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	04/18/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49065 Based on observations, interviews, and record review the facility failed to Identify and eliminate all known and foreseeable accident hazards in the resident's environment, to the extent possible for 1of 4 residents (Resident #1) reviewed for safety. The facility failed to ensure 1 of 4 residents (Resident #1) was free from risk of accidents and injuries when he was allowed to elope from the facility. The facility failed to properly repair a door for years. An IJ was identified on 04/16/2025. The IJ Template was provided to the facility on [DATE] at 05:09 PM. While the IJ was removed on 04/18/2025, the facility remained out of compliance at a scope of isolated and a severity with no actual harm due to the facility's need to complete repairs and evaluate the effectiveness of the corrective systems. These failures could place cognitively impaired residents at risk for accidents, injuries, and possible death. Findings included: Record review of Resident #1's undated face sheet, revealed he was a [AGE] year-old male admitted [DATE] with Alzheimer's, stroke, dysphasia (difficulty speaking), heart failure, pacemaker, and lack of coordination. Record review of Resident #1's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 99, which indicated the resident's cognitive and communication abilities were too impaired for him to complete the assessment. Record review of Resident #1's Care Plan, reflected Focus areas were initiated for the following areas: Communication problems-Resident can make basic needs known was initiated on 7/5/23 with an intervention stating, Monitor any changes in ability to communicate. Risk for elopement was initiated on 7/22/24 with an intervention stating, Make sure that wander guard is working . (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	ADL self-care deficit related to stroke was initiated on 7/5/23 with an intervention stating, The resident requires EXTENSIVE assistance by 1 person with personal hygiene. Incontinence focus related to Dementia was initiated on 7/5/23 with an intervention stating, Ensure the resident has unobstructed path to the bathroom. Impaired cognitive function/dementia related to Alzheimer's was initiated on 7/5/23 with an intervention stating, Administer medications as ordered. Monitor/document for side effects and effectiveness. Risk for falls related to gait/balance problems was initiated on 1/18/24 with an intervention stating, Anticipate and meet the resident's needs. Record review of Resident #1's Orders, reflected an order on 7/20/24 to monitor the wander guard to the right ankle, every shift, every day, and night shift. Observation on 4/16/25 at 11:20 AM of the facility's video surveillance revealed Resident #1 was observed on 4/9/25 going out of the door on basement egress side (Door OHD) with no alarm sounding. The video did not show any staff in the area. The Resident crossed the facility back parking lot and walked along the south side of the neighboring Urgent Care Building. The front of the Urgent Care Building was located along the feeder road of a major interstate. Observation of video surveillance revealed Resident #1 went to the front of the urgent care building corner facing the interstate feeder road; then, he turned back to the facility and crossed the back and the front parking lot. He continued going south and crossed a busy residential street then turned left on another residential street. A white car (later identified as C.N.A.-A) driving by stopped and picked him up. He was brought back to the facility at that point. The video revealed the resident was gone for 10 minutes. Observation on 4/16/25 at 12:24 PM revealed Resident #1 wearing a wander guard on his ankle (device that triggers a special alarm and locked the doors if the resident got near the door). Observation on 4/16/25 at 01:10 PM revealed multiple staff going in and out of the OHD for breaks with the alarm sounding shortly each time. Observed the alarm was loud but very short as the staff shut the door quickly to stop the noise. In an interview on 4/16/25 at 10:15 AM the DM stated a lightning strike knocked 3 doors out a couple of years ago. He stated the repair company came out on 4/11/25 to assess the doors and they were waiting on a quote from them. He stated at this point, 3 doors were not working with the wander guard alarms system, and they all had access to the outside of the building. He identified the non-working doors as WHD, WLD, and the OHD. He stated the resident went out the OHD and no alarm sounded, and the wander guard system did not lock the door. He stated the facility was aware the wander guard system was not working on those doors for years, but he was unsure why they had not been repaired. He had installed a contact alarm system on all 3 doors that would alarm only when anyone held the door open and would stop upon the door closing and making contact. The noise/contact alarm was also broken on OHD door, and it failed to work when the resident eloped. DM was the facility person responsible for checking the doors weekly. