

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675095	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
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.			
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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident's right to formulate an advance directive for one (Resident #12) of twenty-five residents reviewed, in that: Resident #12's OOH-DNR was witnessed by two unqualified witnesses and was therefore invalid. This deficient practice could place residents at risk of having their end of life wishes dishonored, and of having CPR performed against their wishes. The findings were: Record review of Resident #12's facesheet, dated [DATE], revealed the resident was admitted to the facility on [DATE] with diagnoses including: unspecified dementia, acute kidney failure, and generalized anxiety disorder. Record review of Resident #12's Quarterly MDS, dated [DATE], revealed a BIMS score of 3 which indicated severe cognitive impairment. Record review of Resident #12's care plan, dated [DATE], revealed, Resident is a DNR. Record review of Resident #12's OOH-DNR, dated [DATE], revealed Witness #1 was the facility's Director of Human Resources and Witness #2 was the facility's Business Office Director. During an interview with DON and Administrator on [DATE] at 10:25 a.m., the DON and Administrator confirmed the witnesses for Resident #12's OOH-DNR form were the facility's Director of Human Resources and the facility's Business Office Director, and acknowledged neither were considered qualified witnesses. Record review of the Texas Health and Human Services webpage titled, Out of Hospital Do Not Resuscitate Program, updated [DATE], revealed, Completing the Texas Out of Hospital Do Not Resuscitate Form: When Using Two Witnesses. Witness one is a qualified witness and may not be: An officer, director, partner, or business office employee of a health care facility in which the patient is being cared for or any parent organization of the health care facility. Further review revealed, Frequently Asked Questions for DNR: What happens if the form is not filled out correctly or EMS has doubts about any of the information? Health professionals can refuse to honor a DNR if they think: The form is not signed twice by all who need to sign it or is filled out incorrectly. Record review of the Texas Health and Safety Code Title 2 Health, Subtitle H Public Health Provisions, Chapter 166 Advance Directives, Section 166.083 Form of Out-Of-Hospital DNR order, effective [DATE], revealed, (a) A written out-of-hospital DNR order shall be in the standard form specified by department rule as recommended by the department. (b) The standard form of an out-of-hospital DNR order specified by department rule must, at a minimum, contain the following: . (13) a statement at the bottom of the document, with places for the signature of each person executing the document, that the document has been properly completed.		

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 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** Based on observation, interview and record review, the facility failed to ensure it was free of a medication error rate of five percent (5%) or greater. A total of 6 errors out of 36 opportunities were observed, resulting in a 16.67% error rate for 1 of 3 residents (Resident #33) reviewed during medication pass, in that: Medication Aide E failed to administer Resident #33's medications at the correct time. These deficient practices could place residents at risk for not receiving the intended therapeutic benefits of their medications and exacerbation of their medical conditions. The findings were: Record review of Resident #33's face sheet, dated 01/15/2026, revealed the resident was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included: Type 2 diabetes mellitus (high level of sugar in the blood), Hyperlipidemia (Elevated level of any or all lipids(fat) in the blood), Dementia (decline in cognitive abilities), Chronic kidney disease (gradual loss of kidney function), Hypertension (High blood pressure), Hemiplegia (Paralysis of one side of the body). Record review of Resident #33's consolidated physicians' orders for January 2026 revealed orders for Carvedilol Oral Tablet 3.125 MG (Carvedilol) Give 1 tablet by mouth two times a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) hold if systolic bp is less than 100, Docusate Sodium Capsule 100 MG Give 1 capsule by mouth two times a day for constipation, metFORMIN HCl Oral Tablet 500 MG (Metformin HCl) Give 1 tablet by mouth two times a day related to TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS, Sertraline HCl Oral Tablet 100 MG (Sertraline HCl) Give 1 tablet by mouth two times a day for depression, busPIRone HCl Oral Tablet 10 MG (Buspirone HCl) Give 1 tablet by mouth three times a day for anxiety and HydrOXYzine HCl Tablet 10 MG Give 2 tablet by mouth four times a day for anxiety give two 10 mg tablets to equal 20 mg. Record review of the MAR dated January 2026, indicated Carvedilol Oral Tablet 3.125 MG (Carvedilol) Give 1 tablet by mouth two times a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) hold if systolic bp is less than 100, Docusate Sodium Capsule 100 MG Give 1 capsule by mouth two times a day for constipation, metFORMIN HCl Oral Tablet 500 MG (Metformin HCl) Give 1 tablet by mouth two times a day related to TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS, Sertraline HCl Oral Tablet 100 MG (Sertraline HCl) Give 1 tablet by mouth two times a day for depression, busPIRone HCl Oral Tablet 10 MG (Buspirone HCl) Give 1 tablet by mouth three times a day for anxiety and HydrOXYzine HCl Tablet 10 MG Give 2 tablet by mouth four times a day for anxiety give two 10 mg tablets to equal 20 mg. All medications were to be administered at 8:30 a.m. for the first dose in the morning. Observation on 01/15/2026 at 11:50 a.m. revealed Medication Aide E administered Carvedilol, Docusate sodium, Metformin, Sertraline, Buspirone, and Hydroxyzine to Resident #33. The 6 medications were scheduled for 8:30 a.m., the medications were given more than 2 hours late. During an interview on 01/15/2026 at 12:15 p.m., the Medication Aide E confirmed she had administered the 6 medications scheduled for 8:30 a.m. at 11:50 a.m. to Resident #33. She stated the medications were 2 hours late and out of the one hour before or after time frame. During an interview on 01/15/2026 at 3:30 p.m., the DON stated medications must be administered within one hour before or after their prescribed times. Review of facility's policy, titled Medication Administration, dated 10/24/2022, revealed Administer with 60 minutes prior to or after scheduled time unless otherwise ordered by physician.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in one of one kitchen reviewed for sanitation. 1. The facility failed to clean an approximate 2x2 ft ceiling vent in the main kitchen area. 2. The facility failed to replace a light bulb in the main kitchen area. 3. The facility failed to clean an approximate 6x5 inch ceiling vent and paint several areas of missing paint in the food storage room. 4. The facility failed to clean an approximate 1x1 ft ceiling vent in the dish-room. 5. The facility failed to clean an approximate 6x6 inch ceiling vent in the employee's bathroom. 6.-The facility failed to clean an approximate 1 ft in parameter size ceiling vent in the Dietary Manager's office. These failures could place residents at risk for food borne illness. The findings included: 1-Observation on 1/13/26 from 9:9:55-10:25 a.m., with the Dietary Manager revealed:a-there was an approximate 2x2ft ceiling air vent in the main kitchen area that had dust and dirt in the vent slots.b-there was an overhead light in the main kitchen area that did not turn on.c-there was an approximate 6x5 inch ceiling air vent that had dust and dirt in the vent slots in the food storage room.d-there were several areas of missing paint on the ceiling in the food storage room. e-there was an approximate 1x1 ft ceiling air vent that had dust and dirt in the vent slots in the employee bathroom andf-there was an approximate 1 ft in parameter ceiling air vent in the Dietary Manager's office that had dust and dirt in the vent slots. During an interview on 1/13/26 at 10:20 a.m., with the Dietary Manager and Administrator, the Dietary Manager stated she had not placed a work order for the observed areas that needed cleaning or repair. The Administrator stated that dust and dirt could affect the food preparation surfaces in the kitchen. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed: 3-305.11, Food Storage, (A) Food shall be protected from contamination by storing the food: (1) in a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination. Record review of the facility policy, Sanitation, revised January 2024, revealed, The food service area shall be maintained in a clean and sanitary manner. I. Ice machines and ice storage containers will be drained, cleaned, and sanitized per manufacturer's instructions and facility policy. The Food Services Manager will be responsible for scheduling staff for regular cleaning of kitchen and dining areas. Food service staff will be trained to maintain cleanliness throughout their work areas during all tasks, and to clean after each task before proceeding to the next assignment.Record review of the facility's policy titled-Cleaning-Keeping the Floors, Walls, and Ceilings Clean dated 7/10/20 revealed Floors, walls, and ceiling must be free of dirt, letter, and moisture. Record review of the facility policy titled General Kitchen Sanitation dated 10/1/18 revealed Clean non-food-contact surfaces of equipment at intervals as necessary to keep them free of dust, dirt, and food particles and otherwise in a clean and sanitary condition. Record review of the facility policy titled General Kitchen Safety Guidelines dated 10/2018 revealed Keep all equipment in working order and report any malfunctioning to the Maintenance Department.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public on 1 of 6 resident hallways (Hallway 500) and 2 of 5 shower rooms (Hallways 100 and 200), and the laundry room reviewed for environmental concerns. The facility failed to: 1-replace a light bulb in room [ROOM NUMBER]'s bathroom. 