STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676047	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Town Hall Estates Keene Inc	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)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47772 Based on observation, interview, and record review the facility failed to ensure each resident had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 3 of 9 residents (Resident #43, Resident #64, and Resident #21) reviewed for accommodation of needs. The facility failed to ensure Resident # 64's call light was within reach. The facility failed to ensure Resident # 43's call light was within reach. The facility failed to ensure Resident # 21s call light was within reach. This failure could place residents at risk of falls, skin breakdown, frustration, and having their needs gone unmet. Findings included: Record review of Resident #64's AR, dated 6/5/2024, indicated Resident #64 was a [AGE] year-old female who admitted to the facility on [DATE]. She was diagnosed with Hemiplegia (which caused one-sided paralysis,) Hemiparesis (which caused one-sided muscle weakness,) and Chronic Kidney Disease, Stage 3 (which was a disease of the kidney that disrupted the body's ability to filter impurities.) Record review of Resident #64's Annual MDS, dated [DATE], reflected Section C., Cognitive Patterns: Resident #64 had severe cognitive impairment. Section GG., Functional Abilities and Goals: Resident #64 was dependent upon staff for eating, oral hygiene, toileting, showering, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. Resident #64 was dependent upon staff for rolling left to right, sitting to lying, and lying to sitting on side of bed. (Dependent meant the helper did all the work). Section H., Bladder and Bowel (Bladder;) indicated Resident #64 was frequently incontinent; Bladder and Bowel (Bowl;) indicated Resident #64 was always incontinent. Record review of Resident #64's CP indicated a Focus area, revised 2/16/2024, for communication evidenced by cognitive limitations. The goal, revised on 4/25/2024, indicated resident would be understood in spite of cognitive limitations. The goal for nursing staff, initiated on 2/3/2021, indicated Resident #64's call light was supposed to be in reach and answered in a timely manner. (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

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 06/06/2024

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F 0558

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

The CP indicated a Focus area, created on 2/3/2021, for ADLs evidenced by the need for staff assistance. The goal, revised on 4/25/2024, indicated resident would perform/participate in ADLs. The goal for nursing staff, initiated on 11/12/2021 indicated Resident #64's call light was supposed to be always in reach and answered in a timely manner. The CP indicated a Focus area, revised 3/15/2024, for communication evidenced by falls. The goal, revised on 4/25/2024, indicated resident would be free of falls. The goal for nursing staff, initiated on 3/15/2021, indicated Resident #64's call light was supposed to be in reach and encouraged to use it.

Record review of Resident #43's AR, dated 6/5/2024, indicated Resident #43 was an [AGE] year-old male who admitted to the facility on [DATE]. He was diagnosed with Cerebral infarction (which was a pathologic process that resulted in necrotic tissue in the brain, caused by disrupted oxygen and blood supply,) Major Depression (which was a mental condition mental characterized depressed mood and long-term loss of pleasure or interest in life,) Hemiplegia (which caused one-sided paralysis,) and Hemiparesis (which caused one-sided muscle weakness.)

Record review of Resident #43's Quarterly MDS, dated [DATE], reflected Section C., Cognitive Patterns: Resident #43 had severe cognitive impairment. Resident had impairment on one side of his upper extremities (shoulder, elbow, wrist, and hand.) Resident had impairment on one side of his lower extremities (hip, knee, ankle, and foot.) Section GG., Functional Abilities and Goals: Resident #43 was dependent upon staff for eating, oral hygiene, toileting, showering, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. Resident #43 was dependent upon staff for rolling left to right, sitting to lying, and lying to sitting on side of bed. Section H., Bladder and Bowel (Bladder;) indicated Resident #43 was always incontinent; Bladder and Bowel (Bowl;) indicated Resident #43 was always incontinent.

Record review of Resident #43's CP indicated a Focus area, revised 8/31/2023 for communication evidenced by cognitive limitations. The goal, revised on 5/29/2024, indicated resident would be understood in spite of cognitive limitations. The goal for nursing staff, initiated on 2/22/2021, indicated Resident #43's call light was supposed to be in reach and answered in a timely manner. The CP indicated a Focus area, revised 2/18/2023 for alteration in musculoskeletal status evidenced by contractures. The goal, revised on 5/29/2024, indicated resident would exhibit adequate coping skills, remain free from pain, and remain free of injuries. The goal for nursing staff, initiated on 7/18/2023, indicated Resident #43's call light was supposed to be in reach and answered in a timely manner.

