection. During interview with LVN H on 01/20/26 at 10:18 AM, LVN H was informed of the catheter bag laying on the floor. She stated it should not be touching the floor. She replied that a negative outcome of a foley catheter bag being on the floor was the catheter wouldn't drain well and pick up bacteria from floor. LVN H stated that she receives infection control training very often, about once a month, which includes hand washing, enhanced barrier precautions, foley catheter care, nebulizer care and equipment sanitation and avoiding cross contamination. During interview with DON on 01/22/26 at 3:00 PM, she stated that for catheters they should be on the side of the bed, not on the part that goes up and down, so it does not fall, but on the frame. DON stated, no, it should not be touching the floor, if on the floor it could cause a urinary infection to the resident. She stated they would be thinking of ways to prevent bags from touching the floor on residents with low lying beds, perhaps putting another bag to serve as a barrier. Record Review of Policy Titled Catheter Care, Urinary with revised date September 2014, revealed: Be sure the catheter tubing and drainage bag are kept off the floor.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that a resident who needs respiratory care was provided such care, consistent with professional standards of practice for 2 of 4 residents (Resident#132 and Resident #3) reviewed for oxygen in that: 1. Resident #132 received oxygen at 2 LPM via nasal cannula without a physician's order. 2. The facility failed to ensure Resident #3's oxygen was administered at the correct setting of 3 LPM on [DATE] as ordered by the physician. These deficient practices could affect the residents who received oxygen continuously and could result in residents receiving incorrect or inadequate oxygen support and could result in a decline in health. The findings were: 1. Record review of Resident #132's face sheet, dated [DATE], reflected an [AGE] year-old female admitted to the facility on [DATE] with pertinent diagnoses that included Pneumonia (a lung infection that inflames the air sacs, causing them to fill with fluid or pus, which makes it hard to breathe), Congestive Heart Failure (heart muscle weakens and can't pump enough blood, causing fluid backup), Moderate Persistent Asthma, and Dementia (an umbrella term for a decline in mental function - including memory, language, problem-solving, and reasoning - severe enough to interfere with daily life and independent functioning). Record review of Resident #132's care plan dated [DATE] reflected Resident #132 was at risk for complication with the respiratory system due to shortness of breath. Interventions -Oxygen therapy as ordered. Record review of Resident #132's electronic chart reflected there was no physician order for oxygen. During an observation on [DATE] at 3:10 p.m. Resident #132 was laying in bed with O2 via NC at 2LPM. No distress was noted. During an interview on [DATE] at 3:23 p.m., LVN Q confirmed that there was no physician order in place for Resident #132's oxygen. She stated that Resident #132 required continuous oxygen via NC. LVN Q stated that it was important to have a physician order in place to administer the adequate amount of oxygen to Resident #132. She stated that they were nurses who work on a as needed basis and knowing what the setting was supposed to be at was important. LVN Q stated that the negative outcome of not having a physician order in place would be that the nurse would then not realize that they need to be on oxygen and the resident can desaturate (blood oxygen drops) making it hard to breath and would have to perform CPR. During an interview on [DATE] at 3:25 p.m., LVN D stated that she was the ADON covering the 600 hall due to the assigned ADON was out today, [DATE]. She confirmed that there was no physician oxygen order in place for Resident #132. LVN D stated that the admitting nurse was responsible for entering the physician order right away. She stated the ADON audits physician orders daily. LVN D stated that it was important for the physician oxygen order to be in place to make sure that they were fulfilling the residents' medical needs. She stated that the resident can desaturate and get rehospitalized or cause death. During an interview on [DATE] at 2:15 p.m., the DON stated that the nurse who admitted the resident was responsible for entering the physician oxygen order. She stated that the nurses were responsible for following physician orders. The DON stated that she does not know how it got missed. She stated that it was their responsibility to check that it was in place. The DON stated that it was important to have a physician's order in place to make sure that they were following the physician orders and for patients' safety. She stated that they cannot administer oxygen without a physician order. 