

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: 676074	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2024
NAME OF PROVIDER OR SUPPLIER Town Hall Estates Whitney Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 101 San Marcus Whitney, TX 76692	
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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47926 Based on interview and record review, the facility failed to ensure the physician was consulted for a change of condition for 1 of 7 residents reviewed for notification of changes. (Resident #1) The facility failed to ensure a UA was collected, notify the physician, family, and provide treatment to Resident #1 died of sepsis and complications of a urinary tract infection because of her change in condition. The facility failed to identify a change in condition and notify her physician including a decline in cognitive status and a fall. On [DATE] at 12:00 p.m. an Immediate Jeopardy (IJ) was identified. While the IJ was removed on [DATE] at 6:15PM, the facility remained out of compliance at a scope of isolated and severity of actual harm due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. These failures could place residents from receiving the adequate care needed to treat their infections leading to sepsis, injuries, hospitalization , or even death. Findings Included: A record review of Resident #1's undated face sheet reflected Resident #1 was an [AGE] year-old female who was admitted to the facility on [DATE] with a diagnosis of Type 2 diabetes mellitus (elevated blood sugar), depression, anorexia, chronic obstructive pulmonary disease (a group of disease that cause airflow blockage), constipation, and glaucoma (a disease that damages the optic nerve causing impaired vision). A record review of admission summary dated [DATE] at 10:30 AM reflected Resident #1 could ambulate short distances with a walker but required a wheelchair for long distances. Resident #1 was alert with some confusions, was able to feed herself and was continent of bowel and bladder. (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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A record review of facility 24-hour change in condition report dated [DATE] (a report used to communicate exchange of pertinent information related to resident care between nursing staff) reflected from 6:00AM to 10:00PM signed by LVN#A. Resident #1 was a new admission for 5-day respite (a short stay to provide the family a relief from care). Resident #1 had dentures. She had no skin issues. Resident #1 was eating a regular diet and health shake with meals. Resident #1 was continent of bowel and bladder. She was able to feed herself and was taking the medication Megace (a medication to stimulate appetite). She was confused and used her walker to ambulate short distances. A record review of nursing progress note dated [DATE] at 1:36PM by RN#C reflected that she spoke with the doctor regarding Resident #1's intermittent confusion and that Resident #1 was incontinent of urine with increased weakness. RN #C received a new order for Urinalysis with C&S to check for UTI. Family was at the facility and aware of new order. A record review of order recap report reflected an order for urinalysis with C&S one time related to Urinary Tract Infection dated [DATE]. A record review of facility 24-hour changes of condition report (a report used to communicate exchange of pertinent information related to resident care between nursing staff) dated [DATE] time frame from 6:00AM-2:00PM signed by LVN #A reflected that Resident #1 had intermittent confusion and required assistance of ,d+[DATE] staff, maximum staff assistance with transfers, was in a wheelchair, and incontinent of bowel and bladder. Resident #1 had attempted to urinate in the trash and had a new order for urinalysis. A record review of facility 24-hour changes of condition report dated [DATE] reflected ,d+[DATE]PM shift, Resident #1 refused urinalysis and was agitated and combative. The report reflected that LVN#B attempted a clean catch specimen and catheter but was unable to collect UA. A Record Review of Resident #1's Nursing Progress notes for date [DATE] reflected there were no medical record documentation related to the findings on the 24-hour change in condition report. A record review of facility 24-hour changes of condition report dated [DATE] signed by LVN#A reflected 6am-10pm shift Resident #1 had loose stools x2, PCP was notified about the need for urinalysis, and stated will have her come to his office when discharged on [DATE]. On the same change of condition report 10pm -6 am LVN #B noted that Resident #1 was confused and refused to toilet . A Record Review of Resident #1's Nursing Progress notes for date [DATE] reflected there were no medical record documentation related to the findings on the 24-hour change in condition report. A record review of facility 24-hour changes of condition report dated [DATE] 6am-10pm shift signed by LVN#A reflected Resident #1 was follow-up from fall that was witnessed. A Record Review of Resident #1's Nursing Progress notes for date [DATE] reflected there were no medical record documentation related to the findings on the 24-hour change in condition report. A Record Review of the Facility Historical Incident reports reflected there were no documented incident or accident reports related to Resident#1 for date of [DATE]. (continued on next page)		

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A record review of progress note dated [DATE] at 12:37PM by LVN#A reflected resident was sitting in front of the nurses ' station and started to vomit. Resident vomited a large amount of chocolate milkshake with undigested food mixed in. The doctor was notified and made aware and a new order for Zofran (a medication for nausea and vomiting) was received. The RP was made aware. Record review of order recap report reflected an order for Ondansetron HCl (Zofran) tablet 4mg every 6 hours as needed for vomiting dated [DATE]. Record review of nursing progress notes dated [DATE] at 3:20PM reflected Resident #1 vomited again a large amount of undigested food and curdled milk. Resident #1 was medicated with Zofran offered Gatorade but resident #1 refused. Record review of nursing progress notes dated [DATE] at 6:33PM reflected that Resident #1 vomited more curdled milk. Record review of nursing progress notes dated [DATE] at 4:30PM written by LVN#B reflected Resident #1 was sitting across from the nurse's station and appeared to be napping. Resident's oxygen level on room air was 84% (normal oxygen level should be above 90%), Oxygen level 89% on oxygen via nasal cannula at 2 liters per minute. The family stated Resident #1 was not right. Resident #1 was transported to the hospital by ambulance. A record review of the Discharge MDS dated [DATE] reflected Resident #1 was substantial maximal assistance with lying to sitting on the side of the bed, and dependent for chair to bed transfers (the helper does all the effort. Resident does none of the effort to complete the activity). The MDS also indicated Resident #1 was frequently incontinent of urination. Section I of the MDS was coded for infection of UTI. In an interview with Resident #1's RP on [DATE] at 12:05PM she stated she arrived at the facility on [DATE] and noticed Resident #1 was slumped over at the nurses' station with oxygen on and dried food on her clothes. Resident #1's RP stated she spoke with the facility staff about sending Resident #1 to the hospital and was told by the facility nurse the hospital would do nothing for Resident #1 except for IV fluids and send her back. She said after further discussion, the facility nurse and RP agreed to send Resident #1 to the hospital. She stated Resident #1 was diagnosed with sepsis related to the UTI and aspiration pneumonia. She stated Resident #1 died on [DATE] related to the sepsis from the UTI. She stated Resident #1 was originally scheduled for respite care for five days but then Resident #1's RP extended the stay. She stated she was not notified that Resident #1 was continuing to refuse the UA and she was not notified that Resident #1 had a fall on [DATE]. She stated she was not notified that Resident #1 needed to be taken to her PCP clinic on the date Resident #1 was supposed to be discharged from the facilities care. (continued on next page)		

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with LVN #A on [DATE] at 1:04PM she said Resident #1 was new to her and she was not sure if Resident #1's change in condition (a sudden clinical deviation from a resident's baseline in physical, cognitive, behavioral or functional domains) were from the UTI, she was not sure what the resident's baseline cognitive status was. She stated Resident #1 was able to ambulate with a walker upon admission but then required a wheelchair. She said Resident #1 was supposed to see her PCP upon discharge from respite care, but Resident #1's RP extended her stay. She stated Resident #1's RP was not notified of the need for Resident #1 to be seen by her PCP. There were no further attempts to obtain a urinalysis. Resident #1 had a fall attempting to sit on the trashcan and there was not an incident report completed in the medical record. LVN#A stated she probably didn't do an incident report. LVN #A said she might have been having a difficult day. She stated normal practice for change in condition and falls would be to assess vital signs and call the PCP for further orders. In an interview with LVN #B on [DATE] at 1:16PM LVN B said she was the nurse who sent Resident #1 to theER on [DATE] but could not remember any details regarding Resident #1 . She said a Change of conditions should be assessed by a nurse and documented in the medical record. LVN #B stated with any changes in a residents condition the nurses are report it to the DON, family, and physician. She said if she were unable to obtain a UA on a resident, she would have shipped the resident to the hospital. She said a UTI left untreated could cause serious illness. In an interview with the DON on [DATE] at 1:26PM the DON stated Resident #1 refused the UA and it was her right to refuse the treatment. She stated Resident #1 was experiencing a decline prior to being admitted and subsequently passed away. She stated Resident #1's MD was not notified that Resident #1 had continued refusing the UA. She stated she would expect nurses to document if a resident refused labs. The facility did not make any attempts to take Resident #1 into the clinic. The facility did not make any further attempts to obtain the UA. The DON stated the negative outcome for not obtaining an UA would have possibly been becoming septic or worsening of infection. The expectation was for the nurses to report and document and follow up on labs, falls, and changes in condition. The DON stated the PCP, and the family should have notified related to changes of condition, falls, anything related to the patient. The DON said she was responsible for monitoring incident and accidents, both the ADON and the DON monitor the 24-hour report and clinical documentation checked in medical record every 24 hours for changes in condition. The DON said the negative outcome for not reporting the fall could be an injury and no one would know to follow up. In an interview on [DATE] at 4:45 PM with Resident #1's PCP, he said if Resident #1 refused the UA the nurse should have contacted him for further instructions. He said he had not seen Resident #1 while at the facility. The PCP stated he was notified by the nurse that Resident #1 vomited, and he prescribed Zofran. He said he was not made aware at that point that the UA had not been completed. He said he was not made aware of the fall. Resident #1's PCP said the nausea and vomiting could have been a symptom of the urinary infection turning into sepsis. Record review of facilities policy and procedure titled Change in a Resident's Condition or Status dated [DATE] reflected: 1) The Nurse will notify the residents attending physician or physician on call when there has been a: Accident or incident involving the resident. (continued on next page)		