Record review of Resident #21's AR, dated 6/5/2024, indicated Resident #21 was an [AGE] year-old female who admitted to the facility on [DATE]. She was diagnosed Dementia (which was a disease that affected memory, thought, and interfered with daily life) and Type 2 Diabetes (which was a condition that impedes the body's ability to use sugar as fuel).

Record review of Resident #21's Quarterly MDS, dated [DATE], reflected Section C., Cognitive Patterns: Resident #21 had a BIMS of 13. A BIMS of 13 indicated Resident #21 was not cognitively impaired. Section GG., Functional Abilities and Goals: Resident #21 was dependent upon staff for toileting, showering, and personal hygiene. Dependent meant the helper did all the work. Resident #21 required partial assistance for rolling left to right, sitting to lying, and lying to sitting on side of bed. Partial assistance meant the helper did less than half the effort. Section H., Bladder and Bowel (Bladder;) indicated Resident #21 was always incontinent; Bladder and Bowel (Bowl;) indicated Resident #21 was always incontinent.

(continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #21's CP indicated a Focus area, created on 3/9/2023, for communication evidenced by cognitive alibies within normal limits The goal, revised on 3/11/2024, indicated resident would be able to communicate and be understood. The goal for nursing staff, initiated on 3/9/2023, indicated Resident #21's call light was supposed to be in reach and answered in a timely manner. The CP indicated a Focus area, created on 5/24/2023, for falls evidenced by gait and balance problems. The goal, revised on 3/11/2024, indicated resident would be free from falls and injuries. The goal for nursing staff, initiated on 5/24/2023, indicated Resident #21's call light was supposed to be in reach and encouraged to use it for assistance. The CP indicated a Focus area, created on 8/7/2023, for mobility issues based on musculoskeletal status and bone density. The goal, revised on 3/11/2024, indicated resident would be free of pain and free from complications related to injury. The goal for nursing staff, initiated on 8/7/2023, indicated Resident #21's call light was supposed to be in reach and responded to promptly. Observation and interview on 6/4/2024 at 10:59 AM with Resident #64 reflected her in her wheelchair with her back to the door. She was facing the window. Her bed was 3 feet from her to the front. The call light button was wrapped around her right bed rail. The distance from her arm to the call light button was 6 feet. She was unable to reach the call light in the position she was. When asked, Resident #64 was unable to verbalize how she would call staff for help. Interview and observation on 6/4/2024 at 11:03 AM with CNA A revealed her entering Resident #64's room, during the observation and interview, to take Resident #64 to the dining facility. When asked about the correct placement of the resident's call light, she stated the call light was supposed to be within the resident's reach; however, she admitted Resident #64's call light was not placed correctly for the resident. Observation on 06/04/24 at 12:39 PM of Resident #43 revealed the resident sleeping in his Geri-Chair in his room. His chair was facing his television set and his bed was behind him to his right. The call light button was located at the head of his bed, which was 5 feet away. The call light button was tucked underneath his mattress. The call light button was not in reach. The call light button was not visible. Observation and interview on 06/04/24 at 2:01 PM with Resident #21 revealed the resident sitting in her wheelchair facing the window. Her bed was to her right. Her call light button was near the head of her bed 4 feet away. She stated staff rolled her to the position she was currently in. When asked how she called for help, she stated she could yell for help or use the call light button. When asked if she could reach and use the button, she attempted to roll herself the call light button location, but she was unable to get close enough and reach it. Observation and interview on 06/04/24 at 2:04 PM revealed CNA B entering Resident #21's room, during the observation and interview, to tell Resident #21 she was going to make her bed when her covers were ready. When she was leaving the room, CNA B reminded Resident #21 that her call light was there, observed pointing at the call light that was 4 feet away. Before she exited the door, she returned to Resident #21 and repositioned Resident #21 closer to her call light button. When asked about the correct placement of the call light button, CNA B stated they were trained to keep the call lights within the residents reach, but the call light button cords did not always have clips and were hard to affix to a resident's chair. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and observation on 06/06/24 at 12:18 PM with Resident #43 revealed the resident reclined in his Geri-Chair in his room. His chair was facing his television set and his bed was behind him to his right. The call light button was located at the head of his bed, which was 5 feet away. The call light button it was tucked underneath his mattress. The call light button was not in reach. The call light button was not visible. When asked about how he called for help, he was unable to verbalize; he was however, able to verbalize in the affirmative that he wanted the light next to him. Interview and observation on 06/06/24 12:24 PM with CNA B revealed Resident #43 did have the ability to use his call light to call for help. For him to use it, she stated Resident #43 needed to be handed the call light button and reminded it was there. She was observed removing the call light button from the mattress and placed the call light button in his hand. Observation on 06/06/24 at 12:04 PM of Resident #21's call light revealed the call light button cord in the resident's room had a clip on it. Interview on 06/06/24 at 12:07 PM with CNA A revealed the call light was used by the residents to call for help. Staff was trained to always keep the call light button within the resident's reach, whether in a chair or on bed. When not able to utilize the call light to call for help, the residents were placed at risk for falls, dehydration, frustration, skin breakdown, or having specific needs gone unmet. She stated staff can look in the resident's Kardex, or plan of care, to see the requirement for call light placement. Interview on 06/06/24 at 12:30 PM with ADON B revealed that the residents' call light always needed to reachable, whether they were in bed or in their chair. The call light buttons had clips and they were supposed to be clipped to an area close to their hands, like on a blanket, a pillow, or a shirt. There was no condition, mental or physical, that would negate the resident's right to have their call light within arm's reach. Inaccessible call lights placed the resident at risk of falls, choking, skin breakdown, sadness, and frustration. A safeguard in place, to ensure a resident's call light was in reach, consisted of daily room rounds and checks throughout the day. At each instance of care, the staff member was supposed to make sure the call light button was in reach before leaving the room. Interview on 6/6/2024 at 2:32 PM with the ADMIN revealed correct placement of the call light buttons was supposed to be within arm's reach of each resident whether they were in the bed or in a chair. If a resident was able to go in and out, it was hard to keep track of that, but stationary residents were supposed to have them in arms reach. There was no medical, physical, or mental limitation that would negate a resident's right to have their call light next to them. A resident, without access their call light, would have been placed at risk for falls, dehydration, skin breakdown, frustration, or unmet needs. A safeguard in place to check for call light placement was daily room rounds and rounds done periodically through the day. If a resident did not have their call light next to them, the failure would lie on training and having not observed the correct placement. Record review of the facility's Answering the Call Light Policy, dated 2001, indicated the call light was supposed to be accessible to the resident when in bed, from the toilet, from the shower, or bathing. The call light was supposed to be accessible if the resident were on the floor.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** 47772 Based on observation, interview, and record review the facility failed to ensure the resident assessment accurately reflected the resident's status for 1 of 9 residents (Resident #68) who were reviewed for accuracy of assessments. The facility incorrectly coded Resident #68 with Pneumonia. 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 #68's AR, dated 6/6/2024, indicated Resident #68 was a [AGE] year-old female, who admitted to the facility on [DATE]. She was diagnosed with Cerebral Infarction (which was a pathologic process that resulted in necrotic tissue in the brain, caused by disrupted oxygen and blood supply,) and Post Traumatic Stress Disorder (which was a mental health disorder that developed due to shocking, scary, or dangerous events.) Record review of Resident #68's Quarterly MDS, dated [DATE], reflected Section I- Active Diagnosis: Resident #68 had Pneumonia. Record review of Resident #68's Active Diagnosis, in PCC (which was the facility's documentation platform,) indicated Resident #68 was diagnosed with Pneumonia on 2/23/2024. Record review of Resident #68's Order Summary, in PCC, indicated Resident #68 was prescribed Benzonatate 100 MG Capsules -three times daily for an upper respiratory infection from 2/23/2024 until 3/9/2024. The Order Summary, in PCC, indicated the Benzonatate 100 MG Capsule was completed on 3/9/2024. Interview and observation on 6/4/2024 at 12:18 PM with Resident #68 revealed she did have Pneumonia back in February but it had since been resolved. She stated she had been prescribed medication. She was not observed having displayed any respiratory infection distress, such as wheezing, altered breath, or coughing. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and record review on 06/06/2024 at 1:30 PM with MDS B revealed MDS Coordinators reviewed resident characteristics and entered that information into the resident MDS. Resident characteristics were obtained through record review and one-on-one visits with the residents and were updated quarterly, annually, upon significant changes, or changes in condition. MDS B reviewed all above record reviews with the surveyor. MDS B stated the information in Resident #68's Quarterly MDS, dated [DATE], was not correct because Resident #68 did not have Pneumonia at the time of the assessment; furthermore, Resident #68 did not have Pneumonia during the seven-day lookback prior to the MDS assessment. MDS B stated there were systems in place to identify MDS errors, such as team meetings, to ensure a resident's MDS, CP, and diagnosis were accurate. In addition, there was a third-party agency, who continually reviewed MDS information, and communicated errors to the facility. If a resident's MDS was miscoded, the resident was