

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: 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.			
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F 0655 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 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 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 (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 0655 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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. 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. Findings included: Resident #27 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. 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. Resident #44 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, (continued on next page)		

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F 0655 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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." 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. The following Plan of Removal, submitted by the facility, was accepted on 09/05/25. Plan of Removal Immediate Threat: 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. 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. Action: 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. Start Date: 09/04/2025 Completion Date: 09/05/2025 Responsible: Director of Nursing Action: 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. (continued on next page)		

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F 0655 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Start Date: 09/04/2025 Completion Date: 09/05/2025 Responsible: Director of Nursing/Assistant Director of Nursing Action: 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. Start Date: 09/05/2025 Completion Date: 09/05/2025 Responsible: Director of Nursing/Assistant Director of Nursing Action: 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). Start Date: 09/05/2025 Completion Date: Ongoing Responsible: Director of Nursing/Assistant Director of Nursing On 09/6/2025 the Surveyor confirmed the facility implemented their plan of removal sufficiently to remove the IJ by: 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. 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 (continued on next page)		

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F 0655 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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. 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. 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. 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. 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.		

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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** 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 #17Record 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 (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 needed for residents. LVN D stated the nursing assistants never told her that the Kardex (a section of the medical record showing how much and why type of assistance a resident needs) and care plan were never populated for Resident #17 or Resident #22. LVN D stated staff were aware the baseline care plan and Kardex information were important to prevent falls and assist with rehabilitation to ensure residents needs were met. In an interview on 08/21/2025 at 2:36 PM the DON stated the DON stated she was unsure if Resident #17 used any assistive devices other than a cane from home. She stated he was using the furniture for balance. She stated the facility did provide a walker and encouraged him to use that. The DON stated she was not sure therapy did an evaluation on Resident #17. She stated he was admitted late on a Friday and discharged quickly. In an interview on 08/21/2025 at 2:46pm the ADON stated that resident #22 entered the facility on respite care. She stated that the family decided to leave her at the facility under the care of hospice until she passed. The ADON stated that she did not feel that Resident #22 was a fall risk because there were lot of family members around and the resident was not active. The ADON stated that she did not feel that there was a need to have fall precautions in place. 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). 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). 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. 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. Record review of the facility policy dated September 2012 titled Falls - Clinical Protocol reflected: As part of the initial assessment, the physician will help identify (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	individuals with a history of falls and risk factors for subsequent falling. Staff will ask the resident and the caregiver or family about a history of falling. The staff will document risk factors for falling in the resident's record and discuss the resident's fall risk. Risk factors for subsequent falling include lightheadedness or dizziness, multiple medications, musculoskeletal abnormalities, peripheral neuropathy, gait and balance disorders, cognitive impairment, weakness, environmental hazards, confusion, 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. The following Plan of Removal, submitted by the facility, was accepted on 09/05/25. Plan of Removal Immediate Threat: 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 Jeopardy (IJ) to resident health and safety. The notification of Immediate Jeopardy (IJ) states as follows: F689 - The facility failed to ensure each resident receives adequate supervision and assistance devices to prevent accidents