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 4/16/25 at 10:26 AM the DON stated there were 3 doors that did not work on the wander guard system and this was not a new problem. She stated 2 of the 3 doors have contact (noise) alarms but the OHD did not have a contact alarm either. She stated the OHD door was the door the resident exited from, and the facility was unaware he had left. She stated the resident was seen by CNA-A as she returned from lunch, and she stopped and brought him back. She stated he was about 1.5 blocks away and going towards a local store. She stated he crossed a residential street but was not injured. She stated he was very confused and was looking for his family. She stated his antipsychotic medication had been reduced from 50mg to 12.5 mg over a couple of months per the Gradual Dose Reduction policy. She said he had gotten near other doors a few times and his wander guard had set of the alarms, but he wasn't exit seeking until 4/9/25. She stated he could get to the freeway and get hurt. In an interview on 4/16/25 at 10:41 AM the DM stated he had replaced the contact alarm on OHD today and moved it higher to avoid it getting broken off. He stated the contact alarm would activate when the door was open now until closed but the wander guard alarm was still disabled pending repairs by the electronic company. In an interview on 4/16/25 at 11:25 AM the DM stated packages were delivered through the OHD, so they likely damaged the previous contact alarm during delivery. He stated the quote for repairs 2 years ago on the wander guard alarm system went to the previous administrator and there was no record of that quote. The wander guard alarm did sound a different alarm and it locked the doors. In an interview on 4/16/25 at 11:40 AM the ADM stated she thought all the doors were repaired and she was unaware 1 was not working. She said the OHD door did not have the contact noise alarm on it that sounds when the connection was broken (when opened). She did not know why that door was not working. She stated they were working with family to try to discharge that resident, but they were waiting on the family and they would just have to monitor him until he could be discharged . She stated the facility was unaware the resident had eloped until their staff saw him outside. She was unsure if you could walk to the interstate but stated they would be putting something up as a barrier if that was a possibility. She said they did have a couple of other doors with noise alarms that did not have wander guard alarms. The DM was checking the doors. In an interview on 4/16/25 at 03:49 PM the DON stated there was not a policy for the facility cameras to be monitored continuously. She stated the wander guard on Resident #1 was definitely working because when he returned through the other door, it set of the wander guard alarm system. In an interview on 4/16/25 at 03:50 PM the DAJ stated there is not a policy to monitor the cameras continuously. There is no paperwork from the 4/11/25 visit from the electronic company assessing the door problems. She stated she would try to get email confirmation from them to provide to me. She stated that some of the cameras are off from real time, but she provided a log to show real time and which camera (multiple cameras around the facility) the resident was showing on as he traveled around the facility on 4/9/25. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a telephone interview on 4/17/25 at 01:29 PM LVN-A stated during her lunch time she saw the resident was with the activity director on the basement level watching activities. Shortly after that, the DON told LVN-A the resident had eloped. LVN-A stated she saw CNA-A holding the resident by his hand and leading him back to the building. She assessed him and there were no injuries, gave him water, and took his vitals which were stable. The doctor had just reduced his antipsychotic medication. She stated most of the time elopement risks need to have alarms on doors like the wander guard. She stated the wander guard makes a different noise and the other type alarms do become like background noise when people open and close the doors. She stated the negative outcome to a resident wandering could be death. She stated people do not pay attention driving and they hit other cars, and they could hit people. She stated we were very close to the interstate. In a telephone interview on 4/17/25 at 01:34 PM the ENG stated he did not look at the alarm system 2 years prior, but he thinks a lightning strike caused the damage. He thinks a repair proposal was sent in December, but that staff was no longer working for his company, so he was not sure if his company followed-up on that. He stated 3 doors need new product/keypads and those doors did not work with the wander guard system now. In a telephone interview on 4/17/25 at 01:45 PM CNA-A stated as she was returning from lunch, she saw Resident #1 walking and she stopped and asked him where he was going. Resident #1 stated he was leaving but he agreed to get in her car, and he let her take him back to the facility. She stated he could have made it to the freeway. She said there was a lot of traffic and people don't pay attention and he could have been hit. She admitted that alarms were sometimes tuned-out and they may assume a staff opened the door. She stated the main door has a wander guard alarm. She stated if dementia residents elope, they could get away and harm themselves. A record review of email correspondence dated 4/16/25 (copy received) between the facility and the engineering company that maintains the alarm systems revealed: Repair person had been out 4/11/25 and confirmed