

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676033	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/06/2025
NAME OF PROVIDER OR SUPPLIER  Town Hall Estates		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0655</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meets professional standards of quality care for 2 (Resident's #17, #22) of 6 residents reviewed for baseline care plans. The facility failed to ensure Resident #17's and Resident #22's baseline care plans addressed their mobility abilities. The facility failed to complete Resident #27 and Resident #44's baseline care plans. This failure could place residents at risk of getting insufficient care, not having personal needs not met resulting in hospitalizations and injuries related to falls. An IJ was identified on 09/04/25. The IJ template was provided to the facility on [DATE] at 4:53 pm. While the IJ was removed on 09/06/25, the facility remained at a level of no actual harm at a scope of isolated that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. Resident #17</p> <p>Record review of facility admission Record dated 08/19/25 reflected Resident #17 was admitted to the facility on [DATE]. Diagnoses included urinary tract infection, Hypoxemia (a condition characterized by a below normal level of oxygen), anxiety (a feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome), and heart failure</p> <p>Record review of facility Progress Notes dated 08/04/25 at 4:44PM reflected Resident #17's family member states resident had a fall on 8/3/2025, resident had a bruise near right eye and a large contusion on top of his head near his forehead on the right side, bruising behind both arms, notified Dr and DON, neuro checks initiated, waiting for Dr order.</p> <p>Record review of admission MDS dated [DATE] for Resident #17 reflected section GG: Functional abilities chair/bed-to-chair transfer was marked 04 Supervision or touching assistance-Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.</p> <p>Record Review of Radiology report from The Hospital dated 08/04/25 reflected the fall resulted in minimally displaced acute fractures of the eighth and ninth ribs laterally. Nondisplaced acute intra-articular fracture medial left clavicle extending to the sternoclavicular joint (clavicle fracture).</p> <p>Record review of Resident #17s Medical Records for Baseline Care Plan reflected it was not completed.</p> <p>Resident #22</p> <p>(continued on next page)</p>

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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<p>F 0655</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of facility admission Record dated 08/21/25 reflected Resident #22 was admitted to the facility on [DATE]. Diagnoses included Malignant Neoplasm of Pancreas (cancer of the pancreas), Neoplasm related pain (pain due to cancer), protein calorie malnutrition, and elevated blood pressure. Resident #22 was admitted on Hospice Respite.</p> <p>Record review of Resident #22's progress notes dated 08/04/25 at 7:55PM reflected patient observed laying on the floor of her bathroom. CNA stated patient had requested to go to the restroom with assistance of 1 (one) staff. CNA gave patient some privacy and gave patient instructions to pull emergency call light when done, patient has successfully used emergency light before. Patient had a small but deep laceration above the right eyebrow. Patient was drowsy but responding to questions, could tell us her name and date of birth . 911 called or transport to emergency room. X3 assisted back into bed using (mechanical) lift. Vital signs: 83/56,100,94%. Dressing applied to head laceration. Emergency medical services in building and provided transport, patient hypotensive and believed to have had a syncopal episode (fainting). She is alert at this time, oriented x2-3. POA called and notified of fall and send out to emergency room. Primary Care Physician and hospice called and notified of fall with emergency room visit. Instructions left with this nurse to call hospice when patient is in facility so follow up visit can be completed. Signed by LVN F.</p> <p>Record review of Resident #22's admission MDS dated [DATE] reflected section GG: Functional abilities toilet transfer was marked 03 Partial/Moderate Assistance-Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. Resident #22 was coded as using a walker and a wheelchair for mobility devices.</p> <p>Record review of Resident #22s Medical Records for Baseline Care Plan reflected it was not completed.</p> <p>Findings included:</p> <p>Resident #27</p> <p>Record review of Resident #27's comprehensive MDS assessment dated [DATE] reflected a [AGE] year-old male who admitted to the facility on [DATE] with the following diagnoses: high blood pressure, diabetes mellitus (a disease in which the body's ability to produce or respond to insulin is impaired), high cholesterol, aphasia (a communication disorder that affects a person ability to speak, write, and understand both spoken and written language), stroke, hemiplegia (paralysis on one side of the body), muscle weakness, and dysarthria (a motor speech disorder that occurs when the muscles used for speech are weak or difficult to control). His BIMS score was a 12, indicating he had moderately impaired cognition.</p> <p>Record review of Resident #27's "Care Plan Conference" dated 11/19/2024 reflected Resident #27 was admitted on [DATE], the reason for conference was "initial", and it included nursing, social worker, dietary, activity notes, and the members present were documented.</p> <p>Resident #44</p> <p>(continued on next page)</p>		