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Significant change in the residents physical/emotional/mental condition. Need to alter the resident's medical treatment significantly. Need to transfer the resident to a hospital/treatment center. This was determined to be an Immediate Jeopardy (IJ) on [DATE] at 12:00PM. The Administrator was notified. The ADM and the DON was provided with the IJ template on [DATE] at 12:00PM. The following Plan of Removal was submitted by the facility and was accepted on 03/ ,d+[DATE] at 4:30 PM: Record review of facility plan of removal for F580 reflected: Plan of Removal Immediate Threat On [DATE] an abbreviated survey was initiated at The Facility. On [DATE] the surveyor provided an Immediate Jeopardy (IJ) Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate threat to resident health and safety. The notification of Immediate Threat states as follows: F580 The facility must immediately inform the resident, consult with the resident's physician, and notify the resident representative when there is a significant change in the resident's physical, mental, or psychosocial status. All residents could be affected by this. Action: The DON and the ADON will review 24-hour reports, nursing documentation, incidents and accidents, all new orders, and labs daily to ensure change of conditions are handled appropriately. If labs are found missing, the physician will be notified, and labs will be collected per physician orders. This will be an ongoing process. Lab audit was conducted for all residents last 3 months. 1 resident was found that had not received a lab collection due to lab technician quitting without notice. Physician notified and a new req was made. Lab collected and awaiting results. Start Date: [DATE]. Completion Date: Ongoing Process Responsible: The DON and the ADON Action: The DON and the ADON will audit orders, labs, documentation and 24-hour reports to ensure no labs are missed for all residents, both long term, and short stay (respite) for the last 3 months and will be an ongoing process. Start Date: [DATE]. Completion Date: Ongoing Process Responsible: The DON and the ADON (continued on next page)		

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2) Action: The DON and the ADON have been in-serviced on change of condition upon hire, through The Facility Meeting, QRM, and TMF . In-service all staff about change of condition, notifying the residents attending physician or physician on call, RP and documenting in the medical record when there has been a: Accident or incident involving the resident. Significant change in the residents physical/emotional/mental condition. Need to alter the resident's medical treatment significantly. Need to transfer the resident to a hospital/treatment center. Ensure PCP orders were followed including, PRN , agency, new hires, and staff not currently in the facility before the start of their next shift. Start Date: [DATE]. Completion Date: [DATE] Responsible: The Don and ADON 3) Action: The Facility had a QAPI meeting held with the DON, the Administrator, the DM, the MR, the VP of Operations and the ADON. Medical Director notified. The DON and the ADON have been in-serviced on Incidents and Accidents upon hire, through the Facility, QRM, and TMF throughout the year. In-service all staff about incidents and accidents and ensure responsible party and PCP notified, including PRN, agency, new hires, and staff not currently in facility before the start of their next shift. Start Date: [DATE]. Completion Date: [DATE] Responsible: The Don and the ADON Action: The DON and the ADON have been in-serviced on Falls, Fall Management, definitions of Falls, upon hire, through the facility Meetings, QRM, and TMF (last one on [DATE]). In-service all staff including, PRN, agency, new hires, and staff not currently in facility before the start of their next shift about falls, fall management, definitions of falls and incidents & accidents completion. All staff were also educated about change in conditions related to falls and notification to on call nurse, physician, and resident's responsible party. Start Date: [DATE]. Completion Date: [DATE] Responsible: The Don and the ADON (continued on next page)		

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Action: the DON and the ADON have been in-serviced on respite care through the National Institute on Aging. In-service all staff including PRN, agency, new hires, and staff not currently in facility before the start of their next shift about respite care and treating them the same as all other residents. Physician will be notified of all changes in condition and physician orders will be followed with notification to resident's responsible party as well as on call nurse. This will be monitored by the DON and the ADON as each respite is admitted for the next 3 months. Start Date: [DATE]. Completion Date: [DATE] Responsible: The Don and the ADON Action: Both the DON and the ADON have been in-service through Texas Board of Nursing on documentation. In-service all staff including PRN, agency, new hires, and staff not currently in facility before the start of their next shift about documentation and it is to be completed during shift. This will be monitored by the DON and the ADON Monday - Friday for the next 3 months. Start Date: [DATE]. Completion Date: [DATE] Responsible: The Don and the ADON On [DATE] the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy (IJ) by: A lab audit was completed on [DATE] for all residents for the last 3 months. 1 (one) resident was found that had not received a lab collection due to lab technician quitting without notice. That residents Physician was notified, and a new requisition was made. The Lab was collected, and the facility is awaiting results. The audit was completed by: DON and ADON. On [DATE] A QAPI meeting was held with the Medical Director, the Facility Administrator, Business Office Manager, the Director of Nursing, and Assistant Director of Nursing to review root cause analysis and implement procedure and plan of correction. Staff education was initiated on abuse and neglect, falls, and fall management, incidents and accidents, respite care, collection of urinalyses, and documentation. (continued on next page)		

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	There were 20 out of 51 staff members interviewed on [DATE] between 9:00 a.m. and 4:00 p.m. from a variety of shifts (LVN A, RN C, LVN D, CMA E, CNA F, CNA G, CNA H, CNA J, CNA K, CNA L, Maintenance Man, Housekeeping Supervisor, Laundry Supervisor, Cook, Housekeeper , Kitchen staff) The facility staff confirmed they were in-serviced on abuse and neglect. The staff were able to identify the administrator as the abuse coordinator. The facility staff were able to give examples of different forms of abuse such as neglecting resident care, stealing money, and being verbally aggressive with residents. The staff were in-serviced on change of condition. The staff were able to give examples of changes in condition such as not eating, increased confusion, and how they would report and document changes in condition. The staff confirmed they were in-serviced on incidents and accidents, falls, fall management, the definitions of falls, and were able to give fall prevention interventions such as keeping mobile devices close to resident and pathways clear. The staff could explain the process if they were to find a resident on the floor, they would call for help, not move the resident, and allow the nurse to assess the fall/incident. All staff confirmed they were also educated about change in conditions and notification to on call nurse, physician, and resident's responsible party for any changes in condition. Staff confirmed they were educated on documentation and all documentation was to be completed prior to the end of their shifts. Staff confirmed they had been in-serviced on respite care and treating those residents the same as all other residents. During an interview, on [DATE] at 4:45PM the ADON said she was in-serviced on abuse and neglect, change of condition, notification of changes in condition to the RP and PCP, incidents, and accidents, falls, fall management, the definitions of falls, and respite care. All staff were also educated about change in conditions related to falls and notification to on call nurse, physician, and resident's responsible party. She said she had been in-serviced on respite care and treating them the same as all other residents. She said the Physician would be notified of all changes in condition and physician orders would be followed with notification to resident's responsible party as well as the on-call nurse. The ADON said that documentation would be completed during the staffs shift. The ADON was able to describe process in place for prevention of future incidents including the monitoring of the documentation, monitoring of the orders, labs, and 24-hour report daily. The ADON said the management staff would continue to educate staff through in-services. During an interview, on [DATE] at 4:50PM the DON said she was in-serviced on abuse and neglect, change of condition, notification of changes in condition to the RP and PCP, incidents, and accidents, falls, fall management, the definitions of falls, and respite care. All staff were also educated about change in conditions related to falls and notification to on call nurse, physician, and resident's responsible party. She said she had been in-serviced on respite care and treating them the same as all other residents. She said the Physician would be notified of all changes in condition and physician orders would be followed with notification to resident's responsible party as well as on call nurse. That documentation would be completed during the shift. The DON was able to describe process in place for prevention of future incidents including the monitoring of the documentation, orders, labs, and 24-hour report. The DON said the management staff would continue to educate staff through in-services. (continued on next page)		

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview, the ADM on [DATE] at 5:00PM the ADM said she was in-serviced on abuse and neglect, notification of changes to the RP and PCP, Change of Condition, incidents, and accidents, falls, fall management, the definitions of falls, and respite care. All staff were also educated about change in conditions related to falls and notification to on call nurse, physician, and resident's responsible party. She said she had been in-serviced on respite care and treating them the same as all other residents. She said the Physician will be notified of all changes in condition and physician orders will be followed with notification to resident's responsible party as well as on call nurse and that documentation completed during shift. The ADM was able to describe process in place for prevention of future incidents including the monitoring of the documentation, orders, labs, incident reports and 24-hour report to identify changes in condition. Those changes would be communicated to the physician and RP. The ADM said she was confident her staff could recognize and act according to policy related to changes in condition. The Facility was informed the Immediate Jeopardy was removed on [DATE] at 6:15PM. The facility remained out of compliance at a severity level of potential for more than minimum harm that is not immediate jeopardy with a scope identified as isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47926 Based on interviews and record review, the facility failed to ensure that residents are free from abuse, neglect, misappropriation of resident property, and exploitation; the facility failed to provide goods and services to a resident that were necessary to avoid physical harm, pain, mental anguish, or emotional distress for 1 (Resident #1) of 7 residents reviewed for neglect. The facility failed to ensure a UA was collected and provide treatment to Resident #1 who subsequently died of