

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676047	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/24/2025
NAME OF PROVIDER OR SUPPLIER  Town Hall Estates Keene Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  207 S Old Betsy Rd Keene, TX 76059	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49048</b></p> <p>Based on observation, interview, and record review the facility failed to ensure staff interacted with residents in a manner that assures communication, maintains respect, and enhances his/her quality of life for one (Resident #1) of six residents reviewed for resident rights.</p> <p>The facility failed to ensure Resident #1 was treated with respect and dignity while being fed by staff.</p> <p>These failures could place residents at risk for poor nutrition and hydration and diminished quality of life.</p> <p>Findings included:</p> <p>Record Review of the undated Face Sheet for Resident #1 reflected a [AGE] year-old female who was admitted to the facility on [DATE] with the following diagnoses: Parkinson (conditions that affect movement), Unspecified Dementia (group of symptoms affecting memory), Unspecified Protein-Calorie Malnutrition (lack of sufficient energy or protein to meet the body's metabolic demands, and Senile Degeneration of the Brain (age related cognitive decline).</p> <p>Record Review of Resident #1's MDS, dated [DATE] reflected a BIMS score of 9, which indicated the resident had moderate cognitive impairment. Resident #1's MDS Section GG also reflected the resident's functional ability for eating was coded as:</p> <p>02. Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.</p> <p>During an interview on 2/24/2025 at 10:35 AM with Resident #1's family member, they stated, They are not taking care of her. I have a video that showed the aide walked into her room with her lunch, took a spoon, jabbed it into her mouth and walked out of the room. Then another aide came in and said, 'I guess you are done now.' She had not eaten.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 2/24/2024 at 12:35 PM of electronic monitoring video dated 2/23/2025 at 12:48 PM provided (via email) by family member, revealed a CNA had brought a lunch tray into the room of Resident #1. The CNA appeared to have been [NAME] or Hispanic and had dark hair, pulled into a ponytail, approximately four inches past the shoulders. The CNA was wearing dark pants with a light-colored draw string and a white t-shirt that had a graphic on the front. The gender of the CNA was not identifiable from the video. The CNA slid the rolling bedside table over the resident who was lying in a slightly inclined, bed. The CNA was standing with their back to the resident, then turned sideways, placed food on a spoon and put it into Resident #1's mouth. Then put the spoon down and walked out of Resident #1's room. The CNA did not speak to the resident during this interaction, did not smile, nor did they bend over to look Resident #1 in the face. Resident #1 was heard to say, I guess you aren't going to help me either.</p> <p>During an observation on 2/24/2025 at 2:41pm of electronic monitoring video dated 2/23/2025 at 2:19 PM provided (via email) by family member, revealed a female CNA, who wore navy blue scrubs and had hair that was either short or pulled on top of her head. The CNA took the residents tray away and did not offer any fluids. It appeared Resident #1 had not eaten the meal. The fortified shake in a red bottle appeared to be unopened.</p> <p>During an interview on 2/24/2025 at 4:35 PM with the DON he stated when feeding residents, Interaction is very crucial. You would get feedback if the meals were good, were they full or if they wanted more. He said it was not acceptable for any staff to have walked into a resident's room, fed the resident one spoonful of food, exited the room, and never have spoken to the resident.</p> <p>During an interview on 2/24/2025 at 4:45 PM with the ADM she stated, it was not acceptable for any staff to have walked into a resident's room, fed the resident one spoonful of food, exited the room, and never have spoken to the resident. She stated, My expectation was that staff would have interacted with residents.</p> <p>A Record Review of the facility's policy Resident Rights, Revised February 2021, reflected:</p> <p>Policy Statement</p> <p>Employees shall treat all residents with kindness, respect, and dignity.</p> <p>1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to:</p> <p>a. A dignified existence;</p> <p>b. Be treated with respect, kindness, and dignity.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49048</b></p> <p>Based on interview and record review, the facility failed to ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team after a change of condition for 1 of 6 residents (Resident #1) reviewed for care plans.</p> <p>The facility failed to ensure Resident #1's care plan was revised to reflect the resident's decline and inability to feed themselves.</p> <p>This failure could place residents at risk of not receiving appropriate care to meet their current needs, compromised nutritional intake, aspiration, and choking.</p> <p>Findings included:</p> <p>Record Review of the undated Face Sheet for Resident #1 reflected a [AGE] year-old female who was admitted to the facility on [DATE] with the following diagnoses: Parkinson (conditions that affect movement), Unspecified Dementia (group of symptoms affecting memory), Unspecified Protein-Calorie Malnutrition (lack of sufficient energy or protein to meet the body's metabolic demands, and Senile Degeneration of the Brain (age related cognitive decline).</p> <p>Record Review of Resident #1's MDS, dated [DATE] reflected a BIMS score of 9, which indicated the resident had moderate cognitive impairment. Resident #1's MDS Section GG also reflected the resident's functional ability for eating is coded as:</p> <p>02. Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.</p> <p>Record Review of the Comprehensive Care Plan for Resident #1 reflected the following:</p> <p>Focus:</p> <p>ADLs [eating, dressing, mobility, transfer, toilet, hygiene, bed mobility, bath], Date Initiated and Created [DATE].</p> <p>Interventions:</p> <p>*EATING: Resident is able to feeding self each meal daily. Resident may need set-up/supervision assistance. Date Initiated [DATE].</p> <p>During an observation on [DATE] at 8:30 AM, revealed the resident was lying in bed with a breakfast tray on rolling, bedside table. The resident did not speak and turned head slightly when spoken to. A CNA came into the resident's room and said, I'll be back to feed her in a moment and then was gone quickly.</p> <p>(continued on next page)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 4:15 PM with CNA A stated she was made aware of residents change of condition each day when she arrived at work. She stated she has never looked at care plans.</p> <p>During an interview on [DATE] at 4:27 PM with CNA B stated she was given a full report when she began her shift and she always gave a full report to the next shift, when her shift ended. She stated the residents' chart should have indicated changes with incontinent status and when eating status (i.e., thickened liquids, feeding assistance) changed. She identified risks for residents who care plans were not updated as, If someone switched to mechanical soft [diet] and I didn't know about it or thickened liquids, they could get hurt or die.</p> <p>During an interview on [DATE] at 4:35 PM with the DON, he revealed care plans should have been updated every day. He said social services was responsible to ensure care plans were updated. He said his expectation was for the care plan to have been updated for a resident who experienced a significant decline within the last month. He identified potential negative outcomes for residents without updated care plans as, Multiple negative outcomes, they could have gone downhill, died , or any other consequences that neglect may have caused.</p> <p>During an interview on [DATE] at 4:45 PM with the ADM, she stated, care plans should have been updated quarterly, at a minimum. She said the two ADONs and the two MDS staff were responsible to update the nursing components of the care plans. She said she would have hoped a care plan would have been updated for a resident who had declined within the last month. She said the negative outcome for residents was that the nursing staff would not have known what they needed to do for the resident.</p> <p>Record Review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, Revised [DATE], reflected:</p> <p>Policy Statement</p> <p>A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.</p> <p>Policy Interpretation and Implementation</p> <p>11. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's conditions change.</p>		