STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676033	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Town Hall Estates	300 Happy LN Hillsboro, TX 76645

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46708 Based on observation, interview and record review the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming and personal and oral hygiene for 1 of 8 residents (Resident #4) reviewed for ADL care. The facility failed to ensure toenails for diabetic Resident #4 were smooth and trimmed. This failure could place residents at risk of skin tears and infection. Findings include: Record review of Resident #4's face sheet, dated 03/07/25, reflected a [AGE] year-old male who was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident #4 had diagnoses which included chronic pain, acute myocardial infarction (heart attack), cerebral infarction (a condition where blood flow to the brain is interrupted, causing brain cells to die) and Type 2 diabetes mellitus (a chronic condition where the body does not use insulin effectively or does not produce enough insulin to regulate blood sugar levels). Record review of Resident #4's care plan record reflected a focus, dated 03/21/24, of Activities of Daily Living self-care performance deficit related to activity intolerance due to COPD (a group of lung diseases that cause airflow obstruction and breathing difficulties), pneumonia , and respiratory failure with a goal dated 03/21/24 to maintain current level of function in Activities of Daily Living. Resident #4 had the following intervention, dated 03/21/24: 1. The resident requires limited assistance by staff with personal hygiene. 2. The resident requires skin inspection Q Day, observe for redness, open areas, scratches, cuts, bruises, and report changes to the nurse Record review of Resident #4's quarterly MDS, dated [DATE], reflected a BIMS score of 11, which indicated moderately impaired cognition. Observation on 03/06/25 at 3:57 PM of Resident #4's nails, revealed Resident #4 lying in his bed with his feet bare. His nails were yellowish in color, thick and overly long with uneven jagged edges. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/06/25 at 3:57 PM with Resident #4 revealed the only thing he really needed was someone to look at his toenails because when he put socks on, his toenails made his toes sore, and it bothered and aggravated him. He couldn't cut his toenails himself because he was a diabetic and he couldn't reach his toes to cut them. He said he had not had his toes trimmed in about a year. Resident #4 gave the State Surveyor permission to take a photograph of his toenails. Interview on 03/07/25 at 1:58 PM with LVN D reflected, after showing her the photograph of Resident #4's toenails, Resident #4 needed toenail care . She said the possible negative effects of not getting toenails cared for were infection or an open skin injury. Interview on 03/07/25 at 2:21 PM with LVN C reflected, after showing her the photograph of Resident #4's toenails, Resident #4 needed toenail care. She stated the nurses were supposed to trim the nails for diabetic residents. She said if nails were not trimmed, residents could get scratches and cuts from sharp nails. The jagged edges of the toenails could get filed and he should have been referred to podiatry. She said the charge nurses were responsible for making sure nail care is taken care of . Interview on 03/06/25 at 11:14 AM with the DON reflected Resident #4 was a diabetic and a nurse would need to do his nail care but there was nothing in Resident #4's chart that reflected he was receiving nail care. The possible outcome of a resident not getting their nails clipped were wounds and Resident #4 was a diabetic and there could be wound complications . Record review of the facility's Activities of Daily Living Policy, dated 2018, reflected Resident who are unable to carry out activities of daily living independently will receive the services necessary to maintain grooming, and personal and hygiene. Policy Interpretation and Implementation: Appropriate care and services will be provided for residents who are unable to carry out activities of daily living independently, with the consent of the resident and in accordance with the plain of care, including appropriate support and assistance with: a. Hygiene (grooming)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46708 Based on observation , interview and record review the facility failed to ensure, based on the comprehensive assessment of a resident, that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for three of ten (Resident #1, Resident #2 and Resident #3) residents reviewed for quality of care. 1. The facility failed to ensure skin assessment orders for Resident #1 and Resident #2 were followed. 2. The facility failed to ensure Resident #3 was not left in bedding saturated with urine. 3. The facility failed to ensure Resident #3 received incontinent care for over two hours from 3:12 PM until 5:13 PM on 03/06/25. These failures could place residents at risk of skin breakdown, infection, and injury. Findings include: 1. Record review of Resident #1's face sheet, dated 03/07/25, reflected a [AGE] year-old female who was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1 had diagnoses which included dementia , schizoaffective disorder (a mental health condition that combines schizophrenia and mood disorder, such as depression or bipolar disorder) and anxiety disorder . Record review of Resident #1's care plan, dated 10/02/21, reflected a focus of potential for pressure ulcer development related to immobility with a goal of intact skin, free of redness, blister or discoloration, dated 10/02/21, with interventions which included: 1. Follow facility policies/protocols for the prevention/treatment of skin breakdown, dated 10/02/21. 