2. Record review of Resident #3's admission record dated [DATE] revealed a [AGE] year-old female with an admission date of [DATE] and with an initial admission date of [DATE]. Pertinent diagnoses included Cerebral Infarction (brain tissue death caused by a blocked blood vessel), Congestive heart failure (heart muscle weakens and can't pump enough blood, causing fluid backup), Heart disease, Chronic Kidney Disease, Hypertension (high blood pressure), and Type 2 Diabetes Mellitus. Record review of Resident #3's Quarterly MDS assessment dated [DATE] revealed oxygen therapy. Record review of Resident #3's physician order dated [DATE], revealed oxygen at 3 LPM continuous via nasal cannula per concentrator. Record review of Resident #3's person-centered care plan initiated date [DATE] (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed Resident #3 used oxygen therapy related to Congestive heart failure and Shortness of breath. Intervention included, Administer oxygen as ordered. O2 at 3 LPM continuous via nasal cannula per concentrator. During an observation of Resident #3 on [DATE] at 9:25 am, the oxygen level on the oxygen concentration machine was at 2 LPM via nasal cannula. Observed Resident #3 in bed with head of the bed slightly elevated. No signs of respiratory distress were noted. In an interview on [DATE] at 9:27 am, Resident #3's family member stated the nurse had not checked the oxygen machine in the morning. In an interview on [DATE] at 9:34 am, LVN P stated she was the nurse for Resident #3. LVN P verified that the setting on the oxygen machine was set at 2 LPM. LVN P checked Resident #3's oxygen order and stated the doctor's order was for 3 LPM. LVN P stated she had not had a chance to go into Resident #3's room to check on the oxygen setting. She stated that the assigned ADON was in charge of checking oxygen settings once a day. LVN P stated she normally checked on resident's oxygen settings, but she had just not been able to get to Resident #3's room yet. LVN P stated if an oxygen setting was not correct, a resident could have had hypoxia (a serious condition where tissues don't get enough oxygen), shortness of breath or respiratory distress. In an interview on [DATE] at 1:32 pm, LVN C stated she was the ADON assigned for Resident #3's hall. LVN C stated that Resident #3 was a resident that needed to be constantly monitored. LVN C stated that the family tended to move the oxygen setting. LVN C stated she went in the morning to check the oxygen settings, and it was at 2 LPM and raised it to 3 LPM. LVN C stated she was not sure of what had happened or how the oxygen setting was changed. LVN C stated she had spoken with the family about no moving the setting. LVN C stated the floor nurse should have also checked the oxygen setting but did not know why it was not checked. LVN C stated if oxygen settings were wrong, the resident could have lost oxygen and desatted (slang term for decrease in oxygen saturation). LVN C stated Resident #3 had a history of pneumonia, and it was important for the oxygen settings to be as the doctor ordered them. In an interview on [DATE] at 1:44 pm the DON stated everyone was responsible for checking the oxygen settings. Every nurse that went into the room should have checked the oxygen settings to ensure the right setting and the right rate. DON stated if the family was indeed moving the settings, then the nurses should have checked on the resident more frequently. Record review of the facility's Oxygen Administration Policy with a revised date of [DATE] revealed, Preparation 1. Verify that there is a physician's order for this procedure. Review the physicians' orders or facility protocol for oxygen administration. Review the physician's orders or facility protocol for oxygen administration. Review the resident's care plan to assess for any special needs of the resident.		

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NAME OF PROVIDER OR SUPPLIER Fox Hollow Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 310 America Dr Brownsville, TX 78526	
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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure a medication error rate below 5% for 27 medication administration opportunities with 3 errors resulting in a 11.11% medication error rate, for 2 of 5 residents (Resident #92 and Resident #56) reviewed for medication administration. 1. The MA failed to check Resident #92's pulse prior to the administration of his medications Amiodarone (used to regulate rapid and/or irregular heart rhythms) and Metoprolol (used to treat high blood pressure, chronic chest pain, and to improve survival following a heart attack) as ordered by the physician during medication pass observation on 01/21/2026 at 7:50 a.m. 2. The facility failed to ensure Resident #56 received medication Novolin R insulin (used to control high blood sugar) as ordered by the physician on 01/21/2026 at 4:00 p.m These failures could place residents at risk of low heart rate, dizziness, risk of falling, severe low blood pressure, hospitalization, and high blood sugars which can lead to death if not receiving the intended therapeutic benefits of the medication. The Findings included: 1. Record review of Resident #92's face sheet reflected a [AGE] year-old male admitted to the facility on [DATE] and original admit date on 03/14/2024 with the following pertinent diagnoses of Primary Hypertension (high blood pressure), Unspecified Atrial Fibrillation (irregular heartbeat), Peripheral Vascular Disease (poor blood flow to arms, legs or organs), Other Disorder of Circulatory System (issues with the heart, blood, or vessels that impair blood flow). Record review of Resident #92's quarterly MDS dated [DATE] reflected he was assessed to have a BIMS score of 13 indicating he was cognitively intact. Record review of Resident #92's comprehensive care plan dated 01/05/2026 reflected a problem Cardiac: At risk for impaired cardiac function and complications related to Atherosclerotic Heart Disease, Atrial Fibrillation, Hypertension, Diabetes. Interventions