

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 09/19/2024
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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35489 Based on observation, interview and record review, the facility failed to ensure each resident received an accurate assessment, reflective of the resident's status for two (Residents #24 and #32) of 24 residents reviewed for accuracy of assessments. The facility failed to ensure Resident #24's and Resident #32's most recent comprehensive assessments did not inaccurately reflect the residents each having a urinary catheter (a tube inserted into the body to allow urine to drain). This failure could place residents at risk for not receiving care and services to meet their needs, diminished function of health, and regressions in their overall health. Findings included: Review of Resident #24's Admission Record, dated 09/19/24, reflected she was an [AGE] year-old female, admitted on [DATE], with diagnoses of respiratory failure with hypoxia (the body not receiving enough oxygen), unspecified convulsions, dementia, and diabetes. Review of Resident #24's MDS, dated [DATE], reflected she was usually able to understand others and be understood by others. She had a BIMS score of three, and continuous inattention and disorganized thinking, as well as verbal behavioral symptoms on 1-3 days of a 7-day lookback period. The document reflected Resident #24 had an indwelling catheter (including suprapubic catheter or nephrostomy tube). The document was electronically signed by the MDS Coordinator and the DON. Review of Resident #24's EMR on 09/18/2024 reflected no orders related to a catheter. Review of Resident #24's MAR and TAR for 07/01/2024 through 09/17/2024 reflected no orders or treatments related to a catheter. Review of Resident #24's care plans reflected there were none related to a catheter. Review of Resident #32's Admission Record, dated 09/17/2024, reflected she was an [AGE] year-old female, admitted on [DATE], with diagnoses of an intestinal obstruction (unspecified as to whether partial or complete), heart failure, cardiac pacemaker, diabetes, and atrioventricular block, complete (a slowed heart rate that occurs because of a malfunction with the heart's electrical system). (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #32's MDS, dated [DATE], reflected she was usually able to understand others and be understood by others. She had a BIMS score of five and exhibited fluctuating inattention. The document reflected Resident #32 had an indwelling catheter (including suprapubic catheter or nephrostomy tube). The document was electronically signed by the MDS Coordinator and the DON. Review of Resident #32's EMR on 09/18/2024 reflected no orders related to a catheter. Review of Resident #32's MAR and TAR for 07/01/2024 through 09/17/2024 reflected no orders or treatments related to a catheter. Review of Resident #32's care plans reflected there were none related to a catheter. An observation on 09/16/2024 at 12:00 PM revealed Resident #24 in the dining room, seated in her wheelchair, awake, with flat affect. No catheter bag was visible. An interview on 09/17/2024 at 10:55 AM with the ADON revealed Resident #24 did not have a catheter while in the facility. An interview on 09/17/2024 at 10:58 AM with the MDS Coordinator revealed that her soft file (informal record) for Resident #24 had her marked as having a catheter, but she did not know why, and had corrected the MDS, but was going to try to figure out why she was marked that way in her file. An interview and observation on 09/17/2024 at 11:26AM with Resident #32 revealed she did not have a catheter. An interview on 09/18/2024 at 11:18 AM with the MDS Coordinator revealed she was the person who did the MDS for both Residents, #24 and #32. She said they were both marked as having catheters in her soft files. She said she was the one who made the soft files, and she did not know why she had catheters marked on either of them, as neither of them had them. She said she had already corrected the issue, and she did not think the error could directly affect residents, but it could be construed as falsification if they did not correct it. An interview on 09/19/2024 at 12:06 PM with the DON revealed she had been made aware of the MDS errors, and they had been corrected. She said she did the care plans herself, because she wanted to know everything about the residents, and they also had a consultant who reviewed them. She said when she found errors, she pointed them to the MDS Coordinator's attention, and they corrected them immediately. She said they were able to double check things, but they were human, and sometimes made mistakes. She said there would not be any direct consequence to the residents for this error, but it could affect their quality measures (data collected by CMS, related to various areas of resident care, used to show where the facility ranks in each care area compared to all other nursing homes). An interview On 09/17/2024 at 12:57 PM with CNA E revealed she was familiar with Residents #24 and #32, and neither had ever had a catheter, that she knew of. She said it was possible Resident #32 might have come back from the hospital with one a few months ago, but if she did it was very short-term, and she did not remember it. (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy Resident Assessment Instrument, revised 09/2010, reflected 7. All persons who have completed any portion of the MDS Resident Assessment Form MUST sign such document attesting to the accuracy of such information. Review of the facility's policy MDS Error Correction, revised 09/2010, reflected Policy Interpretation and Implementation: () 3. If an error in data is discovered within 7 days of the completion of the MDS and before submission to the QIES ASAP system (the encoding and editing period): a. The correction is made to the hard copy of the form using standard editing procedures (cross out, enter correct response, initial and date); b. Corresponding corrections are made to the facility's MDS database. (Note: Software used to encode the MDS runs all standard edits as defined in the CMS data specifications); and c. The resident's care plan is reviewed and modified as necessary. 4. If an error is discovered after the encoding and editing period and the record in error is an Entry, Discharge or PPS Assessment, then correct the record and submit to the QIES ASAP system. 5. If an error is discovered after the encoding period and the record in error is an OBRA Assessment, determine if the error is major or minor. a. A minor error is one related to the coding of the MOS. For minor errors, correct the record and submit to the QIES ASAP system. b. A major error is one that inaccurately reflects the resident's clinical status and/or may result in an inappropriate plan of care. For major errors: (1) Correct the original assessment to reflect the resident's status as of the original Assessment Reference Date and submit the record; AND (2) Perform a new Significant Change in Status (if this has occurred) OR a new Significant Correction to a Prior Assessment with a new observation period and Assessment Reference Date. 6. If an error is discovered in a record that has already been accepted by the QIES ASAP system, implement procedures for either Modification or Inactivation of the information in the system within 14 days of the discovery of the error. 7 o Modification Requests are used when information in the record contains clinical or demographic errors. [Note: The only MOS items that cannot be altered with a Modification Request are: Type of Provider (A0200), Submission Requirement A0410); and the state-assigned facility submission ID (FAC_ID). These items require a Special Manual Record Correction Request.] 8. To modify errors in Entry, PPS, or Discharge records that are not OBRA: a. Create a corrected record with all items included, not just the items in error; b. Complete the Correction Request Section (X) items and include with the corrected record (Item X0100 should have a value of 2, indicating a Modification Request.); and c. Submit the Modification Request record. 9. To modify errors in an OBRA Assessment when the errors are minor: a. Create a corrected record with all items included, not just the items in error; b. Complete the Correction Request Section (X) items and include with the corrected record (Item X0100 should have a value of 2, indicating a Modification Request.); and c. Submit the Modification Request record. 10. To modify errors in an OBRA Assessment when the errors are major: a. Create a corrected record with all items included, not just the items in error; b. Complete the Correction Request Section (X) items and include with the corrected record (Item X0100 should have a value of 2, indicating a Modification Request.); c. Submit the Modification Request record; and d. Perform a new Significant Change in Status Assessment (if this has occurred) OR a new Significant Correction of a Prior Assessment. 11 . Inactivation Requests are used when a record has been accepted to the QJES ASAP system but the corresponding event did not occur (e.g a discharge record was submitted for a resident but there was no discharge). 12. To submit an Inactivation request, complete and submit an MOS record with only Section X items completed.		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48122 Based on observations, interviews, and record reviews the facility failed to review the risks and benefits of bed rails and enabler/grab bars (smaller 1/8 size bars affixed to the bed frame used by the person in bed to reposition themselves), with the resident or resident representative and obtain informed consent prior to installation for six (Residents #7, #11, #26, #29, #41, and #143) of six resident rooms observed and reviewed for bed rails/grab bars. The facility failed to have evidence of informed consent, assessment of the resident for risk of entrapment, and care planning for the quarter bed rails/enabler bars for Residents #7, #11, #26, #29, #41, and #143. This failure could affect residents who used bed rails/enabler bars at risk of the resident/responsible party not being aware of the risks, informed consent not being obtained from the resident or responsible party, physician not being aware of use of the enabler/grab bars, and care plan not being properly documented. Findings included: Resident #7: Record review on 09/18/2024 of Resident #7's face sheet, dated 09/16/2024, revealed an [AGE] year old female who was originally admitted to the facility on [DATE]. Resident #7 was noted to have diagnoses including Chronic Obstructive Pulmonary Disease (a common, progressive lung disease that makes it hard to breathe), Epilepsy, unspecified, intractable, without status epilepticus (a chronic brain disorder that causes seizures and continues to occur after a person has taken two or more seizure medications; also known as uncontrolled or drug resistant), Type 2 Diabetes Mellitus (when the body does not respond to insulin properly, resulting in high blood sugar levels), Cerebral Aneurysm (a weak spot in a brain artery that balloons and fills with blood), Essential (Primary) Hypertension (high blood pressure that is multifactorial and does not have one distinct cause), Unsteadiness