in that: The facility failed to ensure new admissions received timely and completed fall risk assessments to prevent accidents. Action: All residents assessed for safety and injury. Neurological checks and follow-up assessments initiated on residents with new falls . Two residents were identified with falls requiring neurological checks. Neuro checks were initiated immediately. Licensed nursing staff will perform and document all neurological checks per policy. Nursing staff educated on performing neurological check on resident post fall. All nurses, including PRN and agency nurses will be required to read, acknowledge understanding and sign the in-services before the start of their shift. Start Date: 09/04/2025Completion Date: 09/05/2025Responsible: Director of Nursing/ Assistant Director of Nursing Action:100% audit of all residents' fall risk assessments completed to ensure they are fully documented.Start Date: 09/04/2025Completion Date: 09/05/2025Responsible: Director of Nursing/ Assistant Director of Nursing Action:Registered nurses and license nurses including PRN and agency nurses re-educated on completing fall risk assessments within 24 hours of admission and ensuring proper supervision by the Director of Nursing or designee. PRN and agency nurses will be required to read, acknowledge understanding and sign the in-services before the start of their shift. Nurse consultant or designee will re-educate the Director of Nursing and the Assistant director of Nursing on monitoring that the fall risk assessments are being completed by the charge nurses within 24 hours of admission and ensuring proper supervision by the Nurse Consultant.Start Date: 09/04/2025Completion Date: 09/05/2025Responsible: Director of Nursing/Nurse Consultant Action:Monitoring tool will be put in place to capture daily audits of new admissions for 30 days, then weekly for 60 days, then monthly ongoing, findings will be reported in Quality Assurance and Performance Improvement (QAPI).Start Date: 09/05/2025Completion Date: OngoingResponsible: Director of Nursing/ Assistant Director of Nursing On 09/6/2025 the Surveyor confirmed the facility implemented their plan of removal sufficiently to remove the IJ by: Record review of an audit completed on 09/05/25 by The DON reflected that an all-resident review was completed by The DON ensuring Neurological checks and follow-up assessments were initiated on residents with new falls. Neuro checks were initiated immediately for two residents identified with recent falls verified with record review. Nursing staff were educated on performing neurological check on resident post fall as evidenced by an in-service signed and dated for 09/05/25. Record review of an audit completed on 09/05/25 for all residents for admission fall risk assessment and quarterly fall risk assessments was signed completed by the ADON. Residents had current completed fall risk assessments as evidenced by a review of medical records for 7 residents within the facility. Record review completed on 09/05/25 of an Inservice verified that license nurses including PRN and agency nurses were re-educated on completing fall risk assessments within 24 hours of admission and ensuring proper supervision. The Director of Nursing and the Assistant director of Nursing on monitoring that the fall risk assessments are being completed by the charge nurses within 24 hours of admission and ensuring proper supervision by the Nurse Consultant on 09/05/25. Education was verified for 6 of 8 (continued on next page)		

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Form Approved OMB
No. 0938-0391

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	nursing staff Record review completed on 09/05/25 of new admission Monitoring tools was conducted. The tool included resident name, date of admission, verifying the fall risk assessment was completed along with a baseline care plan. The facility did not have any new admission as of time of exit. The [NAME] stated the tool will be reviewed daily in their morning meeting for verification of completion. 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 Fall Policy, Fall Risk Assessments, including assessment of neurological status. The staff stated they had been educated on need for assistive devices and fall prevention measures including keeping beds in low positions, more frequent rounding, and call light placement. The staff were able to identify the report sheet located at the nurses' station to be signed each shift verifying resident changes in condition had been reviewed from one shift to the next. 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.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that the residents were free from chemical restraints not required to treat the residents' medical symptoms for 1 of 5 residents (Resident #25) reviewed for unnecessary medications. The facility failed to ensure Resident #25's PRN Lorazepam (medicine used to treat the symptoms of anxiety) was discontinued after 14 days or document a rationale for the continued provision of the medication. This failure could place residents at risk for adverse reactions and negative side effects from the administration of medication and dependence on unnecessary medications. Findings included: Record review of facility admission Record dated 08/19/2025 reflected Resident #25 was admitted to the facility on [DATE]. Diagnoses included unspecified dementia (a decline in the mental ability interfering with daily life), traumatic brain injury, heart failure, and anxiety (a feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome). Record review of Resident #25's comprehensive care plan dated 06/27/2025 for Resident #25 reflected Resident #25 uses anti-anxiety medications related to anxiety disorder. Interventions included Monitor/record occurrence of for target behavior symptoms pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others and document per facility protocol. Monitor/document/report PRN any adverse reactions to anti-anxiety therapy: drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, confusion and disorientation, depression, dizziness, lightheadedness, impaired thinking and judgment, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision. Unexpected side effects: Mania, hostility, rage, aggressive or impulsive behavior, hallucinations. Record review of facility Significant change in status MDS dated [DATE] reflected Resident #25 had received an antianxiety medication within the last 7 days. Record review of Resident #25's Physician Order Report dated 8/20/25 reflected an order for Lorazepam oral tablet 0.5mg give 1 tablet by mouth every 4 hours as needed for agitation with a start date of 08/03/2025. Record review of Medication Administration record for the month of August 2025 reflected Resident #25 had been administered Lorazepam 0.5mg 1 tablet on 08/07/2025, 08/08/2025, and 08/16/2025. In an interview on 08/21/2025 at 1:10 PM LVN C stated she was not sure why Resident #25's PRN Lorazepam did not have a stop date on it. LVN C stated she was aware PRN Lorazepam should have a stop date and the nurse putting the order into the computer was responsible for obtaining the stop date. LVN C stated the negative effects for not having a stop date on psychotropic medication would be oversedation, dehydration, and changes in mental status. In an interview on 08/21/2025 at 2:36 PM the DON stated staff were aware that there was a 14 day stop date on all PRN psychotropic medications. She stated the stop date did get overlooked at times. The DON stated there needed to be a system put in place to double check that a stop date was added for PRN psychotropic medications. The DON stated not having a stop date on medications such as lorazepam could lead to unnecessary risk of side effects. Record review of facility policy titled Medication Monitoring Medical Management dated 2007 reflected PRN orders for psychotropic drugs are limited to 14 days. Exception: If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.		

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a Significant Change MDS assessment with 14 days after the facility determined, or should have determined, there has been a significant change in a resident's physical or mental condition for 1 of 5 residents reviewed for assessments (Resident #25).The facility failed to complete a Significant Change MDS for Resident #25 within 14 days of the resident's admission to hospice services. This failure placed residents who had a significant change in condition requiring an MDS assessment at risk of not receiving needed services. Findings included:Record review of facility admission Record dated 08/19/2025 reflected Resident #25 was admitted to the facility on [DATE]. Diagnoses included unspecified dementia (a decline in the mental ability interfering with daily life), traumatic brain injury, heart failure, and anxiety (a feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome).Record review of Resident #25's comprehensive care plan dated 06/27/2025 for Resident #25 reflected Resident is now receiving Hospice care related to senile degeneration resulting in a declining condition. Interventions included Facility nursing staff to coordinate medical care with hospice nursing staff, Hospice to follow up in a timely manner to facility and family concerns.Record review of facility Significant change in status MDS dated [DATE] reflected Resident #25 was receiving Hospice services while a resident. In an interview on 08/21/2025 at 2:36 PM Tthe DON stated the facility has a remote MDS coordinator , and they do miss things sometimes. The DON stated the significant change MDS for Resident #25 was one that had been missed and was caught later. She stated the negative effects for missing an MDS assessment could affect the plan of care for the resident. Record review of facility policy titled Comprehensive Assessment and the Care Delivery Process dated 2001 and revised December 2016 reflected to complete the Minimum Data Set within 14 days after admission and within 14 days after it is determined that the resident has had a significant change in physical or mental condition, and annually.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review the facility failed to ensure the resident assessment accurately reflected the resident's status for 1 of 4 residents (Resident #26) who were reviewed for accuracy of assessments. The facility failed on 5/16/2025 to accurately document Resident #26's diagnosis of depression on her quarterly MDS assessment. This failure placed residents at risk of incorrect care and services necessary for their physical, mental, and psychosocial well-being. Findings included: Record review of Resident #26's quarterly MDS assessment dated [DATE] reflected a [AGE] year-old female who was admitted to the facility on [DATE] with the following diagnoses: high blood pressure, diabetes mellitus (a body's impaired ability to produce or respond to insulin), hyperlipidemia (excess of lipids or fat in the blood), non-Alzheimer's dementia (decline in cognitive function severe enough to interfere with daily life), adult failure to thrive, muscle weakness, lack of coordination, gastro-esophageal reflux disease (when stomach acid flows back into the esophagus), muscle wasting and atrophy (decrease in size of body part, cell, organ, or other tissue) and ataxia (poor muscle coordination). In Section