

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675095	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/04/2024
NAME OF PROVIDER OR SUPPLIER  Hallettsville Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>41651</p> <p>Based on observation, interview, and record review, the facility failed to ensure the resident environment remains as free of accident hazards as is possible, and resident receives adequate supervision and assistance devices to prevent accidents for 1 (100 hall) of 6 hallways reviewed for accidents and hazards, in that:</p> <p>The shower room on 100 hall was unlocked and contained a disinfectant cleaner with a warning label, Danger, Keep Out of Reach of Children.</p> <p>This deficient practice could result in residents, staff, and or the public exposure to a potentially dangerous substance.</p> <p>The findings were:</p> <p>Observation on 10/01/2024 at 10:42 a.m. revealed the shower room on 100 hall was unlocked. Further observation revealed a supply cabinet was unlocked with both doors open and at the front of the cabinet was located a 16-ounce spray bottle of disinfectant labeled Danger, Keep Out of Reach of Children.</p> <p>During an interview with LVN A on 10/01/2024 at 10:45 a.m., LVN A confirmed the shower room on 100 hall was unlocked and contained an open supply cabinet with a 16-ounce spray bottle of disinfectant labeled Danger, Keep Out of Reach of Children. LVN A confirmed that the disinfectant was potentially accessible to residents and should not have been.</p> <p>During an interview with the Administrator on 10/03/2024 at 5:15 p.m., the Administrator confirmed that disinfectant cleaner should not be accessible to residents.</p> <p>Record review of the facility policy, General Housekeeping Policies, undated, revealed, The facility provides sufficient housekeeping and maintenance personnel, equipment, and supplies to maintain the interior and exterior of the facility in a safe, clean, orderly, and attractive manner.</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33866</b></p> <p>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 to help prevent the development and transmission of communicable diseases and infections for 5 of 7 residents (Residents #22, #26, #42, #61 and #71) reviewed for infection control in that:</p> <ol style="list-style-type: none"> <li>1. The facility failed to ensure CNA-B sanitized her hands after blowing her nose, wiping her runny nose with her finger, and coughing into her hand while feeding Resident #26 during the noon meal.</li> <li>2. The facility failed to ensure CNA-C changed his gloves after going from dirty to clean while providing incontinent care to Resident #71.</li> <li>3. The facility failed to ensure LVN-D followed Enhanced Barrier Precautions (EBP) by not wearing a gown while administering medications via g-tube for Resident #71.</li> <li>4. The facility failed to ensure LVN-E sanitize his hands in between medication administration for Residents #42, #22 and #61 and after picking up dropped pills on the floor.</li> </ol> <p>These failures could place residents at risk for cross contamination and the spread of infection.</p> <p>Finding include:</p> <ol style="list-style-type: none"> <li>1. Record review of Resident #26's face sheet dated 10/04/2024 revealed she was a [AGE] year-old female admitted to the facility initially on 05/05/2019 with re-admission on 08/02/2020. Diagnoses included dementia (general term for loss of memory, language, and other thinking abilities), Cerebral Infarction (stroke) Type 2 Diabetes Mellitus (a long-term condition where body has trouble controlling blood sugar and using it for energy) and Need for assistance with personal care.</li> </ol> <p>Record review of Resident #26's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 00, indicating severe cognitive impairment and an assessment of needing maximal assistance with eating.</p> <p>Record review of Resident #26's Care plan dated 10/01/2024 revealed a problem area of ADL self-care performance ., with interventions which included The resident requires limited to extensive assistance by 1 staff to eat.</p> <p>Observation on 10/01/2024 at 12:26 pm in the main dining room revealed CNA-B sitting in a chair adjacent to Resident #26, feeding Resident #26 her lunch meal. During the course of the meal, CNA-B was observed blowing her nose with a tissue, wiping her runny nose with her finger and coughing into her hand, without sanitizing or washing her hands afterwards, and while continuing to feed Resident #26.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During interview with CNA-B on 10/01/2024 at 12:43 pm, CNA-B stated she has been having cold and allergy symptoms for about a week, but no fever, and had tested negative for COVID. When asked about observations of coughing, wiping nose with finger, blowing her nose with tissue and then returning to feed Resident #26 without sanitizing her hands, she made a scrunched up facial expression and stated yeah, I should not have done that. She stated she should have sanitized her hands after touching and blowing her nose and coughing, but that she forgot to put the sanitizer In her fanny pack that morning. CNA-B stated she worked at the facility for about 3 years, and received training in infection control, and that by not sanitizing her hands, she could have passed on any infection she may have had to Resident #26.</p> <p>During an interview with the DON on 10/02/2024 at 09:48 a.m , the DON revealed she was aware of the observations made during the noon meal the day before and stated that CNA-B had frequent allergies and had been tested for COVID, but also confirmed that CNA-B should have used correct hand hygiene and cough etiquette procedures after coughing and touching her nose while feeding Resident #26. The DON stated that all employees received training in hand hygiene and infection control annually and when needed, and that the Infection Preventionist made periodic observations of staff to assess compliance. The DON further stated that not following correct hand hygiene procedures could result in spread of infection.