on Feet, Weakness, Muscle Wasting and Atrophy, Other Lack of Coordination, Contracture of Muscle, Multiple Sites (when muscles, tendons, joints, and other tissues tighten or shorten causing a deformity), and History of Falling. Record Review on 09/16/2024 of Resident #7's Assessments in the EHR, an assessment for safe use of bed rails/grab bars for the resident was not seen. Record Review on 09/16/2024 of Resident #7's Clinical Physician Orders was shown an order for bed rails/grab bars. Record Review on 09/16/2024 of Resident #7's Clinical Miscellaneous documents did not reveal any assessment, consent, order, or care plan addition for bed rail/grab bar usage. (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review on 09/18/2024 of Resident #7's Quarterly MDS assessment dated [DATE], revealed a BIMS score of 9 suggesting moderate cognitive impairment. Section GG Functional Ability indicated that Resident #7 had impairments on both sides of their arms and both legs; used a manual wheelchair; supervision or touching assistance was needed with the following tasks: eating, oral hygiene, rolling left and right; needed substantial assistance with the following tasks: upper body dressing, personal hygiene; and was completely dependent for: toileting, showering/bathing, lower body dressing, and transfers. Section P Restraints and Alarms indicated that Resident #7 used in bed no bed rails, trunk restraint, limb restraint, or other; no restrains or chair that prevented rising was used when in a chair or out of bed; and no alarms used. Section Q Participation in Assessment and Goal Setting indicated that only Resident #7 participated. Record review on 09/18/2024 of Resident #7's Care Plan, last updated 06/24/2024, revealed there was no indication of alternatives attempted prior to grab bars being placed on the resident's bed. Record Review on 09/18/2024 of Resident #7's Clinical Consents did not reveal any consent form related to bed rails to be placed on the resident's bed or that the risks and advantages had been reviewed with the resident or the responsible party. Observation of Resident #7's room on 09/17/2024 at 10:18 AM revealed the resident in bed with grab bars on resident's bed in a raised position . During interview of Resident #7 on 09/17/2024 at 10:18 AM, the resident was laying in the bed with the head of the bed raised, oxygen tube at resident's side. The resident stated she had always had the grab bars on her bed at the facility. Resident #7 stated she did not know or remember if someone from the facility discussed dangers, asked for consent, or performed an assessment for the grab bars with her or not. Resident #11 Record review on 9/18/2024 of Resident #11's face sheet, dated 09/18/2024, revealed an [AGE] year old female originally admitted to the facility on [DATE]. Resident #11 was noted to be her own responsible party and have diagnoses including unspecified dementia, mild, with anxiety, Chronic Obstructive Pulmonary Disease (a common, progressive lung disease that makes it hard to breathe), Bell's Palsy (a temporary, unexplained condition that causes facial paralysis on one side of the face), Type 2 Diabetes Mellitus With Diabetic Polyneuropathy (when the body does not respond to insulin properly, resulting in high blood sugar levels; when the peripheral nerves malfunction), adjustment disorder with mixed anxiety and depressed mood, Parkinson's Disease (chronic brain disorder that causes movement problems, mental health issues, and other health concerns), unsteadiness on feet, Essential (Primary) Hypertension (high blood pressure that is multifactorial and does not have one distinct cause), and other reduced mobility. Record review on 9/18/2024 of Resident #11's Care Plan, last updated on 08/30/2024, revealed there was no indication of alternatives attempted prior to grab bars being placed on the resident's bed. The care plan indicated on 01/18/2024 entry for ADL Self Care Performance Deficit r/t Dementia that intervention for Bed Mobility showed The resident is able to turn and reposition with set up and standby assist and Transfer intervention was The resident requires limited assistance by (1) staff to move between surfaces. (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review on 09/18/2024 of Resident #11's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 13, indicating intact cognition. Section GG Functional Ability indicated Resident #11 was noted as having impairment of both lower extremities and utilized a manual wheelchair for mobility. Section P Restraints and Alarms indicated Resident #11 used no bed rails, trunk restraint, limb restraint or other while in bed. Section P also indicated the resident used no restraints or chair that prevented rising was used when in a chair or out of bed; and no alarms used. Section Q Participation in Assessment and Goal Setting indicated that Resident #11 and family participated in the assessment. Record review on 09/18/2024 of Resident #11's Clinical Consents did not reveal any consent form related to bed rails to be placed on the resident's bed or that the risks and advantages had been reviewed with the resident or the responsible party. Record review on 09/18/2024 of Resident #11's Clinical Miscellaneous documents did not reveal any assessment, consent, order, or care plan addition for bed rail/grab bar usage. Record Review on 09/19/2024 of Resident #11's Assessments in the EHR did not show an assessment for safe use of bed rails/grab bars for the resident. Record review on 09/19/2024 of Resident #11's Clinical Physician Orders showed an order for bed rails/grab bars. Observation on 09/16/2024 at 1:20 PM of Resident #11's bed area revealed the resident watching television while sitting in a manual wheelchair beside the bed which had grab bars installed on both sides of the bed. During an interview with Resident #11 on 09/16/2024 at 1:20 PM, the resident expressed that the facility staff help the resident as much as she will let them. Resident #11 shared she was trying to maintain as much independence as possible however her eyes were giving out due to a vision condition that nothing could be done about. Resident #11 stated she did not recall if anyone had spoken to her about the grab bars on the bed or any benefits or risks associated with the bars. Resident #26: Record review on 09/18/2024 of Resident #26's face sheet, dated 09/18/2024, revealed a [AGE] year old female who initially admitted to the facility on [DATE]. Resident #26 is noted to have diagnoses including Alzheimer's Disease (a brain disorder that gradually destroys memory and thinking skills, and eventually the ability to perform even simple tasks), Senile Degeneration of the Brain (progressive decline in cognitive function that can lead to memory loss, impaired thinking, and difficult with daily activities), Generalized Anxiety Disorder (mental health condition that causes people to experience persistent, excessive, and uncontrollable worry), Muscle Weakness, generalized, Unspecified Abnormalities of Gait and Mobility, and Unspecified Lack of Coordination. (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review on 09/18/2024 of Resident #26's Quarterly MDS assessment dated [DATE], revealed a BIMS score of 8 suggesting moderate cognitive impairment. The MDS also indicated the resident hallucinated. Section GG Functional Ability indicated that Resident #26 had no impairment on either side of their arms or legs and used a manual wheelchair. No other information was provided for Resident #26 on self-care abilities or mobility capabilities. Section P Restraints and Alarms indicated that Resident #26 used in bed no bed rails, no trunk restraints, no limb restraints and no other restraints. Resident #26 was also rated as having used in chair or out of bed no bed rails, no trunk restraints, no limb restraints and no chair that prevented raising. Resident #26 was also rated as using no alarms. Section Q Participation in Assessment and Goal Setting indicated that only Resident #26 participated. Record review on 09/18/2024 of Resident #26's Care Plan, last updated on 08/19/2024, revealed there was no indication of alternatives attempted prior to grab bars being placed on the resident's bed. On 08/06/2024 Resident #26's Care Plan had an entry with the Focus of Safety, Goal of Resident Will Remain Safe, and Interventions of Encourage use of prescribed assistive devices and Safety measures - including strategies to reduce the risk of infection, falls, injury initiated as appropriate with target date of 08/20/2024. No further information on what devices or strategies was found. Record Review on 09/18/2026 of Resident #26's Assessments in the EHR did not show an assessment for safe use of bed rails/grab bars for the resident. Record Review on 09/18/2024 of Resident #26's Clinical Consents revealed no Bed Rail Consent form (bed rail/enabler bar consent) for the 1/8 bed rails/enabler bars signed by the resident or resident's responsible party or noted to have verbal permission for the enabler bars. Record Review on 09/18/2024 of Resident #26's Clinical Physician Orders did not show an order for bed rails/grab bars. Record Review on 09/18/2024 of Resident #26's Clinical Miscellaneous documents did not reveal any assessment, consent, order, or care plan addition for bed rail/grab bar usage. Observation of Resident #26's bed area on 09/16/2024 at 12:01 PM revealed the one grab bar raised on the right side of the resident's bed. The resident was not present in the room at the time. Interview with Resident #26 on 9/17/2024 at 10:20 AM revealed that Resident wasis comfortable in the facility. Resident #26 did not remember having discussed anything about the grab bar on her bed with facility staff but that the grab bar had been there a long time. Resident #29: (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review on 09/19/2024 of Resident #29's face sheet revealed an [AGE] year old female originally admitted to the facility on [DATE]. Resident #29 was listed as her own responsible party. Resident #29 had diagnoses including Unspecified Dementia, Unspecified Severity (dementia without a specific diagnosis; mild cognitive impairment), Type 2 Diabetes Mellitus (when the body does not respond to insulin properly, resulting in high blood sugar levels), Essential (Primary) Hypertension (high blood pressure that is multifactorial and does not have one distinct cause), Angina Pectoris (chest pain or discomfort that happens when the heart muscle does not receive enough oxygen-rich blood), Chronic Atrial Fibrillation (abnormal heart rhythm that causes the upper chambers of the heart to beat irregularly and quickly), Muscle Weakness, Unspecified Lack Of Coordination, Difficulty In Walking, Repeated Falls, Unsteadiness On Feet, Ataxic Gait, Fistula Of Intestine (abnormal connection between the intestine and another organ or surface), Major Depressive Disorder, Anxiety Disorder, and Atherosclerotic Heart Disease Of Native Coronary Artery Without Angina Pectoris (chronic condition that occurs when plaque builds up in the walls of the arteries, narrowing them and potentially blocking blood flow) Record review on 09/18/2024 of Resident #29's Annual Comprehensive MDS assessment dated [DATE], revealed a BIMS score of 3 suggesting severe cognitive impairment. Section