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<p>F 0655</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #44's face sheet reflected a [AGE] year-old female who admitted to the facility on [DATE]. Her diagnoses included: congestive heart failure (a chronic condition where the heart cannot pump blood effectively), respiratory failure (inadequate gas exchange by the respiratory system), high blood pressure, severe kidney disease (gradual loss of kidney function), type 2 diabetes mellitus (chronic condition that affects the body's way of metabolizing sugar), iron deficiency, elevated white blood cell count, atrial fibrillation, edema (swelling caused by excess fluid in the body's tissues), tachycardia (when the heart rate exceeds 100 beats per minute), and tachypnea (rapid, shallow breathing).</p> <p>Record review of Resident #44's undated baseline care plan reflected she was admitted on [DATE] and under part "C. Social Services"; all needs/goals were left blank.</p> <p>In an interview on 08/21/2025 at 1:16 PM LVN D stated the Nursing assistants never told her that the care plan was never populated for Resident #17 or Resident #22. LVN D stated staff were aware the baseline care plan information was important to prevent falls and assist with rehabilitation to ensure residents needs were met.</p> <p>In an interview on 08/21/2025 at 2:36 PM the DON stated that she and ADON were responsible for filling out the base line care plans. The DON stated the baseline care plans should have been completed within the first 48 hours of admission. The DON stated the baseline care plan for Resident #17 and Resident #22 were overlooked and could not say why those or the others were not fully completed. The DON stated the negative effects for having an incomplete baseline care plan could be increased falls.</p> <p>In an interview on 09/04/25 at 1:30pm LVN E stated that she was not present when Resident #17 admitted (7/31) to the facility. When she took his blood pressure on 08/03/25 at 9:16am she saw a bruise on his head, but she thought the bruise was from when he admitted . She did not see the knot on his head until the family told her about it. She stated that she initiated a neuro check and post fall assessment at 6:13pm on him. She stated it was an agency nurse working the night shift of 08/03/25, and when she got report from that agency nurse, she was not told that Resident #17 had a fall. She stated that he had a wheelchair and very unsteady gait (ability to walk).</p> <p>LVN E stated Resident #22 could not get up and walk to the bathroom on her own. Resident #22 had a lot of edema (swelling) in her legs and could not toilet transfer on her own. She stated Resident #22 needed active assistance during toileting. She stated that moderate assistance means 1 person assisting, and 1 person could have assisted Resident #22 because she was so thin. She stated that Resident #22 was not to be left alone on the toilet, she could have privacy (meaning standing in the doorway with your back toward the resident).</p> <p>In an interview on 09/04/25 at 2:28pm The DON stated that an agency nurse was working the night of 08/03/2025 when Resident #17 fell. The DON stated the nurse failed to conduct a neuro check, post fall evaluation, and report to the ongoing nurse that Resident #17 had a fall during her shift. The DON stated that agency nurse was the one who helped Resident #17 up from the fall, even though originally the resident told the DON he did not tell anyone about the fall.</p> <p>(continued on next page)</p>		

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<p>F 0655</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The DON stated Resident #22 used a wheelchair and typically was able to be left alone on the toilet due to being cognitively intact and her ability to sit on the toilet without assistance and had previously demonstrated successful ability to use her call light and sit on the toilet without assistance. She stated that at the time of the fall The DON was told the resident was seated on the toilet, the CNA felt the resident was safe, the call light was in reach, and the CNA was no longer present in the bathroom. She stated that she or the ADON are checking fall risk assessments, check charts every 24 hours to ensure assessments are completed fully. The DON stated she opens baseline care plans upon a resident's admission, the BOM contacts families and will set up baseline care plan meeting with RP within 48 hours of admission.</p> <p>Review of the facility policy titled, "Care Plans- Baseline" dated December 2016 reflected, "A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission. The Interdisciplinary Team will review the healthcare practitioners' orders and implement a baseline care plan to meet the resident's immediate care needs. The Interdisciplinary Team will review the healthcare practitioner's orders (e.g., dietary needs, medications, routine treatments, etc.) and implement a baseline care plan to meet the resident's immediate care needs including but not limited to: a. Initial goals based on admission orders;b. Physician orders;c. Dietary orders;d. Therapy services;e. Social services; andf. PASARR recommendation, if applicable."</p> <p>An Immediate Jeopardy was identified on 09/04/25 at 4:53 PM. and an IJ template was provided to the ADM and DON. A plan of removal was requested at that time.</p> <p>The following Plan of Removal, submitted by the facility, was accepted on 09/05/25.</p> <p>Plan of Removal Immediate Threat:</p> <p>On 09/04/2025 an abbreviated survey was initiated at the facility. On 09/04/2025 the surveyor provided an Immediate Jeopardy (IJ) notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate threat to resident health and safety.</p> <p>The notification Immediate Jeopardy (IJ) states as follows: F655 –The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The facility failed to ensure Resident #17's and Resident #22's baseline care plans addressed their mobility abilities.</p> <p>Action:</p> <p>Director of Nursing reviewed all care plans including baseline care plans to ensure resident mobility, transfers, and supervision needs are included. Findings are recorded in an audit log and no negative findings at this time.</p> <p>Start Date: 09/04/2025</p> <p>Completion Date: 09/05/2025</p> <p>Responsible: Director of Nursing</p> <p>(continued on next page)</p>		