sepsis and complications of a urinary tract infection. The facility failed to identify a change in condition and notify her physician including a decline in cognitive status and a fall. ON [DATE] an Immediate Jeopardy (IJ) was identified. The POR was accepted on [DATE] at 10:00 AM and verified. Additional IJs were called [DATE] and the IJs were removed on [DATE] at 6:15PM. Although the IJ was removed, the facility remained out of compliance at an isolated scope of isolated and severity of actual harm due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. These failures could lead to sepsis or injury of unknown origin which could require medical intervention in the hospital, and place residents at risk of neglect and not having their needs met to reach their highest practicable mental, physical, and psycho-social wellbeing. Findings included: A record review of Resident #1s undated face sheet Reflected Resident #1 was an [AGE] year-old female who was admitted to the facility on [DATE] with a diagnosis of Type 2 diabetes mellitus (elevated blood sugar), depression, anorexia, chronic obstructive pulmonary disease (a group of disease that cause airflow blockage), constipation, and glaucoma (a disease that damages the optic nerve causing impaired vision). A record review of admission summary dated [DATE] at 10:30 AM reflected Resident #1 could ambulate short distances with a walker but required a wheelchair for long distances. Resident #1 was alert with some confusions, was able to feed herself and was continent of bowel and bladder. A record review of facility 24 hour report change in condition report (a report used to communicate exchange of pertinent information related to resident care between nursing staff) dated [DATE] reflected from 6:00AM to 10:00PM signed by LVN#A Resident #1 was a new admission for 5-day respite (a short stay to provide the family a relief from care). Resident #1 had dentures. She had no skin issues. Resident #1 was eating a regular diet and health shake with meals. Resident #1 was continent of bowel and bladder. She was able to feed herself and was taking the medication Megace (a medication to stimulate appetite). She was confused and used her walker to ambulate short distances. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Town Hall Estates Whitney Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 101 San Marcus Whitney, TX 76692	
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A record review of nursing progress note dated [DATE] at 1:36PM by RN#C reflected that she spoke with Doctor regarding Resident #1s intermittent confusion and that Resident #1 was incontinent of urine with increased weakness. RN #C received a new order for Urinalysis with C&S to check for UTI. Family was at the facility and aware of new order. A record review of order recap report reflected an order for urinalysis with C&S one time related to Urinary Tract Infection dated [DATE]. A record review of facility 24-hour report changes of condition report dated [DATE] time frame from 6:00AM-2:00PM signed by LVN #A reflected That Resident #1 had intermittent confusion and was requiring assistance of ,d+[DATE] staff, maximum staff assistance with transfers was in a wheelchair and incontinent of bowel and bladder. Resident #1 had attempted to urinate in the trash and had a new order for urinalysis. A record review of facility 24-hour report changes of condition report dated [DATE] reflected ,d+[DATE] shift reflected Resident #1 refused urinalysis and was agitated and combative. The report reflected that LVN#B Attempted a clean catch and catheter. A Record Review of Resident #1s Nursing Progress notes for date [DATE] reflected there were no medical record documentation related to the findings on the 24-hour change in condition report. A record review of facility 24-hour report changes of condition report dated [DATE] signed by LVN#A reflected 6am-10pm shift Resident #1 had loose stools x2, PCP was notified about need for urinalysis and states will have her come to his office when discharged . On the same change of condition report 10pm -6 am LVN #B noted that Resident #1 is confused refusing to toilet. A Record Review of Resident #1s Nursing Progress notes for date [DATE] reflected there were no medical record documentation related to the findings on the 24-hour change in condition report. A record review of facility 24-hour report changes of condition report dated [DATE] 6am-10pm shift signed by LVN#A reflected Resident #1 was follow up from fall that was witnessed. A Record Review of Resident #1s Nursing Progress notes for date [DATE] reflected there were no medical record documentation related to the findings on the 24-hour change in condition report. A Record Review of Facility Historical Incident reports reflected there were no documented incident or accident reports related to Resident#1 for date of [DATE]. A record review of progress note dated [DATE] at 12:37PM by LVN#A reflected Resident was sitting in front of the nurses' station and started to vomit. Vomiting a large amount of chocolate milkshake with undigested food mixed in. Doctor was notified and made aware and a new order for Zofran (a medication for nausea and vomiting) was received. The RP was made aware. Record review of order recap report reflected an order for Ondansetron HCl (Zofran) tablet 4mg every 6 hours as needed for vomiting dated [DATE]. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of nursing progress notes dated [DATE] at 3:20PM reflected Resident #1 vomited again a large amount of undigested food and curdled milk Resident #1 was medicated with Zofran offered Gatorade but resident #1 refused. Record review of nursing progress notes dated [DATE] at 6:33PM reflected that Resident #1 vomited more curdled milk. Record review of nursing progress notes dated [DATE] at 4:30PM Written by LVN#B reflected Resident #1 was sitting across from nurse's station appeared to be napping oxygen level on room air was 84% (normal oxygen level should be above 90%), Oxygen level 89% on oxygen via nasal cannula at 2 liters per minute. Family stated Resident #1 was not right. Resident #1 was transported to the hospital by ambulance. A record review of the Discharge MDS dated [DATE] reflected Resident #1 was substantial maximal assistance with lying to sitting on the side of the bed, and dependent for chair to bed transfers (the helper does all the effort. Resident does none of the effort to complete the activity). The MDS also indicated Resident #1 was frequently incontinent of urination. Section I of the MDS was coded for infection of UTI. In an interview with Resident #1's RP on [DATE] at 12:05PM stated she arrived at the facility on [DATE] and noticed Resident #1 was slumped over at the nurses' station with oxygen on and dried food on her clothes. Resident #1's RP stated she spoke with facility staff about sending Resident #1 to the hospital and was told by the facility nurse the hospital would do nothing for Resident #1 except for IV fluids and send her back. She said after further discussion, the facility nurse and RP agreed to send Resident #1 to the hospital. She stated Resident #1 was diagnosed with sepsis related to the UTI and aspiration pneumonia. She stated Resident #1 died on [DATE] related to the sepsis from the UTI. She stated Resident #1 was originally scheduled for respite care for five days but then Resident #1's RP extended the stay. She stated she was not notified that Resident #1 was continuing to refuse the UA and she was not notified that Resident #1 had a fall on [DATE]. She stated she was not notified that Resident #1 needed to be taken to her PCP clinic on the date Resident #1 was supposed to be discharged from the respite care. In an interview with LVN #A on [DATE] at 1:04PM she said Resident #1 was new to her and she was not sure if behaviors were from the UTI, she was not sure what the Residents baseline cognitive status was. She stated Resident #1 was able to ambulate with a walker upon admission but then required a wheelchair. She said Resident #1 was supposed to see her PCP upon discharge from respite care, but Resident #1's RP extended her stay. She stated Resident #1's RP was not notified of the need for Resident #1 to be seen by her PCP. There were no further attempts to obtain a urinalysis. Resident #1 had a fall attempting to sit on the trashcan and there was not an incident report completed. LVN#A stated she probably didn't do an incident report. LVN #A said she might have been having a difficult day. She normal practice for change in condition and falls would be assess vital signs and call the PCP for further orders. LVN#A said its policy that an incident report would be completed for falls and documented in nurses' progress notes, notify family, and notify PCP that is policy. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with LVN #B on [DATE] at 1:16PM LVN B said she was the nurse who sent Resident #1 to theER on [DATE] but could not remember any details regarding Resident #1 . She said a Change of conditions should be assessed by a nurse and documented in the medical record. LVN #B stated with any changes in a residents condition the nurses are report it to the DON, family, and physician. She said if she were unable to obtain a UA on a resident, she would have shipped the resident to the hospital. She said a UTI left untreated could cause serious illness. In an interview with the DON on [DATE] at 1:26PM the DON stated Resident #1 refused the UA and it was her right to refuse the treatment. She stated Resident #1 was experiencing a decline prior to being admitted and subsequently passed away. She stated Resident #1's MD was not notified that Resident #1 had continued refusing the UA. States she would expect nurses to document if a resident refuses lab. The facility staff did not make any attempts to take Resident #1 into the clinic and the facility staff did not make any further attempts to obtain the UA. The DON stated the negative outcome for not obtain UA would have possibly been becoming septic, worsening of infection. The expectation is for the nurses to report document and follow up on labs, falls, and changes in condition. The DON stated PCP and family should have notified related to changes of condition, falls, anything related to the pt. The Don said she is responsible for monitoring incident and accidents, both the ADON and DON monitor the 24-hour report and clinical documentation checked in medical record every 24 hours for changes in condition. The DON said the negative out for not reporting the fall-could be an injury and no one would know to follow up . In an interview with PCP on [DATE] at 4:45 PM with Resident #1's PCP, said if Resident #1 refused the UA the nurse should have contacted him for further instructions. He said he had not seen Resident #1 while at the facility. The PCP stated he was notified that Resident #1 vomiting and he prescribed Zofran. He said he was not made aware at that point that the UA had not been completed. He said he was not made aware of the fall. Resident #1s PCP said the nausea and vomiting could have been a symptom of the urinary infection turning into sepsis . Record review of facilities undated policy and procedure titled Resident Rights reflected the resident has the right not to be abused, neglected, or mistreated. The same policy defined neglect as the failure to provide goods and services which include medical services which are necessary to provide quality of care and quality of life. In a record review of facility policy titled Accidents and Incidents, dated [DATE], reflected all accidents or incidents involving residents, employees, and visitors occurring on our premises shall be investigated and reported to the Administrator. Policy Interpretation reflected: 1. The Nurse Supervisor/Charge nurse and or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. 