</p> <p>2. Record review of Resident #71's face sheet dated 10/04/2024 revealed he was a [AGE] year-old male who was admitted on [DATE], with diagnoses that included: Unspecified Dementia (general term for loss of memory, language, and other thinking abilities); Hemiplegia and hemiparesis following Cerebral Infarction (condition that causes stiffness or paralysis on one side of body resulting from a stroke) affecting left non-dominant side.</p> <p>Record review of Resident #71's Optional State MDS assessment dated [DATE] revealed Resident #71 had a BIMS score of 08, indicating moderate cognitive impairment, and was assessed as total dependence in bed mobility and toileting.</p> <p>Record review of Resident #71's Care Plan dated 08/24/2024 revealed a problem area of Mixed bladder incontinence and bowel incontinence r/t [related to] cognitive deficit and decreased mobility, with interventions that include: provide peri care after each incontinent episode.</p> <p>Observation of incontinent care for Resident #71 on 10/01/2024 at 02:38 p.m. revealed that CNA-C cleaned Resident #71's penis and peri area and then without changing gloves touched Resident #71 on his shoulder and legs, to reposition Resident #71 onto his side, and proceeded to clean the buttocks area. Without changing his gloves CNA-C removed the soiled brief, obtained and placed a clean brief on Resident #71, and adjusted his clothing,</p> <p>During an interview with CNA-C on 10/01/2024 at 02:55 p.m., CNA-C stated he had been working at the facility since April 2024, after obtaining his CNA certification, and was not aware he needed to change gloves or sanitize his hands while performing peri-care. CNA-C stated he had received training in incontinent care during his training to become a CNA.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with the DON on 10/02/2024 at 09:48 a.m., the DON was aware of the observation of peri-care performed by CNA-C and noted that CNA-C had informed her immediately after the observation. The DON stated CNA-C had just completed his CNA training a few months ago and wanted to learn. She confirmed that CNA-C should have changed gloves or sanitized hands when going from dirty to clean during peri-care and not doing so could lead to cross-contamination.</p> <p>3. Record review of Resident #71's face sheet dated 10/04/2024 revealed he was a [AGE] year-old male who was admitted on [DATE], with diagnoses that included: Unspecified Dementia (general term for loss of memory, language, and other thinking abilities); Hemiplegia and hemiparesis following Cerebral Infarction (condition that causes stiffness or paralysis on one side of body resulting from a stroke) affecting left non-dominant side and dysphagia (difficulty swallowing) with gastrostomy status (a G-tube, or artificial opening into the stomach for nutrition).</p> <p>Record review of Resident #71's Optional State MDS assessment dated [DATE] revealed Resident #71 had a BIMS score of 08, indicating moderate cognitive impairment, and was assessed as having a feeding tube.</p> <p>Record review of Resident #71's Care plan dated 08/24/2024 revealed a problem area of need for Enhanced Barrier Precautions due to G-tube with interventions that included Gown and gloves only for high-contact resident care activities.</p> <p>Record review of Resident #71's Order Summary dated 10/04/2024 revealed an order for: a. Enteral Feed Order three times a day and use gown and gloves for high-contact resident care activities for those with . increased risk of MDRO[residents with wounds or indwelling medical devices].</p> <p>Observation on 10/03/2024 at 08:25 a.m. revealed that there was an Enhanced Barrier Protection (EBP) sign resting on the handrail on the wall to the left of Resident #71's door, and a PPE supply drawer next to the wall on the opposite side of the hall from Resident #71's room. Further observation revealed LVN-D prepared Resident #71's medications on the nursing cart outside his room, then entered his room, sanitized her hands, and put on gloves, but failed to put on and wear a gown while she proceeded to administer medications via G-tube to Resident #71.</p> <p>During an interview with LVN-D on 10/03/2024 at 09:00 am, LVN-D stated she did not see the Enhanced Barrier Protection (EBP) sign to the left of the door, noting EBP signs were normally posted on the door. LVN-D further stated that Enhanced Barrier Protections consisted of wearing gown and gloves when working in close contact with residents who had catheters to help prevent the spread of germs. She stated she had not realized a gown should be used also when working with residents who had g-tubes.</p> <p>4. Record review of Resident #42's Face Sheet dated 10/04/2024 revealed he was a [AGE] year-old male with an admitted [DATE] with diagnoses that included Dementia (loss of cognitive functioning that interferes with daily life), Cerebrovascular Accident (CVA) (stroke) and Diabetes Mellitus (a condition that affects blood sugar levels and can cause serious complications).</p> <p>Record review of Resident #42's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 00 indicating severe cognitive impairment.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #22's Face Sheet dated 10/04/2024 revealed he was an 84- year-old male with an admitted [DATE] with diagnoses that included: Dementia; Coronary Artery Disease (a type of heart disease) and Hypertension (high blood pressure).</p> <p>Record review of Resident #22's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 00, indicating severe cognitive impairment.</p> <p>Record review of Resident #61's Face Sheet dated 10/04/2024 revealed he was a [AGE] year old male with an admitted [DATE], and diagnoses that included: Alzheimer's Disease (a brain disorder that causes memory loss), Anemia (not having enough healthy red blood cells) and Hypertension (high blood pressure).