N-Medications, Resident #26 was indicated as taking an Antidepressant. Her BIMS score was a 10, indicating she had had moderately impaired cognition. Record review of Resident #26's comprehensive care plan dated last revised 6/11/2025 reflected Resident #26 used antidepressant medications Bupropion and Mirtazapine related to depression. Record review of Resident #26's active diagnoses report as of 08/21/2025 reflected no diagnoses of depression listed. Record review of Resident #26's active orders report as of 08/21/2025 reflected an order for 300 MG Bupropion extended release to be given 1 time a day for depression. In an interview on 08/21/2025 at 12:41pm with the MD he stated that Resident #26 had a diagnosis of depression and that she had been doing well on her antidepressant medication. In an interview on 08/21/2025 at 3:21pm with the DON she stated that Resident #26 admitted on an antidepressant, and the facility failed to put depression under her active diagnoses. She stated that inaccurate assessments could lead to incomplete care plans and or need for services such as medications or therapies. Review of the Long-Term Care Facility RAI 3.0 User's Manual dated last revised October 2024 reflected, The RAI process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that (1) the assessment accurately reflects the resident's status		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure all medications that were reviewed by the licensed pharmacist were reported to the attending physician and if there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record for 1 of 4 residents (Resident #26) reviewed for unnecessary medications. The facility failed on 04/07/2025 to ensure the medical director documented in Resident #26's medical record the rationale for no action being taken on a GDR recommendation by the licensed pharmacist for Resident #26's Bupropion order (used to treat depression). This deficient practice could affect all residents who have pharmacy recommendations which could place the residents at risk of receiving unnecessary medications. Findings included: Record review of Resident #26's quarterly MDS assessment dated [DATE] revealed a [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses: high blood pressure, diabetes mellitus (a body's impaired ability to produce or respond to insulin), hyperlipidemia (excess of lipids or fat in the blood), non-Alzheimer's dementia (decline in cognitive function severe enough to interfere with daily life), adult failure to thrive, muscle weakness, lack of coordination, gastro-esophageal reflux disease (when stomach acid flows back into the esophagus), muscle wasting and atrophy (decrease in size of body part, cell, organ, or other tissue) and ataxia (poor muscle coordination). In Section N-Medications, Resident #26 was indicated as taking an Antidepressant. Her BIMS score was a 10, indicating she had had moderately impaired cognition. Record review of Resident #26's comprehensive care plan dated last revised 6/11/2025 reflected Resident #26 used antidepressant medications Bupropion and Mirtazapine related to depression. Record review of Resident #26's active diagnoses report as of 08/21/2025 reflected no diagnoses of depression listed. Record review of Resident #26's Orders revealed that Resident #26 received Bupropion HCl ER tablet 300 mg, given one tablet by mouth one time a day for depression. Record review of Resident #26's consultation report dated 04/07/2025 revealed the following recommendation: This 92yo resident is currently receiving an antidepressant order for bupropion-ER (Wellbutrin-XL) 300mg QD for depression. Clinical Guidelines recommend that these medications be reviewed periodically for dosage reductions in an effort to achieve the lowest effective dose. This resident's records show no behaviors are being documented. Please consider reducing this medication to 150mg QD on a trial basis if you feel this would be helpful. Record review of Resident #26's medication consultation report revealed it was sent to the physician on 04/07/2025 and the Physician's response stated, No Changes and was dated with his signature on 4/10/25. In an interview on 08/21/2025 at 12:55 PM with the MD he stated that when he got GDR recommendation from the pharmacist, he would document his review of the irregularities, the action, if any taken, and a rationale if no action was taken, on the individual printed sheets for each resident, provided by the pharmacist. He stated he would document any changes on the sheet and turned it back into the ADM. He stated that not following the recommendation by the pharmacist depended on the patient and if the recommendation was clinically necessary. He stated it would depend on if the recommendation would help or harm the resident based on their individual needs. He stated that Resident #26 was doing well on the current dose of Bupropion. He stated his rationale for not taking the recommendation by the pharmacist was that he didn't want the resident to have an increase in depressive episodes, as she had been doing well. He stated that she had a diagnosis of major depressive disorder, and it was indicated in his notes. Record review of the facility's policy titled, Medication Utilization and Prescribing, dated July 2016, revealed The consultant pharmacist should use the monthly and interim drug regimen review to help identify potentially problematic medications, including medication regimens that are not supported based on clinical signs or symptoms. The physician and staff will adjust existing medications based on their efficacy and the continued presence of relevant conditions (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and risks. The physician