2. The following data as applicable shall be included on the report of incident/accident form. a) The date of the incident b) The nature of the injury/illness (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	c) The circumstances surrounding the accident or incident. d) The names of witnesses and their accounts of the accident or incident e) The injured persons account of the accident or incident f) The time the attending physician was notified as well as the time the physician responded. g) The date and time the injured persons family was notified and by whom. h) The condition of the injured person including his/her vital signs i) The disposition of the injured person j) Any corrective action taken. k) Other pertinent data as necessary l) The signature and title of the person completing the report. In a record review of facility policy titled Change in Residents Condition or Status dated [DATE] reflected our facility shall promptly notify the resident, his or her attending physician, and representative of changes in the residents medical/mental condition and/or status. 1. The nurse will notify the residents attending physician or on call physician when there has been: a. an accident or incident involving the resident. b. significant change in residents physical/emotional/mental condition c. need to alter the resident's medical treatment. d. refusal of treatment or medications two (2) or more attempts 2. A significant change of condition is a major decline or improvement in the resident's status that: a. will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions. b. impacts more than one area of the resident's health status. c. unless otherwise instructed by the resident a nurse will notify the residents representative when: d. the resident is involved in any accident or incident that results in an injury including injuries of unknown origin. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	e. there is a significant change in the residents physical mental or psychosocial status. In a record review of facility policy titled Lab and Diagnostic Test Results dated [DATE] reflected 1. The physician will identify, and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs. 2. The staff will process test requisitions and arrange for tests. 3. The laboratory, diagnostic radiology provider, or other testing source will report test results to the facility. In a record review of facility policy titled Charting and Documentation dated [DATE] reflected that all services provided to the resident progress towards the care plan goals or any changes in the residents medical, physical, functional, or psychosocial condition shall be documented in the residents' medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident. The Administrator was notified on [DATE] at 6:15PM. that an Immediate Jeopardy situation was identified due to the above failure. The ADM and the DON was provided the Immediate Jeopardy template at that time. On [DATE] at 10:00AM the POR was accepted, and Record review of facility plan of removal for F600 reflected: Plan of Removal Immediate Threat On [DATE] an abbreviated survey was initiated at The Facility On [DATE] the surveyor provided an Immediate Threat (IT) Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate threat to resident health and safety. The notification of Immediate Threat states as follows: F600 The facility must ensure residents remain free from neglect. All residents could be affected by this. Action: The DON and the ADON will review 24-hour report, nursing documentation, incidents and accidents, all new orders, and labs daily to ensure change of conditions are handled appropriately. If labs are found missing, the physician will be notified, and labs will be collected per physician orders. Start Date: [DATE]. Completion Date: [DATE] Responsible: The DON and the ADON Action: The DON and the ADON will audit orders, labs, documentation and 24-hour reports to ensure no labs are missed for all residents, both long term and short stay (respite) for the last 3 months and forward indefinitely. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Start Date: [DATE]. Completion Date: [DATE] Responsible: The DON and the ADON Action: In-service all staff about Abuse, Neglect, Exploitation and Dignity including PRN, agency, new hires, and staff not currently in facility before the start of their next shift Start Date: [DATE]. Completion Date: [DATE] Responsible: The Don and the ADON Action: In-service all staff about Change of Condition and ensure the PCP orders are followed including, PRN, agency, new hires, and staff not currently in facility before the start of their next shift Start Date: [DATE]. Completion Date: [DATE] Responsible: The Don and the ADON Action: The Facility had a QAPI meeting held with the DON, the Administrator, the DM, the MR, the VP of Operations and the ADON. Medical Director notified. In-service all staff about Incidents and Accidents and ensure responsible party and PCP notified, including PRN, agency, new hires, and staff not currently in facility before the start of their next shift. Start Date: [DATE]. Completion Date: [DATE] Responsible: The Don and the ADON Action: In-service all staff including, PRN, agency, new hires, and staff not currently in facility before the start of their next shift about Falls, Fall Management, Definitions of falls and Incidents & Accidents completion Start Date: [DATE]. Completion Date: [DATE] Responsible: The Don and the ADON (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Action: In-service all staff including, PRN, agency, new hires, and staff not currently in facility before the start of their next shift about Respite Care and treating them the same as all other residents. This will be monitored by the DON and ADON as each respite is admitted for the next 3 months. Start Date: [DATE]. Completion Date: [DATE] Responsible: The Don and the ADON Action: In-service all staff including, PRN, agency, new hires, and staff not currently in facility before the start of their next shift about Documentation and it is to be completed during shift. This will be monitored by the DON and ADON Monday - Friday for the next 3 months. Start Date: [DATE]. Completion Date: [DATE] Responsible: The Don and the ADON Action: In-service all staff including, PRN, agency, new hires, and staff not currently in facility before the start of their next shift about Collection of labs per physician orders and follow up with physician for new orders. If unable to collect labs or resident refuses labs, physician and Responsible Party are to be notified and all documented by nurse. Start Date: [DATE]. Completion Date: [DATE] Responsible: The Don and the ADON On [DATE] the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy (IJ) by: A lab audit was completed on [DATE] for all residents over the last 3 months. 1 (one) resident was found that had not received a lab collection due to lab technician quitting without notice. That residents Physician was notified, and a new requisition was made. The Lab was collected, and the facility is awaiting results. The audit was completed by: DON and ADON. On [DATE] A QAPI meeting was held with the Medical Director, the Facility Administrator, Business Office Manager, the Director of Nursing, and Assistant Director of Nursing to review root cause analysis and implement procedure and plan of correction. Staff educations were initiated on abuse and neglect, falls, and fall management, incidents and accidents, respite care, collection of urinalyses, and documentation. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	There were 20 out of 51 staff members interviewed on [DATE] between 9:00 a.m. and 4:00 p.m. from a variety of shifts (LVN A, RN C, LVN D, CMA E, CNA F, CNA G, CNA H, CNA J, CNA K, CNA L, Maintenance Man, Housekeeping Supervisor, Laundry Supervisor, Cook, Housekeeper , Kitchen staff) The facility staff confirmed they were in-serviced on abuse and neglect. The staff were able to identify the administrator as the abuse coordinator. The facility staff were able to give examples of different forms of abuse such as neglecting resident care, stealing money, and being verbally aggressive with residents. The staff were in-serviced on change of condition. The staff were able to give examples of changes in condition such as not eating, increased confusion, and how they would report and document changes in condition. The staff confirmed they were in-serviced on incidents and accidents, falls, fall management, the definitions of falls, and were able to give fall prevention interventions such as keeping mobile devices close to resident and pathways clear. The staff could explain the process if they were to find a resident on the floor, they would call for help, not move the resident, and allow the nurse to assess the fall/incident. All staff confirmed they were also educated about change in conditions and notification to on call nurse, physician, and resident's responsible party for any changes in condition. Staff confirmed they were educated on documentation and all documentation was to be completed prior to the end of their shifts. Staff confirmed they had been in-serviced on respite care and treating those residents the same as all other residents. During an interview, the ADON on [DATE] at 4:45PM the ADON said she was in-serviced on Abuse and Neglect, Change of Condition, notification of changes in condition to the RP and PCP, Incidents and Accidents, Falls, Fall Management, the Definitions of falls, and Respite Care. All staff were also educated about change in conditions related to falls and notification to on call nurse, physician, and resident's responsible party. She said she had been in-serviced on Respite care and treating them the same as all other residents. She said Physician would be notified of all Changes in Condition and physician orders would be followed with notification to resident's responsible party as well as on call nurse. The ADON said Documentation would be completed during the staffs shift. The ADON was able to describe process in place for prevention of future incidents including the monitoring of the documentation, monitoring of the orders, labs, and 24-hour report daily. The ADON said the management staff would continue to educate staff through in-services. During an interview, the DON on [DATE] at 4:50PM the DON said she was in-serviced on Abuse and Neglect, Change of Condition, notification of changes in condition to the RP and PCP, Incidents and Accidents, Falls, Fall Management, the Definitions of falls, and Respite Care. All staff were also educated about change in conditions related to falls and notification to on call nurse, physician, and resident's responsible party. She said she had been in-serviced on Respite care and treating them the same as all other residents. She said Physician would be notified of all Changes in Condition and physician orders would be followed with notification to resident's responsible party as well as on call nurse. Documentation would be completed during the shift. The DON was able to describe process in place for prevention of future incidents including the monitoring of the documentation, orders, labs, and 24-hour report. The DON said the management staff would continue to educate staff through in-services. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview, the ADM on [DATE] at 5:00PM the ADM said she was in-serviced Abuse and Neglect, Change of Condition, notification of changes in condition to the RP and PCP, Incidents and Accidents, Falls, Fall Management, the Definitions of falls, and Respite Care. All staff were also educated about change in conditions related to falls and notification to on call nurse, physician, and resident's responsible party. She said she had been in-serviced on Respite care and treating them the same as all other residents. She said Physician will be notified of all Changes in Condition and physician orders will be followed with notification to resident's responsible party as well as on call nurse and Documentation completed during shift. The ADM was able to describe process in place for prevention of future incidents including the monitoring of the documentation, orders, labs, incident reports and 24-hour report to identify changes in condition. Those changes would be communicated to the physician and RP. The ADM said she was confident her staff could recognize and act according to policy related to changes in condition. The Facility was informed the Immediate Jeopardy was removed on [DATE] at 6:15PM. The facility remained out of compliance at a severity level of potential for more than minimum harm that is not immediate jeopardy with a scope identified as isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47926 Based on interviews and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice for one 1 (Resident #1) of 7 residents reviewed for quality of care. The facility failed to ensure a UA was collected and provide treatment to Resident #1 who subsequently died of sepsis and complications of a urinary tract infection. On [DATE] at 12:00 p.m. an Immediate Jeopardy (IJ) was identified. While the IJ was removed on [DATE] at 6:15PM, the facility remained out of compliance at a scope of isolated and severity of actual harm due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. This failure could place residents at risk for decreased quality of care by failing to treat infections which could impact their health causing sepsis and even death. Findings Included: A record review of Resident # 1s undated face sheet Reflected Resident #1 was an [AGE] year-old female who was admitted to the facility on [DATE] with a diagnosis of Type 2 diabetes mellitus (elevated blood sugar), depression, anorexia, chronic obstructive pulmonary disease (a group of disease that cause airflow blockage), constipation, and glaucoma (a disease that damages the optic nerve causing impaired vision). A record review of admission summary dated [DATE] at 10:30 AM reflected Resident #1 could ambulate short distances with a walker but required a wheelchair for long distances. Resident #1 was alert with some confusions, was able to feed herself and was continent of bowel and bladder. A record review of facility 24 hour report change in condition report (a report used to communicate exchange of pertinent information related to resident care between nursing staff) dated [DATE] reflected from 6:00AM to 10:00PM signed by LVN#A Resident #1 was a new admission for 5-day respite (a short stay to provide the family a relief from care). Resident #1 had dentures. She had no skin issues. Resident #1 was eating a regular diet and health shake with meals. Resident #1 was continent of bowel and bladder. She was able to feed herself and was taking the medication Megace (a medication to stimulate appetite). She was confused and used her walker to ambulate short distances. A record review of nursing progress note dated [DATE] at 1:36PM by RN#C reflected that she spoke with Doctor regarding Resident #1s intermittent confusion and that Resident #1 was incontinent of urine with increased weakness. RN #C received a new order for Urinalysis with C&S to check for UTI. Family was at the facility and aware of new order. A record review of order recap report reflected an order for urinalysis with C&S one time related to Urinary Tract Infection dated [DATE]. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Town Hall Estates Whitney Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 101 San Marcus Whitney, TX 76692	
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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A record review of facility 24-hour report changes of condition report dated [DATE] time frame from 6:00AM-2:00PM signed by LVN #A reflected That Resident #1 had intermittent confusion and was requiring assistance of ,d+[DATE] staff, maximum staff assistance with transfers was in a wheelchair and incontinent of bowel and bladder. Resident #1 had attempted to urinate in the trash and had a new order for urinalysis. A record review of facility 24-hour report changes of condition report dated [DATE] reflected ,d+[DATE] shift reflected Resident #1 refused urinalysis and was agitated and combative. The report reflected that LVN#B Attempted a clean catch and catheter. A Record Review of Resident #1s Nursing Progress notes for date [DATE] reflected there were no medical record documentation related to the findings on the 24-hour change in condition report. A record review of facility 24-hour report changes of condition report dated [DATE] signed by LVN#A reflected 6am-10pm shift Resident #1 had loose stools x2, PCP was notified about need for urinalysis and states will have her come to his office when discharged . On the same change of condition report 10pm -6 am LVN #B noted that Resident #1 is confused refusing to toilet. A Record Review of Resident #1s Nursing Progress notes for date [DATE] reflected there were no medical record documentation related to the findings on the 24-hour change in condition report. A record review of facility 24-hour report changes of condition report dated [DATE] 6am-10pm shift signed by LVN#A reflected Resident #1 was follow up from fall that was witnessed. A Record Review of Resident #1s Nursing Progress notes for date [DATE] reflected there were no medical record documentation related to the findings on the 24-hour change in condition report. A Record Review of Facility Historical Incident reports reflected there were no documented incident or accident reports related to Resident#1 for date of [DATE]. A record review of progress note dated [DATE] at 12:37PM by LVN#A reflected Resident was sitting in front of the nurses' station and started to vomit. Vomiting a large amount of chocolate milkshake with undigested food mixed in. Doctor was notified and made aware and a new order for Zofran (a medication for nausea and vomiting) was received. The RP was made aware. Record review of order recap report reflected an order for Ondansetron HCl (Zofran) tablet 4mg every 6 hours as needed for vomiting dated [DATE]. Record review of nursing progress notes dated [DATE] at 3:20PM reflected Resident #1 vomited again a large amount of undigested food and curdled milk Resident #1 was medicated with Zofran offered Gatorade but resident #1 refused. Record review of nursing progress notes dated [DATE] at 6:33PM reflected that Resident #1 vomited more curdled milk. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of nursing progress notes dated [DATE] at 4:30PM Written by LVN#B reflected Resident #1 was sitting across from nurse's station appeared to be napping oxygen level on room air was 84% (normal oxygen level should be above 90%), Oxygen level 89% on oxygen via nasal cannula at 2 liters per minute. Family stated Resident #1 was not right. Resident #1 was transported to the hospital by ambulance. A record review of the Discharge MDS dated [DATE] reflected Resident #1 was substantial maximal assistance with lying to sitting on the side of the bed, and dependent for chair to bed transfers (the helper does all the effort. Resident does none of the effort to complete the activity). The MDS also indicated Resident #1 was frequently incontinent of urination. Section I of the MDS was coded for infection of UTI. In an interview with Resident #1's RP on [DATE] at 12:05PM stated she arrived at the facility on [DATE] and noticed Resident #1 was slumped over at the nurses' station with oxygen on and dried food on her clothes. Resident #1's RP stated she spoke with facility staff about sending Resident #1 to the hospital and was told by the facility nurse the hospital would do nothing for Resident #1 except for IV fluids and send her back. She said after further discussion, the facility nurse and RP agreed to send Resident #1 to the hospital. She stated Resident #1 was diagnosed with sepsis related to the UTI and aspiration pneumonia. She stated Resident #1 died on [DATE] related to the sepsis from the UTI. She stated Resident #1 was originally scheduled for respite care for five days but then Resident #1's RP extended the stay. She stated she was not notified that Resident #1 was continuing to refuse the UA and she was not notified that Resident #1 had a fall on [DATE]. She stated she was not notified that Resident #1 needed to be taken to her PCP clinic on the date Resident #1 was supposed to be discharged from the respite care. In an interview with LVN #A on [DATE] at 1:04PM she said Resident #1 was new to her and she was not sure if behaviors were from the UTI, she was not sure what the Residents baseline cognitive status was. She stated Resident #1 was able to ambulate with a walker upon admission but then required a wheelchair. She said Resident #1 was supposed to see her PCP upon discharge from respite care, but Resident #1's RP extended her stay. She stated Resident #1's RP was not notified of the need for Resident #1 to be seen by her PCP. There were no further attempts to obtain a urinalysis. Resident #1 had a fall attempting to sit on the trashcan and there was not an incident report completed. LVN#A stated she probably didn't do an incident report. LVN #A said she might have been having a difficult day. She normal practice for change in condition and falls would be assess vital signs and call the PCP for further orders. LVN#A said its policy that an incident report would be completed for falls and documented in nurses' progress notes, notify family, and notify PCP that is policy . In an interview with LVN #B on [DATE] at 1:16PM LVN B said she was the nurse who sent Resident #1 to theER on [DATE] but could not remember any details regarding Resident #1 . She said a Change of conditions should be assessed by a nurse and documented in the medical record. LVN #B stated with any changes in a residents condition the nurses are report it to the DON, family, and physician. She said if she were unable to obtain a UA on a resident, she would have shipped the resident to the hospital. She said a UTI left untreated could cause serious illness. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with the DON on [DATE] at 1:26PM the DON stated Resident #1 refused the UA and it was her right to refuse the treatment. She stated Resident #1 was experiencing a decline prior to being admitted and subsequently passed away. She stated Resident #1's MD was not notified that Resident #1 had continued refusing the UA. States she would expect nurses to document if a resident refuses lab. The facility did not make any attempts to take Resident #1 into the clinic. The facility did not make any further attempts to obtain the UA. The DON stated the negative outcome for not obtain UA would have possibly been becoming septic, worsening of infection. The expectation is for the nurses to report, document, and follow up on labs, falls, and changes in condition. The DON stated PCP and family should have notified related to changes of condition, falls, anything related to the pt. The Don said she is responsible for incident and accidents, both the ADON and DON monitor the 24-hour report and clinical documentation checked in medical record every 24 hours for changes in condition. The DON said the negative out for not reporting the fall-could be an injury and no one would know to follow up. In an interview with PCP on [DATE] at 4:45 PM with Resident #1's PCP, said if Resident #1 refused the UA the nurse should have contacted him for further instructions. He said he had not seen Resident #1 while at the facility. The PCP stated he was notified that Resident #1 vomiting and he prescribed Zofran. He said he was not made aware at that point that the UA had not been completed. He said he was not made aware of the fall. Resident #1s PCP said the nausea and vomiting could have been a symptom of the urinary infection turning into sepsis . In a record review of the facility policy titled Change in Residents Condition or Status dated [DATE] reflected our facility shall promptly notify the resident, his or her attending physician, and representative of changes in the residents medical/mental condition and/or status. 