the keypads for the system were not working on 3 exit doors and the damage was most likely got fried because of the lightning storm. A record review of the facility policy titled, Wandering, Unsafe Resident dated 2001 with a last revision date of August 2014 reflected the following: The facility will strive to prevent unsafe wandering . for residents who are at risk for elopement. A missing resident is considered a facility wide emergency. A record review of the facility policy titled, Hazardous Areas, Devices, and Equipment dated 2001 with a last revision date July 2017 reflected the following: All hazardous areas, devices, and equipment in the facility will be identified and addressed appropriately to ensure resident safety and mitigate accident hazards to the extent possible. Resident vulnerability is based on risk factors including the individual resident's functional status, medical condition, cognitive abilities, mood, and health treatments (e.g., medications). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Safety Committee will recommend measures to ensure that vulnerable residents cannot access hazardous areas in the facility (locks, alarms, supervision, etc.) A hazard is defined as anything in the environment that has the potential to cause injury or illness. Examples of environmental hazards include but are not limited to: Equipment or devices that are malfunctioning. Devices and equipment that are improperly maintained. Disabled locks, latches, or alarms. The POR were accepted: 4/18/2025 at 8:30 AM and included: PLAN OF REMOVAL IMMEDIATE- Jeopardy On 4/16/25 an abbreviated survey was initiated at this Facility. On 4/16/25 the surveyor provided an Immediate Threat (IT) Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate threat to resident health and safety The notification of Immediate Threat states as follows: F689 The facility failed to ensure Resident #1 was free from risk of accidents and injuries. I. Immediate Action Taken A. Resident # 1 is currently in the facility. B. On 4/9/25 Resident #1 was returned to the facility via private vehicle by staff and placed on q15 minute monitoring which entails the following: staff visually confirming the resident's location, a log sheet for documenting the resident's location, including space for staff signatures, and timestamp for each observation. C. On 4/16/2025 The DON/ Designee completed a head-to-toe physical assessment on Resident #1 with no negative findings noted D. On 4/16/25 The DON/ Designee updated Resident #1 care plan for wandering/exit seeking E. On 4/16/25 The DON/ Designee completed elopement assessments on all facility residents with no changes noted. F. On 4/16/25 The maintenance director/ Designee completed environmental assessments to include checks on all door alarms. These checks identified 3 nonfunctioning door alarms (100 hall door, west hall door that faces the facility parking lot, and downstairs hallway office door). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	G. On 4/16/25 The administrator/Designee assigned facility staff to monitor identified nonfunctioning doors and the elevator will be locked during non-business overnight hours to allow no access without facility code to ensure that no resident exits the facility. Upstairs assigned staff will be physically present at the area that accesses the two doors waiting for repair. Department Head staff downstairs will be rotated to ensure visual observation of that door between 8a-5p. After 5p, elevators will be locked and only accessible via key access. Elevators will only be accessible via key access on the weekends. H. On 4/11/25 The Social Worker/Designee checked the wander guard appliances utilized by residents to ensure they were functioning properly with the doors that are currently functioning. No issues were identified with the appliances, and they were identified to be currently functioning properly. I. On 4/16/25 The DON/ Designee completed in-service education with facility direct care staff on the elopement policy. No employee will be allowed to work until they receive this education with drill and posttest. J. On 4/16/25 The DON/ Designee completed a Missing Resident Drill with facility direct care staff to ensure staff know the proper procedure for locating missing residents to include when a staff member hears the alarm sound they will initiate the code silver alert via overhead paging to notify all other staff members of the missing resident and to not turn the alarm sound off until all staff are notified of the missing resident and headcount guidelines which requires visual confirmation and documentation regarding the location of each resident in the center. The designated head count coordinator will be the Administrator or DON during business hours (8a-5p) and the designated charge nurse and/or the Manager on Duty during non-business hours. (5p-8a).On 4/16/25 The facility administrator spoke with alarm company in regard to the nonfunctioning door alarm who stated they would have a tech support person to the facility on [DATE] to repair the nonfunctioning door alarms. K. 2. Identification of Residents Affected or Likely to be Affected: A. No other residents identified, on 4/16/25, the DON/Designee completed elopement assessments on all facility residents with no new changes noted. 