will provide and/or document a rationale when the dose, duration, or frequency of a prescribed medication is greater than commonly accepted practice or the manufacturer's recommendations or the medication is considered high-risk compared to other available, relevant alternatives. The physician will explain and/or document the rationale for not modifying a medication in a situation where an adverse drug reaction is likely. Review of the facility's policy titled, Tapering Medications and Gradual Drug Dose Reduction, dated July 2022, revealed All medications shall be considered for possible tapering. Tapering that is applicable to psychotropic medications are referred to as gradual dose reductions. Residents who use psychotropic medications shall receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. The staff and practitioner will consider tapering under certain circumstances, including when: the resident's clinical condition has improved or stabilized; the underlying causes of the original target symptoms have resolved; non-pharmacological interventions, including behavioral interventions, have been effective in reducing symptoms. The physician will review periodically whether current medications are still necessary in their current doses; for example, whether an individual's conditions or risk factors are sufficiently prominent or enduring that they require medication therapy to continue in the current dose, or whether those conditions and risks could potentially be equally well managed or controlled without certain medications, or with a lower dose.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident's drug regimen was free from unnecessary drugs for 1 (Resident #44) of 4 residents reviewed for unnecessary medications. The facility failed on 08/19/2025 to have an adequate indication for use of Midodrine HCl 10mg for Resident #44. This failure could place residents at risk of not receiving the needed monitoring or interventions to prevent potential harm related to adverse side effects. Findings included: Record review of Resident #44's undated 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 (irregular and often very rapid heart rhythm), 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). 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. Record review of Resident #44's Orders dated 8/19/2025 revealed an order for Midodrine Oral Tablet 10 MG (used to treat low blood pressure) with a summary of Give 1 tablet by mouth three times a day for with every meal. No diagnosis was listed in the order. In an interview on 08/21/2025 at 12:55 pm, the MD stated he saw Resident #44 for the first time on 08/19/2025. He stated the order for Midodrine 10mg was necessary to combat the residents' low blood pressure. He stated Resident #44's previous order was 5mg, but he increased it due to her recent blood pressures. He stated the order should have indicated the diagnosis it was used to treat and could lead to inaccurate monitoring of side effects by facility staff. Review of the facility's policy titled, Medication Monitoring dated 2007 revealed, Each resident's drug regimen is reviewed to ensure it is free from unnecessary drugs. This includes any drug - without adequate monitoring;- without adequate indications for its use;- in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or- any combination of these reasons.		

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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. Based on observation, interview, and record review, the facility failed to ensure that drugs and biologicals used in the facility were stored properly for 1 (Middle Hall-RN Cart) of 2 medication carts reviewed for drug storage. The facility failed on 08/19/2025 to ensure one medication cart (Middle Hall-RN Cart) was locked and that medications were securely stored. This failure could place residents at risk of obtaining and taking medications not prescribed for them which could result in resident's harm due to adverse medication reactions. Findings included: In a continuous observation on 08/19/2025 at 1:04 PM, the medication cart, assigned to LVN E located in front of the nurse's station on the Middle Hall, was unattended and unlocked for approximately 3 minutes, and medications were accessible to residents . No residents were observed near the medication cart at that time. In an interview on 08/19/2025 at 1:07 PM, LVN E stated she was assigned to the medication cart in question, and that she had been attending to another resident, and then she did not lock the cart back when she went to tend to another resident . She stated that a negative outcome of leaving the medication cart unlocked was that a resident could get in it and get medication. She stated she was required to ensure the cart was locked and computer was blank before leaving the cart unattended. In an interview on 8/19/2025 at 1:56 PM, the DON stated, the policy was for the medication cart to be locked and the computer screen blank when not in use in order to secure medications and resident privacy. She stated residents could take medication from the cart which could cause adverse effects with their own medications. Record review of facility policy titled, Storage of Medications, dated April 2007, reflected the following: The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, distribute, and serve food in accordance with professional standards for food safety for 1 of 1 kitchen reviewed for food safety. The facility failed on 08/19/2025 to maintain a properly cleaned ice machine used to serve ice to residents. The facility failed on 08/20/2025 to ensure staff who passed trays to residents properly sanitized their hands in between individual