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	06/23/2026

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 - Minimal harm or potential for actual harm 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** Based on interview, and record review, the facility failed to ensure that residents received care in accordance with professional standards of practice, for 1 (Resident #1) of 4 resident reviewed for resident rights. The facility failed to implement interventions, according to the comprehensive plan of care, to check on and change Resident #1 on rounds, and as needed, to keep Resident #1's and dry, and keep her free from falls. The failure placed residents at risk of falls, injuries, a decline or decrease in their quality of life and quality of care.Findings included: Record review of Resident #1's face sheet, dated 6/23/2026, revealed a [AGE] year-old female, admitted on [DATE] and readmitted [DATE] with diagnosis Alzheimer's Disease with Late Onset (a progressive neurodegenerative disorder that primarily affects memory, thinking, and behavior, and is the most common cause of dementia), Unspecified Dementia, Unspecified Severity, With Other Behavioral Disturbance (a form of cognitive decline where the exact type of dementia (e.g., Alzheimer's, vascular) and its severity are not determined), Metabolic Encephalopathy (a brain dysfunction caused by systemic metabolic disturbances, leading to confusion, altered consciousness, and potentially permanent brain damage if untreated). Record Review of Resident #1's quarterly MDS assessment, dated 5/06/2026, revealed BIMS score of 4, indicating severe cognitive impairment. The MDS indicated Resident #1 had 2 or more falls with no evidence of injury. This is noted on physical assessment by the nurse or primary care clinician; no complaints or pain or injury by the resident; no change in the resident's behavior is noted after the fall. Record review of Resident #1's care plan, dated 06/23/2026, revealed the Focus: [Resident #1] has had an actual fall r/t poor balance, poor communication/comprehension, unsteady gait, lack of safety awareness. Goal: [Resident #1] will have no further incidents through the review date. Interventions/Tasks: Anticipate and meet the resident's needs; be sure the call light is within reach and encourage the resident to use it for assistance as needed. The residents needs prompt to all request for assistance; educate the resident/family/caregivers about safety reminders and what to do if a fall occurs; follow facility protocol; resident has been moved in a room closest to the nurse's station for fall prevention precaution. [Staff] to encourage resident to keep door open while in room so that [staff] can frequently monitor for resident safety. Record review of Resident #1's care plan dated 06/23/2026 reflected the resident had multiple falls: 2/6/26 - Resident had an unwitnessed fall in room. Resident went to the bathroom without assistance and fell in her bedroom. C/O left hip pain. Sent to the ER via EMS and admitted into the hospital for left hip fracture. 2/10/26 - Resident had unwitnessed fall in bedroom. No injuries noted. Resident has dementia and new left hip fracture. Resident does not remember to use call light to get assistance. Staff check on resident frequently and offer frequent reminders to use call light for assistance. 5/8/26 - Resident had unwitnessed fall in bedroom with no injury. Resident reminded to use call light for assistance. 5/20/26 - Resident reported she fell in her bedroom overnight and got herself up without telling anyone. She reported that she did not hurt herself and no injuries were noted. Resident has been noted with hallucinations and delusions lately. RP stated that the resident is seeing ants, rats, birds, and cats in her room. Staff check in on resident frequently for safety and reorientation as needed. 5/25/26 - Resident had an (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unwitnessed fall in bedroom. Resident stated her slippers slid and she slid on the floor. Resident denied pain or injury. No injuries noted. 6/15/26 - Nurse noted bruising and swelling to resident's forehead this AM and notified RP who has a camera set up in the resident's room. RP played back footage from the night and saw that resident had a fall at 3:46 and did not report it to the staff. MD notified. Staff continued rounds for safety. During an interview with the ADM on 06/23/26 at 1:28 p.m., the ADM revealed Resident #1 had a fall and CNA A had not been in the resident room all night. She stated, however, the nurse did go into the resident's room [ROOM NUMBER] times. checked on her and administered her medication. ADM stated when she called to report the incident to the RP, the RP revealed that the resident had fallen 6 different times (the times were not provided) when she reviewed the camera. ADM stated LVN B went into the room at 4:55 a.m. to give Resident #1 her medication and found her on the floor. CNA A had no reason why he had not gone in Resident #1's room to check on her throughout his shift. ADM advised RP of the disciplinary action taken with LVN B and CNA A; RP was happy with the results. ADM stated anything could happen