1) The nurse will notify the residents attending physician or on-call physician when there has been: a. an accident or incident involving the resident. b. significant change in residents physical/emotional/mental condition c. need to alter the resident's medical treatment. d. refusal of treatment or medications two (2) or more attempts 2) A significant change of condition is a major decline or improvement in the resident's status that: e. will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions. f. impacts more than one area of the resident's health status. g. unless otherwise instructed by the resident a nurse will notify the residents representative when: (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	h. the resident is involved in any accident or incident that results in an injury including injuries of unknown origin. i. there is a significant change in the residents physical mental or psychosocial status. In a record review of facility policy titled Lab and Diagnostic Test Results dated [DATE] reflected 4. The physician will identify, and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs. 5. The staff will process test requisitions and arrange for tests. 6. The laboratory, diagnostic radiology provider, or other testing source will report test results to the facility. In a record review of facility policy titled Charting and Documentation dated [DATE] reflected that all services provided to the resident progress towards the care plan goals or any changes in the residents medical, physical, functional, or psychosocial condition shall be documented in the residents' medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident. This was determined to be an Immediate Jeopardy (IJ) on [DATE] at 12:00PM. The Administrator was notified. The ADM and the DON was provided with the IJ template on [DATE] at 12:00PM. The following Plan of Removal was submitted by the facility and was accepted on 03/ ,d+[DATE] at 4:30 PM: Record review of facility plan of removal for F684 reflected: Plan of Removal Immediate Threat On [DATE] an abbreviated survey was initiated at The Facility On [DATE] the surveyor provided an Immediate Jeopardy (IJ) Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate threat to resident health and safety. The notification of Immediate Threat states as follows: F684 The facility must ensure residents, based on the comprehensive assessment (for which the DON was last trained on [DATE] through RUG Online Training, both the DON and the ADON were trained on upon hire and periodically throughout the year through The Facility , QRM, and TMF and staff are trained on upon hire and throughout the year), receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. All residents could be affected by this. Action: The DON and the ADON will review 24-hour report, nursing documentation, incidents and accidents, all new orders, and labs daily to ensure change of conditions are handled appropriately. If labs are found missing, the physician will be notified, and labs will be collected per physician orders. Lab audit was conducted for all residents last 3 months. One resident was found that had not received a lab collection due to lab technician quitting without notice. Physician notified and a new req was made. Lab collected and awaiting results. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Start Date: [DATE]. Completion Date: [DATE] Responsible: The DON and the ADON Action: The DON and the ADON will audit orders, labs, documentation and 24-hour reports to ensure no labs are missed for all residents, both long term and short stay (respite) for the last 3 months and will be an ongoing process. Start Date: [DATE]. Completion Date: [DATE] Responsible: The DON and the ADON Action: Both the DON and the ADON have been previously in-serviced in Abuse, Neglect and Exploitation through Joint Training by HHSC both in person and through webinars. In-service all staff about Abuse, Neglect, Exploitation and Dignity including PRN, agency, new hires, and staff not currently in facility before the start of their next shift. Start Date: [DATE]. Completion Date: [DATE] Responsible: The DON and the ADON Action: In-service all staff about Change of Condition and ensure PCP orders followed including, PRN, agency, new hires, and staff not currently in facility before the start of their next shift Start Date: [DATE]. Completion Date: [DATE] Responsible: The DON and the ADON Action: The Facility had a QAPI meeting held with the DON, the Administrator, the DM, the MR, the VP of Operations and the ADON. Medical Director notified. In-service all staff about Incidents and Accidents and ensure responsible party and PCP notified, including PRN, agency, new hires, and staff not currently in facility before the start of their next shift. Start Date: [DATE]. Completion Date: [DATE] Responsible: The Don and the ADON (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Action: In-service all staff including, PRN, agency, new hires, and staff not currently in facility before the start of their next shift about Falls, Fall Management, Definitions of falls and Incidents & Accidents completion Start Date: [DATE]. Completion Date: [DATE] Responsible: The DON and the ADON Action: In-service all staff including, PRN, agency, new hires, and staff not currently in facility before the start of their next shift about Respite Care and treating them the same as all other residents. This will be monitored by the DON and ADON as each respite is admitted for the next 3 months. Start Date: [DATE]. Completion Date: [DATE] Responsible: The DON and the ADON Action: In-service all staff including, PRN, agency, new hires, and staff not currently in facility before the start of their next shift about Documentation and it is to be completed during shift. This will be monitored by the DON and ADON Monday - Friday for the next 3 months. Start Date: [DATE]. Completion Date: [DATE] Responsible: The DON and the ADON Action: In-service all staff including, PRN, agency, new hires, and staff not currently in facility before the start of their next shift about Collection of labs per physician orders and follow up with physician for new orders. If unable to collect labs or resident refuses labs, physician and Responsible Party are to be notified and all documented by nurse. Start Date: [DATE]. Completion Date: [DATE] Responsible: The DON and the ADON On [DATE] the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy (IJ) by: (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A lab audit was completed on [DATE] for all residents over the last 3 months. 1 (one) resident was found that had not received a lab collection due to lab technician quitting without notice. That residents Physician was notified, and a new requisition was made. The Lab was collected, and the facility is awaiting results. The audit was completed by: DON and ADON. On [DATE] A QAPI meeting was held with the Medical Director, the Facility Administrator, Business Office Manager, the Director of Nursing, and Assistant Director of Nursing to review root cause analysis and implement procedure and plan of correction. Staff educations were initiated on abuse and neglect, falls, and fall management, incidents and accidents, respite care, collection of urinalyses, and documentation. There were 20 out of 51 staff members interviewed on [DATE] between 9:00 a.m. and 4:00 p.m. from a variety of shifts (LVN A, RN C, LVN D, CMA E, CNA F, CNA G, CNA H, CNA J, CNA K, CNA L, Maintenance Man, Housekeeping Supervisor, Laundry Supervisor, Cook, Housekeeper , Kitchen staff) The facility staff confirmed they were in-serviced on abuse and neglect. The staff were able to identify the administrator as the abuse coordinator. The facility staff were able to give examples of different forms of abuse such as neglecting resident care, stealing money, and being verbally aggressive with residents. The staff were in-serviced on change of condition. The staff were able to give examples of changes in condition such as not eating, increased confusion, and how they would report and document changes in condition. The staff confirmed they were in-serviced on incidents and accidents, falls, fall management, the definitions of falls, and were able to give fall prevention interventions such as keeping mobile devices close to resident and pathways clear. The staff could explain the process if they were to find a resident on the floor, they would call for help, not move the resident, and allow the nurse to assess the fall/incident. All staff confirmed they were also educated about change in conditions and notification to on call nurse, physician, and resident's responsible party for any changes in condition. Staff confirmed they were educated on documentation and all documentation was to be completed prior to the end of their shifts. Staff confirmed they had been in-serviced on respite care and treating those residents the same as all other residents. During an interview, the ADON on [DATE] at 4:45PM the ADON said she was in-serviced on Abuse and Neglect, Change of Condition, Incidents and Accidents, Falls, Fall Management, the Definitions of falls, and Respite Care. All staff were also educated about change in conditions related to falls and notification to on call nurse, physician, and resident's responsible party. She said she had been in-serviced on Respite care and treating them the same as all other residents. She said Physician would be notified of all Changes in Condition and physician orders would be followed with notification to resident's responsible party as well as on call nurse. The ADON said Documentation would be completed during the staffs shift. The ADON was able to describe process in place for prevention of future incidents including the monitoring of the documentation, monitoring of the orders, labs, and 24-hour report daily. The ADON said the management staff would continue to educate staff through in-services. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview, the DON on [DATE] at 4:50PM the DON said she was in-serviced on Abuse and Neglect, Change of Condition, Incidents and Accidents, Falls, Fall Management, the Definitions of falls, and Respite Care. All staff were also educated about change in conditions related to falls and notification to on call nurse, physician, and resident's responsible party. She said she had been in-serviced on Respite care and treating them the same as all other residents. She said Physician would be notified of all Changes in Condition and physician orders would be followed with notification to resident's responsible party as well as on call nurse. Documentation would be completed during the shift. The DON was able to describe process in place for prevention of future incidents including the monitoring of the documentation, orders, labs, and 24-hour report. The DON said the management staff would continue to educate staff through in-services. During an interview, the ADM on [DATE] at 5:00PM the ADM said she was in-serviced Change of Condition, Incidents and Accidents, Falls, Fall Management, the Definitions of falls, and Respite Care. All staff were also educated about change in conditions related to falls and notification to on call nurse, physician, and resident's responsible party. She said she had been in-serviced on Respite care and treating them the same as all other residents. She said Physician will be notified of all Changes in Condition and physician orders will be followed with notification to resident's responsible party as well as on call nurse and Documentation completed during shift. The ADM was able to describe process in place for prevention of future incidents including the monitoring of the documentation, orders, labs, incident reports and 24-hour report to identify changes in condition. Those changes would be communicated to the physician and RP. The ADM said she was confident her staff could recognize and act according to policy related to changes in condition. The Facility was informed the Immediate Jeopardy was removed on [DATE] at 6:15PM. The facility remained out of compliance at a severity level of potential for more than minimum harm that is not immediate jeopardy with a scope identified as isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.		