GG Functional Ability indicated that Resident #29 had no upper or lower body impairment; used a manual wheelchair; supervision or touching assistance was needed with the following tasks: oral hygiene, upper and lower body dressing, personal hygiene, rolling side to side, sit to lying, sit to stand, lying to sitting, and transfers; and was completely dependent for: toileting and showering/bathing. Section P Restraints and Alarms indicated that Resident #29 used in bed no bed rails, no trunk restraints, no limb restraints and no other restraints. Resident #29 was also rated as having used in chair or out of bed no bed rails, no trunk restraints, no limb restraints and no chair that prevented raising. Resident #29 was also rated as using no alarms. Section Q Participation in Assessment and Goal Setting indicated that only Resident #29 participated. Record review on 09/18/2024 of Resident #29's Care Plan, last updated on 6/24/2024, revealed there was no indication of alternatives attempted prior to grab bars being placed on the resident's bed. In the Bed Mobility section, it was indicated that the resident requires assistance by 2 staff to turn and reposition in bed as necessary. Record Review on 09/18/2024 of Resident #29's Assessments in the EHR did not show an assessment for safe use of bed rails/grab bars for the resident. Record Review on 09/18/2024 of Resident #29's Clinical Consents revealed no Bed Rail Consent form (bed rail/enabler bar consent) for the 1/8 bed rails/enabler bars signed by the resident or resident's responsible party or noted to have verbal permission for the enabler bars. Record Review on 09/18/2024 of Resident #29's Clinical Physician Orders did show an order for bed rails/grab bars. Record Review on 09/18/2024 of Resident #29's Clinical Miscellaneous documents did not reveal any assessment, consent, order, or care plan addition for bed rail/grab bar usage. Observation of Resident #29's bed area on 09/16/2024 at 10:48 AM revealed both sides of the bed had grab bars attached and in a raised position. Resident was not in the room at the time. (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #41: Record review on 9/18/2024 of Resident #41's face sheet, dated 09/16/2024, revealed a [AGE] year old female originally admitted to the facility on [DATE]. Resident #41 was listed as her own responsible party. Resident #41 was noted as having diagnoses such as Female Acute Pelvic Peritonitis (an inflammation and infection of the peritoneum, the membrane that lines the abdomen in the pelvic area), Type 2 Diabetes Mellitus (when the body does not respond to insulin properly, resulting in high blood sugar levels), Colostomy (surgical procedure that creates an opening in the abdomen to divert the large intestine, or colon, to an external pouch), Ileostomy (procedure in which part of the small bowel is brought through the abdominal wall via a surgically created opening called a stoma to evacuate stool from the body rather than through the anus), Spinal Enthesopathy (condition that affects the connection points between bones and ligaments in the spine), Unspecified Dementia (mild cognitive impairment has yet to be diagnosed as a specific type), Ventricular Tachycardia (cardiovascular disorder that causes the heart's lower chambers to beat abnormally fast), Generalized Anxiety Disorder (a mental health condition that causes people to experience excessive, persistent, and uncontrollable worry), Essential (Primary) Hypertension (high blood pressure that is multi-factorial and doesn't have one distinct cause), Sciatica, Right Side (condition that affects the sciatic nerve, usually on one side of the body, and can cause pain, numbness, tingling, or muscle weakness), and Low Back Pain. Record review on 09/18/2024 of Resident #41's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 14 suggesting intact cognition. Section GG Functional Ability indicated that Resident #41 had no impairment on upper or lower body; used a walker; supervision or touching assistance was needed with the following tasks: oral hygiene, toileting, upper and lower body dressing, sit to stand, and transfers; needed moderate assistance with shower/bathing. Section P Restraints and Alarms indicated that Resident #41 used in bed no bed rails, no trunk restraints, no limb restraints and no other restraints. Resident #41 was also rated as having used in chair or out of bed no bed rails, no trunk restraints, no limb restraints and no chair that prevented raising. Resident #41 was also rated as using no alarms. Section Q Participation in Assessment and Goal Setting indicated that Resident #41 participated along with other legally authorized representative. Record review on 09/18/2024 of Resident #41's Care Plan, last revised on 09/09/2024, revealed there was no indication of alternatives attempted prior to grab bars being placed on the resident's bed. Focus area of has potential impairment to skin integrity: Pressure relief mattress: Turns self in bed and interventions of Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short; Educate resident/family/caregivers of causative factors and measures to prevent skin injury; Encourage good nutrition and hydration in order to promote healthier skin; Identify/document potential causative factors and eliminate/resolve where possible; Monitor/document location, size and treatment of skin injury. Report abnormalities however no mention of grab bars and potential skin injuries. Record Review on 09/18/2024 of Resident #41's Assessments in the EHR did not show an assessment for safe use of bed rails/grab bars for the resident. Record Review on 09/18/2024 of Resident #41's Clinical Consents revealed no Bed Rail Consent form (bed rail/enabler bar consent) for the 1/8 bed rails/enabler bars signed by the resident or resident's responsible party or noted to have verbal permission for the enabler bars. (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review on 09/18/2024 of Resident #41's Clinical Physician Orders did not show an order for bed rails/grab bars. Record Review on 09/18/2024 of Resident #41's Clinical Miscellaneous documents did not reveal any assessment, consent, order, or care plan addition for bed rail/grab bar usage. Observation of Resident #41's bed area on 09/16/2024 at 1:50 PM revealed grab bars installed an in the the raised position on both sides of resident's bed. Resident was not available for interview at the time. Resident #143: Record review on 09/18/2024 of Resident #143's face sheet revealed a [AGE] year old female who initially admitted to the facility on [DATE]. Resident #143 was listed as her own responsible party. Resident #143 was noted as having diagnoses such as Obstructive And Reflux Uropathy(disorder of the urinary tract that occurs due to obstructed urinary flow and can be either structural or functional), Atherosclerotic Heart Disease Of Native Coronary Artery (common heart condition that occurs when plaque builds up in the arteries that supply blood to the heart), Chronic Kidney Disease (long term condition that occurs when the kidneys are damaged and can not filter blood properly), Type 2 Diabetes Mellitus With Diabetic Neuropathy (when the body does not respond to insulin properly, resulting in high blood sugar levels), Unspecified Dementia (mild cognitive impairment not yet diagnosed as a specific type of dementia), Chronic Atrial Fibrillation (abnormal heart rhythm when the upper chambers of the heart beat irregularly and quickly), Essential (Primary) Hypertension (high blood pressure that is multifactorial and does not have one distinct cause), Chronic Respiratory Failure (long term condition that occurs when the lungs can not exchange oxygen and carbon dioxide effectively), Severe Sepsis With Septic Shock (serious conditions that occur when the body has an extreme response to an infection), History Of Falling, Chronic Kidney Disease, Stage 3b (moderate to severe loss of kidney function), Bipolar Disorder (mental illness that causes extreme mood swings, affecting the person's energy, activity level, and concentration), Chronic Pain Syndrome (condition that involves persistent pain and other symptoms that last longer than the expected healing time for the affected tissue), and Unspecified Systolic (Congestive) Heart Failure (condition where the heart's ventricles are unable to pump enough blood, resulting in a lack of blood supply to the body). Record review on 09/18/2024 of Resident #143's Quarterly MDS assessment dated [DATE], revealed a BiMS score of 15 suggesting no cognitive impairment. Section GG Functional Ability indicated that Resident #143 used a manual wheelchair; supervision or touching assistance was needed with the following tasks: oral hygiene, rolling left and right; needed substantial assistance with the following tasks: personal hygiene; and was completely dependent for: toileting, showering/bathing, and transfers. Record review on 09/18/2024 of Resident #143's Care Plan, last revised o 07/17/2024, revealed there was no indication of alternatives attempted prior to grab bars being placed on the resident's bed. Record Review on 09/18/2024 of Resident #143's Assessments in the EHR did not show an assessment for safe use of bed rails/grab bars for the resident. Record Review on 09/18/2024 of Resident #143's Clinical Consents revealed no Bed Rail Consent form (bed rail/enabler bar consent) for the 1/8 bed rails/enabler bars signed by the resident or resident's responsible party or noted to have verbal permission for the enabler bars. (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review on 09/18/2024 of Resident #143's Clinical Physician Orders haddid shown an order for bed rails/grab bars. Record Review on 09/18/2024 of Resident #143's Clinical Miscellaneous documents did not reveal any assessment, consent, order, or care plan addition for bed rail/grab bar usage. Observation of Resident #143's bed area on 09/17/2024 at 2:25 PM revealed grab bars attached to resident's bed on both sides and in a raised position. Interview with Resident #143 on 09/17/2024 at 2:25 PM revealed that the resident believed facility staff spoke to her about grab bar hazards when she returned from the last hospitalization however does not recall any consent forms. Resident #143 stated that one of the grab bars was loose at one point and maintenance tightened it after the nursing staff was informed of the issue. Resident #143 informed that the facility has a good staff and no concerns to voice. In an interview on 09/19/2024 at 8:57 AM with CNA F revealed that a restraint was anything where a resident cannot free themselves such as bed rails or tying them down. CNA F stated that a bed rail was a bar that went down the entire length of the bed. According to CNA F a grab bar was what the facility uses and when asked if there was a potential for entrapment with a grab bar she stated probably not and if there were there is the grab bar on the grab bar that could be used for assistance. When CNA F was asked if grab bars were a safety issue, she stated "Yes, if residents were to fall the grab bar could cause a safety issue but that CNA F had seen the resident do more good than harm with grab bars installed on their bed. While at the facility CNA F stated that there have had some residents request to have the grab bars removed