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<p>F 0655</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Action:</p> <p>Revised admission process and policy to require baseline care plan initiation within 48 hours, verified by Director of Nursing/Assistant Director of Nursing. Education will be provided to nurses, direct care staff and agencies on the revised admission process and policy to require baseline care plan initiation within 48 hours. Nurses, direct care staff and agencies staff will be required to read, acknowledge understanding and sign the in-services before the start of their shift. In addition, competency check (test) has been implemented to ensure understanding. The competency check (test) will be verified by DON for comprehension.</p> <p>Start Date: 09/04/2025</p> <p>Completion Date: 09/05/2025</p> <p>Responsible: Director of Nursing/Assistant Director of Nursing</p> <p>Action:</p> <p>Implemented admission checklist and new 'admission Quality Check' form to verify care plan and fall risk completion. Changes will be updated on the report sheet located at the nurses' desk. Education will be provided to nurses, direct care staff and agencies staff to look at the report sheet located at the nurses' desk before start of the shift and a signature is required on the report sheet acknowledging that the changes has been reviewed by the staff. Nurses, direct care staff and agencies staff will be required to read, acknowledge understanding and sign the in-services before the start of their shift. In addition, competency check (test) has been implemented to ensure understanding. The competency check (test) will be verified by DON for comprehension.</p> <p>Start Date: 09/05/2025</p> <p>Completion Date: 09/05/2025</p> <p>Responsible: Director of Nursing/Assistant Director of Nursing</p> <p>Action:</p> <p>Monitoring tools will be put in place to capture ongoing audits of all new admits' baseline care plans (daily for 30 days, weekly for 60 days, then monthly ongoing), and findings will be reported in Quality Assurance and Performance Improvement (QAPI).</p> <p>Start Date: 09/05/2025</p> <p>Completion Date: Ongoing</p> <p>Responsible: Director of Nursing/Assistant Director of Nursing</p> <p>On 09/6/2025 the Surveyor confirmed the facility implemented their plan of removal sufficiently to remove the IJ by:</p> <p>(continued on next page)</p>		

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<p>F 0655</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of an audit completed on 09/05/25 by The DON reflected that all care plans and baseline care plans were reviewed ensuring residents mobility, transfers and supervision needs were included. The Audit was verified by a checkoff for each resident completed signed and dated for 09/05/25 by the DON. The Surveyor audited 7 Resident medical records including new admission and readmissions within the last 30 days for verification of baseline care plan included residents' mobility and supervision needs.</p> <p>Record review completed on 09/05/25 of Revised reflected the admission process and policy was updated to require baseline care plan initiation within 48 hours. The policy reflected to include assistive devices needed. Record review of education provided to nurses, direct care staff and agencies on the revised admission process and policy to require baseline care plan initiation within 48 hours. Nurses, direct care staff and agencies staff were required to read, acknowledge understanding and sign the in-services before the start of their shift. A competency check (test) had been implemented to ensure understanding. The competency check (test) was completed and signed by 5 LVNs and 2 RNs from both day and night shifts.</p> <p>Record review completed on 09/05/25 of an Implemented admission checklist and new 'admission Quality Check' form was verified to include care plan and fall risk completion. An Inservice given to Nursing staff was completed to include an updated report sheet located at the nurses' desk directing care staff and agencies staff to look at the report sheet located at the nurses' desk before start of the shift requiring a signature acknowledging that the changes had been reviewed by the staff. Education verification and acknowledgement of understanding per the competency check was signed by 5 LVNs and 2 RNs from both day and night shifts.</p> <p>Record review completed on 09/05/25 of new Monitoring tools was conducted to capture ongoing audits of all new admits' baseline care plans (daily for 30 days, weekly for 60 days, then monthly ongoing). The tool included Baseline care plan initiated within 48 hours of admission.