included Administer medications as ordered. Observe, document, and notify MD of adverse side effects. Review of Resident #92's physician order summary reflected an order dated 02/19/2025 for Amiodarone HCL oral tablet 200mg give 1 tablet by mouth one time a day for HTN, Hold if SBP less than 100, DBP less than 60 or PULSE less than 60, Notify MD. He also had an order dated 02/19/2025 for Metoprolol Tartrate oral tablet 50mg give 1 tablet by mouth two times a day for hypertension Hold if SBP less than 100, DBP less than 60 or PULSE less than 60, Notify MD. During an observation on 01/21/2026 at 7:50 a.m., the MA checked Resident #92's blood pressure manually. She stated that the blood pressure reading was 152/80 and that she did not get the pulse. MA proceeded to prepare and administer 11 medications for Resident #92. She then documented on each medication that was administered but when she got to Amiodarone, the system prompted her to enter the pulse reading. MA exited out of the computer and went back into the room to check Resident #92's pulse. She returned to the computer and documented pulse 88 for Amiodarone and Metoprolol. During an interview on 01/21/2026 at 8:15 a.m., the MA stated she was supposed to check Resident #92's pulse before administering Amiodarone and Metoprolol. She stated that it was important to check the pulse before administering medication because she needs to know if the reading was not low. If it was too low and not within the parameters, then she cannot administer it. She stated that she did not check the pulse before administering medications because she got nervous. The MA stated that the negative outcome would be that Resident #92's heart rate can drop and he can have a heart attack. During an interview on 01/21/2026 at 8:21 a.m., ADON E stated that both Metoprolol and Amiodarone have parameters to hold the medication if the pulse was less than 60. She stated that the pulse was to be checked before administering these medications to know if they would need to hold it and not administer. ADON E stated that the negative outcome would be that the resident can go into bradycardia (slow heart rate) and become unstable to where they would have to send them out to the hospital. During an interview on 01/22/2026 at 2:15 p.m., the DON stated that her expectation was that the blood pressure and pulse were to be checked prior to administering blood pressure medications. She stated the negative outcome for not checking prior to administering was that if the (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pulse was less than 60 the resident can have cardiac problems, low blood pressure, and could become unresponsive. 2. Record review of Resident #56's face sheet reflected an [AGE] year-old female admitted to the facility on [DATE] and original admit date [DATE] with the following pertinent diagnoses of Type 2 Diabetes Mellitus with Hyperglycemia (high blood sugar), Chronic Kidney Disease, and Muscle Wasting and Atrophy (wasting or shrinkage of muscles). Record review of Resident #56's quarterly MDS dated [DATE] reflected she was assessed to have a BIMS score of 13 indicating she was cognitively intact. Record review of Resident #56's comprehensive care plan dated 12/12/2025 reflected a problem Diabetes: Resident #56 had a diagnosis of diabetes and was at risk for complications. Interventions included Give medications per order. Review of Resident #56's physician order dated 01/18/2026 reflected Novolin R Injection Solution 100unit/ml (insulin Regular Human) Inject as per sliding scale: if 150-199=2250-299=6300-349=8350-499=10 call MD to report, subcutaneously before meals and at bedtime. Record review of Resident #56's Medication Administration Record for January 2026, dated 01/21/2026, reflected that Resident #56 blood sugars were checked 14 times from 01/18/2026 through 01/21/2026. 1 out of the 14 times that the blood sugar was checked since the order began, Resident #56 had one blood sugar reading of 206 and was not administered insulin. During an observation of medication administration on 01/21/2026 at 4:00 p.m. for Resident #56, LVN G was observed that insulin Novolin R was not administered. LVN G stated that the computer system would prompt her if insulin needed to be administered once she entered the blood sugar reading. LVN G entered the blood sugar reading of 233 and the system did not prompt her to administer insulin. She then stated that she would go to another resident since Resident #56 does not require insulin to be administered. LVN G documented in Resident #56's medication administration record that no insulin was administered. During an interview on 01/21/2026 at 4:10 p.m., LVN G reviewed the Novolin R insulin order along with surveyor. She stated that the insulin sliding scale order had been entered incorrectly. LVN G stated that the range in the insulin sliding scale that was omitted was 200-249=4 units. She stated that she was the nurse who had entered the insulin order on 01/18/2026. LVN G corrected the order and administered 4 units. LVN G stated that the negative outcome of not administering the insulin due to having a missing range would be that Resident #56 could have a hyperglycemic (condition in which the sugar level in the blood was higher than normal) episode, which could be critical. During an interview on 01/21/2026 at 4:26 p.m., LVN D stated that she was the ADON overseeing the 400 hall. She stated that the nurse responsible for entering the order was