and the facility would do so. In an interview on 09/19/2024 at 9:15 AM with LVN A, the LVN stated that a restraint was holding someone down by something, and that even a bed alarm or wheelchair alarm could be considered a constraint. LVN A stated that a bed rail had different kinds such as a mobility (or M) rail, a safety rail used for repositioning, half and whole rails which were not used at this facility as they are considered restraints. LVN A shared that a grab bar would not feel like entrapment. LVN A stated that having a call light wrapped around any size of bed rail/grab bar was not safe to have as it could have caused a resident to trip or get wrapped around the resident's neck. LVN A stated that other safety risks of a bed rail/grab bar would be if a resident were to fall then the bars would cause a safety issue, however, LVN A had seen grab bars that were more good than harm. When LVN A was asked about a safety assessment for bed rails/grab bars the LVN stated they were not sure about an assessment however believe the facility had done some type of training/orientation/assessment to see if the resident needed the device. LVN A stated that a safety assessment would have been documented but not sure where in the EHR. (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 09/19/2024 at 9:26 AM with the MDS Coordinator, a restraint was stated to have been something that physically kept someone from being able to move about freely like a seat belt that is not a self-release, side rails or bed rails ranging in length from 1/4, 1/2, and full lengths while the 1/4 length could have also been used to help a resident with mobility. The MDS Coordinator stated a 1/4 rail, or grab bar, could have potentially been a source of entrapment for a resident without mobility who got against it and was not able to get away however had only seen this issue with residents who had some mobility still. When asked if bed rails or grab bars posed a safety risk, the MDS Coordinator stated yes but the grab bars/bed rails could also have been as much risk to a resident as without for example a resident being hurt from hitting face against bar when slipping or with getting an arm stuck and was why residents needed to be monitored closely every 2 hour checks or any time a staff member walked down the hall. The MDS Coordinator was asked if an assessment was completed for bed rails/grab bars and the MDS Coordinator responded they were not sure but that there was an assessment with elopement alarms and that there were quarterly assessments including safety in some form. The MDS Coordinator shared that for grab bars/bed rails to be placed on a resident bed there needed to be a safety assessment, a doctor's order, family or resident consent, and for the bed rails/grab bars to be care planned. In an interview on 09/19/2024 at 9:56 AM with the DON a restraint was said to be something that will keep someone from being as mobile and independent as they possibly could be. The DON stated that a bed rail was something that would keep someone from being able to get out of bed safely and that the facility used the mobility rail to assist patients getting out of bed safely. When asked if mobility or grab bars could have posed as a source of entrapment, the DON stated no. When asked if the mobility or grab bars could have posed a safety risk to residents, the DON stated no, that is why we have them on there (the beds) so patients could have something to hang on to. The DON was asked if a safety assessment was completed with the resident when they admitted to the facility and a mobility/grab bar was on the bed, the DON responded yes, therapy helps with that and that therapy would go over verbally and visually with the resident. When asked if anything was required before a mobility/grab bar were to be installed on the resident bed, the response from the DON was not for a mobility rail; it was used as enable device to help a resident pull up if they need it. In an interview with the ADM on 09/19/2024 at 10:40 AM, when asked what the facility policy was for a resident to have bed rails/grab bars/mobility bars on their bed, the ADM responded that the facility used to have standing orders for grab bars/mobility rails, and that consent was additionally required for bed rails in lengths of 1/4 and 1/2. The ADM stated the facility was planning to review their current policy and add to in-service trainings already scheduled for all nursing staff on 9/20/2024. The ADM indicated that the DON had informed of the mobility rail/grab bar issue and the additional need for each resident with the bars/rails to have included in their EHR doctor's orders, safety assessment, consent, and care planning . Record review of the facility's provided Bed Safety policy from Nursing Services Policy and Procedure Manual for Long Term Care (C)2001 MED-PASS INC. (Revised December 2007) states, in part: Policy Interpretation and Implementation 1.The resident's sleeping environment shall be assessed by the interdisciplinary team, considering the resident's safety, medical conditions, comfort, and freedom of movement, as well as input from the resident and family regarding previous sleeping habits and bed environment. (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. The facility's education and training activities will include instruction about risk factors for resident injury due to beds, and strategies for reducing risk factors for injury, including entrapment. 5. If side rails are used, there shall be an interdisciplinary assessment of the resident, consultation with the Attending Physician, and input from the resident and/or legal representative. 6. Staff shall obtain consent for the use of side rails from the resident or resident's legal representative prior to their use. 7. After appropriate review and consent as specified above, side rails may be used at the resident's request to increase the resident's sense of security (e.g. if he/she has a fear of falling, his/her movement is compromised, or he/she is used to sleeping in a larger bed). 8. Side rails may be used if assessment and consultation with the Attending Physician has determined that they are needed to help manage a medical symptom or condition, or to help the resident reposition or move in bed and transfer, and no other reasonable alternatives can be identified. 9. Before using side rails for any reason, the staff shall inform the resident and family about the benefits and potential hazards associated with side rails.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observation, interviews, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for 1 (Resident #24) of 8 residents reviewed for pharmacy services. The facility failed to ensure Resident #24's insulin was used within 28 days of opening date [DATE] prior to LVN B administering it. These failures could place residents at risk for medication errors, ineffective relief from pain medication, and drug diversion of controlled substances. Findings included: 1.Resident #24 Review of Resident #24's face sheet, dated [DATE], reflected she was an [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included respiratory failure with hypoxia (the body not receiving enough oxygen), unspecified convulsions (seizure like activity), dementia (this is a brain disease that alters brain function causes cognitive decline), and type 2 diabetes mellitus (uncontrolled blood sugar), Review of Resident #24's quarterly MDS, dated [DATE], reflected Resident #24 usually was able to understand others and be understood by others. She had a BIMS score of three, and continuous inattention and disorganized thinking, as well as verbal behavioral symptoms on ,d+[DATE] days of a 7-day lookback period. Resident #24 needed staff assistance with self-care, such as bathing, dressing, and toileting. She required staff to do over half the effort in eating, dressing, and hygiene and was dependent on staff for toileting and bathing. Review of Resident #24's care plan dated [DATE] reflected resident had a focus of Diabetes Mellitus: Currently on Metformin (Black Box Warning): Blood sugar checks during the day and at night before bed. Glargine Insulin 20 Units subcutaneous in the morning: Sliding scale insulin started [DATE] due to elevated A1C 7.6 which was high. Date Initiated: [DATE] Revision on: [DATE]. Record review of Resident #24's orders dated [DATE], reflected the following diabetes medication: 1.Insulin Regular Human Injection Solution [short/fast acting insulin]. Inject as per sliding scale: if 200 - 219 = 5 units; 220 - 239 = 6 units; 240 - 259 = 7 units; 260 - 279 = 8 units; 280 - 299 = 9 units; 300 - 319 = 10 units, subcutaneously as needed for diabetes call physician for greater than 320. Start date [DATE]. 2. Black box warning medication (this is an FDA warning for a group of medications that have a potential to cause severe risk associated with the drug); Metformin HCL tablet 500 MG. Give 2 tablet by mouth two times a day for Type 2 diabetes mellitus without complication. Order active [DATE]. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Insulin Glargine [long-acting insulin] Solution 100 UNIT/ML Inject 10 unit subcutaneously one time a day for diabetes. Start date [DATE] 0800. Record review of Resident #24's MAR dated from [DATE] to [DATE] reflected blood sugar readings and Regular insulin administration as follows: Inject as per sliding scale: if 200 - 219 = 5 units; 220 - 239 = 6 units; 240 - 259 = 7 units; 260 - 279 = 8 units; 280 - 299 = 9 units; 300 - 319 = 10 units, subcutaneously as needed for diabetes call physician for greater than 320. Start date [DATE]. [DATE] at 11:00 AM blood sugar reading 203, 5 units of sliding scale regular human insulin were administered. [DATE] at 9:00 PM blood sugar reading 278, 8 units of sliding scale regular human insulin were administered. [DATE] at 9:00 PM blood sugar reading 200, no insulin administered. [DATE] at 11:00 AM blood sugar reading 218, no insulin administered. [DATE] at 9:00 PM blood sugar reading 209, no insulin administered. [DATE] at 11:00 AM blood sugar reading 205, no insulin administered. [DATE] at 11:00 AM blood sugar reading 230, no insulin administered. [DATE] at 11:00 AM blood sugar reading 225, 6 units of sliding scale regular human insulin were administered. [DATE] at 4:00 PM blood sugar reading 225, no insulin administered. [DATE] at 9:00 PM blood sugar reading 205, no insulin administered. [DATE] at 11:00 AM blood sugar reading 223, 6 units of sliding scale regular human insulin were administered. [DATE] at 9:00 PM blood sugar reading 211, 5 units of sliding scale regular human insulin were administered. [DATE] at 11:00 AM blood sugar reading 231, no insulin administered. [DATE] at 11:00 AM blood sugar reading 205, no insulin administered. [DATE] at 11:00 AM blood sugar reading 221, no insulin administered. [DATE] at 11:00 AM blood sugar reading 227, 6 units of sliding scale regular human insulin were administered. [DATE] at 9:00 PM blood sugar reading 244, 7 units of sliding scale regular human insulin were administered. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] at 11:00 AM blood sugar reading 249, no insulin administered. [DATE] at 11:00 Am blood sugar reading 265, 8 units of regular human insulin were administered. Observation and interview with LVN B on [DATE] at 10:47 AM, revealed LVN B checked Resident #24's blood sugar by poking her finger and used a small drop of blood to measure her blood sugar. Resident #24's blood sugar reading was 265. LVN B then went to her computer to determine how much insulin was required for Resident #24. LVN B stated she was going to administer 8 units of insulin. In her medication cart LVN B took out an insulin box with Resident #24's name. The insulin was in a white box with small yellow trim read Humulin R, on the front side of insulin box, it read opened [DATE] and on the back side of the insulin box it read opened [DATE]. LVN B stated she did not know which date on the Humulin R was accurate. LVN B did not discard Resident #24's insulin with the two different opening dates out of the medication cart and she did not replace it with new insulin. LVN B then took out a syringe with needle attached and drew from the insulin bottle into the syringe 10 units of Humulin insulin for Resident #24. LVN B proceeded back to Resident #24 to attempt to administer the 10 units of Humulin insulin to Resident #24. Intervention by surveyor was provided and LVN B removed the extra 2 units of Humulin insulin, and she proceeded to administer the 8 units of Humulin insulin to Resident #24. LVN B stated it was the responsibility of the nurses to make sure that all insulins were dated clearly with an open date and residents name if it did not have the pharmacy label on it. She stated the facility expected them to use opened insulin within 28 days of opening it. She stated it was hard for her to see the small numbers on the syringe because the numbers went all the way to 100 ml. She stated she preferred the 50 ml syringes because the numbers were bigger and easier to see. LVN B stated the facility did not have any 50 ml insulin syringes. She stated using expired insulin can have low potency effects on residents and can cause residents not to have the desired effect of controlling their blood sugars. She stated giving too much insulin or too little insulin can cause low blood sugar or higher blood sugars. In an interview with the ADON on [DATE] at 02:24 PM, she stated all nursing staff should check insulin prior to administering to resident. She stated the risk to residents getting expired insulin was potency inaccuracy. The ADON also said that she expected all staff to document when insulin was given or not given. She said all medication administration or refusal need to be charted. The ADON stated vitals should be rechecked if they had been done an hour ago before medication administration. She stated giving BP medication without checking it can cause adverse effects of low BP/hypotension. The ADON stated medication safety will be on her mandatory in-service on [DATE]. Interview with the DON on [DATE] at 02:24 PM, she stated she expected nursing staff and medication Aides to look at the Medication Administration Record (MAR) to verify the residents name, the room number, the medication and to look at the residents' picture. She said that she expects them to look at the medication card or container and verify the name written on it. She said that she expected them to always follow the 5 Rights to medication (Right patient, Right drug, Right time, Right dose, Right route). She said she expected nursing staff and med aides to follow the medication policy. She said medication errors can cause harm to the resident and the wrong dose can over medicate and/or under dose the resident. The DON stated facility medication safety practice was BP medications could be administered within 1 hour of vitals being checked. Review of the facility's policy Administration Procedures for All Medications, revised ,d+[DATE] reflected the following: (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy Medications will be administered in a safe and effective manner. III. 5 Rights (at a minimum) At a minimum, review the 5 rights at each of the following steps of medication administration. 1. Prior to removing the medication package/container from the cart/drawer: a. Check the MAR for the order. 2. Prior to removing the medication from the container: a. Check the label against the order on the MAR. IV. Administration 9. If a resident refuses medication, document refusal on the MAR. Review of insulin manufacturer lilly.com Wash your hands with soap and water. Check the insulin label to make sure you are taking the right type of insulin. This is especially important if you use more than 1 type of insulin. Insulin should look clear and colorless. Do not use Insulin if it is thick, cloudy, or colored, or if you see lumps or particles in it. Do not use past the expiration date printed on the label or 28 days after you first use it. Always use a new syringe and needle for each injection to prevent infections and blocked needles. Do not mix insulin U-100 with other insulins.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observation, interview, and record review, facility failed to ensure the medication error rate was not 5 percent (5%) or greater for 2 of 31 opportunities resulting in a 6.14 % medication error rate for two of nine residents observed for medication pass (Resident #24 and Resident #96). 1. The facility failed to ensure Resident #24's insulin was administered according to the sliding scale as physician ordered by LVN B 2. The facility failed to ensure Resident #96's blood pressure medication Metoprolol was held and not administered by MA D as physician had order for blood pressure reading of ,d+[DATE]. These failures could place residents at risk for significant medication errors and jeopardize the resident health and safety. Finding included: 1.Resident #24 Review of Resident #24's face sheet, dated [DATE], reflected she was an [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included respiratory failure with hypoxia (the body not receiving enough oxygen), unspecified convulsions (seizure like activity), dementia (this is a brain disease that alters brain function causes cognitive decline), and type 2 diabetes mellitus (uncontrolled blood sugar), Review of Resident #24's quarterly MDS, dated [DATE], reflected Resident #24 usually was able to understand others and be understood by others. She had a BIMS score of three, and continuous inattention and disorganized thinking, as well as verbal behavioral symptoms on ,d+[DATE] days of a 7-day lookback period. Resident #24 needed staff assistance with self-care, such as bathing, dressing, and toileting. She required staff to do over half the effort in eating, dressing, and hygiene and was dependent on staff for toileting and bathing. Review of Resident #24's care plan dated [DATE] reflected resident had a focus of Diabetes Mellitus: Currently on Metformin (Black Box Warning): Blood sugar checks during the day and at night before bed. Glargine Insulin 20 Units subcutaneous in the morning: Sliding scale insulin started [DATE] due to elevated A1C 7.6 which was high. Date Initiated: [DATE] Revision on: [DATE]. Record review of Resident #24's orders dated [DATE], reflected the following diabetes medication: 1.Insulin Regular Human Injection Solution [short/fast acting insulin]. Inject as per sliding scale: if 200 - 219 = 5 units; 220 - 239 = 6 units; 240 - 259 = 7 units; 260 - 279 = 8 units; 280 - 299 = 9 units; 300 - 319 = 10 units, subcutaneously as needed for diabetes call physician for greater than 320. Start date [DATE]. (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Black box warning medication (this is an FDA warning for a group of medications that have a potential to cause severe risk associated with the drug); Metformin HCL tablet 500 MG. Give 2 tablet by mouth two times a day for Type 2 diabetes mellitus without complication. Order active [DATE]. 3. Insulin Glargine [long-acting insulin] Solution 100 UNIT/ML Inject 10 unit subcutaneously one time a day for diabetes. Start date [DATE] 0800. Record review of Resident #24's MAR dated from [DATE] to [DATE] reflected blood sugar readings and Regular insulin administration as follows: Inject as per sliding scale: if 200 - 219 = 5 units; 220 - 239 = 6 units; 240 - 259 = 7 units; 260 - 279 = 8 units; 280 - 299 = 9 units; 300 - 319 = 10 units, subcutaneously as needed for diabetes call physician for greater than 320. Start date [DATE]. Observation and interview with LVN B on [DATE] at 10:47 AM, revealed LVN B checked Resident #24's blood sugar by poking her finger and used a small drop of blood to measure her blood sugar. Resident #24's blood sugar reading was 265. LVN B then went to her computer to determine how much insulin was required for Resident #24. LVN B stated she was going to administer 8 units of insulin. In her medication cart LVN B took out an insulin box with Resident #24's name. LVN B then took out a syringe with needle attached and drew from the insulin bottle into the syringe 10 units of Humulin insulin for Resident #24. LVN B proceeded back to Resident #24 to attempt to administer the 10 units of Humulin insulin to Resident #24. Intervention by surveyor was provided and LVN B removed the extra 2 units of Humulin insulin, and she proceeded to administer the 8 units of Humulin insulin to Resident #24. She stated it was hard for her to see the small numbers on the syringe because the numbers went all the way to 100 ml. She stated she preferred the 50 ml syringes because the numbers were bigger and easier to see. LVN B stated the facility did not have any 50 ml insulin syringes. She stated giving too much insulin or too little insulin can cause low blood sugar or higher blood sugars. 2.Resident #96 Review of Resident #96's face sheet dated [DATE], reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included paroxysmal atrial fibrillation (this is a heart disease that causes an irregular heart rhythm), hypertension (high blood pressure), type 2 diabetes mellitus (uncontrolled blood sugar), glaucoma (this is an eye disease that causes vision loss). Chronic kidney diseases, muscle wasting and muscle dying, urinary tract infection, idiopathic peripheral autonomic neuropathy (nerve damage) and bladder cancer. Resident #96's family was her RP. Her advance directive was DNR-Do Not Do CPR. Review of Resident #96's quarterly MDS dated [DATE], reflected a BIMS assessment of 15 indicating Resident #96 was cognitively intact. She could understand others and others could understand her. Resident #96 was dependent on staff for ADL's. Resident #96 required substantial/maximal assist to transfer. The MDS reflected Resident #96 had a diagnoses of high blood pressure. Her prognosis assessment reflected Resident #96 had a condition or chronic diseases that may result in a life expectancy of less than 6 months. Further review of the MDS reflected Resident #96 had a fall in the facility without injury and no change in behavior was noted after the fall. Review of Resident #96's orders dated [DATE], reflected a Black box warning medication: Metoprolol Tartrate Tablet 25 MG, give 1 tablet by mouth two times a day related to essential (primary) hypertension. Hold for SBP less than 120. Order active on [DATE]. (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview with LVN A on [DATE] at 06:34 AM, revealed LVN A checking residents blood pressures. She went into Resident #96 and checked her blood pressure. Reading for