2. Inform the resident/family/caregivers of any new area of skin breakdown, dated 10/02/21. 3. Monitor/document/report as needed any changes in skin status, appearance, color, wound healing, signs and symptoms of infection, wound size (lengthy X width X depth) stage, dated 10/02/21. 4. Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate (fluid that leaks out of blood vessels into nearby tissues). Record review of Resident #1's quarterly MDS, dated [DATE], reflected a BIMS score of 11, which indicated moderaterly impairted cognitive. Resident #1 was frequently incontinent. A record review of Resident #1's orders reflected an order for weekly skin assessments, dated 12/04/24 . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of the facility's, undated, list of residents with skin issues reflected Resident #1 had a facility acquired skin issue on 03/05/25 etiology (causation) trauma. A record review of Resident #1's skin assessments reflected the following 4 (four) skin assessments between 12/04/24 and 03/07/25: 12/25/24 skin check 01/22/25 skin check 01/29/25 skin check 02/5/25 skin check A record review of the facility's, undated, list of residents with skin issues, reflected Resident #1 had a facility acquired skin issue on 03/05/25 etiology (causation) trauma. A record review of Resident #1's Post Fall Evaluation, dated 03/05/25, reflected a small scratch to her left upper back. A record review of the Resident #1's skin assessments reflected no skin assessments after the Post Fall Evaluation, dated 03/05/25 . 2. Record review of Resident #2's face sheet, dated 03/07/25, reflected a [AGE] year-old female who was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident #2 had diagnoses which included blindness, one eye, intervertebral disc degeneration, lumbosacral region (a common condition characterized by age-related wear and tear of the spinal discs, potentially causing pain, stiffness, and nerve issues) and Type 2 diabetes mellitus (a chronic condition where the body does not use insulin effectively or does not produce enough insulin to regulate blood sugar levels). Record review of Resident #2's care plan record, dated 10/02/23, reflected a focus of potential for pressure ulcer development related to immobility with a goal, dated 08/19/24, of intact skin, free of redness, blister or discoloration with intervention, dated 08/19/24, of follow facility policies/protocols for the prevention/treatment of skin breakdown. A record review of Resident #2's MDS, dated [DATE], reflected a BIMS score of 15, which reflected no cognitive impairment. A record review of the facility's, undated, list of residents with skin issues reflected Resident #2 had a facility acquired skin issue on 03/02/25 etiology (causation) skin tear. A record review of Resident #2's orders reflected an order for weekly skin assessments, dated 02/25/25. A record review of Resident #2's Post Fall Evaluation, dated 03/02/25, reflected an open lesion (a region in an organ or tissue which has suffered damage through injury or disease, such as a wound) location buttocks, a skin tear located right lower arm, and skin tear left outer forearm. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident #2's skin assessments reflected one skin assessment, Skin & Wound - Total Body Skin Assessment, dated 02/02/25 . 3. Record review of Resident #3's face sheet, dated 03/0/625, reflected a [AGE] year-old female originally admitted to the facility on [DATE]. Resident #3 had diagnoses which included metabolic encephalopathy (a condition where the brain's function is impaired due to an underlying metabolic disturbance), dementia and muscle wasting. Record review of Resident #3's care plan, dated 08/01/23, reflected a focus of occasional bladder incontinence (involuntary loss of urine) with a goal, dated 08/10/23, that resident will remain free from skin breakdown due to incontinence and brief use through the review date. Resident #3 had the care plan intervention, dated 08/10/23, of Resident #3 used disposable briefs, change Q2 hours and prn. Record review of Resident of #3's care plan focus, dated 08/10/23, reflected Activities of Daily Living self-care performance deficit related to aggressive behavior, confusion, dementia, and impaired balance with a goal, dated 08/10/23, resident was dependent for all Activities of Daily Living, staff to anticipate and meet all needs. Resident #3 had care plan intervention, dated 08/01/23, - personal hygiene: the resident required Extensive assistance by 2 staff with personal hygiene. Record review of Resident #3's care plan, dated 08/10/23, reflected a focus, dated 08/10/23, of communication problem related to dementia, Resident #3 was unable to answer questions appropriately, unable to make needs known, her speech was mostly word salad (a jumble of extremely incoherent speech) with a goal, dated 08/10/23, the resident would have basic needs met by staff on a daily basis. Resident had care plan intervention, dated 08/10/23 - anticipate and meet Resident #3's needs. Observation on 03/06/25 at 3:10 PM revealed Resident #3 in her room. While standing at the open door to the resident's room, the