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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47926 Based on record review and interviews, the facility failed to maintain clinical laboratory services to meet the needs of each resident for 1 of 7 residents (Resident #1) reviewed for laboratory services. The facility failed to ensure a UA was collected and provide treatment to Resident #1 who subsequently experienced a change in condition, died of sepsis and complications of a urinary tract infection. On [DATE] at 12:00 p.m. an Immediate Jeopardy (IJ) was identified. While the IJ was removed on [DATE] at 6:15PM, the facility remained out of compliance at a scope of isolated and severity of actual harm due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. This failure could place residents at risk of failing to treat infections which could impact their health causing sepsis and even death. Findings included: A record review of Resident #1s undated face sheet Reflected Resident #1 was an [AGE] year-old female who was admitted to the facility on [DATE] with a diagnosis of Type 2 diabetes mellitus (elevated blood sugar), depression, anorexia, chronic obstructive pulmonary disease (a group of disease that cause airflow blockage), constipation, and glaucoma (a disease that damages the optic nerve causing impaired vision). A record review of admission summary dated [DATE] at 10:30 AM reflected Resident #1 could ambulate short distances with a walker but required a wheelchair for long distances. Resident #1 was alert with confusions, was able to feed herself and was continent of bowel and bladder. A record review of facility 24 hour report change in condition report dated [DATE] reflected from 6:00AM to 10:00PM signed by LVN#A Resident #1 was a new admission for 5-day respite (a short stay to provide the family a relief from care). Resident #1 had dentures. She had no skin issues. Resident #1 was eating a regular diet and health shake with meals. Resident #1 was continent of bowel and bladder. She was able to feed herself and was taking the medication Megace (a medication to stimulate appetite). She was confused and used her walker to ambulate short distances. A record review of nursing progress note dated [DATE] at 1:36PM by RN#C reflected that she spoke with Doctor regarding Resident #1s intermittent confusion and that Resident #1 was incontinent of urine with increased weakness. RN #C received a new order for Urinalysis with C&S to check for UTI. Family was at the facility and aware of new order. A record review of order recap report reflected an order for urinalysis with C&S one time related to Urinary Tract Infection dated [DATE]. (continued on next page)		

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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A record review of facility 24-hour report changes of condition report (a report used to communicate exchange of pertinent information related to Resident care between nursing staff) dated [DATE] time frame from 6:00AM-2:00PM signed by LVN #A reflected That Resident #1 had intermittent confusion and was requiring assistance of ,d+[DATE] staff, maximum staff assistance with transfers was in a wheelchair and incontinent of bowel and bladder. Resident #1 had attempted to urinate in the trash and had a new order for urinalysis. A record review of facility 24-hour report changes of condition report dated [DATE] reflected ,d+[DATE] shift reflected Resident #1 refused urinalysis and was agitated and combative. The report reflected that LVN#B Attempted a clean catch and catheter. A Record Review of Resident #1s Nursing Progress notes for date [DATE] reflected there were no medical record documentation related to the findings on the 24-hour change in condition report. A record review of facility 24-hour report changes of condition report dated [DATE] signed by LVN#A reflected 6am-10pm shift Resident #1 had loose stools x2, PCP was notified about need for urinalysis and states will have her come to his office when discharged . On the same change of condition report 10pm -6 am LVN #B noted that Resident #1 is confused refusing to toilet. A Record Review of Resident #1s Nursing Progress notes for date [DATE] reflected there were no medical record documentation related to the findings on the 24-hour change in condition report. A record review of facility 24-hour report changes of condition report dated [DATE] 6am-10pm shift signed by LVN#A reflected Resident #1 was follow up from fall that was witnessed. A Record Review of Resident #1s Nursing Progress notes for date [DATE] reflected there were no medical record documentation related to the findings on the 24-hour change in condition report. A Record Review of Facility Historical Incident reports reflected there were no documented incident or accident reports related to Resident#1 for date of [DATE]. A record review of progress note dated [DATE] at 12:37PM by LVN#A reflected Resident was sitting in front of the nurses' station and started to vomit. Vomiting a large amount of chocolate milkshake with undigested food mixed in. Doctor was notified and made aware and a new order for Zofran (a medication for nausea and vomiting) was received. The RP was made aware. Record review of order recap report reflected an order for Ondansetron HCl (Zofran) tablet 4mg every 6 hours as needed for vomiting dated [DATE]. Record review of nursing progress notes dated [DATE] at 3:20PM reflected Resident #1 vomited again a large amount of undigested food and curdled milk Resident #1 was medicated with Zofran offered Gatorade but resident #1 refused. Record review of nursing progress notes dated [DATE] at 6:33PM reflected that Resident #1 vomited more curdled milk. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Town Hall Estates Whitney Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 101 San Marcus Whitney, TX 76692	
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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of nursing progress notes dated [DATE] at 4:30PM Written by LVN#B reflected Resident #1 was sitting across from nurse's station appeared to be napping oxygen level on room air was 84% (normal oxygen level should be above 90%), Oxygen level 89% on oxygen via nasal cannula at 2 liters per minute. Family stated Resident #1 was not right. Resident #1 was transported to the hospital by ambulance. A record review of the Discharge MDS dated [DATE] reflected Resident #1 was substantial maximal assistance with lying to sitting on the side of the bed, and dependent for chair to bed transfers (the helper does all the effort. Resident does none of the effort to complete the activity). The MDS also indicated Resident #1 was frequently incontinent of urination. Section I of the MDS was coded for infection of UTI. In an interview with Resident #1's RP on [DATE] at 12:05PM stated she arrived at the facility on [DATE] and noticed Resident #1 was slumped over at the nurses' station with oxygen on and dried food on her clothes. Resident #1's RP stated she spoke with facility staff about sending Resident #1 to the hospital and was told by the facility nurse the hospital would do nothing for Resident #1 except for IV fluids and send her back. She said after further discussion, the facility nurse and RP agreed to send Resident #1 to the hospital. She stated Resident #1 was diagnosed with sepsis related to the UTI and aspiration pneumonia. She stated Resident #1 died on [DATE] related to the sepsis from the UTI. She stated Resident #1 was originally scheduled for respite care for five days but then Resident #1's RP extended the stay. She stated she was not notified that Resident #1 was continuing to refuse the UA and she was not notified that Resident #1 had a fall on [DATE]. She stated she was not notified that Resident #1 needed to be taken to her PCP clinic on the date Resident #1 was supposed to be discharged from the respite care. In an interview with LVN #A on [DATE] at 1:04PM she said Resident #1 was new to her and she was not sure if behaviors were from the UTI, she was not sure what the Residents baseline cognitive status was. She stated Resident #1 was able to ambulate with a walker upon admission but then required a wheelchair. She said Resident #1 was supposed to see her PCP upon discharge from respite care, but Resident #1's RP extended her stay. She stated Resident #1's RP was not notified of the need for Resident #1 to be seen by her PCP. There were no further attempts to obtain a urinalysis. Resident #1 had a fall attempting to sit on the trashcan and there was not an incident report completed. LVN#A stated she probably didn't do an incident report. LVN #A said she might have been having a difficult day. She normal practice for change in condition and falls would be assess vital signs and call the PCP for further orders. LVN#A said its policy that an incident report would be completed for falls and documented in nurses' progress notes, notify family, and notify PCP that is policy. In an interview with LVN #B on [DATE] at 1:16PM LVN B said she was the nurse who sent Resident #1 to theER on [DATE] but could not remember any details regarding Resident #1 . (continued on next page)		