Resident #96 was , d+[DATE], pulse 65. LVN A stated she checks vitals for the residents every morning on her shift. Observations and interview with MA D during medication observation on [DATE] at 08:52 AM, revealed MA D took Resident #96's morning medications which included blood pressure Metoprolol 25 mg. The BP medication package read Metoprolol Tartrate Tablet 25 MG, give 1 tablet by mouth two times a day. Hold for SBP less than 120. MA D did not recheck resident #96's blood pressure before administering the BP medication. MA D stated LVN A had already checked Residents #96's blood pressure and the reading was , d+[DATE] with pulse of 65. MA D stated if there was an issue with her requiring to hold a medication, the nurse would have told her. MA D stated if there was risk to the resident, the nurse would have informed her to hold the medication. She stated she only held medications when told by the nurses otherwise she administered them. MA D stated she normally worked evening shift and did not have to do vitals. MA D did not state the risk to Resident #96. In an interview and observation with LVN C on [DATE] at 02:14 PM, She stated she was not aware of BP medication administered to Resident #96 earlier. She went to Resident #96's room and rechecked her BP. Reading was ,d+[DATE], pulse 80. LVN C stated it was good practice to check vitals before medication administration. She stated BP can change when a person was lying down and when they get up. She stated BP medication should be administered in 30 minutes to an hour. LVN C stated she would notify the physician of the incident and possibly see if they could change Resident #96's BP perimeters. She stated the risk too that administering medication and not following perimeter can cause BP to drop too low. Interview with LVN A on [DATE] at 10:15 AM she stated the BP vitals were good for medication administration for 2 hours, an hour before medication and another hour after medication administration. LVN A stated after that time frame the blood pressure should be rechecked. LVN A stated the provider for Resident #96's changed her medication perimeters. She stated Resident #96's general BP perimeter was to hold medication when BP was ,d+[DATE]. LVN A stated it was good practice to look at the MAR and follow the required perimeter or to ask the nurse. LVN A stated it was her responsibility as a nurse to monitor her residents' vitals. She stated she made it her general practice to go back and monitor or recheck questionable vitals. LVN A did not state risk to Resident #96. In an interview with the ADON on [DATE] at 02:24 PM, she stated all nursing staff should check insulin prior to administering to resident. She said all medication administration or refusal need to be charted. The ADON stated vitals should be rechecked if they had been done an hour ago before medication administration. She stated giving BP medication without checking it can cause adverse effects of low BP/hypotension. The ADON stated medication safety will be on her mandatory in-service on [DATE]. (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the DON on [DATE] at 02:24 PM, she stated she expected nursing staff and medication Aides to look at the Medication Administration Record (MAR) to verify the residents name, the room number, the medication and to look at the residents' picture. She said that she expects them to look at the medication card or container and verify the name written on it. She said that she expected them to always follow the 5 Rights to medication (Right patient, Right drug, Right time, Right dose, Right route). She said she expected nursing staff and med aides to follow the medication policy. She said medication errors can cause harm to the resident and the wrong dose can over medicate and/or under dose the resident. The DON stated facility medication safety practice was BP medications could be administered within 1 hour of vitals being checked. Record review of facility policy titled labelling of Container, revision date [DATE], reflected policy statement All medications maintained in the facility shall be properly labelled in accordance with current state and federal regulations. Policy interpretation and implementations .read in part 1. Medications labels must be legible at all times. 3. Labels for individual drug containers shall include all necessary information such as a) Residents name, f) Date medication was dispensed, h) Expiration date .7. The individual administering the medication must check the label to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication .		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observations, interviews, and record review, the facility failed to in accordance with State and Federal laws, store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys for one of two nurse medication carts (Cart A) and one of two med aide medications cart (Cart B) that were reviewed for security and storage of drugs and biologicals. The facility failed to ensure nurse medication Cart A had dated insulin and unexpired insulin in it for Resident # 24, and Resident #25 per manufactueres recommendation to be used in 28 days after opening the insulin. The facility failed to ensure MA D locked and secured medication Cart B when it was unattended and out of view while inside Resident # 96's room. This failure could place residents at risk of having access to unauthorized medications, drug diversions, and could lead to possible harm. Findings included: Resident #24 Review of Resident #24's face sheet, dated [DATE], reflected she was an [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included respiratory failure with hypoxia (the body not receiving enough oxygen), unspecified convulsions (seizure like activity), dementia (this is a brain disease that alters brain function causes cognitive decline), and type 2 diabetes mellitus (uncontrolled blood sugar). Resident #25 Review of Resident #25's face sheet dated [DATE], reflected a [AGE] year-old male, admitted to the facility on [DATE]. His diagnoses included aphasia (difficulty or loss of ability in speech) due to stroke, chronic kidney disease, diabetes mellitus (uncontrolled blood sugar), dementia (this is a brain disease that alters brain function causes cognitive decline), anxiety disorder, gastronomy status (use of a feeding tube), anxiety disorder, major depressive disorder, bipolar disorder (this is a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), and a below-the-knee amputation. Resident #96 (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #96's face sheet dated [DATE], reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included paroxysmal atrial fibrillation (this is a heart disease that causes an irregular heart rhythm), hypertension (high blood pressure), type 2 diabetes mellitus (uncontrolled blood sugar), glaucoma (this is an eye disease that causes vision loss). Chronic kidney diseases, muscle wasting and muscle dying, urinary tract infection, idiopathic peripheral autonomic neuropathy (nerve damage) and bladder cancer. Observations and interview with MA D during medication observation on [DATE] from 08:52 AM to 09:11 AM, revealed MA D took medications from medication Cart B for Resident #96. The medication cart was outside Resident #96's doorway. She closed the drawers and went into Resident #96's room. The privacy curtain was closed, and MA D could not see medication Cart B. Upon examination of medication Cart B, drawers could easily be opened, and the silver lock button was released. A staff member walked by the med cart to go to another room with a resident in a wheelchair. MA D stated she was told it was acceptable to leave the medication cart unlocked when it was in the doorway. MA D stated she could not see the medication Cart B while in Resident #96's room because the privacy curtain was closed blocking doorway view. She stated she could see how not being able to see the medication cart in her view can give access to unauthorized persons. She stated she was responsible for the medication cart when it was in her possession, making sure it was secure. MA D did not state the risk to the residents. Observation and interview with LVN B on [DATE] at 10:47 AM, revealed nurse medication Cart A had an insulin pen named Humalog Kwik pen dated 08/missing number/24. The insulin pen had Resident #25's name on it. Another insulin named glargine last filled on [DATE] belonging to Resident #25 had no open date on it. Another insulin in a box named Humulin R belonging to Resident #24 had two different dates on it. On front side of insulin box, it read opened [DATE] and on the back side of the insulin box it read opened [DATE]. LVN B stated she did not know which date on the Humulin R was accurate. She stated it was the responsibility of the nurses to make sure that all insulin was dated clearly with an open date and residents name if it did not have the pharmacy label. She stated the facility expected them to use opened insulin within 28 days of opening them. She stated using expired insulin can have low potency effects on residents and can cause residents not to have the desired effect of controlling their blood sugars. She stated she would replace Resident #25 glargine insulin. She did not remove Resident #24's insulin out of Medication Cart A. In an interview with the ADON on [DATE] at 02:24 PM, she stated all nursing staff should check insulin prior to administering to resident and she expected all medication carts to be locked when not in use. She stated the risk to residents getting expired insulin was potency inaccuracy. The ADON also said that she expected all staff to document when insulin was given or not given. She said all medication administration or refusal need to be charted. The ADON stated medication safety will be on her mandatory in-service on [DATE]. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the DON on [DATE] at 02:24 PM, she stated she expected all persons with authorized access to lock medication carts when not in use and when out of sight. The DON stated the medication cart could be placed in doorway and unlocked when in use, but the nurse or medication aide must have it in their view. The DON stated the risk of leaving a medication cart unlocked was a safety and security concern and someone could have access to the medication cart. The DON also stated nurses were responsible for the insulins and making sure that they were dated and had the correct names on them. She stated there was a chart in the medication room that specified how long an insulin was good for after opening. She stated the pharmacist had just done an audit on the medication cart and was not sure how those insulins had been missing. She stated administering expired insulin could have adverse outcomes due to low potency. She stated she was responsible for auditing the medication carts. Interview with the administrator was not possible on exit [DATE] at 12:30 PM due to a medical appointment she had to leave the facility. Record review of facility policy titled, Security of Medication Cart, revision date [DATE], reflected policy statement The medication cart shall be secured during medication passes. Policy interpretation and implementations .4. The medication cart must be securely locked at all times when out of the nurse's view . Record review of facility policy titled labelling of Container, revision date [DATE], reflected policy statement All medications maintained in the facility shall be properly labelled in accordance with current state and federal regulations. Policy interpretation and implementations .read in part 1. Medications labels must be legible at all times. 