not necessarily placed in any harm. The fact that Resident #68's MDS still indicated she still have active pneumonia, was simple oversight and the failure fell on human error. Resident #68 was not placed in any harm and was not provided medical interventions that were not warranted. Interview on 6/6/2024 at 2:43 PM with the ADMIN revealed accurate MDSs were important because the MDS assessments contributed to the resident's plan of plan. If an MDS was inaccurate, a resident might not receive a required service or receive a service other than intended. A failsafe was in place to identify and correct MDS errors consisted of care plan meetings, where information was reviewed for accuracy by CNAs, LVNs, and other IDT members. An additional failsafe measure in place to identify MDS errors was that of a secondary quality assurance company, who audited MDS assessments for accuracy. With regards to the incorrect MDS of Pneumonia coding with Resident #68, the resident was not denied any medical care and was not provided with any unnecessary medical treatments. The ADMIN stated the inaccurate assessment for Resident #68 did not cause any harm and the failure for the inaccurate assessment fell on human error. Record review of the facility's MDS Assessment Coordinator Policy, dated November 2019, indicated a registered nurse was responsible for having conducted and having coordinated the development and the completion of the resident assessment. Each individual, who completed a portion of the assessment, must have certified the accuracy of the portion of the assessment by having dated and signed the assessment and having identified each section was completed. Record review of the facility's MDS Error Correction Policy, dated July 2017, indicated an error having related to coding, that did not result in an inappropriate plan of care, was considered a minor error. The remedy was to correct the error and resubmit.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49556 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety for 1 of 1 kitchen reviewed for food safety and sanitation. The facility failed to ensure food that was prepped labeled and dated in the walk-in refrigerator and in storage bins. The facility failed to discard of food products that were past the use by date or in accordance with facility policy in the dry storage area. These failures could place residents at risk of cross contamination, loss of nutritional value, weight loss and food borne illness. Findings included: Observation of the kitchen on 06/04/2024 at 9:10am revealed in the walk-in refrigerator there was prepared coleslaw in a bowl covered with clear plastic wrap. There was no label or date. Mushrooms, pineapple, cucumber, onions, chopped hard boiled eggs, and pickles were in individual round containers on a rolling cart in the walk-in refrigerator individually covered with clear plastic wrap but no labels or dates. In the walk-in freezer, there was an opened box of uncooked lasagna noodles with ice on the noodles with date of 9/10/23 on outside of the box. In the walk-in freezer there were three large metal pans of cooked lasagna with aluminum foil covered loosely over the lasagna exposing the lasagna to the freezing air. The label was smeared and unreadable. There were small pieces of ice on top of the lasagna. In the dry storage area, there was a bin labeled flour and dated 2/23/23. The white sugar bin was labeled but use by dates was smeared and unreadable. There was a bin next to the sugar, but the label was unreadable and smeared. Unable to read the name of the food or the use by dates on the container. An interview on 6/6/2024 at 9:15 am with [NAME] A revealed that if the food was not sealed or labeled you cannot tell how old it was or if it was bad. She revealed that if the food was not dated or labeled, it could by mistake be served to the residents and the residents could get sick. An interview on 6/6/2024 at 9:20 am with [NAME] B revealed that a resident could get sick if they eat food that has not been safely stored in the refrigerator or freezer. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 6/5/2024 at 11:10 am with the Dietary Manager revealed that if food was not properly labeled and sealed the residents could get sick. He also stated that there was no way to tell how long the food has been there. The Dietary Manager stated they have recently hired new staff and he tells them frequently the importance of labeling all food items in the refrigerator and freezer and when opened. An interview on 6/6/2024 at 10:00 am with the Administrator revealed that she was aware if food was not properly sealed or labeled a resident could become sick because there was no way to know how old the food was or if it has gone bad. Record Review of the Food Safety policy, not dated revealed open food should be labeled, dated, and safely stored. Record Review of the Receiving of Deliveries policy not dated revealed all foods are to be dated. Record Review of in-service dated 6/5/2024 revealed an in-service to all the kitchen employees. Titled How to Label Food: Importance of Properly Labeled Food.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47772 Based on observation, interview and record review, the facility failed to maintain an infection and prevention control program that included, at a minimum, a system for preventing and controlling infections for 2 of 7 residents (Resident #292 and Resident #50) reviewed for infection control, in that: 1. LVN A did not perform hand hygiene and change her gloves while performing wound care on Resident #292 and performed wound care on two wounds at the same time while performing wound care on Resident #292. 