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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with the DON on [DATE] at 1:26PM the DON stated Resident #1 refused the UA and it was her right to refuse the treatment. She stated Resident #1 was experiencing a decline prior to being admitted and subsequently passed away. She stated Resident #1's MD was not notified that Resident #1 had continued refusing the UA. States she would expect nurses to document if a resident refuses lab. The facility did not make any attempts to take Resident #1 into the clinic. The facility did not make any further attempts to obtain the UA. The DON stated the negative outcome for not obtain UA would have possibly been becoming septic, worsening of infection. The expectation is for the nurses to report document and follow up on labs, falls, and changes in condition. The DON stated PCP and family should have notified related to changes of condition, falls, anything related to the pt. The Don said she is responsible for incident and accidents, both the ADON and DON monitor the 24-hour report and clinical documentation checked in medical record every 24 hours for changes in condition. The DON said the negative out for not reporting the fall-could be an injury and no one would know to follow up. In an interview with PCP on [DATE] at 4:45 PM with Resident #1's PCP, said if Resident #1 refused the UA the nurse should have contacted him for further instructions. He said he had not seen Resident #1 while at the facility. The PCP stated he was notified that Resident #1 vomiting and he prescribed Zofran. He said he was not made aware at that point that the UA had not been completed. He said he was not made aware of the fall. Resident #1s PCP said the nausea and vomiting could have been a symptom of the urinary infection turning into sepsis . In a record review of facility policy titled Lab and Diagnostic Test Results dated [DATE] reflected 7. The physician will identify, and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs. 8. The staff will process test requisitions and arrange for tests. 9. The laboratory, diagnostic radiology provider, or other testing source will report test results to the facility. The Administrator was notified on [DATE] at 12:00PM. that an Immediate Jeopardy situation was identified due to the above failure. The ADM and DON was provided the Immediate Jeopardy template at that time. The following Plan of Removal was submitted by the facility and was accepted on 03/ ,d+[DATE] at 4:30 PM for F770. Plan of Removal Immediate Threat On [DATE] an abbreviated survey was initiated at The Facility. On [DATE] the surveyor provided an Immediate Threat (IT) Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate threat to resident health and safety. The notification of Immediate Threat states as follows: F770 The facility must provide or obtain laboratory services to meet the needs of its residents. All residents could be affected by this. (continued on next page)		

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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Action: The DON and the ADON will review 24-hour report, nursing documentation, incidents and accidents, all new orders, and labs daily to ensure change of conditions are handled appropriately. If labs are found missing, the physician will be notified, and labs will be collected per physician orders. Lab audit was conducted for all residents last 3 months. 1 resident was found that had not received a lab collection due to lab technician quitting without notice. Physician notified and a new req was made. Lab collected and awaiting results. Start Date: [DATE]. Completion Date: [DATE] Responsible: The DON and the ADON Action: The DON and the ADON will audit orders, labs, documentation and 24-hour reports to ensure no labs are missed for all residents, both long term and short stay (respite) for the last 3 months and will be an ongoing process. Start Date: [DATE]. Completion Date: [DATE] Responsible: The DON and the ADON Action: Both the DON and the ADON have been previously in serviced in Abuse, Neglect and Exploitation through Joint Training by HHSC both in person and through webinars. In-service all staff about Abuse, Neglect, Exploitation and Dignity including PRN, agency, new hires, and staff not currently in facility before the start of their next shift. Start Date: [DATE]. Completion Date: [DATE] Responsible: The DON and the ADON Action: The Facility had a QAPI meeting held with the DON, the Administrator, the DM, the MR, the VP of Operations and the ADON. The Medical Director was notified. In-service all staff about Incidents and Accidents and ensure responsible party and PCP notified, including PRN, agency, new hires, and staff not currently in facility before the start of their next shift. Start Date: [DATE]. Completion Date: [DATE] Responsible: The Don and the ADON Action: In-service all staff including, PRN, agency, new hires, and staff not currently in facility before the start of their next shift about Documentation and it is to be completed during shift. This will be monitored by the DON and the ADON Monday - Friday for the next 3 months. (continued on next page)		

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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Start Date: [DATE]. Completion Date: [DATE] Responsible: The DON and the ADON Action: In-service all staff including, PRN, agency, new hires, and staff not currently in facility before the start of their next shift about Collection of labs per physician orders and follow up with physician for new orders. If unable to collect labs or resident refuses labs, physician and Responsible Party are to be notified and all documented by nurse. Start Date: [DATE]. Completion Date: [DATE] Responsible: The DON and the ADON On [DATE] the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy (IJ) by: A lab audit was completed on [DATE] for all residents over the last 3 months. 1 (one) resident was found that had not received a lab collection due to lab technician quitting without notice. That residents Physician was notified, and a new requisition was made. The Lab was collected, and the facility is awaiting results. On [DATE] A QAPI meeting was held with the Medical Director, the Facility Administrator, Business Office Manager, the Director of Nursing, and Assistant Director of Nursing to review root cause analysis and implement procedure and plan of correction. Staff educations were initiated on abuse and neglect, falls, and fall management, incidents and accidents, respite care, collection of urinalyses, and documentation. There were 20 out of 51 staff members interviewed on [DATE] between 9:00 a.m. and 4:00 p.m. from a variety of shifts (LVN A, RN C, LVN D, CMA E, CNA F, CNA G, CNA H, CNA J, CNA K, CNA L, Maintenance Man, Housekeeping Supervisor, Laundry Supervisor, Cook, Housekeeper , Kitchen staff) The facility staff confirmed they were in-serviced on abuse and neglect. The staff were able to identify the administrator as the abuse coordinator. The facility staff were able to give examples of different forms of abuse such as neglecting resident care, stealing money, and being verbally aggressive with residents. The staff were in-serviced on change of condition. The staff were able to give examples of changes in condition such as not eating, increased confusion, and how they would report and document changes in condition. The staff confirmed they were in-serviced on incidents and accidents, falls, fall management, the definitions of falls, and were able to give fall prevention interventions such as keeping mobile devices close to resident and pathways clear. The staff could explain the process if they were to find a resident on the floor, they would call for help, not move the resident, and allow the nurse to assess the fall/incident. All staff confirmed they were also educated about change in conditions and notification to on call nurse, physician, and resident's responsible party for any changes in condition. Staff confirmed they were educated on documentation and all documentation was to be completed prior to the end of their shifts. Staff confirmed they had been in-serviced on respite care and treating those residents the same as all other residents. (continued on next page)		

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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview, the ADON on [DATE] at 4:45PM the ADON said she was in-serviced on Abuse and Neglect, Change of Condition, Incidents and Accidents, Falls, Fall Management, the Definitions of falls, and Respite Care. All staff were also educated about change in conditions related to falls and notification to on call nurse, physician, and resident's responsible party. She said she had been in-serviced on Respite care and treating them the same as all other residents. She said Physician would be notified of all Changes in Condition and physician orders would be followed with notification to resident's responsible party as well as on call nurse. The ADON said Documentation would be completed during the staffs shift. The ADON was able to describe process in place for prevention of future incidents including the monitoring of the documentation, monitoring of the orders, labs, and 24-hour report daily. The ADON said the management staff would continue to educate staff through in-services. During an interview, the DON on [DATE] at 4:50PM the DON said she was in-serviced on Abuse and Neglect, Change of Condition, Incidents and Accidents, Falls, Fall Management, the Definitions of falls, and Respite Care. All staff were also educated about change in conditions related to falls and notification to on call nurse, physician, and resident's responsible party. She said she had been in-serviced on Respite care and treating them the same as all other residents. She said Physician would be notified of all Changes in Condition and physician orders would be followed with notification to resident's responsible party as well as on call nurse. Documentation would be completed during the shift. The DON was able to describe process in place for prevention of future incidents including the monitoring of the documentation, orders, labs, and 24-hour report. The DON said the management staff would continue to educate staff through in-services. During an interview, the ADM on [DATE] at 5:00PM the ADM said she was in-serviced Change of Condition, Incidents and Accidents, Falls, Fall Management, the Definitions of falls, and Respite Care. All staff were also educated about change in conditions related to falls and notification to on call nurse, physician, and resident's responsible party. She said she had been in-serviced on Respite care and treating them the same as all other residents. She said Physician will be notified of all Changes in Condition and physician orders will be followed with notification to resident's responsible party as well as on call nurse and Documentation completed during shift. The ADM was able to describe process in place for prevention of future incidents including the monitoring of the documentation, orders, labs, incident reports and 24-hour report to identify changes in condition. Those changes would be communicated to the physician and RP. The ADM said she was confident her staff could recognize and act according to policy related to laboratory services. The Facility was informed the Immediate Jeopardy was removed on [DATE] at 6:15PM. The facility remained out of compliance at a severity level of potential for more than minimum harm that is not immediate jeopardy with a scope identified as isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.		