3. Labels for individual drug containers shall include all necessary information such as a) Residents name, f) Date medication was dispensed, h) Expiration date . Review of insulin manufacturer lilly.com Wash your hands with soap and water. Check the insulin label to make sure you are taking the right type of insulin. This is especially important if you use more than 1 type of insulin. Insulin should look clear and colorless. Do not use Insulin if it is thick, cloudy, or colored, or if you see lumps or particles in it. Do not use past the expiration date printed on the label or 28 days after you first use it. Always use a new syringe and needle for each injection to prevent infections and blocked needles. Do not mix insulin U-100 with other insulins.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infections for four of ten residents (Residents #1, #6, #17, and #143) reviewed for infection control. 1.The facility failed to ensure MA D sanitized blood pressure cuff in-between residents use on Residents # 1, #6, and Resident #17. 2.The facility failed to ensure LVN A wore PPE for EBP, cleaned bedside table, and performed hand hygiene during catheter care for Resident #143. These failures could place residents at risk of infectious diseases and cross contamination. Findings included: 1. Resident #1 Record review of Resident #1's face sheet dated [DATE], revealed a [AGE] year-old male that was admitted to the facility on [DATE]. His diagnoses included Epilepsy (is a seizure disorder), hypertension (high blood pressure), idiopathic progressive neuropathy (this is a condition of progressive nerve damage), type 2 diabetes mellitus (uncontrolled blood sugar), cocaine dependence in remission, Bipolar disorder (this is a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), sexual disorder, unspecified allergy initial encounter, hemiplegia affecting left non dominant side (paralyzed on left side). Resident #1 was a full code, and his family was his RP. Resident #1 has no known allergies. Review of Resident #1's quarterly MDS dated [DATE] reflected a BIMS of fifteen, indicating Resident #1 was cognitively intact. He could understand others, and others could understand him. Review of functional status reflected Resident #1 had impaired function on one side, he required supervision when eating and during oral care, he was dependent for transfer, ambulation, toileting, and dressing. Resident #1 was wheelchair dependent for mobility. Review of Resident #1's order summary dated [DATE], reflected Lisinopril 10 mg tablet. Give 1 tablet by mouth daily. Hold for SBP <100 and or DBP <60. Charge nurse to assess and notify MD. Medroxyprogesterone 10 mg tablet. Take 2 tablets by mouth daily. Warning: Hazardous Drug. Review of Resident #1's care plan on [DATE], reflected Resident #1 was had hypertension and taking lisinopril. His goal was to remain free signs and symptoms and complications of hypertension through review date [DATE]. His interventions included giving blood pressure medications as ordered. Monitor for side effects such as orthostatic hypotension [low blood pressure] and increased heart rate. Resident #6 (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #6's face sheet dated [DATE], reflected a [AGE] year-old female that was admitted to the facility on [DATE]. Resident #6 was allergic to antibiotics clindamycin and sulfa and she was allergic to Benadryl. Her advance directive was DNR- Do Not Do CPR. Her diagnosis included unspecified dementia without behaviors (cognitive decline), chronic atrial fibrillation (this is a heart disease that causes an irregular heart rhythm), coronary artery diseases without angina pectoris (heart diseases without heart pain), pace maker (a small device used to treat irregular heartbeat), hypertension (high blood pressure), functional diarrhea (this is chronic or recurring type of diarrhea), allergic contact dermatitis unspecified cause (allergic reaction caused by contact to something unknown), chronic cough, abnormal weight loss, vitamin D deficiency. Review of Resident #6's quarterly MDS dated [DATE], reflected a BIMS assessment score of seven out of fifteen indicating severe cognitive impairment. Review of the section for functional status reflected Resident # 6 required helper sets up or cleaned up after resident completed ADL activities. Review of Resident #6's orders dated [DATE], reflected Digoxin Tablet 125 MCG Give 1 tablet by mouth one time a day every other day for heart failure related to atherosclerotic heart disease of native coronary artery without angina pectoris. Active [DATE]. Hold for SBP <100 and or DBP <60. Charge nurse to assess and notify MD. Active date [DATE]. Resident #17 Review of Resident #17's face sheet dated [DATE], reflected a [AGE] year-old female that was admitted to the facility on [DATE]. Her advanced directive was full code status. Resident #17's diagnoses included generalized anxiety disorder (this is a mental condition characterized by feeling worry, anxiety, or fear that is strong enough to interfere with one's daily activities), type 2 diabetes mellitus (uncontrolled blood sugar), tachycardia (fast heart rate), gastroesophageal reflux diseases, muscle weakness, unsteady on her feet, dry eye syndrome, cataract (is an eye disease that causes vision loss), hypertension (high blood pressure), and encounter for screening for respiratory Tuberculosis (this is a medical procedure that checks for the presence of TB bacteria in the body). Review of Resident #17's quarterly MDS dated [DATE], reflected a BIMS score of thirteen indicating she was cognitively intact. Resident #17 could understand others and others could understand her. Resident #17 required supervision during ADLs. Resident #17 was independent of mobility in bed and could sit on side of bed independently. Review of order summary dated [DATE], reflected Hydrocortisone acetate 1% cream apply to itching areas on face/chin PRN every 8 hours as needed for itching. Order active [DATE]. Metoprolol Tartrate Oral Tablet 50 MG (Metoprolol Tartrate) Give 1 tablet by mouth two times a day for increased HR related to Tachycardia. Hold for SBP <100 and or DBP <60. Charge nurse to assess and notify MD. Active [DATE]. Review of care plan dated [DATE], reflected Resident #17 had a focus of Hypertension and was taking Metoprolol due to increased heat rate. The goal was Resident #17 would maintain a blood pressure within normal limits through review date. The resident would remain free from s/sx of hypertension through the review date. The resident would remain free of complications related to hypertension through review date [DATE]. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations and interview with MA D during medication observation on [DATE] from 08:52 AM to 09:44 AM, revealed MA D took out medications for Resident #6, she separated Digoxin Tablet 125 MCG into a separate cup. MA D took the BP cuff and placed it on her own left wrist. MA D then walked to Resident #6's room with three medication cups, after placing medication cups on Resident #6's table, MA D took the BP cuff off her own wrist and placed it on Resident #6 wrist to take her BP. The MA stated she was using the BP cuff to measure Resident #6's pulse. After administering all of Resident #6's medications MA D went back to medication cart and placed the soiled BP cuff on top of the medication cart. Hand hygiene was performed. MA D did not sanitize the BP cuff after use on Resident #6. MA D then wheeled the medication cart to Resident # 17. MA D looked up Resident #17's medications on the computer, she placed Resident #17's medications in a medication cup. She then went into Resident #17's room with the soiled BP cuff and placed the soiled BP cuff on Resident #17's wrist. MA D then came back to the medication cart and put the soiled BP cuff on top of the medication cart. MA D performed hand hygiene after medication administration to Resident #17. BP cuff was not sanitized after use on Resident #17. MA D went to Resident #1's room. Resident #1 was in the doorway. MA D took the soiled BP cuff off the top of medication cart and placed soiled BP cuff on Resident #1's right wrist. MA D placed soiled BP cuff back on top of the Medication cart. MA D performed hand hygiene after she administered medications to Resident #1. MA D attempted to continue with another resident but was intervened to stop by surveyor. Interview with MA D on [DATE] at 09:45 AM, she stated she did not sanitize the BP cuff until after the third resident. She stated she had been a med aide and CNA for [AGE] years and no one had told her to clean the BP cuff in-between resident use. She stated she had completed in-service training for infection control during Covid-19 outbreak, but she did not associate infection control with cleaning blood pressure after each resident use. MA D stated she did not sanitize the BP cuff in between the residents because she did not know that she was supposed to. She stated she worked evening shift and did not do vitals on the residents, so she was unfamiliar with sanitation of BP cuff in-between resident use. She said she was not paying attention when she placed the BP cuff on her wrist when going into Resident #6's room. She stated her hands were full and that was the only way she could carry the BP cuff. She said that the risk of not sanitizing and cleaning equipment between residents was the spread of infection and placing it on herself was risk for contamination to herself and the residents. In an interview and observation with LVN A on [DATE] at 06:37 AM, LVN A had three BP cuffs on top of her medication cart. LVN A performed hand hygiene and sanitized BP cuff after each resident use. LVN A stated she used three BP cuffs when she was doing residents blood pressures because it gave her time to sanitize the BP cuff and to let the BP cuff cure for five minutes. She stated five minutes was the manufacturer recommendation curing time for sanitization with the purple top cleaning product. LVN A stated she had completed in-service training for infection control during past the pasty period. She stated the reason she sanitized equipment between resident use was to prevent the spread of infection. In an interview with the ADON on [DATE] at 02:24 PM, she stated she was the infection control preventionist and she had completed providing staff with training on infection control practices including hand hygiene . The ADON stated she was responsible for monitoring staff following the infection control practice. The ADON stated she expected MA D to sanitize the BP cuff after each resident's use. She stated the risk for not sanitizing BP cuff in-between resident was risk for spread of infection. The ADON stated she will be conducting mandatory in-services in the different areas of deficiency practices including infection control. (continued on next page)		

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 09/19/2024
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.			