2-clean a ceiling vent and repair missing ceiling paint in hallway 100's shower room. 3-replace a bathroom sink light bulb in hallway 200's shower room. 4-clean a ceiling vent and replace an overhead light bulb in the laundry room. These failures could place residents and staff at risk of a diminished quality of life due to exposure to an environment that is unpleasant, unsanitary, and unsafe. The findings included: Observation rounds on 1/15/26 from 7:40-7:50am with the Administrator and Maintenance Director revealed the following: a-A bath-room sink light did not turn on in room [ROOM NUMBER] on Hallway 500. b-A 6 inch ceiling vent had dust and dirt on the vents and there was an approximate 6x2 inch section of missing ceiling paint in the shower room on hallway# 100. c- A sink overhead light that did not turn on in the shower room on Hallway# 200. d-An approximate 10 inch ceiling vent had dust and dirt on the vents and an approximate 10x2 inch ceiling light that did not turn on in the laundry room. During an interview on 1/15/26 at 7:55am with the Administrator and Maintenance Director the Maintenance Director stated that the facility used the TELS work order system to notify him of needed repairs. The Maintenance Director stated that he had not been notified of the observed areas that needed repair. The Administrator stated that completing the repairs of the observed areas would be necessary for general maintenance of the facility. Record review of facility work orders dated 12/15/25-1/15/25 revealed that the observed areas that needed repair were not included. Record review of the undated facility document titled What is TELS revealed the facility had a protocol for staff to create work orders for facility maintenance purposes.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for 1 of 25 (Residents #8 and #64) residents reviewed for comprehensive care plans, in that: 1.Resident #8's care plan did not include his diet. 2.The facility failed to revise a care plan to address Resident #64's insulin usage. These deficient practices could result in residents' needs not being identified and addressed. The findings were: 1.Record review of Resident #8's face sheet, dated 01/15/2026, revealed the resident was admitted to the facility on [DATE] with diagnoses including: unspecified fracture of right femur, unspecified atrial fibrillation, and essential primary hypertension. Record review of Resident #8's admission MDS, dated [DATE], revealed a BIMS score of 11 which indicated moderate cognitive impairment. Further review revealed Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids). Record review of Resident #8's clinical record as of 01/15/2026, revealed a diet order, dated 12/10/2025, Regular diet, Pureed texture, Regular Liquids. Record review of Resident #8's care plan, as of 01/15/2026, revealed his diet was not addressed in the care plan. During an interview with LVN MDS A on 01/15/26 at 4:00 pm MDS LVN A confirmed Resident #8's diet order should have been addressed in his care plan so that he received the correct diet as ordered by his physician. 2.Record review of Resident #64's face sheet, dated 1/15/26, revealed an [AGE] year old male with an admission date of 5/16/25 with diagnoses that included: unspecified dementia (a condition of cognitive decline that impairs daily life), primary hypertension (a condition of high blood pressure) and type 2 diabetes (a condition in which the body has trouble controlling the blood sugar). Record review of Resident's #64's quarterly MDS assessment, dated 11/2/25, revealed a BIMS score of 8 which indicated moderate cognitive impairment. Record review of Resident #64's Physician's orders initiated on 9/22/25 and revised on 11/14/25 revealed an order for Lantus subcutaneous solution-100 unit ML - inject 25 unit subcutaneous. Record review of Resident #64's ongoing care plan initiated on 5/16/25 revealed that the Resident's insulin's use was not documented in the care plan. During an interview on 1/15/26 at 3:50pm MDS LVN A and RN B stated Resident #64's insulin's use was not documented on his current care plan. MDS LVN A and RN B stated having the insulin use on the care plan was important for care staff to be aware of the resident's care needs so that the needs are met. Record review of the facility policy, Comprehensive Care Plans, dated 10/24/2022, revealed, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to review and revise a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 24 residents (Resident #4) reviewed for care plans, in that: Resident #4's care plan incorreced noted that the resident received tube feeding as well as food by mouth. This failure could have placed residents at risk of not having their needs identified and met. The findings were: Record review of Resident #4's face sheet, dated 01/16/2026, revealed the resident was admitted to the facility on [DATE] with diagnoses including: dysphagia, unspecified convulsions, and unspecified intellectual disabilities. Record review of Resident #4's Significant Change MDS, dated [DATE], revealed the resident was rarely/never understood and a staff assessment for mental status was conducted which indicated both long and short term memory problems. Further review revealed the resident had a feeding tube. Record review of Resident #4's order summary, dated 01/16/2026, revealed aa active diet order, dated 12/02/2025, NPO diet NPO texture, NPO (Nothing by Mouth). Record review of Resident #4's clinical record as of 01/16/2026, revealed a discontinued diet order, food in bowls. was in place from 02/20/2025 to 11/19/2025. Record review of Resident #4's care plan, revised 12/04/2025, revealed, The resident requires tube feeding.