the nurse who takes the order from the doctor. LVN D stated that she prints a daily report and reviews the orders that were entered. She stated that she does not know how this error was missed and not caught. She stated that the standard insulin sliding scale was that any blood sugar reading of 150 would require insulin to be administered. LVN D stated that the negative outcome would be that the resident could have a hyperglycemic episode. During an interview on 01/22/2026 at 2:15 p.m., the DON stated that the nurse responsible for entering the order was the one who takes the order from the doctor. She stated that the orders were reviewed in their morning meetings. She does not know how it was missed. The DON stated that it was her responsibility to have caught it. She stated that the negative outcome of not entering the insulin sliding scale correctly was that the resident could have multiple doses missed. This would cause the resident to become hyperglycemic and cause more complications. Record review of the facility policy and procedure titled Administering Medications with a revised date April, 2019 revealed: Policy Statement Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation 4. Medications are administered in accordance with prescriber orders, including any required time frame. 11. The following information is checked/verified for each resident prior to administering medications: b. Vitals signs, if necessary		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure drugs and biologicals were stored and labeled in accordance with currently accepted professional principle, and included the appropriate accessory and cautionary instructions and the expiration date when applicable for 2 of 6 medication carts (400 hallway nurse cart and 100 hallway cart). 1.The facility failed to ensure that the 400 hall nurses medication cart was locked and secured when LVN G left the medication cart unlocked and unsecured on [DATE]. 2.The OTC medication in the 100 hallway Medication Cart did not have an opened date written on the bottle. These failures could place residents at risk of injury if medications left unsecured were consumed, drug diversion, and not receiving the therapeutic effects of the medication or treatment.The findings included: 1.During an observation on [DATE] at 2:15 p.m., the 400 hall nurse's medication cart was left unlocked and unattended by LVN G. Observed LVN G get supplies out of the medication cart, leave it unlocked, and walk into the resident's room. LVN G then returned to the medication cart again, left the medication cart unlocked once again and walked into the resident's room to administer G-tube medication. During an interview on [DATE] at 2:31 p.m., LVN G stated that she was responsible for the nurse's medication cart that was left unlocked. She stated that she was nervous trying to get supplies for her G-tube medication observation that she forgot to lock it. She stated that if it was left unlocked then a resident or a family member could open it and take medications. During an interview on [DATE] at 2:35 p.m., LVN D stated that she was the ADON overseeing the 400 hall. She stated that it was the nurse's responsibility for her medication cart to be locked. LVN D stated that the nurse's medication cart was to be locked every time they step away from the cart. She stated that the medication carts have all types of medication and if left unlocked it endangers the residents. LVN D stated that the residents can get a hold of medications. During an interview on [DATE] at 2:15 p.m., the DON stated that the nurses were responsible for keeping the medication carts locked. She stated the medication carts should be locked immediately before they walk away from the cart. The DON stated that it was important for the medication carts to be locked to prevent anybody from going into the carts and getting medications. She stated that they would be conducting random checks to monitor that the medication carts are kept locked. Record review of the facility policy and procedure titled Adminstrating Medications with a revised date April, 2019 revealed: Policy Interpretation and Implementation 19. During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. During an observation on [DATE] at 10:00 a.m., of the Medication Cart 100 hallway with LVN F, revealed one over the counter (OTC) medications which did not have an opened date written on the bottle (Melatonin 5 mg). During an interview on [DATE] at 10:05 a.m., LVN F stated the OTCs should have an open date written on them. He said that the bottle of medication was still within the expiration date but should (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have had an open date written on them. He said it was important to write the open date to know for how long the bottle had been opened. During an interview on [DATE] at 3:15 p.m., DON stated that she knew the medication bottle was still within the expiration date. DON stated that she would make sure the bottles found (without an open date written on them) were disposed of because they did not know when the bottles were opened and she did not want residents to get medication that they did not know when it was opened. DON stated that she did not think there was a negative outcome due to the bottle was not expired. Record review of the facility policy and procedure titled Storage of Medications with a revised date November, 2020 revealed: 4. Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.		