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the DON on [DATE] at 02:24 PM, she stated she expected all staff members to sanitize equipment before and after use. The DON stated the purple top was the recommended product to sanitize equipment. The DON stated MA D should not have placed the BP cuff on her own wrist because she contaminated the BP cuff before use on the resident. The DON stated herself and ADON were responsible for making sure all staff were following the infection control policy and that they had completed all in-services. The DON stated the risk to the residents was spread of infection and contamination. 2. Resident #143 Review of Resident #143's face sheet dated [DATE] reflected a [AGE] year-old female with initial admitted [DATE]. Resident #143 was readmitted on [DATE]. Her diagnoses included unspecified dementia without behavior disturbance, chronic anemia (chronic low red blood cell), personal history of neoplasm of bladder (bladder cancer), Chronic respiratory failure with hypoxia (lack of oxygen), Extended spectrum beta lactamase resistance (this is a bacterial infection resistant to many common antibiotics. bacteria commonly found in urine), severe sepsis shock (this is a life-threatening complication of an infection), chronic kidney diseases, impaired vision, complication of incontinent external stoma of urinary, tract calculus of kidney, chronic pain syndrome, acquired absence of other parts of urinary tract displacement of nephrostomy catheter, initial encounter and neuromuscular dysfunction of bladder (dysfunctional bladder). Resident #143 was her own RP, and she was a full code. Resident #143 was allergic to hydroxyzine [an antihistamine], propoxyphene [Opioid/pain medication], Demerol [Analgesics/pain medication] and Nubain [Opioid/pain medication]. Review of Resident #143's readmission MDS dated [DATE] was not complete. Review of Resident #143's orders dated [DATE], reflected change dressing to bilateral nephrostomy bags as needed for soiled or missing dressing. Change dressing to bilateral nephrostomy bags every day-on-day shift. Active [DATE]. Change urostomy bag and wafer with 1 piece [NAME] system # 8460. May also change PRN for leaking. as needed related to personal history of malignant neoplasm of bladder. Change urostomy bag and wafer with 1 piece [NAME] system # 8460. May also change prn for leaking. every day shift every Friday related to other artificial openings of urinary tract status active dated [DATE]. Wound/Skin Cleanser External Liquid (Wound Cleansers) Apply to bilateral PCN topically every day shift every Mon, Wed, Fri related to chronic kidney disease. Cleanse PCN area with wound cleanser, pat dry and cover with non-stick dressing on shower days and as needed until healed. Order active on [DATE]. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #143's care plan on [DATE], revealed Focus Resident #143 had a Kidney infection. Resident #143 returned to facility after hospitalization and rehabilitation with antibiotics, she had urostomy bag (this is a surgical opening in the bladder area created for the urinary tract system), she had two tubes that came from her back in kidney area into leg bags. Dated [DATE], revision date [DATE]. The goal was for Resident #143 to resolve urinary tract infection without complications by review date [DATE]. Interventions included check at least every 2 hours for incontinence. Wash, rinse and dry soiled areas. Further review of the care plan revealed Resident #143 had a urostomy catheter related to bladder cancer and she had a tube coming from her back of each kidney draining into bags. Resident #143 was on Enhanced Barrier Precautions. She also had a fistula to left lower back from kidney/bladder: surgical consult: Date Initiated [DATE], revision date [DATE]. Goals: Resident #143 would be/remain free from catheter-related trauma through review date. The resident will show no s/sx of Urinary infection through review date. Target date [DATE]. Observation with LVN A on [DATE] at 10:21 AM, revealed. LVN A prepared all the items she needed for the catheter for Resident #143 outside the room. LVN A placed a piece of wax paper on top of the treatment cart, she placed some pieces of wet 4X4 gauze in a cup and some pieces of dry 4X4 gauze on the wax paper, 2 pieces of larger sized gauze and some tape. LVN A got a hand full of gloves as she entered Resident #143's room. Signage to Resident #143's room read STOP Enhanced Barrier. Everyone must clean their hands including before and after leaving room. Providers and staff must also: Wear gloves and a gown for the following High Contact Resident Care Activities: Dressing, bathing/showering, transferring, changing linen, providing hygiene, changing briefs or assisting with toileting, Device care or use: Central lines, urinary catheter, feeding tube, tracheostomy, wound care: any skin opening requiring a dressing. Upon entry to the room, Resident #143 was seated in a chair, and she consented to be observed. LVN A placed the wax paper on Resident #143's bedside table. Resident #143's table was visibly soiled with sticky substance and two white straws laid under a small green pillow on the bedside table. LVN A did not clean Resident #143's table before placing the wax paper with the supplies for the catheter care, and she did not remove Resident #143's small green pillow off the table. LVN A washed her hands with soap and water and put on gloves, she did not wear a gown. Resident #143 had two tubes coming from each side of her kidney area attached with black thread at the incision site was observed in place to keep the tubes in place. The two tubes drained into two separate urine bags. LVN A started care by reaching on the bedside table and got some wet gauze and cleaned the right tube and incision area on Resident #143's back and discarded the used gauze in the trash can. She changed her gloves and took some dry gauze and pat dried the tube incision area, discarded the used gauze in the trash can. LVN A changed her gloves again and stated, this is the part I would have used hand sanitizer before putting on new gloves. She stated she did not have hand sanitizer during the catheter care. She reached on the wax paper and got another wet gauze and cleaned the incision site to the left tube. She changed her gloves again and pat dried the left side and discarded the used gauze in the trash can. She put on new gloves and took the larger gauze with a slit and placed it on the left right side with tubing through the slit. LVN A stated Resident #143 might have adhesive allergies there so did not like using a lot of tape. After dating the dressings tubes in Residents #143's back, LVN A removed her gloves and discarded the remainder of supplies. LVN A did not sanitize the bedside table after catheter care. Resident #143 notified LVN A that she had emptied her own urostomy bag during her shower. LVN A went over to the right side to look at the urostomy bag. She touched the outer [NAME] of the urostomy bag without wearing gloves. LVN A performed hand hygiene after touching the urostomy bag. LVN A asked resident about the output and examined the ostomy. The urostomy bag was intact, and it was clean. The stoma was red and had no s/sx of infection. A small amount of urine was in the urostomy bag. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LVN A stated she would start carrying some hand sanitizer on her so that it was readily available when she needed it without going outside the room to get some to sanitize her hands. This will help her for infection control . LVN A stated that ADON and DON informed her that per facility policy, she did not need Enhanced barrier Precautions for Resident #143 unless she was emptying the urine bags. LVN A did not state the risk to Resident #143 for not wearing PPE for EBP before catheter care, she did not state the risk for not cleaning bedside table before and after use and for not wearing gloves when touching the urostomy bag. In an interview with the ADON on [DATE] at 02:24 PM, she stated she was the infection control preventionist and she had completed providing staff with infection control practices including hand hygiene. The ADON stated she was responsible for monitoring staff following the infection control practice. The ADON stated she may have confused LVN A with the explanation regarding precautions. She stated the previous day, LVN A and a CNA went to ask about Enhanced Barrier Precautions and ADON had assumed they were asking about standard precautions and PPE therefore, she had informed them that they only needed to do precautions when handling bodily fluids. The ADON stated the risk to residents for not following facility policy for infection control was a risk for spread of infection. The ADON stated she will be conducting mandatory in-services on various areas of deficiency practices including infection control. In an interview with the DON on [DATE] at 02:24 PM, she stated she expected all staff members to follow facility policy for infection. The DON stated herself and ADON were responsible for making sure all staff were following the infection control policy and that they had completed all in-services. The DON stated the risk to the residents was spread of infection and contamination. Interview with the administrator was not possible on exit [DATE] at 12:30 PM due to a medical appointment she had to leave the facility. Review of the facility's policy titled Infection Control Guidelines for All Nursing Procedures revision date [DATE] read in part .the facilities infection control policies and practices are intended to facilitate maintaining a safe, a sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections . Review of facility's policy titled Enhanced Barrier Precaution, date implanted [DATE] reflected . It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multi-drug resistance organisms. Enhanced barrier Precaution (EBP) refer to an infection control intervention designed to reduce the transmission of multi-drug resistance organisms that employs targeted gown, and gloves use during high contact resident care activities read in part .1. All staff receive training on enhanced barrier precautions upon hire and at least annually and are expected to comply with all designated precautions. 2.b, An order for enhanced barrier precautions will be obtained for residents with any of the following: wounds . indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized by MDRO .3. a) Make sure gown and gloves available immediately .b) Ensure access to alcohol-based hand rub in every resident's room (ideally both inside and outside the room) .e) The infection Preventionist will incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education. 4. High Contact Resident Care Activities: Dressing, bathing/showering, transferring, changing linen, providing hygiene, changing briefs or assisting with toileting, Device care or use: Central lines, urinary catheter, feeding tube, tracheostomy, wound care: any skin opening requiring a dressing .		