resident was seen laying in her bed with the right side of her bed against the wall. The State Surveyor requested Resident #3's permission to come into the room and Resident #3 turned towards the State Surveyor but did not respond. Resident #3 was fingering an adult sensory book (designed for adults who may experience sensory sensitivities or sensory processing difficulties to aid in self-regulation and comfort, featuring textured pages, varied stimuli, and calming elements) and speaking to unintelligibly to herself. The State Surveyor entered the room and stood at the side of Resident #3's bed and asked how she was doing but resident was not interviewable. The State Surveyor felt the following materials approximately 4 inches away from Resident #3's body from her waist to her thighs: 1. Resident #3's fitted sheet 2. the padding above the fitted sheet and placed under Resident #3 3. the top blanket over Resident #3 All three materials were wet and had a strong odor of urine. The State Surveyor asked Resident #3 if she was wet and needed a brief change. Resident #3 looked at the State Surveyor but did not respond and turned her attention to a dog stuffed animal to her left. Observation on 03/06/25 of Resident #3's room beginning at 3:12 PM revealed the following: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staff (name unknown) walked down hallway at 3:42 PM and did enter any resident rooms, at this time, Resident #3 was wet for approximately 25 minutes after initial observation at 3:10 pm. Observation at 4:31 PM, revealed CNA A entered Resident #3's room and no incontinent care performed. Observation at 4:58 PM CNA A entered Resident #3's room and no incontinent care performed . Observation and interview on 03/06/25 at 5:13 PM with CNA A in Resident #3's room, the State Surveyor asked CNA A to check Resident #3 and see if Resident #3 was wet. CNA A checked the front of Resident #3's brief and replied, she was, a little wet. The State Surveyor asked CNA A to feel the areas the State Surveyor felt at 3:10 PM and tell the State Surveyor if she felt fabric was wet. CNA A stated the fabric was wet. Interview on 03/06/25 at 5:17 PM with CNA A, reflected she had worked at the facility for [AGE] years. She said the requirement was for CNAs to round on the residents every 2 hours . CNA A stated rounding meant checking on resident needs and changing their briefs if the resident needed a brief change. She revealed Resident #3 had dementia and could not tell you if she needed her brief changed and she could not use the call light. When asked why she did not change Resident #3's brief when she entered Resident #3's room two times she said she did not think Resident #3 was uncomfortable. CNA A said she was not surprised Resident #3 was wet because Resident #3 was a heavy wetter (urinates frequently and/or in larger volumes). When asked if a resident was a heavy wetter, would that mean that the resident needed to be checked more often , and CNA A said, yes. She said residents who could not use the call light should be checked on more frequently. CNA A said she received incontinence care training and was trained in the importance of incontinence care. She said if you did not check on residents and they were left in briefs soaked in urine for an extended period of time residents could have skin breakdown. Interview on 03/07/25 at 2:41 PM, CNA B stated the facility expectations for residents to be checked on or rounded was every 2 hours. The CNAs were to make sure residents were clean and dry and all their needs were meet. CNA B stated Resident #3 was not able to use the call light and if she had the call light in her hand, she was playing with it. She said if a resident was left in a wet brief for an extended period of time, it could cause chaffing, urinary tract infections, skin sores and it could make residents unhappy. She said the CNAs and the charge nurses were responsible for making sure residents were rounded on and checked, every two hours. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/07/25 at 2:21 PM with LVN C revealed she had worked at the facility for about six years and the facility requirement was for staff to round on residents every two hours. Rounding consisted of at least laying eyes on the residents. The CNAs were required to check the residents for incontinence every two hours and as needed. LVN C stated Resident #3 had severe dementia and she could not use the call light, and therefore needed to be rounded on more often. She said charge nurses were responsible for making sure the CNAs were doing rounds every two hours and changing resident briefs. She said when incontinent care was not provided residents could get a urinary tract infection and have skin breakdown. If the resident had severe dementia, and were in wet or soiled briefs, residents could have behavior issues. She said Resident #3 was a heavy wetter and she should have been changed at least once in the two-hour period of time she was observed by the State Surveyor. She said not checking on a resident every two hours was not good resident care. She said if a resident had an order for skin assessments, the order needed to be followed. She said skin assessments needed to be conducted weekly. She said if you did not conduct skin assessments, residents who might have skin breakdown might be missed and wounds could develop. She stated if wounds were bad, residents could get sepsis and could die. Interview on 03/07/25 at 1:58 PM with LVN D