meal set up. This deficient practice could place residents at risk of food borne illness. Findings included: In an observation on 08/19/2025 at 9:00 AM of the facility's only kitchen revealed the only ice machine in the kitchen, had brown residue in the upper back area of the ice machine, directly above the ice. Further observation revealed that staff were serving the residents drinks with ice used from the ice machine. In an observation on 08/19/2025 at 12pm, 3 CNA's who were assisting in serving food, did not sanitize their hands in between giving residents their trays. In an observation of lunch service on 08/20/2025, at 12:00 PM, 3 CNAs were observed passing residents' trays without gloves on, nor did they sanitize in between providing residents their trays, and setup assistance. It was also observed that there was no sanitizing station located in the dining area. There was a single sink in the dining area that the CNAs used to wash their hands before they started to pass the trays to the residents. In an observation on 08/21/2025 at 2:00 PM in the facility's 1 of 1 kitchen revealed the presence of brown residue on the upper back part of the ice machine. In an interview on 08/21/2025 at 8:47 am, the DS stated her expectation was that staff who assisted with handing out trays were to sanitize their hands between each tray distribution. She stated that housekeeping refilled the sanitation stations in the dining room. The DS stated that she was unsure what the brown residue was in the ice machine. She stated that she would get a wet towel and clean it. Record review of facility invoices on 08/21/2025 revealed the facility hired a maintenance worker from a third-party vendor for routine maintenance. The invoice reflected the worker cleaned the ice machine and bin. 08/21/2025. According to the vendors notes the ice machine was operating within normal conditions upon arrival. The invoice revealed that the ice machine was inspected for any contamination or possible cause for health risks found, no issues at that time all calcium build up is due to normal operation of equipment. Ice machine was descaled and sanitized. Record review of the facility's policy titled, Nutrition Policies and Procedures Hand Hygiene/Hand Washing, dated 09/2021 reflected Hand hygiene is the most important component for preventing the spread of infection. Proper hand washing technique will be always used that hand washing indicated. Employees shall keep their hands and exposed portions of their arms clean.		

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)		
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to, in accordance with accepted professional standards and practices, maintain medical records on each resident that are complete, accurately documented, and readily accessible for 1 (Resident #26) of 4 residents reviewed for clinical records. The facility failed to document Resident #26's diagnosis of depression in her active diagnoses list in the EHR. This failure could place residents at risk for delays in treatment due to incomplete and inaccurate clinical records. Findings included: Record review of Resident #26's quarterly MDS assessment dated [DATE] revealed a [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses: high blood pressure, diabetes mellitus (a body's impaired ability to produce or respond to insulin), hyperlipidemia (excess of lipids or fat in the blood), non-Alzheimer's dementia (decline in cognitive function severe enough to interfere with daily life), adult failure to thrive, muscle weakness, lack of coordination, gastro-esophageal reflux disease (when stomach acid flows back into the esophagus), muscle wasting and atrophy (decrease in size of body part, cell, organ, or other tissue) and ataxia (poor muscle coordination). In Section N-Medications, Resident #26 was indicated as taking an Antidepressant. Her BIMS score was a 10, indicating she had moderately impaired cognition. Record review of Resident #26's comprehensive care plan, dated 6/11/2025, reflected Resident #26 used antidepressant medications, Bupropion and Mirtazapine, related to depression. Record review of Resident #26's active diagnoses report, dated 08/21/2025, reflected no diagnoses of depression listed. Record review of Resident #26's Orders dated 7/4/2024 revealed that Resident #26 received Bupropion HCl ER tablet 300 mg, given one tablet by mouth one time a day for depression. In an interview on 08/21/2025 at 12:55 PM, the MD stated when he got a GDR recommendation from the pharmacist, he would document his review of the irregularities, the action, if any taken, and a rationale if no action was taken, on the individual printed pharmacist consultant sheets for each resident, provided by the pharmacist. He stated he would document any changes on the pharmacist's consultant sheet and turn it back into the ADM. He stated not following the recommendation by the pharmacist depended on the patient and if the recommendation was clinically necessary. He stated it would depend on if the recommendation would help or harm the resident based on their individual needs. He stated Resident #26 was doing well on the current dose of Bupropion. He stated his rationale for not taking the recommendation by the pharmacist was that he did not want the resident to have an increase in depressive episodes. He stated she had a diagnosis of major depressive disorder, and it was indicated in his notes. In an interview on 08/21/2025 at 1:10 PM, the DON stated Resident #26 did not have a diagnosis of depression listed in her active diagnoses, and she was not sure why it was left off. She stated that the resident did have that diagnosis and was being treated with an antidepressant.		