to a resident if they did not checked on. ADM stated an assessment was performed on Resident #,1 and she was sent out to the hospital. She stated safe surveys were completed with other residents. During an interview with the DON on 06/23/26 at 2:55 p.m., the DON revealed staff was supposed to check on residents every 2 hours and nurses every 2 hours. The DON stated she expected the staff to follow policies and procedures. Resident # 1 should be checked on especially since she was a fall risk, every hour. DON stated she was originally on the back of the hall, but they moved her specifically close to the nurse station since she is a fall risk. DON stated Resident #1's door is supposed to be left open to see her moving around, the doorway light left on, and her bed is in a low position. Resident #1 is usually in the bed or sitting in her chair. Resident #1 can ambulate by herself. Resident #1 is advised to use her walker, but she will put the walker in the corner and go back to her chair or bed. DON stated if no one is going to check on the resident regularly, a serious injury could happen or possible death. She stated CNA A allegedly checked on Resident #1 at 11:30 p.m. but once she looked at the camera from both angles, it revealed he had not gone in the room at all. She stated LVN B went in and checked on the resident 3 times that night. DON stated she was sent out to the hospital, and an x-ray was completed and the results revealed nothing was broken. She just had a laceration on her left eye. Resident #1 was sent back to the facility. During an interview with LVN B on 06/23/26 at 4:45 p.m., LVN B revealed she had checked on the residents every 2 hours. She stated her duties were to pass the meds, supervise the nurse aides, provide the residents with any treatments that they need, observe residents if they have a COC and notify the doctor. LVN B stated if the residents are checked upon regularly, they could fall, stop breathing, or they could experience any type of health crisis. LVN B stated she went into Resident #1 room [ROOM NUMBER] times that night. She stated she was not aware CNA A had not gone into the room to check on the resident. She stated he was supposed to go in and make his rounds, and he advised her he did. During an interview with Resident #1 on 06/23/26 at 5:20 p.m., Resident #1 revealed the staff treated her good. She feels safe living at the facility. Resident #1 stated she was going to get a Coke from downstairs when she fell. She hurt both butt cheeks when she fell, but nothing broke or not hurting as of 5:25 pm on 6/23/2026. Resident #1 stated she didn't press her call light, nor did she use her walker to assist her with walking. She stated the staff were making rounds and found her on the floor. She stated she was on the floor just a little bit and could not determine minutes or hours. She stated if she has any concerns, she would tell her RP. During an interview with the CNA A on 06/25/26 at 8:08 p.m., CNA A revealed he was responsible for checking on residents every 2 hours; making sure everyone is okay. He stated his shift is from 6 p.m. to 6 a.m. He stated he was getting residents ready for bed on or around 7:30/8 p.m. and remembered going to check in on Resident #1 during that time. CNA A stated around 2:30 a.m., he was documenting and getting ready to get his residents on dialysis ready for it. He stated he must have gotten busy and sidetracked with documentation as the reason why he did not check on her after that. CNA A stated if residents were not checked on regularly, they could fall, pass away; anything could possibly hurt or (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	harm them in the brief time of not checking on them. He stated he had a brief understanding of notes documented in PCC. He stated he knew Resident #1 fell a couple of times, but he denied knowing she was a fall risk. During an interview with the RP on 06/25/26 at 8:30 p.m., RP revealed she was notified by a staff member from the facility who left a voice message that Resident #1 had a fall and was sent to the ER. The RP stated Resident #1dementia. She stated Resident #1 had been sleeping and woke up, fell a few times, and managed to get herself up. She stated during the last fall she could not get herself up, because she was sleep deprived. LVN B found her and called CNA A to assist her to put her back in the bed. Reviewing the camera revealed she had a laceration to her left eye. RP stated Resident #1's dementia is worsening. RP stated Resident #1 is [AGE] years old, and she doesn't believe she need a walker or a wheelchair because it is for older people. She stated she is trying to find a way to get Resident #1 to utilize the walker to assist with her walking to avoid the falls. Record Review of the facility Abuse, Neglect, and Exploitation Policy dated March 2018 reflected: Failure to provide goods and services necessary to avoid physical harm, pain, mental anguish, or emotional distress. Neglect is defined as the failure of a health care provider or caregiver to perform a duty or give proper care to a patient Although neglect is considered unintentional, it ultimately causes harm to the resident by failure to provide care.