2. CNA E did not conduct hand hygiene and change gloves when performing peri-care (from the front to the back) for Resident #50. These failures placed residents at risk for infections, sepsis, and a diminished quality of life and death. Findings included: Record review of Resident #292's undated face sheet reflected a [AGE] year-old female who was originally admitted to the facility on [DATE], readmitted on [DATE] with diagnoses including history of stroke, sepsis, anemia, type 2 diabetes mellitus, hypertension, perforation of intestine, ileostomy status, and atrial fibrillation. Record review of Resident #292's comprehensive care plan, edited 12/28/2023, reflected Resident #292 will show signs of healing and remain free of infection. Record review of Resident #292's admission MDS, dated [DATE], reflected Resident #292 had a BIMS score of 14, which reflected none to mild cognitive decline. Resident #292's care plan reflected a stage 3 pressure ulcer on left gluteal fold related to previously healed ulcer site that was present on admission. On 6/05/24 WMD obtained measurements which were 0.7cm x 2cm and 0.2cm x 1cm. Resident #292's care plan reflected she had a stage 3 pressure ulcer on right gluteal fold related to previously healed ulcer site that was present on admission. On 6/05/24 WMD obtained measurements which were 0.7cm x 1cm and 4.0cm x 0. 1cm. Record review of Resident #50's face sheet, Care Plan, and MDS was not obtained by surveyor. An observation on 06/05/24 at 10:05 AM for Resident #50 of peri-care with CNA E revealed she did not change her gloves or conduct hand hygiene when cleansing resident from front to back. An interview on 06/05/24 at 10:43 AM with CNA E revealed she knew she had not changed her gloves when going from front to back when providing peri-care to Resident #50. She stated she had received training on peri-care and offered no reason for having forgotten to change her gloves and sanitize her hands when going from front to back. An observation on 06/06/24 at 09:19 AM was conducted for Resident #292 by LVN A. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Wound was documented in physicians' orders as a wound located at left gluteal fold and a wound located at right gluteal fold. LVN A did not change her gloves, and hand hygiene was not performed after first dressing change was complete. LVN A removed both dressings and disposed of them. . Interview on 06/06/24 at 2:45 PM with LVN B stated she wore gloves and changed them frequently when she cleansed the wound, when going from dirty to clean and when there was more than one wound, she would change gloves and conduct hand hygiene when treating one wound to the next one. After cleaning the wound LVN B stated she would conduct hand hygiene and change her gloves and would change her gloves as needed to avoid cross contamination. LVN B stated she had attended in-services on infection control. Interview on 06/06/24 at 2:45 PM with LVN C, stated she would wear gloves during wound care. LVN C stated depending on the type of the wound, she would change gloves throughout the task so that there was no cross contamination, remove gloves after cleaning the wound, and put on a new pair of gloves to apply any medications and when applying a new dressing. LVN C stated she had attended in-services on infection control. Interview on 06/06/24 at 2:45 PM with CNA F, stated she would clean the front and change gloves, then clean the back, change gloves, add any cream, change gloves, and apply new brief. CNA F stated she had attended in-services on infection control. Interview on 06/06/24 at 2:45 PM with CNA C revealed when doing peri-care she would clean the front, change gloves, and clean the back and change gloves. CNA C stated she has attended in-services on infection control. Interview on 06/06/24 at 2:45 PM with CNA D, who stated she changed gloves throughout performing peri care. CNA D stated she would wipe the front, remove gloves, and put new gloves on, wipe the back and change gloves, add cream to bottom if needed. She said she attended in-services on infection control. An interview on 06/06/24 at 02:55 PM with the DON revealed they provide education on conducting hand hygiene, changing gloves when going from one wound to another, and cleansing from front to back during peri-care. The DON further stated these were her expectations. The DON stated a negative outcome of cross-contamination was that infectious bacteria could travel to another area. Review of an Infection Control Policy dated 03/2020 reflected, The facility practices infection control measures, when providing service to its residents in order to minimize the risk of infections to employees, residents and families and the community-at-large in accordance with the antibiotic stewardship program and CMS guidelines/best practice. (continued on next page)

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 06/06/2024
NAME OF PROVIDER OR SUPPLIER: Town Hall Estates Keene Inc		STREET ADDRESS, CITY, STATE, ZIP CODE: 207 S Old Betsy Rd Keene, TX 76059	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Handwashing/Hand Hygiene Policy and Procedure dated October 2023 reflected, Hand hygiene is indicated before performing an aseptic task (for example, placing an indwelling device or handling an invasive medical device), after contact with blood, body fluids, or contaminated surfaces, after touching a resident, before moving from work on a soiled body site to a clean body site on the same resident, and immediately after glove removal.