STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675095	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hallettsville Nursing and Rehabilitation	825 W Fairwinds Hallettsville, TX 77964

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the state plan for all residents regardless of payment source for 1 of 6 residents (Resident #1) reviewed for resident discharge rights in that: The facility failed to allow Resident #1 the ability to discharge with FM A and follow their internal policies for discharge and decision making when no POA or guardianship was available. The failure placed residents at risk of decline in their satisfaction with life and feeling of self-worth. Findings include: Review of Resident #1's face sheet dated 12/18/25 reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included dementia (group of symptoms affecting memory, thinking, and social abilities)-unspecified severity without behavioral disturbance-psychotic disturbance-mood disturbance-and anxiety, major depressive disorder, unsteadiness on feet, and acute kidney failure. The face sheet reflected Resident #1 was his own responsible party and listed FM B only as an EC with no other granted authority. FM A was not listed. Review of Resident #1's EMR reflected there were no documents that established a POA, guardianship, or other advance directive that named anyone with legal authority to make decisions for Resident #1. Review of Resident #1's quarterly MDS assessment dated [DATE] reflected a BIMS score of 05 indicating severe cognitive impairment. Review of Resident #1's care plan last revised 06/19/25 reflected a focus on discharge planning has been discussed with [Resident #1] and [FM B]; discharge to the community is not expected with intervention encourage family to visit as often as possible and follow up as needed to see if there are changes to the discharge plan. Review of Resident #1's progress notes reflected:- A note from social services dated 10/15/25, On October 14, 2025, SW spoke with resident after receiving a call from [Ombudsman]. The call was prompted by FM A [Resident #1's family member], who expressed her desire to have Resident #1 removed from the facility. SW spoke with both resident and FM B, the emergency contact. During the conversation, resident mentioned that he did not want to go back down that road referring to living with [FM A]. On October 15, 2025, resident asked SW to participated in a phone conversation with [FM A]. During the call, [FM A] expressed her concerns, stating that [Resident #1] was being held in the facility against his will and the facility did not have authority to manage his finances, she added that she will be coming to the facility with the police to remove [Resident #1]. Resident appears to be conflicted between making a decision that is in his best interest and considering [FM A's] wishes. SW will speak to [FM B] and consult with the Ombudsman as resident is now stating he wants to live with [FM A].- Another social services progress note dated 10/17/25, SW was conducting an assessment with the resident when his FM A arrived. She asked what was happening and proceeded to pull out some forms for his signature. SW was unaware resident family member [FM A] was in the building. SW ended the assessment session and consulted with the DON. The interim administrator (ADM D) was contacted, and he took over the situation. Review of email dated 12/18/25 at 04:40 PM from HSA, an attorney for an out of state Human Services agency reflecting a request for records made by ADM C on 12/18/25, I have attached a screenshot of the summary of findings from the APS investigation that was completed by the agency in 2021. The summary of findings reflected allegations made between Resident #1 and FM A:- Caretaker Maltreatment: Neglect- Unsubstantiated - Caretaker Maltreatment: Abuse- Unsubstantiated- Caretaker Maltreatment: Verbal Abuse- Inconclusive- Caretaker Maltreatment: Exploitation- Unsubstantiated In an interview on 12/18/25 at 11:51 AM with SW, she stated that based on what she could see from Resident #1's chart, there was nothing restricting Resident #1 from being pulled from the facility or giving one family member more power or authorization than another. She stated Resident #1 did not have an active POA or guardianship granting anyone control over medical decisions. SW stated that she did not have additional information on the events that occurred on 10/17/25 since she was not the social worker at that time and only recently started 12/10/25. In an interview on 12/18/25 at 12:00 PM with Resident #1 in the company of SW, Resident #1 stated that he recalled FM A had spoken to him about his wishes to leave the facility and to live with her. Resident #1 stated he wanted to be able to leave and to live with his family member FM A. Resident #1 stated that he recalled the last time FM A visited the facility and stated that the facility did not treat her respectfully. Resident #1 stated that the facility told her to leave and it really upset him as he believed she did not give them a reason to be that way and kick her out. Resident #1 acknowledged that another family member FM B had been involved while he was being cared for at the facility, but that it was his wishes that he preferred to discharge with FM A. Resident #1