</p> <p>Record review of Resident #61's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 04 indicating severe cognitive impairment.</p> <p>During an observation on 10/03/2024 at 07:35 a.m., LVN-E was observed to drop 2 pills onto the floor while he prepared medications for Resident #42. Further observation revealed he picked up the pills from the floor with his hand, disposed of the pills in the Sharps container, and without sanitizing his hands, dispensed 2 more pills from blister pack to replace those dropped, crushed the pills, mixed them with applesauce and proceeded with medication administration to Resident #42. Continued observation revealed that after completing medication administration to Resident #42, LVN-E then proceeded to administer medications to Resident #22 and then to Resident #61 without sanitizing his hands in between medication administration for each resident.</p> <p>During an interview with LVN-E on 10/03/2024 at 08:10 a.m. LVN-E stated he did not sanitize his hands in between administering medications to Residents #42, #22 and #61, and did not sanitize his hands after picking up the dropped pills from the floor, stating he had gotten nervous and forgot. LVN-C stated he had worked at the facility since 2012, had received training in hand hygiene and infection control, and stated that not sanitizing his hands in between medication administration for different residents and after touching floor could result in the spread of germs.</p> <p>Record review of facility policy titled Hand Hygiene dated 10/24/2022 which revealed in part: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility and 1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice.</p> <p>Record review of the CDC Guideline titled Clinical Safety: Hand Hygiene for Healthcare Workers dated 02/27/2024 reflects that Cleaning your hands reduces: The potential spread of deadly germs to patients . and that hands should be cleaned when moving from soiled to clean activities on the same patient or if moving from care on one patient to another patient and After touching a patient or patient's surroundings</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the facility's policy titled Enhanced Barrier Precautions dated 04/05/2024 revealed Enhanced barrier precautions (EBP) refers to an infection control intervention designed to reduce transmission of multidrug-resistant organism [MDRO] that employs targeted gown and gloves during high contact resident care activities. Further review revealed An order for enhanced barrier precautions will be obtained for residents with any of the following: 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 with a MDRO. The policy further notes High-contact resident care activities include: 6. Device care of use: central lines, urinary catheters, feeding tubes tracheostomy/ventilator tubes.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>41651</p> <p>Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public for 1 of 1 kitchen reviewed for physical environment, in that:</p> <ol style="list-style-type: none"> <li>1. The 8 double florescent lights in the main kitchen area and the 3 double florescent lights in the dish machine room did not have a lid cover over the light bulbs.</li> <li>2. One of the 8 double florescent lights in the main kitchen area and 1 of the 3 double florescent lights in the dish machine room had light bulbs that were not operating.</li> <li>3. One of the 4 panel lights in the main kitchen area did not have a light bulb that was operating.</li> <li>4. The light strip inside the refrigerator in the kitchen storage room was not attached on one side and the LED bulb was not operating.</li> <li>5. The overhead ceiling light in the employee bathroom was not operating.</li> </ol> <p>This deficient practice could result in residents, staff, and or the public exposure to a potentially dangerous substance.</p> <p>The findings were:</p> <p>Observation on 10/01/24 from 10:10 am to 10:40 am during the kitchen tour with the Dietary Manager revealed the following:</p> <ol style="list-style-type: none"> <li>a. The 8 double florescent lights (which each measured 3x2 ft) in the main kitchen area and the 3 double florescent lights in the dish machine room did not have a lid cover over the light bulbs.</li> <li>b. One of the 8 double florescent lights in the main kitchen area and 1 of the 3 double florescent lights in the dish machine room had light bulbs that were not operating.</li> <li>c. One of the 4 panel lights (which measured 1.5x 4ft) in the main kitchen area did not have a light bulb that was operating.</li> <li>d. The light strip (which measured 2.5 ft) inside the refrigerator in the kitchen storage room was not attached on one side and the LED bulb was not operating.</li> <li>e. The overhead ceiling light bulb in the kitchen employee staff room was not operating.</li> </ol> <p>During an interview with the Dietary Manager on 10/1/24 at 10:45 am, she stated that having functioning light bulbs with covers in the kitchen would increase the overall safety of kitchen operations. The Dietary Manager stated that she had not completed a work order request for the lights to be repaired.</p> <p>(continued on next page)</p>

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with the Administrator on 10/1/24 at 10:55 am, he stated that having functioning overhead lights in the kitchen would provide additional illumination for kitchen operations.</p> <p>Record review of the facility's policy on General Kitchen Safety Guidelines, policy number 05.001, Section 5-1, dated 2018 stated that the facility will follow basic safety guidelines to reduce the risk of accidents and ensure the safety of employees. The facility will keep all equipment in working order and report any malfunctioning to the Maintenance Dept.</p>		