revealed she had worked at the facility for 2 years and 4 months. She said she was required to check in and round on residents every two hours. Rounding consisted of checking to make sure the resident had their call light and water, make sure they were responsive, confirming they had their fall interventions and check to see if they needed their brief changed. She stated if a resident was left in urine for a period of time the skin could break down and skin breakdown could happen quickly especially if residents were not independently mobile. She stated Resident #3 could not use the call light and needed more frequent checks. She said it was the responsibility of the charge nurse (LVN D said she was a charge nurse) to confirm the CNAs were doing resident rounds and resident incontinent care. She said skin care orders should be followed because the staff wanted to be sure skin was intact to prevent infections. Interview on 03/06/25 at 11:14 AM with the DON stated both Resident #1 and Resident #2 should have received skin assessments in accordance with their orders and skin assessments after their facility acquired skin issues. She said because the staff were not doing resident skin assessments, a skin assessment order was added for all residents in an effort to make sure the staff did the skin assessments. She stated skin assessments were important because if skin was assessed regularly, skin injury and issues could be prevented. She stated it was a problem that skin assessments were not being completed as ordered. She said CNAs were supposed to make rounds on residents every two hours and if a resident was left too long in a wet brief, a resident's skin could breakdown. When State Surveyor told the DON about her observations of CNA A with Resident #3, the DON said that scenario was not acceptable resident care, and the staff should have 100% checked Resident #3 and changed her brief. The DON stated if a resident was a heavy wetter they needed to be checked more frequently and needed more frequent brief changes. She said Resident #3 had severe dementia and was unable to let staff know about her needs and needed to be checked on and her brief changed more frequently. Record review of facility's Nursing Policy: Certified Nursing Assistant (CNA) Rounding Applicable to: Certified Nursing Assistance (CNAs), Licensed Nursing Staff, dated 10/21/14, reflected Purpose: To ensure timely and consistent care for residents by establishing structured rounding for CNAs. The policy aims to enhance residents' safety, comfort, and satisfaction while promoting a proactive approach to meeting resident needs. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Policy Statement CNAs shall conduct regular rounds during each 12-hour shift to monitor and assist residents with their activities ADLs, ensure safety, and promptly address their needs. Rounding must be structured, documented, and performed at designated intervals to provide high-quality care. Procedure: Frequency of CNA Rounding Each 12-hour shift shall include routine CNA rounding as follows: Two-hour Rounds: Every two hours, CNAs will provide hands-on care, including by not limited to Assisting with toileting and incontinence care Checking for hygiene needs and providing perineal care as needed CNAs much document completed round in the electronic health record or designated rounding log Missed round must be documented with a reason and report to the supervising nurse Record review of the facility's Incontinent Care Policy, dated 10/21/24, reflected: POLICY: Residents are checked for incontinence every 2 hours and as needed. PURPOSE: It is our goal at [facility name] to keep residents incontinent of bowel and bladder clean and dry throughout the shift [12 hr. shifts]. PROCEDURE: CNAs are trained to check for incontinence of bowel and bladder every 2 hours and as needed. CNAs are to change the resident's adult brief and perform incontinent care when the resident is wet and/or soiled. On the occasion a resident is not wet and/or soiled, it may not be necessary to perform incontinent care. The CNA is to notify the nurse the resident did not void. However, if a resident calls the CNA for incontinent care since the last check, the CNA will perform incontinent care for the resident. CNAs are not to leave their residents wet and/or soiled before leaving their shift. Record review of the facility's Pressure Ulcer Policy, undated, reflected: Purpose: [Facility name] holds paramount the quality of care of residents. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Definition: a pressure ulcer (a bed sore or pressure sore) is a dark or red area, a break or a deep, crater like wound in the skin caused by pressure. Pressure ulcers usually develop over bony parts of the body. Factors that may increase the risk of getting pressure ulcers include: Sitting or lying too long in one place Sitting in wet clothing or a wet bed Procedures: Residents' skin is checked: Within 24 hours of admission On a regular schedule At least weekly depending on the situation Whenever their condition changes Any change to the skin or unhealing skin conditions are reported through the change-of-command. Residents at-risk are closely watched by staff especially those that Can't move, don't move or are restrained Are incontinent (not able to control their bladder or bowel) Have active acute medical or psychiatric conditions Any changes to the skin or unhealing skin conditions are reported through the change-of-command .