3. Actions to Prevent Occurrence/Recurrence: A. On 4/16/25, the DON/Designee provided education to facility direct care staff on facility's elopement Policy including missing resident drill. B. On 4/17/25, the DON/Designee provided missing resident posttest to facility direct care staff. These in-services will be accessible via our communications platform (online information system for staff with a required 85% passing score). This will be completed at 6:00 pm on 4/17/2025 and no employee will be allowed to work until they receive this education with drill. Agency staff will be provided these trainings through access from our online communications platform as well. C. Results of facility missing resident drills will be discussed with Facility Administrator/ Designee during the facility recurring daily morning start up meetings. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/16/2025 the facility's Administrator notified the Medical Director regarding the Immediate Jeopardy the facility received related to Accidents/Hazards/Supervision and reviewed plan to sustain compliance with no new orders received. Likelihood for Serious Harm No Longer Exists: 4/17/2025. Signature of ADM on 4/17/2025 On 4/17/25 and 4/18/25 the state surveyor confirmed the facility implemented their plan of removal sufficiently to remove the IJ by: 4/17/25 Monitoring: Observation on 4/17/25 at 11:30 the ENG company at the facility working on the 3 broken doors. Office staff were turning staff away from the OHD door to prevent alarms from sounding when there was not a problem and therefore making a problem very noticeable if it occurred. Observation on 4/17/25 at 04:45 PM revealed the OHD hall staff coordinating if they leave the Office Hall to ensure staff were present to hear the alarm on OHD and to monitor the hall for residents. Observed 1 staff member assigned to the unused nurses station located between WHD and LHD with constant visual monitoring of the doors that weren't working. In an interview on 4/17/25 at 12:48 PM, the DON stated the following steps had been completed: QAPI Meeting held on 4/16/25 at 08:30 PM with the ADM, the DON, and the MD. In-services were done on 4/16/25 and 2 in-services were done on 4/17/25. Another in-service and Elopement Drill were planned for 4/17/25 on the night shift. The ENG company just left, and they confirmed doors not working and ordered the parts. They were supposed to return Monday. She further stated it was important to monitor Dementia residents because they were unaware of their own safety needs and the facility had to keep them safe. She stated the negative outcome to residents if they wander could be injury and death. She stated if alarms sound too often it becomes background noise and that was why they were now coordinating staff to not use the OHD at all so the alarm will not sound if there was not a problem. She stated they were also coordinating the office staff to make sure someone was on the hall. During the business hours the hall was accessible. Record review reflected 3 completed in-services on elopements and alarms with staff signatures attached and dated 4/1625 and 4/17/25. Record review reflected an invoice from the ENG showing doors were worked on and parts were ordered and dated 4/17/25. Record review on 4/17/25 reflected the typed minutes of the QAPI meeting held on 4/16/25 listed topics as facility elopement and the follow-up plan to sustain compliance. Attendees shown as the ADM, the DON, and the MD. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4/18/25 Monitoring: Observation on 4/18/25 at 10:50 AM revealed no residents in rooms or halls on WHD and WLD. Staff were posted specifically at these entrance points and intersections to disallow residents from accessing these doorways. Observed a staff member also posted near the nurse's station (unused station) to ensure residents did not enter that area without staff accompanying them. Observation on 4/18/25 at 11:00 AM revealed the Office Hall where the OHD was located, contained offices in which staff members were observed working with the doors open, monitoring traffic in and out. In an interview on 4/18/25 at 10:48 AM the DON stated the Elopement Drill had been completed and she would provide the documentation for that exercise. The DON stated the 3 doors that were out of service were being monitored and they were disallowing resident traffic on those halls. In an interview on 4/18/25 at 10:53 AM AL stated her role to prevent further elopements until doors were fixed was to sit at the intersection of the 2 [NAME] Halls and not allow anyone to access the malfunctioning doors. She stated this was being done for the safety and protection of the residents. In an interview on 4/18/25 at 11:00 AM the DON stated part of the plan was for staff on this hallway to monitor. She stated the staff were to communicate if they were leaving the hallway with each other to ensure someone was always downstairs. She stated the OHD would sound if opened but not for long, so staff were not to use those doors either to avoid monitoring staff from becoming accustomed to the alarm and unknowingly ignoring the alarm. Record review on 4/18/25 reflected 16 staff signatures on an Elopement Drill Sign-in form. The administrator was notified the IJ was removed on 04/18/2025 at 08:30 AM, however the facility remained out of compliance at a scope of isolated and a severity with no actual harm due to the facility's need to complete repairs and evaluate the effectiveness of the corrective systems.