[related to] Dysphagia. Further review revealed a revision dated 09/29/2025, Diet: Regular diet, Pureed texture, Nectar Thickened Liquids consistency- food in bowls, maroon spoon-1/2 teaspoon/no straws, double handled cup with lid for all liquids. Resident prefers her plate to be left on the serving tray while eating her meal. During an interview with LVN MDS A on 01/15/26 at 4:00 pm MDS LVN A confirmed Resident #4's current diet order was nothing by mouth, the resident received all liquids and nutrition via tube feeding, and that Resident #4's discontinued order from 09/29/2025 should not have continued to be included in the resident's care plan. Record review of the facility's policy titled Care Plan Revisions Upon Status Change dated 10/24/22 revealed that The care plan will be updated with the new or modified interventions.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review, the facility failed to ensure incontinent care was provided in accordance with appropriate treatment and service practices to prevent urinary tract infections and to restore continence to the extent possible for 1 of 2 residents (Resident #22) reviewed for incontinent care, in that: The facility failed to ensure, while providing incontinent care for Resident #22, CNA C used a front to back motion to clean Resident #22's buttocks. These deficient practices could place residents at-risk for infection and skin break down due to improper care practices. The findings were: Record review of Resident #22's face sheet, dated 01/15/2026, revealed an admission date of 09/16/2025, and a readmission date of 01/02/2026, with diagnoses that included: Dementia (decline in cognitive abilities), Hyperlipidemia (Elevated level of any or all lipids(fat) in the blood), and Hypertension (High blood pressure). Record review of Resident #22's Quarterly MDS assessment, dated 01/06/2026, revealed a BIMS score of 0, which indicated the resident was severely impaired cognitively, and was indicated to be frequently incontinent of bowel and bladder. Observation on 01/15/2026 at 10:10 a.m. revealed while providing incontinent care for Resident #22, CNA C used a back to front motion to wipe Resident #22's buttocks. During an interview with CNA C on 10/15/2019 at 10:24 a.m., CNA C stated she used a back to front motion to wipe Resident #22's buttocks. She stated she thought she was using the right motion. She stated she received incontinent care and infection control training within the year. During an interview with the DON on 01/15/2026 at 3:30 p.m., the DON confirmed that during incontinent care the staff must use a front to back motion to clean the resident to prevent fecal matter entering the urinary stream and prevent urinary infection. Review of facility's CNA/NA competency skills checklist, dated 02/04/2025, revealed CNA C met competency for infection control and incontinent care. Record review of facility's policy titled Perineal care dated 10/24/2022, revealed, Cleanse buttocks and anus, front to back.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to establish and 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 diseases and infections for 1 of 6 residents (Resident #22) observed for infection control, in that: The facility failed to ensure, while providing incontinent care for Resident #22, CNA D sanitized her hands after touching part of the resident's environment. This deficient practice could place residents who receive assistance with personal care at risk for infection due to improper care practices. The findings were: Record review of Resident #22's face sheet, dated 01/15/2026, revealed an admission date of 09/16/2025, and a readmission date of 01/02/2026, with diagnoses that included: Dementia (decline in cognitive abilities), Hyperlipidemia (Elevated level of any or all lipids(fat) in the blood), and Hypertension (High blood pressure). Record review of Resident #22's Quarterly MDS assessment, dated 01/06/2026, revealed a BIMS score of 0, which indicated the resident was severely impaired cognitively, required extensive assistance with her activities of daily living, and was indicated to be frequently incontinent of bowel and bladder. Record review of Resident #22's care plan, dated 10/27/2025, revealed a problem of The resident has bowel incontinence r/t immobility, and an intervention of Provide pericare after each incontinent episode. Observation on 01/15/2026 at 10:10 a.m., revealed while providing incontinent care for Resident #22, CNA D washed her hands, then with her bare hands touched Resident #22's bed and the bed remote. CNA D put her gloves on but did not sanitize her hands before she started providing care for Resident #22. During an interview on 01/15/2026 at 10:24 a.m., CNA D stated she did not sanitize her hands before putting her gloves on and did not think about the bed and bed remote being possibly contaminated. She stated she should have washed or sanitize her hands prior to putting her gloves on and before she stated the care for the resident, CNA D stated she received infection control training within a year. During an interview on 01/15/2026 at 3:30 p.m., the DON, she stated the environment around a resident was considered contaminated and staff should wash or sanitize their hands prior to provide care to a resident, to prevent cross contamination and prevent infection for the resident. She stated the staff was trained at least once a year on infection control Review of facility's policy, titled Hand hygiene, dated 10/24/2022, revealed The use of glove does not replace hand hygiene. If your task require gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves.		