</p> <p>Interviews conducted on 09/06/25 between 6:00am and 8:00am with DON, ADON, LVN C, LCN D, LVN I, LVN E, RN F, from both day and night shifts reflected They had been instructed on baseline care plans ensuring residents' mobility, transfers and supervision needs were included. They stated Nurses, direct care staff and agencies staff were required to read, acknowledge understanding and sign the in-services before the start of their shift. The staff stated agencies they were to look at the report sheet located at the nurses' desk before start of the shift and sign it acknowledging that the resident changes had been reviewed by the staff. The staff verified they were given competency test on their education.</p> <p>On 09/06/2025 at 8:18am, the Administrator was notified the IJ was removed. However, the facility remained out of compliance at a level of no actual harm with the potential for more than minimal harm with a scope identified as isolated due to the facility's need to monitor the implementation and effectiveness of its POR.</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistance devices to prevent accidents for 2 (Resident #17 and Resident #22) of 8 residents reviewed for accidents and hazards. The facility failed to ensure each resident receives adequate supervision and assistance devices to prevent accidents in that The facility failed on 08/04/2025 to ensure appropriate supervision and assistive devices were in place for Resident #17 and Resident #22 to prevent falls. This failure could place residents at risk for injury and hospitalizations related to accidents. An IJ was identified on 09/04/25. The IJ template was provided to the facility on [DATE] at 4:53 pm. While the IJ was removed on 09/06/25, the facility remained at a level of no actual harm at a scope of isolated that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. Resident #17 Record review of facility admission Record dated 08/19/25 reflected Resident #17 was admitted to the facility on [DATE]. Diagnoses included urinary tract infection, Hypoxemia (a condition characterized by a below normal level of oxygen), anxiety (a feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome), and heart failure Record review of Fall Risk Assessment for Resident #17 dated 08/01/25 reflected that it was incomplete. Gait / Balance assessment was not observed and left unmarked. Medications and vision were not reviewed on the fall risk assessment. Record review of facility Progress Notes dated 08/04/25 at 4:44PM reflected Resident #17's family member states resident had a fall on 8/3/2025, resident had a bruise near right eye and a large contusion on top of his head near his forehead on the right side, bruising behind both arms, notified Dr and DON, neuro checks initiated, waiting for Dr order. Record review of admission MDS dated [DATE] for Resident #17 reflected section GG: Functional abilities chair/bed-to-chair transfer was marked 04 Supervision or touching assistance-Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. Record Review of Radiology report from The Hospital dated 08/04/25 reflected the fall resulted in minimally displaced acute fractures of the eighth and ninth ribs laterally. Nondisplaced acute intra-articular fracture medial left clavicle extending to the sternoclavicular joint (clavicle fracture). Record review of Resident #17s Medical Records for Baseline Care Plan reflected it was not completed. Resident #22 Record review of facility admission Record dated 08/21/25 reflected Resident #22 was admitted to the facility on [DATE]. Diagnoses included Malignant Neoplasm of Pancreas (cancer of the pancreas), Neoplasm related pain (pain due to cancer), protein calorie malnutrition, and elevated blood pressure. Resident #22 was admitted on Hospice Respite. Review of facility Fall Risk Assessment for Resident #22 dated 07/29/25 reflected that it was incomplete. Medications and vision were not reviewed on the fall risk assessment. Gait / Balance assessment was not observed and left unmarked. Record review of Resident #22's progress notes dated 08/04/25 at 7:55PM reflected patient observed laying on the floor of her bathroom. CNA stated patient had requested to go to the restroom with assistance of 1 (one) staff. CNA gave patient some privacy and gave patient instructions to pull emergency call light when done, patient has successfully used emergency light before. Patient had a small but deep laceration above the right eyebrow. Patient was drowsy but responding to questions, could tell us her name and date of birth . 911 called or transport to emergency room. X3 assisted back into bed using (mechanical) lift. Vital signs: 83/56,100,94%. Dressing applied to head laceration. Emergency medical services in building and provided transport, patient hypotensive and believed to have had a syncopal episode (fainting). She is alert at this time, oriented x2-3. POA called and notified of fall and send out to emergency room. Primary Care Physician and hospice called and notified of fall with emergency room visit. Instructions left with this nurse to call hospice when patient is in facility so follow up visit can be completed. Signed by LVN F. Record review of Resident #22's admission MDS dated [DATE] reflected section GG: Functional abilities toilet transfer was marked 03 Partial/Moderate Assistance-Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. Resident #22 was coded as using a walker and a wheelchair for mobility devices. Record review of Resident #22s Medical Records for Baseline Care Plan reflected it was not completed. In an interview on 08/21/2025 at 1:16 PM LVN D stated Resident #17 did not use a walker or wheelchair. The family had brought in a cane from home, but he got around holding onto furniture. She stated he was very mobile. LVN D stated the CNAs always checked with the nurse to verify assistance</p>		