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NAME OF PROVIDER OR SUPPLIER Town Hall Estates		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Happy LN Hillsboro, TX 76645	
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 3 staff reviewed for infection control. (CNA B)The facility failed on 8/20/2025 to practice effective infection control practices when CNA B applied a brief onto Resident #32 after it had been dropped onto the floor during incontinent care.This failure could place residents at risk of being susceptible to bacteria and cross contamination during incontinent care. Findings included:Record review of Resident #32's comprehensive MDS assessment dated [DATE] revealed an [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses: coronary artery disease (reduced blood flow to the heart muscle), high blood pressure, orthostatic hypotension (sudden drop in blood pressure when a person stands up from a sitting or lying position), gastro-esophageal reflux disease (when stomach acid flows back into the esophagus), renal insufficiency (impaired kidney function), renal failure, or end-stage renal disease, diabetes mellitus (a body's impaired ability to produce or respond to insulin), hyponatremia (low sodium levels in the blood), hyperlipidemia (excess of lipids or fat in the blood), thyroid disorder, arthritis (inflammation of the joints), non-Alzheimer's dementia (decline in cognitive function severe enough to interfere with daily life), Parkinson's disease (movement disorder of the nervous system that worsens over time), Seizure disorder, and depression (persistent feeling of sadness). In Section H-Bladder and Bowel, Resident #32 was indicated as being always incontinent. Her BIMS score was a 02, indicating she had severely impaired cognition.Record review of Resident #32's comprehensive care plan dated 08/12/2025 indicated she was treated for a UTI, beginning 6/29/2025, with antibiotics for 7 days. Her interventions included to be checked at least every 2 hours for incontinence and wash, rinse and dry soiled areas. Record review of Resident #32's active orders as of 8/21/2025 revealed she was being treated for a UTI beginning 8/18/2025 with antibiotics, with a stop date of 8/23/2025. In an observation on 8/20/2025 at 3:35 pm, CNA B was observed checking and changing Resident #32's brief. CNA B dropped the clean brief onto the floor beside the resident's bed, picked the brief up off the floor, and placed it on Resident #32.In an interview on 8/21/2025 at 10:43 AM CNA B stated she worked at the facility for 12 years. She stated she recalled dropping Resident #32's brief onto the floor when she was changing her the day before, and that after she dropped the brief, she should have gotten a new one due to cross contamination, but she was in conversation with resident's family members, and she just did not think about what had happened. She stated she had recently been in-serviced on infection control and gave examples of how to properly wash hands to prevent infections, wiping residents correctly, making sure they were consuming enough fluids, and practicing good hygiene. She stated that they were required to check and change residents every 2 hours. In an interview on 08/21/2025 at 11:36AM with the DON she stated that when CNA B dropped the brief onto the floor, she should have discarded that one and replaced it with a clean brief as the one that fell onto the floor could pick up bacteria off the floor and transfer onto the resident. She stated that Resident #32 was receiving antibiotics at the time, to combat a UTI. An Infection Control policy was verbally requested by the state surveyor on 8/21/2025 and it was not provided by the facility before exit.		